UNIT 3

UNIVERSAL PRINCIPLES OF NURSING CARE MANAGEMENT

Nurses must frequently apply various management principles while caring for their clients in various health care settings. This unit has been crafted to clarify these issues. It begins with a comprehensive view of nursing practice standards as well as legal and ethical aspects of nursing.

Client care management issues such as determining priorities, working with the health care team, making assignments, delegating to unlicensed assistive personnel, and coordinating client care as the client progresses from admission through discharge have been described along with valuable principles to facilitate the nurse's application of this information.

Safety considerations regarding fire, disaster management, electricity, equipment, and the use of physical restraints have been incorporated.

This unit also includes selected principles and interventions related to specific aspects of care such as body mechanics, transfer techniques, positioning, the hazards and prevention of immobility, application of cold and heat, asepsis, and the care of clients who develop or are at risk for pressure ulcers. Additionally, a section on cultural diversity in health practices explores key issues related to cultural, religious, food, and death practices in the process of nursing care delivery.

UNIT OUTLINE

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Nursing Practice Standards

NURSING: SCOPE & STANDARDS OF PRACTICE (2004)

Standards are authoritative statements by which the nursing profession describes the responsibilities for which its practitioners are accountable. Consequently, standards reflect the values and priorities of the profession. Standards provide direction for professional nursing practice and a framework for the evaluation of practice. Written in measurable terms, standards also define the nursing profession's accountability to the public and the client outcomes for which nurses are responsible.

Nursing: Scope & Standards of Practice describes a competent level of nursing practice and professional performance that is common to all registered nurses. The scope of the practice statement articulates the who, what, when, where, and how of practice, for nursing organizations, policy makers and the nurse's accountability to the public. The practice part of the statement consists of 2 components: Standards of Practice, which contains 6 standards and Standards of Professional Performance, which contains 9 standards. These are presented in the following section (ANA, 2004).

Nursing: Scope & Standards of Practice is used in conjunction with *Nursing's Social Policy Statement* (ANA, 2003) and the *Guide to the Code of Ethics for Nurses: Interpretation and Application* (ANA, 2008). Together these resources provide a complete and definitive description that best serves the public's health and the nursing profession. There are additional scope of practice statements specific to those registered nurses in the specialty practices, but have been omitted from this text because the emphasis of this text is preparation of the nurse generalist (one who has graduated from a diploma, associates or baccalaureate level program).

STANDARDS OF PRACTICE

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Standard 1. Assessment

Registered nurse collects comprehensive data pertinent to the client's health or the situation.

Measurement Criteria

A. Data collection process:
  1. Systematic
  2. Ongoing

B. Holistic data collection involves:
  1. Client
  2. Family
  3. Other health care providers as appropriate
  4. Environment

C. Priority of data collection activities determined by:
  1. Client's immediate condition
  2. Anticipated needs of the client or situation

D. Uses appropriate evidence-based:
  1. Assessment techniques
  2. Instruments

E. Uses analytical models and problem-solving tools

F. Synthesizes available relevant data, information, and knowledge to identify patterns and variances

G. Relevant data documented in a retrievable format

Standard 2. Diagnosis

Registered nurse analyzes the assessment data to determine the diagnoses or issues.

Measurement Criteria

A. Diagnoses or issues from assessment data

B. Diagnoses are validated with:
  1. Client
  2. Family
  3. Other health care providers, when possible and appropriate

C. Diagnoses or issues documented to facilitate determination of:
  1. Expected outcomes
  2. Plan of care

Standard 3. Outcomes Identification

Registered nurse identifies expected outcomes for a plan individualized to the client or the situation.

Measurement Criteria

A. Outcomes are formulated with:
  1. Client
  2. Family
  3. Other health care providers, when possible and appropriate

B. Culturally appropriate expected outcomes derived from diagnoses

C. Considers associated risks, benefits, costs, current scientific evidence, and clinical expertise

D. Defines expected outcomes considering associated risks, benefits and costs, and current scientific evidence, in terms of:
   1. Client
   2. Client values
   3. Ethical considerations
   4. Environment
   5. Situation

E. Outcomes include a time estimate for attainment

F. Outcomes provide direction for continuity of care

G. Modifies outcomes based on:
   1. Changes in the status of the client
   2. Evaluation of the situation

H. Documents expected outcomes as measurable goals

Standard 4. Planning

Registered nurse develops a plan that prescribes strategies and alternatives to attain expected outcomes.

Measurement Criteria

A. Develops individualized plan considering client characteristics or the situation, including:
   1. Age
   2. Culturally appropriate
   3. Environmentally sensitive

B. Plan is developed with:
   1. Client
   2. Family
   3. Others, as appropriate

C. Plan includes strategies that address:
   1. Each of identified diagnoses or issues
   2. Promotion and restoration of health
   3. Prevention of illness, injury, and disease

D. Provides for continuity within the plan

E. Incorporates a time line within the plan

F. Establishes the plan priorities with:
   1. Client
   2. Family
   3. Others, as appropriate

G. Utilizes the plan to provide direction to health care team

H. Plan reflects current statutes, rules and regulations, and standards

I. Integrates current trends and research affecting care

J. Considers the economic impact of the plan

K. Plan uses standardized language/recognized terminology

Standard 5. Implementation

Registered nurse implements the identified plan.

Measurement Criteria

A. Implements plan in safe and timely manner

B. Documents implementation of the identified plan, including:
   1. Any modifications
   2. Changes
   3. Omissions

C. Uses evidence-based interventions and treatments specific to the diagnosis or problem

D. Uses community resources and systems to implement plan

E. Collaborates with nursing colleagues and others

Standard 5a. Coordination of Care

Registered nurse coordinates care delivery.

Measurement Criteria

A. Coordinates implementation of the plan

B. Employs strategies to promote health and a safe environment

C. Documents the coordination of the care

Standard 5b. Health Teaching and Health Promotion

Registered nurse employs strategies to promote health and a safe environment.

Measurement Criteria

A. Provides health teaching that addresses:
   1. Healthy lifestyles
   2. Risk-reducing behaviors
   3. Developmental needs
   4. Activities of daily living
   5. Preventive self-care

B. Uses health promotion and health-teaching methods appropriate to:
   1. Situation
   2. Client's developmental level
   3. Learning needs
   4. Readiness
   5. Ability to learn
   6. Language preference
   7. Culture

C. Seeks opportunities for feedback/evaluation of effectiveness of strategies

Standard 6. Evaluation

Registered nurse evaluates progress toward attainment of outcomes.

Measurement Criteria

A. Evaluation of outcomes is:
   1. Systematic
   2. Ongoing
   3. Criterion-based
   4. Related to structures and processes in the plan and time line

B. Client and other care providers are involved in process, as appropriate

C. Effectiveness of planned strategies evaluated by:
   1. Client responses
   2. Attainment of expected outcomes

D. Documents the results of the evaluation
E. Uses ongoing assessment data to revise (as needed):
   1. Diagnoses
   2. Outcomes
   3. Plan
   4. Implementation
F. Disseminates results (as appropriate, in accordance with state and federal laws and regulations) to:
   1. Client
   2. Others involved in the care or situation

STANDARDS OF PROFESSIONAL PERFORMANCE

Standard 7. Quality of Practice

Registered nurse systematically enhances the quality and effectiveness of nursing practice.

Measurement Criteria

A. Documents application of the nursing process in a responsible, accountable, and ethical manner
B. Uses the results of quality improvement activities to initiate changes in:
   1. Nursing practice
   2. Health care delivery system
C. Uses creativity and innovation in nursing practice to improve care delivery
D. Participates in activities to improve quality and effectiveness of nursing practice. May include:
   1. Identifying aspects of practice important for monitoring
   2. Using indicators for monitoring
   3. Collecting data to monitor quality and effectiveness
   4. Analyzing quality data to identify opportunities for improvement
   5. Making recommendations to improve nursing practice or outcomes
   6. Implementing activities to enhance the quality of nursing practice
   7. Developing, implementing, and evaluating policies, procedures, and/or guidelines to improve the quality of practice
   8. Participating on interdisciplinary teams to evaluate clinical care or health services
   9. Participating in efforts to minimize costs and unnecessary duplication
   10. Analyzing factors related to safety, satisfaction, effectiveness, and cost/benefit options
   11. Analyzing organizational systems for barriers
   12. Implements processes to remove or decrease barriers within organizational systems
   13. Incorporates new knowledge to initiate changes in nursing practice if desired outcomes not achieved

Standard 8. Education

Registered nurse attains knowledge and competency that reflects current nursing practice.

Measurement Criteria

A. Participates in ongoing educational activities related to knowledge bases and professional issues
B. Demonstrates a commitment to lifelong learning:
   1. Self-reflection
   2. Inquiry to identify learning needs
C. Seeks experiences that reflect current practice to maintain skills and competence in clinical practice or role performance
D. Acquires knowledge and skills appropriate to the specialty area, practice setting, role, or situation
E. Maintains records that provide evidence of competency and lifelong learning
F. Seeks experiences and formal and independent learning activities to maintain and develop clinical and professional skills and knowledge

Standard 9. Professional Practice Evaluation

Registered nurse evaluates one's own nursing practice in relation to professional practice standards and guidelines, relevant statutes, rules, and regulations.

Measurement Criteria

A. Provides age-appropriate care in a culturally and ethnically sensitive manner
B. Engages in self-evaluation on a regular basis by identifying:
   1. Areas of strength
   2. Areas for further professional development
C. Obtains informal feedback regarding own practice from clients, peers, colleagues, and others
D. Participates in systematic peer review, as appropriate
E. Takes action to achieve goals identified during the evaluation process
F. Provides rationales for practice beliefs, decisions, and actions as part of the informal and formal evaluation processes

Standard 10. Collegiality

Registered nurse interacts with and contributes to the professional development of peers and colleagues.

Measurement Criteria

A. Shares knowledge and skills with peers and colleagues (i.e., client care conferences, presentations, or formal or informal meetings)
B. Provides peers with feedback regarding their practice/role performance
C. Interacts with peers and colleagues to enhance own professional nursing practice/role performance
D. Maintains compassionate and caring relationships with peers and colleagues

E. Contributes to an environment conducive to education of health care professionals
F. Contributes to a supportive and healthy work environment

Standard 11. Collaboration

Registered nurse collaborates with client, family, and others in the conduct of nursing practice.

Measurement Criteria

A. Communicates with client, family, and health care providers regarding client care and the nurse's role in the provision of that care
B. Collaborates with appropriate individuals in creating a documented plan focused on outcomes with decisions related to care and delivery of services that indicate communication
C. Partners with others to effect change and generate positive outcomes through knowledge of the client or situation
D. Documents referrals, including provisions for continuity of care

Standard 12. Ethics

Registered nurse integrates ethical provisions in all areas of practice.

Measurement Criteria

A. Uses current *Code of Ethics for Nurses with Interpretive Statements* (ANA) to guide practice
B. Delivers care in a way that preserves and protects client autonomy, dignity, and rights
C. Maintains client confidentiality within regulatory parameters
D. Serves as a client advocate and fosters skills for self-advocacy
E. Maintains a therapeutic/professional client-nurse relationship with appropriate role boundaries
F. Demonstrates commitment to practicing self-care, managing stress, and connecting with self and others
G. Contributes to resolving ethical issues of clients, colleagues, or systems (i.e., ethics committees)
H. Reports illegal, incompetent, or impaired practices

Standard 13. Research

Registered nurse integrates research findings into practice.

Measurement Criteria

A. Utilizes the best available evidence, including research findings, to guide practice decisions
B. Actively participates in research activities at various levels appropriate to the nurse's level of education and position. Such activities may include:

1. Identifying clinical problems specific to nursing research (client care and nursing practice)
2. Participating in data collection (surveys, pilot projects, formal studies)
3. Participating in a formal committee or program
4. Sharing research activities and/or findings with peers and others
5. Conducting research
6. Critically analyzing and interpreting research for application to practice
7. Using research findings in development of policies, procedures, and standards of practice in client care
8. Incorporating research as a basis for learning

Standard 14. Resource Utilization

Registered nurse considers factors related to safety, effectiveness, cost, and impact on practice in the planning and delivery of nursing services.

Measurement Criteria

A. Evaluates factors such as safety, effectiveness, availability, cost and benefits, efficiencies, and impact on practice when choosing practice options that would result in the same expected outcome
B. Assists client and family to identify and secure appropriate/available services to address health-related needs
C. Assigns or delegates tasks, based on needs and condition of the client, potential for harm, stability of the client's condition, complexity of the task, and predictability of the outcome
D. Assists client and family to become informed consumers about options, costs, risks, and benefits of treatment and care

Standard 15. Leadership

Registered nurse provides leadership in the professional practice setting and the profession.

Measurement Criteria

A. Engages in teamwork as a team player and a team builder
B. Works to create and maintain healthy work environments in local, regional, national, or international communities
C. Displays ability to define a clear vision, associated goals, and a plan to implement and measure progress
D. Demonstrates a commitment to continuous, lifelong learning for self and others
E. Teaches others to succeed by mentoring and other strategies
F. Exhibits creativity and flexibility through times of change
G. Demonstrates energy, excitement, and a passion for quality work

H. Accepts mistakes by self and others to create a culture where risk-taking is not only safe but expected
I. Inspires loyalty through valuing people as the most precious asset in organization
J. Directs coordination of care across settings and among caregivers, including oversight of licensed and unlicensed personnel in any assigned or delegated tasks
K. Serves in key roles in work setting (committees, councils, and administrative teams)
L. Promotes advancement of profession via participation in professional organizations

Legal and Ethical Aspects of Nursing

OVERVIEW

It is important for nurses to recognize that nursing practice is guided by legal restrictions and professional obligations. Legal responsibilities are regulated by state nurse-practice acts and may vary from state to state. In addition, general standards for the practice of nursing have been developed and published by the American Nurses' Association, which has also developed a code of ethics.

Nurses need to be aware of these standards, as well as legal and ethical concepts and principles, because nurses are accountable for their actions in all these areas in their professional role.

Ethical Concepts That Apply to Nursing Practice

A. *Ethics*: rules and principles that guide nursing decisions or conduct in terms of the rightness/wrongness of that decision or action.
B. *Morals*: personally held beliefs, opinions, and attitudes that guide our actions.
C. *Values*: appraisal of what is "good."
   1. Dilemmas may occur when different values conflict.
   2. Example: client's right to refuse treatment may be in conflict with nurse's obligation to benefit client and to carry out treatment.
D. *Ethical dilemma*: a problem in making a decision because there is no clearly correct or right choice. This may result in having to choose an action that violates one principle or value in order to promote another.
E. *Autonomy*: an individual has the right to make his or her own decision regarding treatment and care.
F. *Paternalism*: another person makes decisions about what is right or best for the individual.
G. *Beneficence*: promoting good or doing no harm to another.
H. *Right to know*: right to knowledge necessary or helpful in making an informed decision.
I. *Principle of double effect*: promoting good may involve some expected harm, such as adverse side effects of medication.
J. *Distributive justice*: allocation of goods and services and how or to whom they are distributed.
   1. Equality: everyone receives the same.
   2. Need: greater services go to those with greater needs (e.g., critically ill client receives more intensive nursing care).
   3. Merit: services go to more deserving (used as a criterion for transplant recipients).

GUIDE TO THE CODE OF ETHICS FOR NURSES: INTERPRETATION AND APPLICATION (ANA, 2001)*

The Guide to the Code of Ethics for Nurses: Interpretation and Application contains the full text of the *Code of Ethics for Nurses with Interpretative Statements (ANA, 2001)*, in addition to a history, purpose, application, case studies and examples. This guide is used as a tool for teaching employees and students how to apply the values in the *Code of Ethics*.

The *Code of Ethics for Nurses* serves the following purposes:

- It is a succinct statement of the ethical obligations and duties of every individual who enters the nursing profession.
- It is the profession's non-negotiable ethical standard.
- It is an expression of nursing's own understanding of its commitment to society.

Code of Ethics for Nurses

A. The nurse, in all professional relationships, practices with compassion and respect for the inherent dignity, worth, and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems.

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B. The nurse's primary commitment is to the client, whether an individual, family, group, or community.
C. The nurse promotes, advocates for, and strives to protect the health, safety, and rights of the client.
D. The nurse is responsible and accountable for individual nursing practice and determines the appropriate delegation of tasks consistent with the nurse's obligation to provide optimum client care.
E. The nurse owes the same duties to self as to others, including the responsibility to preserve integrity and safety, to maintain competence, and to continue personal and professional growth.
F. The nurse participates in establishing, maintaining, and improving health care environments and conditions of employment conducive to the provision of quality health care and consistent with the values of the profession through individual and collective action.
G. The nurse participates in the advancement of the profession through contributions to practice, education, administration, and knowledge development.
H. The nurse collaborates with other health professionals and the public in promoting community, national, and international efforts to meet health needs.
I. The profession of nursing, as represented by associations and their members, is responsible for articulating nursing values, for maintaining the integrity of the profession and its practice, and for shaping social policy.

Legal Concepts That Apply to Nursing Practice

A. *Standards*: identify the minimal knowledge and conduct expected from a professional practitioner. Standards are applied as they relate to a practitioner's experience and educational preparation. For example, any nurse would be expected to be certain that an ordered medication was being given to the correct client. However, more complex nursing actions, such as respirator monitoring, would require supervised experience and/or continuing education.
B. *Negligence*: lack of reasonable conduct or care. Omitting an action expected of a prudent person in a particular circumstance is considered negligence, as is committing an action that a prudent person would not.
C. *Malpractice*: professional negligence, misconduct, or unreasonable lack of skill resulting in injury or loss to the recipient of the professional services.
D. *Competence*: ability or qualification to make informed decisions.
E. *Informed consent*: agreement to the performance of a procedure/treatment based on knowledge of facts, risks, and alternatives.
   1. Simple: having capacity to give consent for the treatment or procedure.
   2. Valid: having capacity to give consent and also demonstrating an understanding of the nature of the treatment, expected effects, possible side effects, and alternatives to treatment.
F. *Assault*: unjustifiable threat or attempt to touch or injure another.
G. *Battery*: unlawful touching or injury to another.
H. *Crime*: act that is a violation of duty or breach of law, punishable by the state by fine or imprisonment (see Table 3-1).
I. *Tort*: a legal wrong committed against a person, his or her rights, or property; intentional, willfully committed without just cause (see Table 3-1). The person who commits a tort is liable for damages in a civil action.
   1. Negligence and malpractice are torts.
   2. Victims of malpractice are entitled to receive monetary awards (damages) to compensate for their injury or loss.
J. *Good Samaritan doctrine*: rescuer is protected from liability when assisting in an emergency situation or rescuing a person from imminent and serious peril, if attempt is not reckless and person's condition is not made worse.
K. *Licensure*: Granted by states to protect public
   1. Purposes
      a. Standards for entry into practice
      b. Defines what licensed person can do (e.g., Nurse Practice Acts)
   2. License revocation/suspension
      a. Criteria vary in each state.
      b. Licensed nurses should be aware of their state's Nurse Practice Act.
      c. Nurses who are disciplined in one state may also be disciplined in another state in which they hold a license.

Table 3-1 Examples of Crimes and Torts

Crimes	Torts
Assault and battery	Assault and battery
Involuntary manslaughter: committing a lawful act that results in the death of a client	False imprisonment: intentional confinement of a client without consent
Illegal possession or sale of a controlled substance	Fraud
	Negligence/malpractice: • Medication errors • Carelessness resulting in loss of client's property • Burns from hot water bottles, heating pads, hot soaks • Failure to prevent falls by not using bed rails • Incompetence in assessing symptoms (shock, chest pain, respiratory distress) • Administering treatment to wrong client

Legal Concepts Related to Psychiatric-Mental Health Nursing

A. *Voluntary commitment*: client consents to hospital admission.
  1. Client must be released when he no longer chooses to remain in the hospital.
  2. State laws govern how long a client must remain hospitalized prior to release.
  3. Client has the right to refuse treatment.

B. *Involuntary commitment*: client is hospitalized without consent.
  1. Most states require that the client be mentally ill and be a danger to others/self (includes being unable to meet own basic needs such as eating or protection from injury).
  2. In most states the client who has been involuntarily committed may *not* refuse treatment.

C. *Insanity*: a legal term for mental illness in which an individual cannot be held responsible for or does not understand the nature of his or her acts.

D. *Insanity defenses*: not guilty by reason of insanity.
  1. M'Naghten rule ("right and wrong test"): the accused is not legally responsible for an act if, at the time the act was committed, the person did not, because of mental defect or illness, know the nature of the act or that the act was wrong.
  2. Irresistible impulse: the accused, because of mental illness, did not have the will to resist an impulse to commit the act, even though able to differentiate between right and wrong.
  3. Individuals who commit crimes and successfully plead insanity defenses may be involuntarily committed to psychiatric hospitals under civil commitment laws. There is presently a trend toward finding individuals insane and guilty.

E. *Rights of clients*: rights that each state may grant to its residents committed to a psychiatric hospital.
  1. Right to receive treatment and not just be confined
  2. Right to the least restrictive alternative (locked vs unlocked units, inpatient vs outpatient care)
  3. Right to individualized treatment plan and to participation in the development of that plan and to an explanation of the treatment
  4. Right to confidentiality of records
  5. Right to visitors, mail, and use of telephone
  6. Right to refuse to participate in experimental treatments
  7. Right to freedom from seclusion or restraints
  8. Right to an explanation of rights and assertion of grievances
  9. Right to due process

Legal Responsibilities of the Nurse

A nurse is expected to:

A. Be responsible for his or her own acts
B. Protect the rights and safety of patients
C. Witness, but not obtain, informed consent for medical procedures
D. Document and communicate information regarding client care and responses
E. Refuse to carry out orders that the nurse knows/believes are harmful to the client
F. Perform acts allowed by that nurse's state nurse practice act
G. Reveal client's confidential information only to appropriate persons
H. Perform acts for which the nurse is qualified by either education or experience
I. Witness a will (this is not a legal obligation, but the nurse may choose to do so)
J. Restrain clients only in emergencies to prevent injury to self/others. Clients have the right to be free from unlawful restraint.

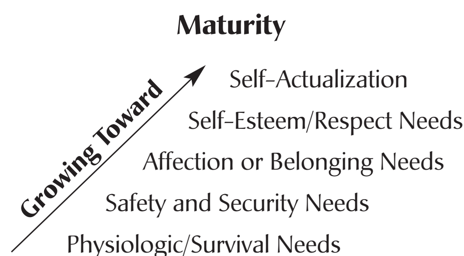
Managing Client Care

PRIORITIES OF CLIENT CARE

For One Client

A. Maslow's Hierarchy of Needs (1954) (see Table 3-2)
  1. Principles
    a. An individual's needs are depicted in ascending levels on the hierarchy.
    b. Needs on one level must be (at least partially) met before one can focus on a higher-level need

Table 3-2 Maslow's Hierarchy of Needs



Adaptation based on Maslow's Hierarchy of Needs.

2. Levels of Maslow's Hierarchy
   a. Physiologic/survival needs: basic human needs (e.g., oxygen, water, food, elimination, physical and mental rest, activity, and avoidance of pain)
   b. Safety and security needs
      1) Protection from physical harm (e.g., mechanical, thermal, chemical, or infectious)
      2) Interpersonal, economic, and emotional security
   c. Affection or belonging needs
      1) Giving and receiving of affection
      2) Sense of belonging (e.g., including client/family in planning of care)
   d. Self-esteem/respect needs
      1) Feeling of self-worth
      2) Need for recognition
   e. Self-actualization
      1) Highest level: not reached by all
      2) Independence
      3) Feeling of achievement or competency

B. Application of Maslow's Hierarchy in health care
   1. Client care
      a. Basic physiologic needs should take precedence over higher-level needs and on up the continuum accordingly.
      b. Professional nurse often delivers care at multiple levels simultaneously (e.g., while feeding a client, you position them to prevent aspiration and converse with them).
      c. Tool to guide decision making of priorities in emergencies and time management of care.
   2. Also applies to families, staff, and yourself

For Multiple Clients

A. Maslow's Hierarchy applies (e.g., more critically ill clients will require more care to meet their physiologic/survival needs)

B. Organizing multiple client assignments
   1. Analyze and plan for entire shift.
   2. Develop a working plan so that priorities get accomplished and all clients receive optimal care.
   3. First consider schedules for nursing activities (e.g., meds, treatments, VS, mealtimes, client appointments, I&Os, etc.).
   4. Then work in the nonscheduled activities that need to be accomplished to meet care plan goals (e.g., supporting family, teaching client, meeting with other departments about scheduling, writing care plan, discharge planning).

ASSIGNMENT METHODS FOR DELIVERY OF CARE

Principles

A. Registered nurse (RN) is the decision maker/delegator
   1. Assesses each client. Determines appropriate plan of care.
   2. Assesses available staff and their job descriptions. Decides how to use human resources to accomplish care.

B. Typical levels of staff
   1. Nursing Assistants
      a. Unlicensed assistive personnel (UAP)
      b. Assign to majority of the "routine" procedures (e.g., baths, bed making, routine VS, etc.)
   2. Licensed Practical Nurse (LPN)/Licensed Vocational Nurse (LVN)
      a. LPN/LVNs work under the direction of a registered nurse or a physician.
      b. Performs most patient care except in some specialty areas.
      c. Some states prohibit IV push medications or to hang the first unit of blood.
   3. Registered Nurse (RN)
      a. Performs the most complex procedures (e.g., starting IVs, developing the plan of care, interpreting ECGs, correlating laboratory results with client status)
      b. Applies the nursing process for each client
      c. Coordinates the medical plan with the nursing care plan
      d. Coordinates client activities
         1) Other departments
         2) Health care workers
         3) Community
      e. Performs client/family teaching
      f. Ensures documentation of care and outcomes
      g. Directs and supervises care given by LPNs and ancillary personnel
      h. Acts as a client advocate; supporting, pleading, or arguing in favor of the client regarding:
         1) Client rights
         2) Facility policy
         3) Treatment/care issues
         4) Personnel issues

Delegation to Unlicensed Assistive Personnel (UAP)

A. *Delegation* is the transfer of authority to a competent individual to perform a selected nursing task in a selected situation.
   1. Based on principle of public safety.
   2. RN has ultimate accountability for the provision and management of nursing care (includes delegation decisions).
   3. When done correctly, it allows more care to be provided in a given time period by distributing the workload and allowing better use of the RN's time.

B. Five Rights of Delegation
   1. Right Task
      a. Often defined by state's Nurse Practice Act
      b. Facility policy

c. Job description of UAP, or specific role delineation for a specific UAP
d. Tasks appropriate for consideration:
    1) Repetitive custodial nature
    2) Not require UAP to make clinical judgment
    3) Not require complex steps or decisions
    4) Results predictable
    5) Potential risk is minimal
    6) Uses standard unchanging procedure

2. Right Circumstances
    a. Assess the client's condition and stability.
    b. Identify the environment/setting (e.g., ICU vs. long-term care).
    c. Identify the collective nursing care needs of the whole assignment.
    d. Assess the client's plan of care and goals.
    e. Provide the appropriate skill-mix and lines of reporting.
    f. Provide the needed supplies and equipment.
    g. Match complexity of the task with the UAP's competence and level of supervision available.
    h. Identify any infection control or safety issues.
3. Right Person
    a. Organization's standards for competency of UAPs.
    b. Instruct or assess the UAP's competence on a client-specific basis.
    c. Perform UAP evaluations based on the standards.
4. Right Direction/Communication
    a. Communicate the task(s) clearly and on client-specific and UAP-specific bases.
    b. Use oral and/or written vehicles to communicate, depending on the circumstances.
    c. Communicate specific information to be reported, specific data to collect, and time lines for reporting.
    d. Communicate specific tasks to be performed and any client-specific instruction or limitations.
    e. Expected outcomes or potential complications and when to communicate this information.
    f. What signs and symptoms to be alert for and how to report it.
    g. Communicate availability of support.
    h. Verify understanding.
5. Right Supervision/Evaluation
    a. Supervision may be provided by the delegating nurse or other designated staff.
    b. Supervising nurse must know the expected method for supervision (direct or indirect), the competency of the UAP, nature of the delegated tasks, and the stability of the client condition.
    c. Ensure adequate time is allotted to providing needed supervision.
    d. Supervise or assign supervision to other appropriate licensed nurses.
    e. Monitor performance, and get and provide feedback as indicated (check intermittently).
    f. Intervene as needed.
    g. Provide education as needed.
    h. Ensure clear documentation.
    i. Evaluate the client outcome.
    j. Evaluate your delegation practice.

C. Other considerations
    1. Plan and start delegating before you get too busy.
    2. The delegation relationship takes time to build.
    3. Select the UAP for the task, if possible (e.g., one UAP might do best with a large, faster-paced assignment, while another may do better with clients who can benefit by a slower conversational approach).
    4. Allow flexibility where possible.
    5. Use positive feedback.
    6. Give credit.

Admission of Client to Hospital

A. Room assignment
    1. Check available data (e.g., diagnosis, age, pertinent history)
    2. Does client need to be close to nurses' station for optimal monitoring?
    3. Does client need isolation or special precautions?
    4. Who will be the client's roommate?
    5. Consider the physical layout of available rooms and bathrooms. What would be best for the client based on his or her functional status?

B. Perform a baseline admission assessment per facility procedure.
C. Obtain needed equipment (e.g., urinal, denture cup, etc.).
D. Explain and document the disposition of valuables per facility policy.
E. Orient to facility/policies (e.g., visiting hours, parking, telephone, chaplaincy services, TV, mealtimes, electrical equipment, etc.).
F. Orient to unit (e.g., layout, lounges, smoking policy, activities, menu selection, medication times, straight vs. prn orders, mealtimes, unit personnel, etc.).
G. Orient to room (e.g., roommate; bedside stand, table, and closet; call light, bathroom call system, bed operation, TV, telephone, etc.).

Caring for the Client Who Leaves the Unit

A. Coordinate scheduling to consider client's diagnosis, activity/test to be performed, and client's other therapeutic goals.
B. Prepare client physically and psychologically as indicated.

C. Consider the client's condition; medication, diet, and treatment regimes; as well as specific precautions and adjust the client's schedule as needed.
D. Communicate pertinent information to other departments/personnel.

Discharge of Client from the Hospital

A. Discharge to home
   1. Begin discharge plan on admission.
   2. Teach client/significant other about disease process, needed precautions, restrictions, treatments, and medications.
   3. Assess and document knowledge of disease and home-care regimen and ability to perform safely.
   4. Make referrals as needed for added support and care (e.g., community/home health nurses, home health aide, community support groups, social worker, physical therapist, etc.).
   5. Arrange for client to obtain needed equipment/supplies (e.g., bedside commode, ostomy supplies, dressings, etc.).
   6. Ensure that client has needed prescriptions.
   7. Provide written/audio/visual educational materials at the level of the client's ability and appropriate community resource contact information.
   8. Schedule or direct client to arrange for appropriate follow-up.
   9. Communicate with individuals/agency(ies) responsible for follow-up care.
B. Discharge of client to long-term care facility: communicate with facility nursing staff
   1. Client's functional abilities and limitations
   2. Present medical regime and schedule
   3. Mental and behavioral status
   4. Family support/involvement
   5. Nursing care plan and response
   6. Existing advance directives
   7. Recent medication administration records
   8. History and physical
   9. Pertinent diagnostic reports
   10. Other: requirements per insurance

Safety

FIRE SAFETY/PREPAREDNESS PRACTICES

A. Be aware of hazards and report immediately.
B. Locate and remember:
   1. Escape routes
   2. Fire drill procedures
   3. Use of available equipment
      a. Fire escapes
      b. Fire doors
      c. Fire alarms
      d. Fire sprinkler controls
      e. Fire extinguishers
      f. Shut-off valves for O_2 and/or medical air
   4. Keep fire exits clear.
C. Fire safety
   1. Prevention is everyone's responsibility.
   2. Three elements needed for a fire to start
      a. Fuel: substance that will burn
      b. Heat: flame or spark
      c. Oxygen: room air contains 21% O_2
   3. See Table 3-3.
D. In the event of a fire:
   1. Follow the RACE acronym:
      R = Remove all persons in immediate danger to safety
      A = Active alarm and have someone call 911

Table 3-3 Fire Hazards and Prevention

Fire Hazards	Fire Prevention
Faulty electrical equipment and wiring	Report frayed or exposed electrical wires Report sparks or excessive heat coming from electrical equipment
Overloaded circuits	Avoid overloaded circuits Don't use adaptors or extension cords
Plugs that are not properly grounded	Use only 3-pronged grounded plugs Do not allow electrical equipment from outside the institution to be used until it is checked by the maintenance department
Clutter	Avoid clutter
Unsafe practices when O_2 in use	No open flames or smoking in the area Remove flammable liquids from the area Post "Oxygen in Use" signs as per institutional policy Secure O_2 storage per institutional policy
Smoking	Remove cigarettes and matches from room Report suspicious odors of smoke or burning immediately Control smoking practices per institutional policy Limit smoking to designated areas No smoking in bed Directly supervise smoking of selected clients Ensure use of safe ashtrays/metal receptacles
Spontaneous combustion	Dispose of chemicals, rags, and combustible substances in proper containers

C = Close doors to prevent spread of smoke and fire
E = Extinguish the fire using the PASS acronym:
P = Pull the pin
A = Aim on the base of fire
S = Squeeze the handle
S = Sweep from side to side

2. Shut off piped-in O_2 and/or medical air.
3. Follow institutional policy concerning announcing the fire and location and notifying fire company.
4. Avoid use of elevators.
5. Follow institutional evacuation plan as needed.

EQUIPMENT

A. Follow facility procedure when using various equipment.
B. Unfamiliar equipment
1. Contact your staff development department or supervisor for information.
2. Read available manufacturer's literature.

C. Suspected malfunction (i.e., equipment that does not do its task consistently or correctly, makes unusual noises, or gives off an unusual odor or extreme temperature)
1. Don't try to repair.
2. Replace it immediately.
3. Contact maintenance department so that it can be checked out safely and repaired.

RESTRAINTS

A. Physical restraints should be used only if necessary to prevent injury to the client or others.
1. Signed, dated, physician's order needs to be written specifying the form of restraint and a time limit for restraint use. (At that time the client will be reevaluated for restraint need to determine if a less restrictive method is appropriate.)
2. Least restrictive form of restraint should be used
   a. Maintain functional abilities
   b. Decrease risk of complications
   c. Minimize behavioral reaction
3. Remove restraints for 10 min q2h for ROM, repositioning/ambulation, toileting, and preventative skin care.
4. Document rationale for restraint, other measures tried in lieu of restraint (e.g., distraction, family notification, environmental modifications), client response, and preventative care.

PRINCIPLES AND INTERVENTIONS FOR SPECIFIC ASPECTS OF CARE

Body Mechanics

A. Safe and efficient use of appropriate muscle groups to do the job
B. Principles for the safe movement of clients
1. Keep your back straight.
2. Ensure a wide base of support (keep your feet separated).
3. Bend from the hips and knees (not the waist).
4. Use the major muscle groups (strongest).
5. Use your body weight to help push or pull.
6. Avoid twisting (pivot the whole body).
7. Hold heavy objects close to your body.
8. Push or pull objects instead of lifting.
9. Ask for help as needed.
10. Synchronize efforts with client and other staff.
11. Use turning or lifting sheets as needed.
12. Use mechanical devices as needed.

Transfer and Movement Principles and Techniques

A. From bed to chair or wheelchair
1. Identify client's strongest side.
2. Place chair beside bed, on same side as client's strongest side, so it faces the foot of bed. Stabilize chair and lock wheels.
3. Lower bed, lock wheels, and elevate head of bed.
4. If assistance is needed:
   a. Place one arm under client's shoulders. The other arm should be placed over and around the knees.
   b. Bring legs over the side of bed while raising the client's shoulders off the bed.
   c. Dangle client and watch for signs of fainting or dizziness. (Stand in front of client for protection in case of balance problems.)
   d. Protect paralyzed arm during transfer. (Use sling or clothing for support.)
   e. Place client's feet flat on the floor. (If client has a weak leg, use your leg and foot to brace the weak foot and knee.)
   f. Face the client and grasp firmly by placing your arms under the armpits. Have client lean forward so that your control of the client's upper body is stabilized.
   g. Using a wide base of support and bending at your knees, coach the client to assist as much as possible by using verbal instruction and counting.
   h. Stand client (if weight bearing is permitted) by pivoting the feet, legs, and hips to a standing position.
   i. Continue the slow pivotal movement until client is positioned over chair. Lower client into chair.

B. Log rolling
  1. Performed when spinal column must be kept straight (post-injury or surgery).
  2. Two or more persons needed
    a. Both staff should be on side opposite where client is to be turned.
      1) One staff places hands under client's head and shoulders.
      2) One staff places hands under client's hips and legs.
      3) Move client as a unit toward you.
      4) Cross arms over chest and place pillow between legs.
      5) Raise side rail.
    b. Both staff move to side of bed to which client is being turned.
      1) One staff should be positioned to keep client's shoulders and hips straight.
      2) One staff should be positioned to keep thighs and lower legs straight.
      3) At the same time the client is drawn toward both staff in a single unified motion. The client's head, spine, and legs are kept in a straight position.
    c. Position with pillows for support and raise side rails.

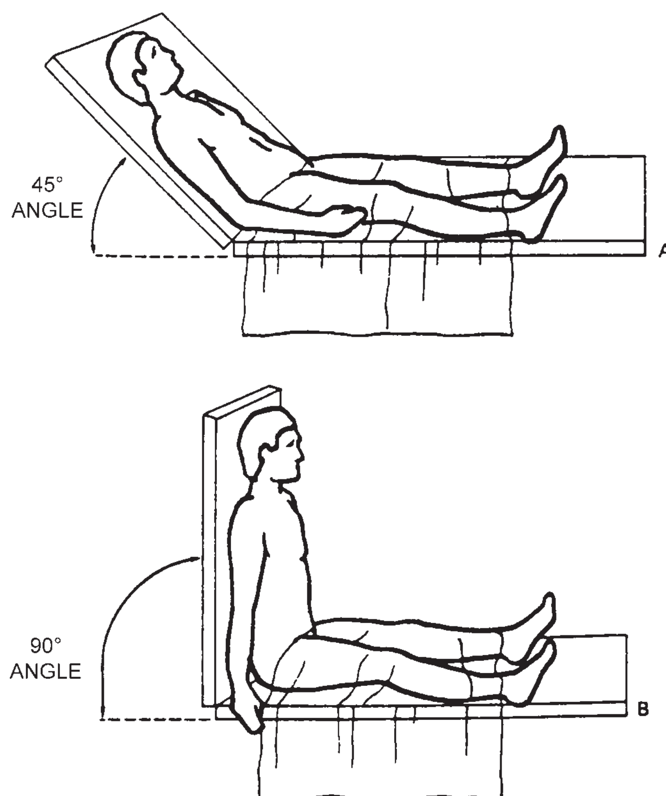


Figure 3-1 (A) Semi-Fowler's position, (B) high Fowler's position

Positioning of the Client

A. General principles
  1. Privacy/draping
  2. Universal precautions as needed
  3. Knowledge of client's condition when moving client (e.g., paresis or paralysis of a limb; need to support joints or limbs in a specific manner; awareness of pressure points)
  4. Good posture and body alignment
  5. Use of added supports as needed (e.g., pillows, wedge cushions, handrolls, foot boards)
  6. Comfort: reduce pressure and strain on body parts
  7. Safety
  8. Bed in a low position once repositioned
  9. Access to personal items and care (e.g., call bell, drinking water, tissues, telephone, etc.)
  10. Clients should change position fairly frequently (at least every 2 hours).

B. Positions
  1. Semi-Fowler's (see Figure 3-1A)
    a. Backrest elevated at 45° angle
    b. Knees supported in slight flexion
    c. Arms rest at sides
  2. High Fowler's (see Figure 3-1B)
    a. Backrest elevated at 90° angle (right angle)
    b. Knees slightly flexed
    c. Arms supported on pillows or bedside table
    d. Allows for good chest expansion in clients with cardiac or respiratory problems
  3. Supine (dorsal/horizontal recumbent)
    a. Client lies on back.
    b. Client's head and shoulders slightly elevated with pillow (modified per client condition, physician order, or agency policy regarding spinal injury, surgery or post spinal anesthesia)
    c. Small pillow under lumbar curvature
    d. Prevent external rotation of legs with supports placed laterally to trocanters
    e. Knees slightly flexed
    f. Prevent footdrop with foot board, rolled pillow or high top sneakers (depends on persistence of client condition)
  4. Prone (see Figure 3-2)
    a. Client lies on abdomen.
    b. Head turned to one side on small pillow or on flat surface.
    c. Small pillow just below diaphragm to support lumbar curve, facilitate breathing, and decrease pressure on female breasts.
    d. Pillow under lower legs to reduce plantar flexion and flex knees.
    e. May be modified in amputees where flexion of hips and knees may be contraindicated.

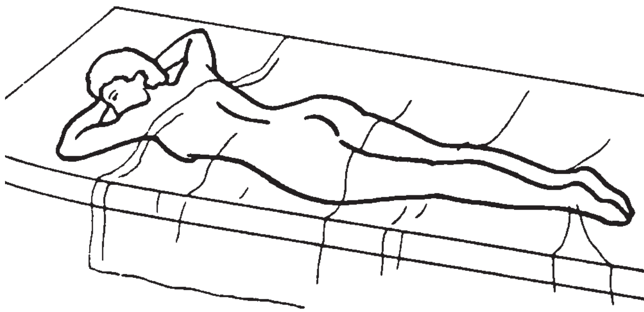


Figure 3-2 Prone position

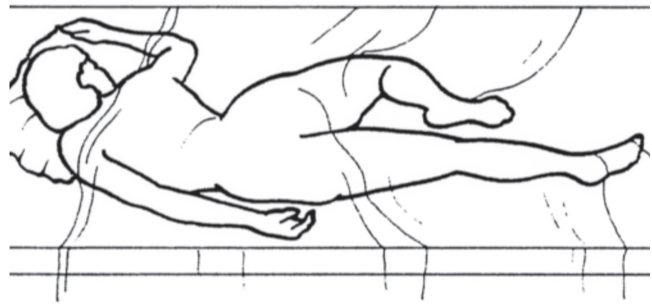


Figure 3-3 Sims' position

5. Trendelenburg
   a. Client lies on back with head lower than rest of body.
   b. Enhances circulation to the heart and brain. Sometimes used when shock is present.
   c. In emergencies, the entire lower bed may be elevated on "shock blocks."
   d. May be used for prolapsed cord outside of the hospital.
6. Modified Trendelenburg
   a. Client is positioned with legs elevated to an angle of approximately 20°, knees straight, trunk horizontal, and head slightly elevated.
   b. Used for persons in shock to improve cerebral circulation and venous return to the heart without compromising respiration. (Contraindicated when head injury is present.)
7. Lateral (side-lying)
   a. Client lies on side.
   b. Pillow under head to prevent lateral neck flexion and fatigue.
   c. Both arms are slightly flexed in front of the body. Pillow under the upper arm and shoulder provides support and permits easier chest expansion.
   d. Pillow under upper leg and thigh prevents internal rotation and hip adduction.
   e. Rolled pillow behind client's back.
8. Sims' (semiprone; see Figure 3-3)
   a. Similar to lateral, but with weight supported on *anterior* aspects of the ilium, humerus, and clavicle.
   b. Used for vaginal and rectal exams, enema administration, and drainage of oral secretions from the unconscious client. Comfortable for the client in the last trimester of pregnancy.
   c. Client placed on side (left side for enema or rectal exam) with head turned to side on a pillow.
   d. Lower arm is extended behind the body.
   e. Upper arm flexed in front of body and supported by a pillow.
   f. Upper leg is sharply flexed over pillow with the lower leg slightly bent.

Figure 3-4 The knee-chest position

Figure 3-5 Dorsal lithotomy position

9. Knee-chest (see Figure 3-4)
   a. Client first lies on abdomen with head turned to one side on a pillow.
   b. Arms flexed on either side of head.
   c. Finally the client is assisted to flex and draw knees up to meet the chest.
   d. Difficult position to be maintained—do not leave client alone. Used for rectal and vaginal exams.
10. Dorsal lithotomy (see Figure 3-5)
    a. Used for female pelvic exam.
    b. Have client void before assuming this position.

c. Client lies on back with the knees well flexed and separated.
d. Frequently stirrups are used. (Adjust for proper feet and lower leg support.)
e. If prolonged use of stirrups, be alert to signs of clot formation in the pelvis and lower extremities.

Immobility

A. Definition: inability to move in environment freely
  1. May be prescribed to limit movement of body/body part(s) as part of treatment/care plan
    a. Bed rest objectives may be:
      1) Reduce physical activity
      2) Allow rest
      3) Reduce oxygen needs
      4) Allow to regain strength
      5) Prevent further injury
      6) Promote healing
      7) Restrict movement of specific body part(s)
  2. May be related to physical inactivity, cognitive, and/or emotional changes
B. Conditions that may require bed rest include cardiovascular, neurological, musculoskeletal, cancer, AIDS, etc.
C. Factors affecting immobility
  1. Length of immobility
  2. Severity of illness or injury
  3. Premorbid physical condition
  4. Emotional state
D. Hazards of immobility (see Table 3-4)

Cold Application

A. Systemic
  1. Lowers metabolic rate
    a. Client lies on top of one, or between two, cooling blankets. Blanket(s) are attached to a machine that circulate(s) coolant solution.
      1) Follow agency policy/procedure for care of client treated with hypothermia blanket(s).
      2) Monitor VS (T, P, R, and BP) regularly and frequently.
      3) Attention to skin hygiene and protection with oil as required.
      4) Frequent repositioning and assessment of body surface areas.
      5) Observe for signs of tissue damage and frostbite (pale areas).
      6) Assist client in basic needs (e.g., hygiene, elimination, nutrition, etc.).
      7) Identify client temperature at which to cease the treatment (temperature may continue to drift downward). Monitor VS frequently until stable for 72 hours.
  2. Alcohol or sponge bath (tepid solutions, 85°–100° F)
    a. Alcohol bath—combination of alcohol and water (alcohol has a drying effect on skin—used less frequently). Alcohol increases heat loss by evaporation.
    b. Sponge bath—cool or tepid (not cold) water.
    c. Frequent and regular VS monitoring (T, P, R, and BP).
    d. Large areas sponged at one time allowing for transfer of body heat to the cooling solution.
    e. Wet cloths applied to forehead, ankles, wrists, armpits, and groin where blood circulates close to skin surface.
    f. Identify temperature to cease treatment due to potential for continued downward temperature drift.
  3. Discontinue systemic cold applications and report and document findings if:
    a. Shivering occurs (this mechanism will raise body temperature);
    b. Cyanosis of the lips or nails occurs; or
    c. Accelerated weak pulse occurs.
B. Local
  1. Purposes
    a. Control bleeding by constriction of blood vessels.
    b. Reduce inflammation:
      1) Inhibit swelling.
      2) Decrease pain.
      3) Reduce loss of motion at site of inflammation.
    c. Control accumulation of fluid.
    d. Reduce cellular activity (e.g., check bacterial growth in local infections).
    e. Effective *initial* treatment after trauma (24-48 hours). This application of cold is then frequently followed by a phase of application of heat.
  2. Ice caps or ice collars
    a. Covered with cotton cloth, flannel, or towel to absorb moisture from condensation. Change as needed.
    b. Not left on for longer than 1 hour.
    c. Cease treatment and report if client complains of cold or numbness, or if area appears mottled.
  3. Cold compresses
    a. Use sterile technique for open wounds. Check site of application after 5–10 minutes for signs of intolerance (cyanosis, blanching, mottling, maceration, or blisters).
    b. Remove after prescribed treatment period (usually 20 minutes).
C. Special considerations
  1. Elderly clients and clients with impaired circulation have decreased tolerance to cold.
  2. Moist application of cold penetrates better than dry application.

Table 3-4 Hazards of Immobility

Potential Negative Effects of Immobility	Nursing Interventions
Cardiovascular:	
Orthostatic hypotension:	
Impaired ability to equalize blood supply upon assuming an upright position (BP drop, weakness, dizziness, or fainting)	• Monitor VS • Dangle client's legs 2–3 times/day, if appropriate • Tilt tables • Encourage progressive weight-bearing, as indicated • Monitor for change in lying and sitting/standing BP
Increased cardiac workload:	
Blood volume redistributes and increases circulating volume (increased heart rate)	• Monitor tolerance for various ADLs • Monitor characteristics of pulses
Valsalva maneuver:	
Holding breath and fixing thorax, breath forced against closed glottis during movement	• Teach to exhale rather than hold breath when moving in bed • Overhead trapeze for repositioning
Thrombus formation:	
Venous stasis, external pressure against veins	• Proper positioning • Assess for Homan's sign • Elastic stockings, sequential compression devices, etc. • Ensure adequate hydration • Anticoagulants
Respiratory:	
Limited chest expansion	• Monitor respiratory rate and depth • Monitor for use of accessory muscles
Decreased movement and pooling of secretions	• Check breath sounds in all lobes and for degree of aeration • Teach to perform deep breathing and coughing exercises
Impaired oxygen exchange	• Assess for effective cough • Note any evidence of adventitious lung sounds
Metabolic:	
Reduced metabolic rate (except with fever)	• Encourage to be up and about during day, if possible
Tissue atrophy and protein catabolism	• Provide diet with increased protein and calories • Nutritional supplements • Check weights
Bone demineralization	• Watch for peripheral edema
Fluid and electrolyte imbalances	• Monitor laboratory studies
Gastrointestinal:	
Slower peristalsis (risk for constipation/nausea and vomiting, fecal impaction)	• Monitor frequency and consistency of BMs • Check for bowel sounds in all four quadrants of abdomen • Prevent or treat constipation • Assess for signs of fecal impaction
Urinary Elimination:	
Stasis of urine (risk of infection)	• Monitor I&O • Assist client to empty bladder
Renal calculi	• Assess for signs of urinary tract infection and renal calculi
Musculoskeletal:	
Decreased strength	• Consult PT and OT, as indicated and endurance • Rehab techniques as indicated
Muscle atrophy	– Active and passive ROM
Contractures	– Isokinetic/resistive
Osteoporosis	– Stretch and flexibility • Change position at least q of 2 h • Monitor height over time • Restorative nursing care • Check ROM

(continues)

Table 3-4 Hazards of Immobility *(continued)*

Pressure Ulcers: *Prolonged pressure on area disturbs blood supply and nutrition to a body part*	• Monitor skin condition • Use pressure reduction/relieving devices • Position to avoid injury to tissues and promote lung expansion • Check intertriginous areas for accumulation of sweat and loss of fluid
Psychological: *Depression, disorientation, social isolation, altered body concept, anxiety, etc.* *Sleep disturbances- disrupted sleep and wake cycles*	• Provide education Consult other interdisciplinary team members, as needed • Encourage participation as capable in ADLs • Provide emotional support • Create pleasant environment • Coordinate care to allow client to get through sleep cycles • Provide orienting materials (e.g., clocks, newspapers, eyeglasses, hearing aids, etc.)

Application of External Heat

A. Rationale
  1. Relaxes muscles in spasm.
  2. Softens exudates for easy removal.
  3. Hastens healing due to vasodilation.
  4. Localization of infection. *Note: Do not apply heat to the abdomen with suspected appendicitis as it may precipitate rupture.*
  5. Hastens suppuration.
  6. Warms a body part.
  7. Reduces congestion of an underlying organ.
  8. Increases peristalsis.
  9. Reduces pressure from accumulated fluids.
  10. Comforts and relaxes.
B. Dry heat
  1. Hot water bottle/bag, electric heating pad, lamp, cradle, or aquamatic pad.
  2. Deeper tissue penetration modes: ultrasound, and shortwave and microwave diathermy (administered by Licensed Physical Therapist).
  3. Follow agency policy for heat application mode ordered:
    a. Check temperature of water and machine setting carefully;
    b. Assess site of application frequently for signs of tissue damage or burns; and
    c. Be alert to potential bleeding resulting from vasodilation.
C. Moist heat
  1. Soaks, compresses, hot packs
    a. Follow agency policy.
    b. Check temperature of application.
    c. Use sterile technique for open wounds.
    d. Assess skin condition after 5 minutes for increased swelling, excessive redness, blistering, maceration, pronounced pallor, or if the client reports pain or discomfort.
    e. Remove the device after 15–25 minutes or as ordered/necessary.
D. Special considerations
  1. Moist heat penetrates deeper than dry and is usually better tolerated.
  2. The skin area involved may vary in any individual depending on the number of heat receptors present.
  3. Heat is less tolerated in the very young, elderly, and clients with circulatory problems.

Asepsis

A. Defined as the absence of disease-producing organisms.
B. Medical asepsis
  1. Practices to reduce the number of microorganisms after they leave the body or to reduce transmission.
  2. Often referred to as *clean technique*.
  3. Includes:
    a. Hand washing/decontamination
    b. Standard precautions
    c. Isolation technique (i.e., contact, droplet, airborne)
    d. Cleaning/disinfecting of equipment
C. Surgical asepsis
  1. Practices aimed at destroying pathological organisms before they enter the body through an open wound.
  2. Referred to as *sterile technique*.
  3. Includes:
    a. Physical barriers: gloves, masks, gowns, drapes, protective eyewear
    b. High-risk procedures:
      1) Catheter insertion
      2) Surgical wound dressing changes
      3) Administration of injections

c. Associated with populations with high risk for infection. The clients in this category are:
   1) Transplant recipients
   2) Burn victims
   3) Neonates
   4) Immunosuppressed/AIDS, clients with cancer receiving chemotherapy

4. Principles of surgical asepsis
   a. Sterile field: area where sterile materials for a sterile procedure are placed (e.g., a table covered with sterile drape).
   b. Sterile field remains sterile throughout procedure.
   c. Movement in and around field must not contaminate it.
   d. Keep hands in front of you and above your waist (never reach across the field with unsterile items).
   e. Barrier techniques (gown, gloves, masks, and drapes are used as indicated to decrease transmission).
   f. Edges of sterile containers are not sterile once opened.
   g. Dry field is necessary to maintain sterility of field.

UNIVERSAL/CLINICAL ISSUES

Pressure Ulcer (Dermal Ulcer, Decubitis Ulcer)

A. Any lesion caused by unrelieved pressure that causes local interference with circulation and subsequent tissue damage.

B. Risk factors
   1. Immobility (e.g., bed- and chair-bound clients as well as those with impaired ability to reposition themselves)
   2. Incontinence
   3. Impaired nutritional status/intake
   4. Impaired level of consciousness
   5. Impaired physical condition (e.g., stability of condition, chronicity, and severity)
   6. Skin condition impaired (e.g., nourishment, turgor, integrity)
   7. Predisposing conditions (e.g., diabetes mellitus, neuropathy, vascular disease, anemia, cortisone therapy)

C. General prevention, care, and treatment
   1. Inspect skin and document status and interventions daily.
   2. Cleanse when soiling occurs (e.g., avoid hot water, harsh or drying cleansing agents).
   3. Minimize dry skin (e.g., avoid cold or dry air and use moisturizers as needed).
   4. Minimize moisture from irritating substances (e.g., urine, feces, perspiration, wound drainage).
      a. Cleanse immediately and apply protective barrier as indicated.
   5. Avoid massage over bony prominences. (Massage around but not directly over pressure sites.)
   6. Change position frequently, every 15 minutes to 2 hours, to decrease prolonged pressure.
   7. Reduce friction and shearing (e.g., promote lifting rather than dragging).
   8. Support surfaces:
      a. Pressure relieving: static surfaces (e.g., air, gel, foam, or a combination)
      b. Pressure reducing: dynamic surfaces (e.g., low air-loss systems or air fluidized beds)
   9. Positioning devices.
   10. Nutritional intake (especially calories, protein, and fluids if not contraindicated). Also vitamin A and C, iron, zinc, and arginine supplemental products.
   11. ROM, ambulation, or activities as appropriate to promote increased circulation.
   12. Avoid pressure from appliances and care equipment.

D. Staging of pressure ulcers
   1. Stage I
      a. Observable pressure-related alteration of intact skin as compared to adjacent or opposite area on body
      b. May include changes in color (red, blue, purple tones), temperature (warmth or coolness), skin stiffness (hardness, edema) and/or sensation (pain) (Temporary blanching from pressure can last up to 30 minutes.)
   2. Stage II
      a. Partial thickness loss of skin involving epidermis and/or dermis.
      b. Superficial breakdown characterized by blister, abrasion, or shallow crater. Wound base is pink and moist, painful, and free from necrosis.
   3. Stage III
      a. Full thickness skin loss involving subcutaneous damage or necrosis. May extend to but not through underlying fascia.
      b. Infection is generally present.
      c. Characterized by deep crater or eschar. May include undermining and exudate. Wound base is not usually painful.
   4. Stage IV
      a. Full thickness loss of skin with severe destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon or joint capsule).
      b. Infection, undermining, and sinus tracts are frequently present.
   5. If wound contains necrotic tissue or eschar, accurate staging cannot be confirmed until wound base is visible.

E. Specific wound care treatments
  1. Goals
    a. Support moist wound healing
    b. Prevent or treat infection
    c. Avoid trauma of tissue and surrounding skin
    d. Comfort
  2. Solutions
    a. Cleansing products
    b. Control of bacteria
  3. Dressings or coverings
    a. Damp to dry dressing (e.g., gauze dressing put on damp and removed at tacky dry status) debrides slough and eschar.
      1) If dries completely and adheres to *viable* tissue, moisten dressing before removal.
    b. Nonadherent dressing impregnated with sodium chloride to draw in wound exudate and decrease bacteria.
      1) Change at least daily.
    c. Transparent films, semipermeable membrane to promote moist healing by gas exchange and prevention of bacterial and fluid penetration.
      1) Change when seal is lost or excessive amount of fluid collected underneath.
    d. Hydrocolloid wafers contain water-loving colloids. Wound exudate mixes with wafer to form a gel, moist environment, and nonsurgical debridement.
      1) Wafers are occlusive and should not be used on infected wounds.
    e. Gels/hydrogels available in sheets or gels and are nonadherent. They provide a moist environment and some absorption of bacteria and exudate from the wound.
      1) Not highly absorptive
        a) Do not use on wounds with copious exudate.
        b) Be alert to maceration of periwound areas. (Use moisture barriers.)
    f. Exudate absorptive dressings, beads, pastes, or powders, which, when mixed, conform to the wound shape. Attracts debris, exudate, and bacteria via osmosis.
      1) Removed only by irrigation. Do not use with deeply undermined wounds or tracts.
    g. Foams create a moist environment and absorption.
      1) Nonadherent to wound. Many require a secondary dressing to secure.
    h. Calcium alginate pads or ropes made from seaweed that convert to a firm substance when mixed with exudate.
      1) Highly absorptive: will dry out wounds that have little exudate.
    i. Moisture barrier (e.g., A & D ointment) protects high-risk skin from moisture and breakdown.
    j. Skin sealant protects high-risk skin from moisture and/or chemical breakdown.
  4. Debridement: Removal of necrotic devitalized tissue (eschar or slough). Necrotic tissue provides nutrients for bacterial growth and needs to be removed for healing to occur.
    a. Methods of debridement
      1) Enzymatic/chemical
      2) Mechanical
      3) Surgical
      4) Physiologic/autolytic
    b. Be alert to bleeding and damage to adjacent viable tissue.
  5. Miscellaneous
    a. Whirlpool: for cleansing.
    b. Hyperbaric O_2: application of high O_2 concentration for healing.
    c. Electrical stimulation: stimulates healing.
    d. Growth factor: cell growth stimulation.
    e. Vacuum-assisted closure (VAC): uses negative pressure.

F. Documentation
  1. Interventions and response to interventions
  2. Address:
    a. Location of lesions
    b. Dimensions: measure and record size (length, width, and depth in cm)
      1) Measuring guides with concentric circles available.
      2) Use sterile applicator to determine accurate depth.
      3) Photographs: need client's written permission.
    c. Stage
    d. Undermining, pockets, or tracts (e.g., measuring underdetermined areas of a wound by length, width, depth)
    e. Condition of tissue
      1) Granulation: red, moist, beefy.
      2) Epithelialized: new pink, shiny epidermis.
      3) Necrotic tissue: avascular.
        a) Slough: yellow, green, gray, brown.
        b) Eschar: hard, black, leathery.
    f. Drainage
      1) Volume (scant, small, moderate, copious, number of soaked dressings)
      2) Color
      3) Consistency
      4) Odor
    g. Periwound condition and wound margins (e.g., erythema, crepitus, induration, maceration, hematoma, desiccation, blistering, denudation, pustule, tenderness, temperature)
    h. Pain: related to procedures or constant, location, severity

Cultural Diversity in Health Practices

A. Culture: socially transmitted behavioral patterns, rules of conduct, arts, values, beliefs, customs, rituals, lifeways, and products of existence that guide the worldview and decision making

B. Key component of the nursing assessment process in order to plan care in a manner that is sensitive and respectful of the individual needs of the client/significant others

C. Cultural considerations

1. An individual may not necessarily identify strongly with a specific group just because he/she was born into it.
2. An individual may identify with more than one group.
3. Clients may choose to practice selected customs of a group while not honoring others.
4. How a client identifies with a culture, ethnic group, or religion may affect his/her health practices and care up to the end of life.
5. Rituals tend to become most important to individuals at times of significant life transitions.
6. When ethical dilemmas arise, the leader of the spiritual or cultural group might be consulted.

D. Assessment

1. Does the client identify strongly with a specific group or groups?
2. What are the beliefs, customs, practices, and rules that are most important to the client?
3. How can the health care team support the client and plan care that will address these needs? Are there special wishes/needs?
4. Is the client part of a community, congregation, or extended family structure? Does this play an important part in his/her life?
5. How do the identified culture(s) influence feelings about health and care? It is important to assess areas related to the situation (e.g., for a client newly diagnosed with AIDS: What gives the client's life meaning? What does pain mean to this client?).

E. Selected examples of diverse cultures that might influence health care practices

1. Jehovah's Witness
   - **a.** Urge members to refuse blood transfusions.
2. Christian Scientists, Orthodox Jews, Greeks, and some Spanish-speaking societies may not allow organ donation because of their belief that the body needs to remain intact and whole.
3. Native Americans believe that health is universal. It is a balancing of mind, body, spirit, and nature.
   - **a.** May choose medicine people or local healers for one problem and modern medicine for others.
4. Seventh-Day Adventists
   - **a.** Prohibit consumption of pork, shellfish, alcohol, coffee, and tea (all meat and fish avoided by the most devout).
5. Hindus
   - **a.** Prohibit consumption of beef (all meat and alcohol are avoided by the most devout).
   - **b.** Food is eaten with right hand (regarded as clean).
6. Muslims
   - **a.** Prohibit consumption of pork and pork products (e.g., lard) and alcohol. Consumption of blood is forbidden; therefore, all meat and poultry are cooked to well done.
   - **b.** Bread is required with each meal (a gift from God).
   - **c.** Food is eaten with the right hand (regarded as clean).
   - **d.** Beverages are not consumed until after the meal (some believe it unhealthy to eat and drink at the same time). Some Muslims do not mix hot and cold foods at the same meal.
   - **e.** Fasting as the start of a remedy: Prophet Mohammed said the "stomach is the house of every disease."
   - **f.** High concern for ingredients in mouthwash, non–home-prepared food, medication (gelatin capsules derived from pig, insulin, etc.).
   - **g.** Special daily prayer times
     1) Need basin of water to wash before praying
     2) Bed or chair facing Mecca
     3) Read or listen to the Qur'an
   - **h.** Death is God's will and foreordained. The worldly life is preparation for eternal life.
   - **i.** Death rituals
     1) Body washed three times by a Muslim of the same gender and wrapped in white
     2) Buried as soon as possible in a brick- or cement-lined grave with the body facing Mecca (no cremation and typically no autopsy)
7. Roman Catholic
   - **a.** Anointing of the Sick (Last Rites) for the seriously ill. This Sacrament of Healing discusses God's grace and brings physical and spiritual strength.

8. Jewish
   a. Prohibit the consumption of pork and shellfish.
   b. Kosher means properly preserved.
      1) Properly slaughtered, prepared, and served
      2) Do not mix dairy products and meat in the same meal
      3) Plates and utensils for preparation and serving of meat and dairy products kept separate
   c. Death rituals
      1) Death is expected part of the life cycle; after death the soul continues to flourish
      2) Respectful to stay with a dying person
      3) No autopsy, cremation, or embalming (keep the body whole, no desecration)
      4) Burial as soon as possible
      5) Shiva: Immediate family "sits Shiva" for 7 days beginning with the burial; the mourners do not work; they think about the deceased; they cover the mirrors of the home, receive visitors, and conduct an evening service
9. Male circumcision is religiously practiced by the followers of Judaism and Islam.
   a. Ceremony, with great festivities, usually conducted 8 days after birth for Jews and within the early few years of age among Muslims

Sample Questions

1. A female client tells the nurse that she has tested positive for HIV, but she does not want the nurse to tell anyone. What is the best action for the nurse to take?
   1. Document this information on the client's chart.
   2. Tell the client's physician.
   3. Inform the health care team who will come in contact with the client.
   4. Encourage the client to disclose this information to her physician.

2. A young woman who has tested positive for HIV tells her nurse that she has had many sexual partners. She tells her nurse that she believes that she will die soon. What would be the best response for the nurse to make?
   1. "Where there's life there's hope."
   2. "Would you like to talk to the nurse who works with HIV-positive clients?"
   3. "You are a long way from dying."
   4. "Not everyone who is HIV positive will develop AIDS and die."

3. An adult is offered the opportunity to participate in research on a new therapy. The researcher asks the nurse to obtain the client's consent. What is the most appropriate action for the nurse to take?
   1. Be sure the client understands the project before signing the consent form.
   2. Read the consent form to the client and give him/her an opportunity to ask questions.
   3. Refuse to be the one to obtain the client's consent.
   4. Give the form to the client and tell him/her to read it carefully before signing it.

4. An adult has signed the consent form for a research study but has changed her mind. The nurse tells the client that she has the right to change her mind based upon which of the following principles?
   1. Paternalism and justice.
   2. Autonomy and informed consent.
   3. Beneficence and double effect.
   4. Competence and right to know.

5. The nurse is preparing to move an adult who has right-sided paralysis from the bed into a wheelchair. Which statement describes the best action for the nurse to take?
   1. Position the wheelchair on the left side of the bed.
   2. Keep the head of the bed elevated 10°.
   3. Protect the client's left arm with a sling during the transfer.
   4. Bend at the waist while helping the client into a standing position.

6. An adult has experienced a cerebrovascular accident that has resulted in right-sided weakness. The nurse is preparing to move the client to the right side of the bed so that he may then be turned to his left side. What is an important principle when moving the client in bed?
   1. To keep the feet close together.
   2. To bend from the waist.
   3. To use body weight when moving objects.
   4. A twisting motion will save steps.

7. Which statement by the nurse best indicates a correct understanding of "log rolling" when moving a client?
   1. One nurse may perform this task alone.
   2. Pillows are needed for positioning in order to provide support.
   3. The legs should be moved before the head is moved.
   4. Keeping the neck in a straight position is the primary concern.

8. The nurse is caring for a client who has a temperature of 105°F (40.5°C). The physician orders the application of a cooling blanket. The nurse should know that which of the following statements is true about the use of a cooling blanket?

1. Cold application will increase the metabolic rate.
2. Vital signs should be monitored every 8 hours.
3. The client should remain in one position to conserve energy.
4. Skin hygiene and protection of body surface areas is essential.

9. Topical heat is ordered for all of the following clients. The order should be questioned for which client?

1. A teenager who is active and rapidly growing.
2. A new mother who is breastfeeding.
3. A middle-aged adult with a cardiac dysrhythmia.
4. An adult with arteriosclerosis obliterans.

10. The nurse is preparing to administer a sponge bath to an infant with a high fever. What should be included in the administration of the bath?

1. Large amounts of alcohol to increase evaporation of heat.
2. Adjustment of the water temperature to 60°–70°F.
3. Wet cloths applied to all areas where blood circulates close to skin surfaces.
4. Small areas of the body sponged at a time to avoid rapid heat loss.

11. The nurse is instructing the family of a homebound, bedridden client in the general prevention of pressure sores. What should be included in the teaching?

1. Promoting lifting rather than dragging when turning the client.
2. Massaging directly over pressure sites.
3. Changing the client's position every 4 hours.
4. Cleaning soiled areas with hot water.

12. A nurse is assessing a client with a Stage I pressure ulcer. Which finding would be noted?

1. Superficial skin breakdown.
2. Deep pink, red, or mottled skin.
3. Subcutaneous damage or necrosis.
4. Damage to muscle or bone.

13. An adult has developed a stage II pressure ulcer. He is scheduled to receive wet to dry dressings every shift. What will the nurse state is the purpose of receiving this type of dressing?

1. Draw in wound exudate and decrease bacteria.
2. Debride slough and eschar.
3. Promote healing by gas exchange.
4. Promote a moist environment and soften exudate.

14. The nurse is performing a wound irrigation and dressing change. Which action, if taken by the nurse, would be a break in technique?

1. Consistently facing the sterile field.
2. Washing hands before opening the sterile set.
3. Opening the bottle of irrigating solution and pouring directly into a container on the sterile field.
4. Opening the sterile set so that the initial flap is opened away from the nurse.

15. An adult is homeless and has gangrene on his foot. The physician has recommended hospitalization and surgery. The client has refused. The nurse knows which of the following is true?

1. The client can be restrained if one physician declares him incompetent.
2. The client can be hospitalized against his will.
3. The client cannot choose which treatment to refuse.
4. The client may sign against medical advice (AMA).

16. An adult has been medicated for her surgery. The operating room (OR) nurse, when going through the client's chart, realizes that the consent form has not been signed. Which of the following is the best action for the nurse to take?

1. Assume it is emergency surgery and the consent is implied.
2. Get the consent form and have the client sign it.
3. Tell the physician that the consent form is not signed.
4. Have a family member sign the consent form.

17. A licensed nurse in one state receives a job offer as a nurse in an adjoining state. Which of the following should the nurse do first?

1. Contact the first state's board of nursing to cancel the 1st received license.
2. Contact the hospital the nurse wants to work in and ask them to contact its state board of nursing.

3. Contact the new state's board of nursing and ask for reciprocity.
4. Take the examining test in the new state.

18. An adult has just returned to the unit from surgery. The nurse transferred him to his bed but did not put up the siderails. The client fell and was injured. What kind of liability does the nurse have?
1. None.
2. Negligence.
3. Intentional tort.
4. Assault and battery.

19. The nurse is in the hospital's public cafeteria and hears two nursing assistants talking about the client in 406. They are using the client's name and discussing intimate details about the client's illness. Which of the following actions is best for the nurse to take?
1. Go over and tell the nursing assistants that their actions are inappropriate, especially in a public place.
2. Wait and tell the assistants later that they were overheard discussing the client. Otherwise, they might be embarrassed.
3. Tell the nursing assistants' supervisor about the incident. It is the supervisor's responsibility to address the issue.
4. Say nothing. It is not the nurse's job or responsibility for the assistants' actions.

20. The nurse is about to medicate a woman for breast cancer lumpectomy. The client says, "I'll be glad when the surgery is over. It will eliminate all the cancer from my body." Which of the following is the best action for the nurse to take?
1. Medicate the client and tell the physician.
2. Correct the client's misconceptions.
3. Call the doctor without medicating the client.
4. Give the medication to the client and note her comment in the chart.

21. A client on your medical-surgical unit has a cousin who is a physician and wants to see the chart. Which of the following is the best response for the nurse to take?
1. Hand the cousin the client's chart to review.
2. Ask the client to sign an authorization, and have someone review the chart with the cousin.
3. Call the attending physician and have the doctor speak with the cousin.
4. Tell the cousin that the request cannot be granted.

22. A nurse comes upon a motor vehicle accident when driving to work. The nurse administers care to the people involved. Under the Good Samaritan Act, for what could the nurse be liable?
1. For nothing, any action is covered.
2. For gross negligence.
3. For not providing the standard of care found in a hospital.
4. For not stopping and offering care.

23. The nurse is supervising a newly trained certified nurse aide (CNA). An adult has just arrived on the unit after surgery. Which of the following is the most appropriate task for the nurse to delegate to the CNA?
1. Taking the client's vital signs while the nurse watches.
2. Suctioning the client's tracheostomy and reporting back to the nurse.
3. Changing the client's postoperative (post-op) surgical dressing then describing it to the nurse.
4. Testing urine with a reactant strip, and recording and reporting the results.

24. The nurse is making the assignment for the floor. There is one LPN and three RNs. Which of the following clients should the LPN be assigned to?
1. A client who is intubated and a newly diagnosed diabetic.
2. A recent ICU transfer and a person with AIDS.
3. A client awaiting a nursing home bed and a client 1 day post-hernia repair.
4. A new admission for cholecystectomy and a client 1 day post-op mastectomy.

25. Which of the following clients should the nurse provide care to first?
1. A client who needs her dressing changed.
2. A client who needs to be suctioned.
3. A client who needs to be medicated for incisional pain.
4. A client who is incontinent and needs to be cleaned.

26. Which of the following clients should the nurse see first?
1. A client who has just returned from the OR.
2. A client whose call light is not working.
3. A client with Alzheimer's disease.
4. A client who is receiving a heating pad treatment.

27. Four clients have signaled with their call bells for the nurse. Who should be seen first?

1. A client who needs to use the toilet.
2. A client who does not have his glasses or hearing aid.
3. A client who has just been given morphine.
4. A client in a geri chair with a restraint vest on.

28. An adult who is in the terminal stages of AIDS is admitted to the floor. During the admission assessment, the nurse would ask her if she brought with her which of the following?

1. A will.
2. Funeral instructions.
3. An organ donation card.
4. Health care proxy.

29. The nurse enters a room and finds a fire. Which is the best initial action?

1. Evacuate any people in the room, beginning with the most ambulatory and ending with the least mobile.
2. Activate the fire alarm or call the operator, depending on the institution's system.
3. Get a fire extinguisher and put out the fire.
4. Close all the windows and doors, and turn off any oxygen or electrical appliances.

30. The nurse is unfamiliar with a new piece of OR equipment that is scheduled to be used today. What is the best course of action?

1. Ask another nurse for instructions on how to use it.
2. Wait until she has attended a class on using the equipment before using it.
3. Get another nurse who is familiar with the equipment to operate it.
4. Read the instructions provided with the equipment.

31. It is the first home care visit to an adult who is in an electric hospital bed with an oxygen tank behind it. The bed's three-prong, grounded electric cord is connected to a frayed, two-prong extension cord. What is the most appropriate action for the nurse to take?

1. Turn off the oxygen supply, so as not to accelerate any spark into a fire.
2. Turn off the electricity, so as to maintain the oxygen supply to the client.
3. Tell the family to replace the extension cord as soon as possible.
4. Unplug the bed after turning off the power.

32. Which action by the CNA demonstrates the best understanding of the use of restraints?

1. Placing all clients in bed with the siderails up.
2. Applying a jacket restraint for the client who pulls out IV lines.
3. Fastens the ends of the restraint(s) to the siderails.
4. Fastens the restraints with a half bow knot to an area the client cannot reach.

33. An adult has had both wrists restrained because she is agitated and pulls out her IV lines. Which of the following would the nurse observe if the client is not suffering any ill effects from the restraints?

1. She cannot reach her water pitcher.
2. She is sleeping with her hands by her side.
3. Her capillary refill is less than 2 seconds.
4. Her feet restraints are tied to the bed.

34. An adult is to be placed in a knee-chest position for an exam by a new staff member. Which of the following should the nurse observe?

1. The arms are at the client's side.
2. The head and upper chest are supported with a pillow.
3. The lower legs are supported with a pillow.
4. The back supports the client's weight.

35. An adult has been placed in Sims' position by the CNA. Which of the following should the nurse observe?

1. The right arm is flat under the hip.
2. The left leg is flexed at the hip and knee.
3. The right leg is flexed at the hip and knee.
4. A pillow under lower legs to reduce plantar flexion.

36. The nurse is evaluating whether the CNAs are correctly log rolling an adult in bed. Which action by the CNA should be observed by the nurse?

1. Use a draw sheet to aid the turning.
2. Do not place a pillow behind the head.
3. Do not put a pillow between the client's legs.
4. Place the bed in the lowest position.

37. An adult is supine. Which of the following can the nurse do to prevent external rotation of the legs?

1. Put a pillow under the client's lower legs.
2. Place a pillow directly under the client's knees.
3. Use a trochanter roll alongside the client's upper thighs.
4. Lower the client's legs so that they are below the hips.

38. A C4 quadriplegic has slid down in the bed. Which of the following is the best method for the nurse to use to reposition him?

1. One nurse lifting under his buttocks while he uses the trapeze.
2. Two people lifting him up in bed with a draw sheet.
3. Two people log rolling the client from one side to the other.
4. One nurse lifting him under his shoulders from behind.

39. A woman is to have a pelvic exam. Which of the following should the nurse have the client do first?

1. Remove all her clothes and her socks and shoes.
2. Go to the bathroom and void, saving a sample.
3. Assume a lithotomy position on the exam table.
4. Have the client sign the consent form.

40. An adult had a left, above-the-knee amputation 2 weeks ago. For what reason should a nurse place the client in a prone position three times a day?

1. Prevents pressure ulcers on the sacrum.
2. Helps the prosthesis to fit correctly.
3. Prevents flexion contractures.
4. Allows better blood flow to the heart.

41. An adult has a chest tube placed and is in a semi-Fowler's position. Why would the nurse place the client in this position?

1. It is necessary to prevent pulmonary emboli.
2. It allows the nurse to have access to the chest tube.
3. It promotes comfort and drainage.
4. It is the only position a chest tube will work in.

42. An adult is to have a rectal examination. In which of the following positions should the nurse position the client?

1. Supine.
2. Prone.
3. Sims'.
4. Right lateral.

43. An adult has just returned to the unit from the OR where he spent more than 2 hours in the lithotomy position. Which of the following assessments should the nurse make because of the positioning during the surgery?

1. Lower extremity pulses, paresthesias, and pain.
2. The presence of bowel sounds.
3. Upper extremity pulses, paresthesias, and pain.
4. Ability to walk.

44. A man who has been in a motor vehicle accident is going into shock. Before placing the client in a modified Trendelenburg position, what problem would the nurse assess for first?

1. Long bone fractures.
2. Air embolus.
3. Head injury.
4. Thrombophlebitis.

45. The client has been placed in the Trendelenburg position. The nurse knows the effects of this position on the client include which of the following?

1. Increased blood flow to the feet.
2. Decreased blood pressure.
3. Increased pressure on the diaphragm.
4. Decreased intracranial pressure.

46. What is the difference between the left lateral and the Sims' position?

1. Sims' position is semiprone, halfway between lateral and prone.
2. Lateral position places the client's weight on the anterior upper chest and the left shoulder.
3. Sims' position places the weight on the right shoulder and hip.
4. Lateral position places the weight on the right hip and shoulder.

47. A woman needs to be placed in position for a pelvic exam. Which of the following describes how the nurse should position the client?

1. Supine with knees and hips bent and thighs abducted.
2. Lying on her back, extremities moderately flexed.
3. Kneeling with arms, upper chest, and head resting on a pillow.
4. Lying on her left side with right knee and thigh flexed toward her chest.

48. An adult is bedridden. The nurse knows which of the following should be included in the plan of care?

1. Asking the client about comfort prior to positioning.
2. Instituting a 4-hour turning schedule.
3. Planning range of motion exercises every 2 hours.
4. Using support devices to maintain alignment.

49. The nurse of a bedridden woman is evaluating whether the family members understand how to position the client correctly. Which of the following should the nurse observe?

1. Lower arm and leg are always supported in the lateral positions.
2. The extremities should always be extended to prevent contractures.
3. The spine should have maximal lordosis in almost all positions.
4. The family should change the position at least every 2 hours.

50. A victim of a motor vehicle accident is brought to the emergency room via ambulance in hypovolemic shock. When placing the client in a modified Trendelenburg position, how will the nurse place the client?

1. Legs out straight and elevated approximately 20°.
2. Supine, with the head of the bed lowered.
3. Prone, with the head of the bed elevated.
4. Supine, tilting the bed so the head is above the heart.

51. A bedridden woman is positioned on her right side. There is a pillow beneath her head. Her right arm is extended near her hip. Her left leg is extended and parallel with the right leg. Which of the following is correct?

1. The client's right leg should be flexed at the hip and knee.
2. The client's right arm should be flexed at the shoulder and elbow.
3. There should not be a pillow under her head.
4. She should be semiprone with the weight on her upper chest.

52. The nurse uses a wide stance when moving a heavy box of supplies. Which of the following is the best reason the nurse would do this?

1. Avoids back strain.
2. Contracts the muscles.
3. Lowers the center of gravity.
4. Increases stability.

53. A woman who is brought in after a motor vehicle accident has suffered a head injury and possible spinal injury. What action should the nurse perform when moving her from the stretcher to the bed?

1. Have the client move segmentally.
2. Sit the woman up and transfer her to the bed.
3. Move the woman with a draw sheet.
4. Log roll the client.

54. Which of the following techniques would the nurse in a nursing home use to transfer a C4 quadriplegic from bed to wheelchair?

1. One nurse dangling the client, then using a transfer belt.
2. Two people, one at the client's knees, the other under his arms.
3. Two nurses using a mechanical lifting device (Hoya).
4. Two nurses, one on either side, lifting the client with a sheet.

55. The nurse will be dangling an adult prior to transferring her from the bed to a wheelchair. Which of the following actions is essential for the nurse to make before moving the client?

1. Assess blood pressure and heart rate.
2. Ensuring that the bed is in the highest position.
3. Assessing the client's height and range of motion.
4. Enlisting the help of another nurse or a CNA.

56. An adult has just been admitted for acute asthma exacerbation and placed in a high Fowler's position. For what reason does the nurse know that this is the best position?

1. Facilitates maximal ventilation.
2. Is required for the aerosol treatments to work.
3. Allows for chest physiotherapy.
4. Is the position for the chest X-ray.

57. An older adult is to go home with her family. The nurse is evaluating that the family members can correctly move the client from the bed to a chair. Which of the following should be seen?

1. The transfer belt is placed loosely around the waist.
2. There is no pause while the client is standing.
3. The family member leans forward from the waist.
4. The client and family member have one foot slightly in front of the other.

58. An adult suffered a stroke and has right-sided hemiparesis. The nurse is going to transfer her from bed to wheelchair. Which of the following is the best method?

1. Have the client put her arms around the nurse's neck.
2. Position the wheelchair closer to the weaker foot.
3. Place the wheelchair about a foot away from the bed on the right side.
4. Put the wheelchair at a 45° angle to the bed on the left side.

59. The nurse knows which of the following is the proper technique for medical asepsis?

1. Gloving for all client contact.
2. Changing hospital linen weekly.
3. Using your hands to turn off the faucet after handwashing.
4. Gowning to care for a 1-year-old child with infectious diarrhea.

60. The nurse is conducting a class on aseptic technique and standard precautions. Which of the following statements is correct and should be included in the discussion?

1. Standard precautions destroy the number of potentially infectious agents.
2. Medical asepsis is designed to decrease exposure to bloodborne pathogens.
3. Medical asepsis is designed to confine microorganisms to a specific area, limiting the number, growth, and transmission of microorganisms.
4. The term standard precautions is synonymous with disease or category-specific isolation precautions.

61. The nurse is to open a sterile package from central supply. Which is the correct direction to open the first flap?

1. Toward the nurse.
2. Away from the nurse.
3. To the nurse's left or right.
4. It does not matter as long as the nurse only touches the outside edge.

62. For which procedure would the nurse use aseptic technique and which would require the nurse to use sterile technique?

1. Aseptic technique for changing the client's linen and sterile technique for placing a central line.
2. Aseptic technique for urinary catheterization in the hospital and sterile technique for cleaning surgical wounds.
3. Aseptic technique for a spinal tap and sterile technique for surgery.
4. Aseptic technique for food preparation and sterile technique for starting an IV line.

63. An adult has a draining pressure ulcer on her sacrum and is to be discharged to her daughter's care. The nurse has taught the client's daughter to perform dressing changes. Which observation by the nurse indicates that the daughter's technique is done correctly?

1. She uses only sterile gloves to remove the old dressing.
2. She irrigates the wound from the bottom up.
3. She places the forceps used to remove the old dressing on the sterile field.
4. She washes her hands before each gloving and after the procedure is done.

64. A woman is transferred to a skilled nursing facility from the hospital because she is unable to ambulate due to a left femoral fracture. Which client description gives a greater risk factor for developing a pressure ulcer?

1. 5 ft 4 in tall, 130 lb, and eats more than half of most meals.
2. Apathetic but oriented to person, place, and time.
3. Slightly limited mobility and needs assistance to move from bed to chair.
4. Good skin turgor, no edema, and her capillary refill is less than 3 seconds.

65. An elderly male client is transferred to a skilled nursing facility from the hospital because he is unable to ambulate due to a left femoral fracture. When doing a skin assessment, the nurse notices a 3-cm, round area partial thickness skin loss that looks like a blister on the client's sacrum. Which stage is apparent?

1. Stage I pressure ulcer.
2. Stage II pressure ulcer.
3. Stage III pressure ulcer.
4. Stage IV pressure ulcer.

66. When planning for the care of a client with a pressure ulcer on the sacrum, the nurse would include which of the following?

1. Positioning the client with a donut around the area to relieve pressure on the ulcer.
2. Massaging the sacrum, concentrating on the bony prominences and reddened areas.
3. Using a heat lamp twice a day to dry the wound.
4. Having a pressure-relieving device such as an air mattress or gel flotation pad.

67. The nurse is to apply a dressing to a stage II pressure ulcer. Which of the following dressings is best?

1. Dry gauze dressing.
2. Wet gauze dressing.
3. Wet to dry dressing.
4. Moisture-vapor permeable dressing.

68. A client with a hip fracture has a sacral pressure ulcer. Which of the following would indicate the best response to treatment?

1. The client's nutritional status including: adequate protein; carbohydrates; fats; vitamins A, B, C, and K; and minerals, including copper, iron, and zinc.
2. The client's skin status, including length, width, depth, condition of the wound margins, and stage of the ulcer as well as the integrity of the surrounding skin.
3. Increased mobility including the ability to reposition self in bed or wheelchair and walking with assistance.
4. Absence of clinical signs of infection including redness, warmth, swelling, pain, odor, and exudate.

69. An adult who has a disorder of the hypothalamus is on a hypothermia blanket. The nurse should make which of the following assessments?

1. Document the client's ability to sweat.
2. Ensure the client's skin is warm and dry.
3. Record baseline vital signs, neurologic status, and skin integrity.
4. Confirm that the client is alert and oriented.

70. The nurse notices that a Jewish client did not eat any of their food on the meal tray. What would be the nurse's first best action?

1. Request the client's family to bring food in for the client.
2. Request a kosher meal from the dietary department.
3. Instruct the client that food will facilitate the healing process.
4. Ask the client why the food has not been eaten.

71. The physician's orders for an adult include warm compresses to the left leg three times a day for treatment of an open wound. What action will the nurse perform?

1. Use medical aseptic techniques throughout the procedure.
2. Wet the compress and apply it directly to the area.
3. Place both a dry covering and waterproof material over the compress.
4. Remove the compress after about 5 minutes.

72. An adult is receiving a hot soak to her right arm. What assessment will the nurse make?

1. The water temperature at the start of the treatment is 120°F (48°C).
2. That the water basin is placed at shoulder height.
3. Throughout the treatment, the water remains at approximately the same temperature.
4. The client's baseline and after-treatment temperature.

73. An adult has chronic lower back pain and receives hot packs three times a week. The nurse knows the treatment is given for which of the following reasons?

1. To help remove debris from the wound.
2. To keep the client warm and raise his temperature.
3. To improve the client's general circulation.
4. To relieve muscle spasm and promote muscle relaxation.

74. While giving an adult a tepid sponge bath to reduce his temperature, the nurse notes that the client is shivering. How does the nurse interpret this action?

1. Sponge bath is being given too slowly.
2. Client has a decreased metabolic demand.
3. Body is trying to warm itself.
4. Temperature of the water is below 90°F (32°C).

75. A caregiver is giving a tepid sponge bath to her invalid mother who has a fever. When evaluating the caregiver to ensure the procedure is being given correctly, the nurse would note the caregiver performing which of the following?

1. Tests the water temperature on the inside of her wrist.
2. Rubs each area with the wet sponge.
3. Sponges one part of the body, and then another.
4. Rubs her mother's skin dry after each area is sponged.

76. An adult is to have a tepid sponge bath to lower his fever. What temperature should the nurse make the water?

1. 65°F (188°C).
2. 90°F (32°C).
3. 110°F (43°C).
4. 105°F (40.5°C).

77. A man has sprained his ankle. Why would the nurse apply cold therapy to the injured area?

1. Reduce the body's temperature.
2. Increase circulation to the area.
3. Aid in reabsorbing the edema.
4. Relieve pain and control bleeding.

78. An adult is going home from the emergency room with directions to apply a cold pack to his ankle sprain. He asks how he will know if the

cold pack has worked. What information would the nurse provide to the client?

1. After the first application, the swelling will be decreased.
2. He will notice the red-blue bruises will turn purple.
3. There should be less pain after applying the cold pack.
4. That the skin will be blanched and numb afterward.

79. The nurse is caring for a client who has recently immigrated from India. Which action is most appropriate when developing the nursing care plan?

1. Ask the client if any special needs are present.
2. Order a diet with no pork products.
3. Assign the client to an east-facing room.
4. Perform a cultural needs assessment.

80. An unconscious adult is admitted to the emergency department in hypovolemic shock. The client's spouse says that the client is a Jehovah's Witness and should not receive a blood transfusion. The physician orders a transfusion. What should the nurse do?

1. Inform the physician of the family's request and encourage exploration of other volume expander options.
2. Call the hospital attorney to get an authorization to administer the transfusion.
3. Discuss the urgent need for a transfusion with the client's spouse.
4. Give the emergency transfusion as ordered.

81. A client of the Muslim faith is admitted with insulin-dependent diabetes mellitus and pneumonia. Which aspects of the client's care would be of greatest concern to the nurse? Select all that apply.

1. _____ Well-done roast beef on the lunch tray.
2. _____ Order for porcine insulin.
3. _____ Chicken for Friday's meal.
4. _____ Medication in a capsule.
5. _____ Elixir of terpin hydrate.

Answers and Rationales

1. 4. A nurse is legally obliged to protect a client's right to privacy. The second point in the ANA Code is the ethical obligation.

2. 2. This provides the client with expert care. Standard 5b provides for client participation in gaining knowledge and for promotion of health.

3. 3. Nurses cannot obtain consent. They may legally witness consent to medical procedures. When the consent is for a research study, the research team is responsible for obtaining consent.

4. 2. Autonomy is the ethical right to decide what treatment you will or will not receive. Informed consent can be withdrawn; it includes the right to know and competence.

5. 1. Place the wheelchair beside the bed, on the client's strongest side, so that it faces the foot of the bed.

6. 3. Objects should be pushed or pulled instead of lifted. Using the body weight to push or pull prevents strain to muscles and joints.

7. 2. A pillow should be placed between the knees/legs for support while the client is being turned.

8. 4. Assessment of the skin, protection of the skin surfaces with oil, and repositioning are all vital to prevent skin breakdown.

9. 4. Heat is not well tolerated in clients with circulatory impairment. If topical heat application is to be carried out in a client with circulatory impairment, the nurse should assess the site frequently for signs of tissue damage.

10. 3. Wet cloths should be applied to forehead, ankles, wrists, axilla, and groin. These are the areas where blood circulates closest to the skin surface.

11. 1. Promoting lifting rather than dragging when turning or moving the client will reduce friction and shearing. This will assist in preventing pressure sores.

12. 2. Stage I pressure ulcers show discoloration of skin to a deep pink, red, or mottled appearance.

13. 2. In a wet to dry dressing, the wet gauze dressing either covers the wound or is packed into the wound and covered with a dry dressing. The dry layer creates a wick and pulls moisture (drainage) from the wound, debriding slough and bacteria.

14. 3. After opening a sterile bottle, the edge of the bottle is considered to be contaminated. The nurse should pour a little solution out first to wash away organisms on the lip of the opening and then pour from the same side of the bottle into the sterile container on the sterile field.

15. **4.** A competent client may decide which treatments and procedures to accept or refuse.

16. **3**. It is the physician's responsibility to obtain the consent and to ensure that the signer is competent. A medicated client generally is not deemed competent and the surgery may have to be postponed.

17. **3**. Endorsement (reciprocity) from one state to another is usually done when the nurse is licensed.

18. **2.** The nurse has been negligent and can be liable for malpractice.

19. **1.** The client has a right to confidentiality and her case should not be discussed in a public place.

20. **3**. The client does not clearly understand the procedure. Medicating the client can cloud her judgment and should be withheld. The doctor is the person to clarify the misconceptions.

21. **2.** The client must agree to and sign an authorization before others can review the chart, including insurance companies. Most institutions require someone on staff to review the chart with the client or client representative.

22. **2.** Actions that a reasonable, prudent person with the same level of skill and training would have provided are covered, but gross negligence is not.

23. **4**. Testing urine via reactant strips (Dip stix) and recording the results is usually within the scope of a CNA's training. The CNA should also report the results to the nurse, especially if they are abnormal.

24. **3**. These clients are the least sick and require the least amount of highly skilled nursing care.

25. **2.** Any client with a potential compromise of the airway should be dealt with first.

26. **1.** A client who has just returned from the OR is at highest risk for potential problems.

27. **3**. An adverse reaction to any drug can be life-threatening and should be dealt with first.

28. **4**. A living will, durable power of attorney for health care, or a health care proxy is an important part of an admission assessment, especially for a terminally ill client.

29. **1.** Rescue and evacuate any people in the room first. Begin with those who are able to walk, then those in wheelchairs, finally those who are nonambulatory in stretchers or beds.

30. **3**. Only those with knowledge of the equipment should operate it.

31. **4.** Because any electrical (or gas) appliance is a hazard around oxygen, it is better to unplug the dangerous cord after turning off the power.

32. **4.** The half bow knot is a secure knot that will not loosen but can be easily released by the nurse in an emergency.

33. **3.** A normal capillary refill is less than 3 seconds, which would indicate good circulation. Answers 1 and 2 are expected, not ill effects.

34. **2.** A pillow can be placed under the head or chest.

35. **3.** The correct position is with the right leg flexed, left arm extended at side, right arm and head on pillow.

36. **1.** A draw sheet helps to maintain tension along the back and allows the body to be turned as one.

37. **3.** A blanket roll along the side of the hips down to the midthighs helps to prevent external rotation.

38. **2.** A draw sheet is the easiest and most effective method to lift a quadriplegic client up in bed.

39. **2.** The client should have an empty bladder, reserving a sample for analysis if needed.

40. **3.** Flexion contractures can be prevented by placing the client in a prone position and by exercising.

41. **3**. This position facilitates drainage and is generally most comfortable.

42. **3**. The rectum is easily accessed when the hip is bent at a right angle.

43. **1.** The lithotomy position places pressure on the nerves and blood vessels of the legs.

44. **3**. Head injuries and chest injuries are contraindications for the Trendelenburg position.

45. **3.** The chest cavity is pushed by the pressure from the abdominal contents.

46. **1.** The Sims' position is halfway between the left lateral position and the prone position.

47. **1.** The dorsal lithotomy position is used for most pelvic exams.

48. **4.** Support devices such as pillows, special mattresses, trochanter rolls, and foot boards help to maintain alignment and prevent contractures.

49. **4.** Position changes should occur at least every 2 hours, more often if needed.

50. **1.** The modified Trendelenburg position raises the legs only.

51. **2.** The lower arm should be flexed, so the body does not rest on it.

52. **4.** The greater the stability, the less chance of injury. When increasing the base of support, the nurse helps to maintain balance.

53. **4.** Log rolling a client would protect the spinal column and keep the body in alignment.

54. **3.** A mechanical lifting device (Hoya, Hoyer) helps to transfer clients and prevents back injury to the nurses.

55. **1.** The client may experience a drop in blood pressure and should be assessed before and after dangling, especially if standing will be included.

56. **1.** A high Fowler's position allows maximal chest expansion and decreases hypoxia.

57. **4.** Both the family member and the client should have one foot slightly in front of the other. This allows for a greater base of support and helps when rocking to achieve a standing position.

58. **4.** This position is best for clients who have difficulty walking. The client can pivot into the chair and lessen the amount of body rotation. The chairs should be on the strong side.

59. **4.** Gowns should be worn when the nurse's clothing is likely to be soiled by infected material.

60. **3.** Medical asepsis should be practiced everywhere. It includes such things as handwashing.

61. **2.** This allows for the least possible potential for contamination while opening the package.

62. **1.** Changing linen should be done with aseptic technique, whereas putting in central lines requires sterile technique.

63. **4.** Handwashing should occur before donning the nonsterile gloves, when changing from nonsterile to sterile gloves, and after the procedure. This prevents the spread of microorganisms.

64. **3.** The fact that the client is chair-bound has the greatest impact on her developing pressure ulcers.

65. **2.** A stage II pressure ulcer may look like a blister, abrasion, or shallow crater and only involve a partial thickness skin loss of the epidermis and/or dermis.

66. **4.** Any supportive device that protects bony prominences aids in relieving pressure. This can include gel flotation devices, sheepskins, alternating pressure mattresses, and various air loss beds.

67. **4**. Moisture-vapor permeable dressings help stage II ulcers heal faster than saline dressings.

68. **2.** The best clinical indicator of healing is observation of the skin and evaluation of the pressure ulcer.

69. **3.** Baseline vital sign assessment is necessary to document against those taken during and after the treatment.

70. **4.** Assessment should be performed first to determine why the client is not eating, which may be due to illness, medication, or cultural beliefs.

71. **3.** The layers act as insulators and prevent moisture loss. Some nurses prefer placing the waterproof layer next to the compress and then covering with a dry cover, whereas others reverse the order, putting the waterproof layer on the outside.

72. **3.** The nurse should check the temperature every 5 minutes or so, and replace some of the water with a hotter solution. Care should be taken to stir the basin while adding the additional water so as not to burn the client.

73. **4.** Most people with chronic lower back pain find relief with applications of heat.

74. **3.** Shivering indicates that the body is trying to warm itself and conserve heat.

75. **3.** Each area is sponged slowly and gently. The face and forehead, the neck, arms, and legs for 3–5 minutes, and the back for 10 minutes.

76. **2.** Unlike a cooling sponge bath where the temperature begins at this point and gradually is lowered to 65°F (18°C) at the end, this is the

temperature that the water begins and ends for a tepid sponge bath.

77. **4.** Cold will produce an anesthetic effect and help to reduce pain as well as control bleeding by constricting blood vessels.

78. **3.** Cold produces an anesthetic effect and can relieve pain.

79. **4.** The nurse should perform a cultural needs assessment. Just because the client is a recent immigrant from India does not mean that the client belongs to a particular religion.

80. **1.** The client's next of kin has stated that the client should not get a transfusion. Jehovah's Witnesses prohibit blood transfusions. The client's family has a right to refuse the treatment. There are other volume expanders that could be tried.

81. **2, 4, 5.** Muslims do not put pork products in their bodies. Porcine insulin is a pork product. Gelatin capsules may come from pork. An elixir is made of alcohol. A devout Muslim does not drink alcohol.

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