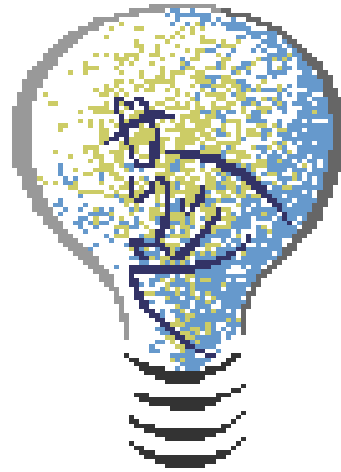


Critical Thinking, Nursing Process Management of Patient Care Leadership

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Critical thinking:

Is a self-directed, dynamic cognitive process that employs purposeful and analytical thinking.

Is a process which helps one utilize knowledge, use the interpretation of information, analysis of data, and the evaluation process to draw inferences or conclusions.

Helps one to provide explanations which ensure accuracy in making clinical decisions

Critical Thinking

- Is a process which stresses an attitude of suspended judgement, incorporates logical thinking, problem solving, evaluation and which ultimately leads to a decision or an action.



Critical Thinking

- Critical thinking is based on reason and reflection, knowledge and instinct derived from experience. “The art of thinking.”
- Critical thinking is a process, an art, a skill -
**THEREFORE IT REQUIRES ...
PRACTICE TO IMPROVE PROFICIENCY**



Points to Consider When Using Critical Thinking

- What is the issue at hand? (Identify the problem)
- Is the problem significant?
- What are the details, facts and relevant criteria?
- What kind of evidence is available for or against possible decisions?
- What are the possible courses of action?
- Which course of action is the most reasonable and/or would be the most beneficial?



Six Cognitive Skills Associated with Critical Thinking

- Interpretation
- Analysis
- Inference
- Explanation
- Evaluation
- Self-regulation



Critical Thinking

Interpretation

- To comprehend, decipher, understand and explain the meaning of written materials.
- Empirical data and graphs.
- Verbal and nonverbal communications

Critical Thinking

Analysis

- Examination of the findings, evidence, facts.
- To organize and categorize data such as signs and symptoms.
- Correlation of the findings to this or a similar situation.
- Validation
- Prioritization of data to identify real or potential consequences.
- Development of the best plan of action.
- Analyze research findings, points of view, concepts and ideas.

Critical Thinking

Inference

- Drawing conclusions from the evidence and identification of needs.
- Identify knowledge gaps or needs.
- To draw conclusions that are logical versus those that are possible.
- To differentiate between conclusions and hypothesis.

Critical Thinking

Explanation

- To justify conclusions based upon evidence
- Written and verbal explanation of the reasoning process in reaching conclusions.
- Use of evidence, concepts, methodologies or contextual considerations.

Critical Thinking

Evaluation

- Assessing the evidence and evaluating strength of information
- To assess information for biases, stereotypes or clichés
- To assess the credibility, relevance, value or applicability of information.
- To assess the credibility of information sources



Critical Thinking

Self-Regulation

- Continuous monitoring, questioning one's own thinking and reflecting on interpretations and judgements.
- Open to new information and willing to examine own views.
- Consideration to possible self-interest and personal biases.



Critical Thinking for the Nurse

- * Observation
- * Deciding what is important
- * Looking for patterns and relationships
- * Identifying the problem
- * Transferring knowledge from one situation to another
- * Applying knowledge
- * Discriminating between possible choices and courses of action
- * Evaluating according to established criteria



Critical Thinking for the Nurse

- * The NCLEX-RN exam is NOT about recognizing facts.
- * Any background information that is not needed to answer the question should be ignored.
- * The NCLEX-RN exam focus is on thinking through a problem or situation.




Commonalities: Critical Thinking, Nursing Process, Problem Solving, Decision Making

- Critical thinking is particularly important in the Nursing Process.
- Critical thinking and the Nursing Process are interrelated and interdependent.
- The Nursing Process requires the use of problem solving and decision making.

Commonalities (cont'd)

- The nurse is able to consider new ideas, and evaluate them in light of accepted information about the patient and personal value systems of client and self.
- Using critical thinking and the **Nursing Process**, the nurse is able to make ethical, creative, rational, independent and interdependent decisions related to patient care.



How Will the **Nursing Process** Help to Answer Prioritizing Questions on the NCLEX-RN Examination?



The Nursing Process

- A Problem-Solving Approach

The Nursing Process

- A systematic problem-solving method
- Dynamic and flexible
- Guides nurses in giving patient-centered and goal-oriented care which is effective and efficient.
- Provides a framework for the delivery of appropriate care to patients and groups.



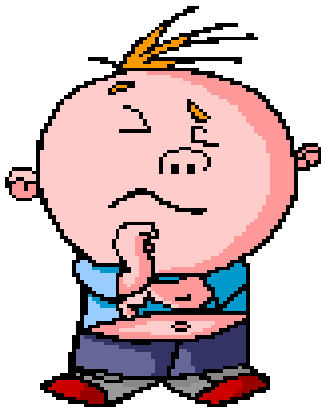
Characteristics of the Nursing Process

- Cyclical versus steps
- The process is continual
- At any point, the apparent outcomes may dictate that one needs to return to the beginning.



Characteristics of the Nursing Process (cont'd)

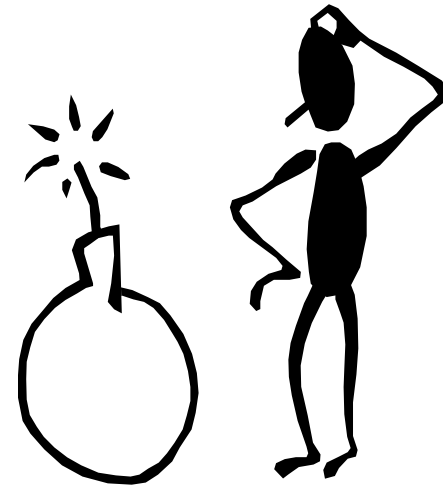
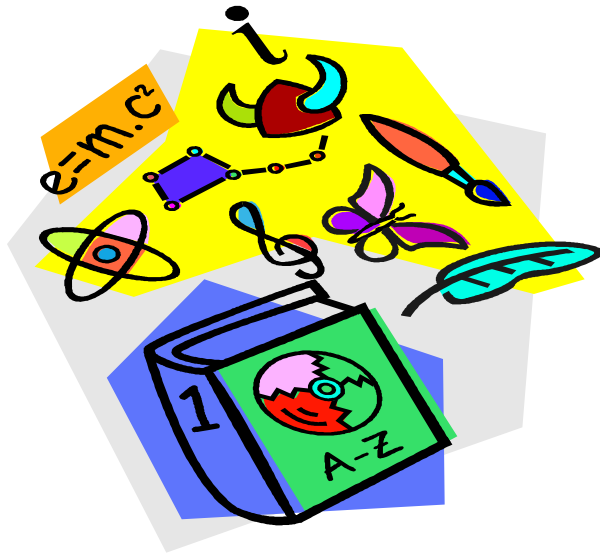
- The **Nursing Process** is patient centered. The patient may be a person, a family or a group of individuals.



Characteristics of the Nursing Process (cont'd)

- The Nursing Process focuses on problem solving and decision making.

(Utilization of critical thinking)



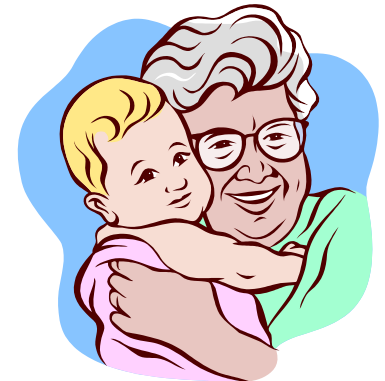
Characteristics of the Nursing Process (cont'd)

- The Nursing Process is interpersonal and collaborative between nurse and patient, significant others and members of the health care team.



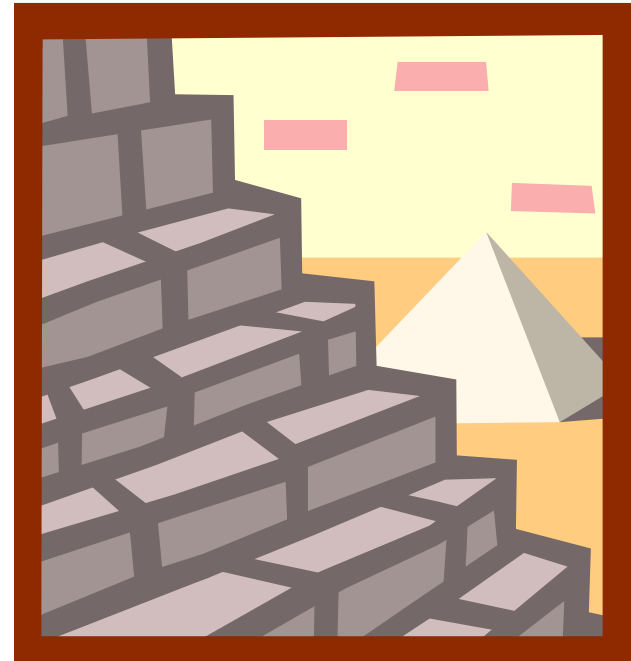
Characteristics of the Nursing Process (cont'd)

- The Nursing Process is a framework for nursing in all types of health care settings and for all ages across the life span.

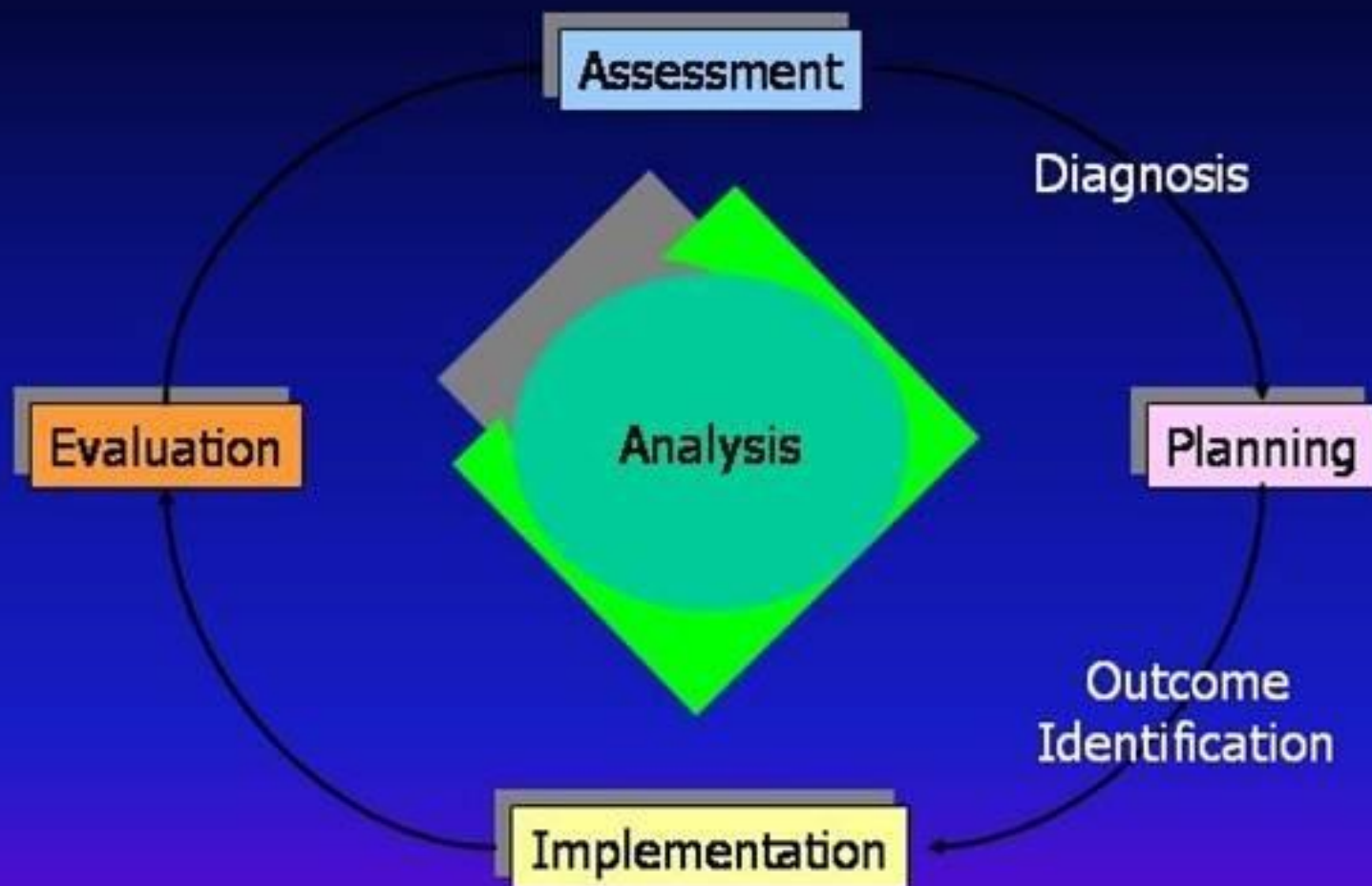


The Five Steps of the Nursing Process

- ***ASSESSMENT***
- ***ANALYSIS***
- ***PLANNING***
- ***IMPLEMENTATION***
- ***EVALUATION***



Phases of the Nursing Process





Assessment

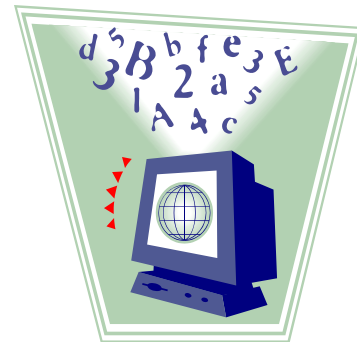
- The process of establishing and verifying a data base about the patient.
- This permits you to identify actual and/or potential health problems.
- The nurse obtains subjective and objective data.

Assessment:

Establish a Database

I. Gather objective and subjective information relative to the client.

- Collect verbal and non-verbal information from all sources.
- Recognize signs, symptoms and significant findings.
- Determine a patient's ability to assume responsibility for their own health needs.
- Assess the patient's environment.

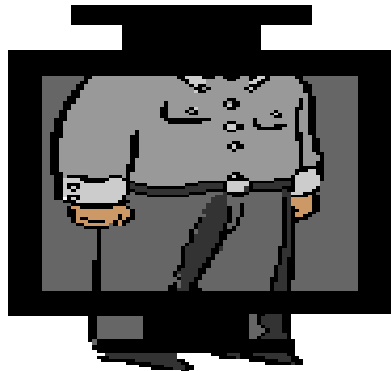


Assessment:

Establish a Database

II. Verify data

- Confirm and verify observations or perceptions with additional information.
- Check a patient's condition personally versus equipment readings to be certain that the information is accurate.



Sample **Assessment** Questions

- In order to assess... the nurse would next...
- The nurse would observe for adverse reactions such as...
- What additional information should the nurse seek from... (ER, MD, family, etc.)
- The most important information that the nurse should gather now is...
- The one finding the nurse is most likely to identify is...
- The nurse would carefully observe for which of the following symptoms?

Assessment Sample Questions

A nurse is teaching a client with coronary artery disease about dietary measures that should be followed. During the session, the patient expresses frustration in learning the dietary regimen. The nurse would initially:

1. Identify the cause of the frustration
2. Continue with the dietary teaching
3. Notify the physician
4. Tell the client that the diet needs to be followed.

Sample **Assessment** Question

The nurse obtains a health history from a patient admitted with acute glomerulonephritis that is associated with beta hemolytic streptococcus. The nurse would expect which of the following to be significant in health history?

1. The patient had a sore throat two weeks earlier.
2. There is a family history of glomerulonephritis.
3. The patient had a renal calculus two years earlier.
4. The patient had an accident involving renal trauma several years ago.

ANALYSIS: Identify actual and/or potential health care needs or problems

Nursing Diagnosis





Analysis

- During this phase of the **nursing process**, you examine the data that you obtained during the assessment phase.
- This allows you to **analyze** and draw conclusion about health problems.

Analysis Sample Questions

The following questions would be asked in the analysis phase of the **Nursing Process**:

- The patient's behavior indicates a nursing diagnosis of ...
- Before administering ...the nurse should check...
- Which finding would interfere with the effective functioning of ...?
- Which findings indicate ...?



Analysis Questions

- **Most difficult questions because:**
 - Requires an understanding of the principles of physiological responses
 - Requires an interpretation of data on the basis of assessment
 - Requires critical thinking and determining rationale for therapeutic interventions

Sample **Analysis** Question

A nurse is reviewing the laboratory results of an infant suspected of having hypertrophic pyloric stenosis. Which of the following laboratory findings would the nurse most likely expect to note in this infant?

1. A blood pH of 7.50
2. A blood pH of 7.30
3. A blood bicarbonate of 22 mEq/L
4. A blood bicarbonate of 19 mEq/L

Analysis Sample Question

A nurse is caring for a patient after a craniotomy (supratentorial surgery) involving the pituitary gland. Which finding indicates a complication of the surgical procedure and the need to notify the physician?

- A. Urine specific gravity of 1.001
- B. Client reports of mouth dryness
- C. 30 mL fluid in the Jackson-Pratt drain
- D. Periorbital edema

Components of a Nursing Diagnosis: Potential Problems

- Potential problems are **two**-part statements which describe an individual, family or group's responses to a situation or health problem.
- **Two**-part statements refer to potential diagnoses because no symptoms are available.

Situation:

A client has a hip fracture and is on strict bed rest.

Nursing Diagnosis:

Potential for alteration in skin integrity related to immobility

Components of Nursing Diagnosis: Actual Problems

Actual problems have a three-part statement.

- State the problem or nursing diagnosis...
- “Related to” phrase or etiology...
- Defining characteristics – symptoms or “manifested by”...

Situation:

Client develops alopecia after receiving radiation.

Nursing Diagnosis:

Body image disturbance related to loss of hair
manifested by verbalization of a fear of rejection.

Planning

During this phase, the **nursing care plan** is formulated. Steps in planning include:

- Assigning priorities to **nursing diagnosis**
- Specifying goals
- Identifying interventions
- Specifying expected outcomes
- Documenting the **nursing care plan**

Planning: Setting Goals and Identifying Strategies

- Establish priorities
- Anticipate needs and/or problems
- Involve patient, family and/or significant other
- Include all pertinent patient information such as age, cultural influences, religious and/or spiritual considerations



Planning: Setting Goals and Identifying Strategies

- Select nursing measures necessary for the delivery of appropriate care.
- Collaborate with members of the health care team.
- Delegate tasks and responsibilities where necessary.



Planning

- Planning questions address **nursing diagnoses**.
- Questions require:
 - Prioritizing **nursing diagnoses**
 - Determining goals and outcome criteria for goals of care
 - Developing the plan of care
 - Communicating and documenting the plan of care

Examples of **Planning** Questions

The following questions should be asked in the planning phase of the **Nursing Process**:

- Which of the following measures should be included in a female patient's post-op care?
- Which intervention is the most appropriate?
- Care should include the monitoring of ...
- Which item is most important for the nurse to have available prior to beginning the procedure?
- Which nursing intervention is the highest priority?

Sample **Planning** Question

A nurse is reviewing the plan of care for a pregnant client with a diagnosis of sickle cell anemia. Which nursing diagnosis is the highest priority?

1. Anxiety
2. Ineffective coping
3. Disturbed body image
4. Fluid volume deficit

Sample **Planning** Question

A 56-year-old man comes to the emergency room complaining of nausea, vomiting and severe right, upper quadrant pain. His temperature is 101.3 F and an abdominal x-ray reveals an enlarged gall bladder. He is scheduled for surgery. The nurse recognizes that which of the following actions is a priority.

1. Determining whether the patient has a history of allergies to antibiotics.
2. Evaluating the patient's fluid and electrolyte status.
3. Examining the patient's health history for allergies to antibiotics.
4. Determining whether the patient has signed consent for surgery.



Implementation

Actions you take in caring for your patient include:

- Assisting in the performance of activities of daily living
- Counseling and educating the patient and family
- Giving care to patients
- Supervising and evaluating the work of other members of the health team



Implementation

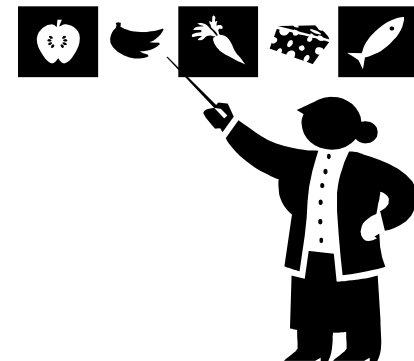
Nursing Interventions may be:

- Independent actions
- Dependent actions
- Interdependent actions

Implementation:

Initiating and Completing Actions Necessary to Achieve Nursing Goals

- Organize and manage a patient's care.
- Perform or assist with Activities of Daily Living.
- Provide comfort measures.
- Assist patient to attain optimal functioning.
- Teach patients, families and significant others.





Implementation: Initiating and Completing Actions Necessary to Achieve Nursing Goals

- Refer patients to appropriate resources.
- Use correct techniques when providing care.
- Use appropriate protective techniques.
- Maintain required patient documentation accurately and in a timely manner.

Implementation

- **Implementation questions address:**
 - The process of organizing and managing care
 - Counseling and teaching
 - Providing care to achieve established goals
 - Supervising and coordinating care
 - Communicating and documenting nursing interventions

Sample **Implementation** Question

A 25-year-old man is being treated for second and third degree burns. The physician's orders include silversulfadiazine (Silvadene cream). The best way to apply this medication is to use a sterile:

1. 4 x4 soaked in saline.
2. Tongue depressor
3. Gloved hand
4. Cotton-tipped applicator

Sample **Implementation** Questions

- Which of these actions should the nurse perform first? Last?
- The nurse should now administer... or provide...?
- Which response would be most appropriate?
- The highest priority nursing intervention at this time would be ...?
- The nurse's next most appropriate action would be...?
- The nurse should now institute ...?



Implementation Sample Question

A nurse is caring for a preoperative patient who verbalizes a great deal of anxiety about the surgical procedure scheduled in 2 hours. Which action by the nurse would best alleviate the patient's anxiety?

1. Tell the patient that you will spend some time answering his questions as soon as you get your other tasks completed.
2. Talk to the patient for 15 minutes and return shortly thereafter to check on the patient.
3. Call the patient's wife and ask her to visit the patient before surgery.
4. Stay with the patient until he is brought to the operating room.



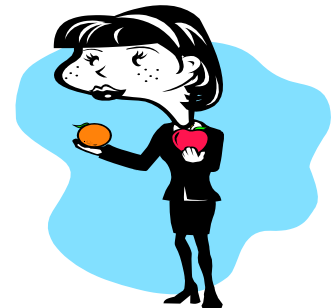
Evaluation

- Measuring the patient's response to nursing interventions.
- Response indicates the patient's progress towards achieving the goals established in the care plan.
- Compare the observed results to the expected outcomes.

Evaluation:

Determine the Extent to which the Nursing Goals Have Been Met

- Compare actual outcomes of care with expected outcomes.
- Evaluate a patient's compliance with the prescribed therapy or regimen.
- Make a judgment concerning a patient's response to therapy or nursing action.



Evaluation: Determine the Extent That the Nursing Goals Have Been Met

- Determine the patient's and/or family's understanding of the educational information that was initiated.
- Determine the patient's (or family's) ability for self-care
- Determine the need for a change in patient care goals, degree of monitoring or need for additional nursing interventions.





Evaluation: Communicate & Document

Communicate the results of the evaluation process to the healthcare team by:

- Updating the patient's care plan
- Documenting outcome in nurse's notes
- Including a summary of findings during change-of-shift report

Evaluation Sample Question

When caring for a patient with anorexia nervosa, which of the following observations indicate to the nurse that the patient's condition is improving?

1. The patient eats all the food on her meal tray.
2. The patient asks friends to bring her special foods.
3. The patient weighs herself daily.
4. The patient's weight has increased.

Sample Evaluation Questions

The following questions should be asked in the evaluation phase of the nursing process in order to determine the effectiveness of interventions.

- Which response indicates patient compliance with the nursing intervention?
- Which comment would indicate that the patient understands his or her medication regimen ?
- Documentation should include which of the following side effects of the prescribed medication...?
- Which patient statement indicates a need for further teaching?
- Which behavior will the nurse identify as a sign of a patient's compliance with antibiotic therapy?

Evaluation Sample Question

A client recovering from an exacerbation of left-sided heart failure has a nursing diagnosis of “activity intolerance.” The nurse determines that the patient best tolerates mild exercise if the patient exhibits which of the following changes in vital signs during activity?

1. Pulse rate increased from 80 to 104 beats/min
2. Respiratory rate increased from 16 to 19 breaths/min
3. Oxygen saturation decreased from 96% to 91%
4. Blood pressure decreased from 140/86 to 112/72 mmHg.



Delegation: The RN as Supervisor

- The RN for whom the unlicensed assistive personnel (UAP)—CNAs, LVNs—and other RNs receive assignments.
- Work title may be team leader, charge nurse or Director of Nursing.



Delegation: The RN as Supervisor

- Supervising RN has responsibility for the nursing care provided by those being directed.
- Those individuals receiving assignments are accountable to supervising RN.

Delegating Care

- Must be within scope of practice
- Priorities of care identified
- Coordination of all care provided
- Balance the workload
- Balance the stress
- Consider fairness of assignment
- Consider appropriateness of assignment
- Consider efficiency of assignment
- Consider compatibility



The **Five Rights** of Delegation

1. **RIGHT TASK:** Tasks that are repetitively performed, require minimal problem solving or innovation.
2. **RIGHT CIRCUMSTANCES:** Appropriate patient setting with appropriate resources and the right timing.
3. **RIGHT PERSON:** The right person is delegating the right tasks to the right person to be performed on the right patient.

The **Five Rights** of Delegation

(cont'd)

4. **RIGHT DIRECTION:** Clear, concise description of the task, including its limits, purpose and expectations. Right information about a patient that must also be communicated - any variation needed in how the task is to be performed.
5. **RIGHT SUPERVISION:** Appropriate monitoring, evaluation, intervention and feedback.



Assignment versus Delegation of Nursing Care

- **Assignment** – allocating patient care to members of the health care team.
- Determine nursing care required to meet patients' needs including factors affecting patient safety, the number of patients to be assigned, patient acuity and the complexity of the tasks to be performed throughout the shift.
- Consider knowledge and abilities of staff members.
- Decide which staff person is best able to provide care.



Assignment versus Delegation of Nursing Care

Assignment (cont'd)

- Take into account continuity of care
- Determine assignments to increase efficiency
- Describe assignments in measurable terms
- Be specific regarding expected results
- Give assignments to staff members



Assignment versus Delegation of Nursing Care

Delegation

- Responsibility and authority for performing a task is transferred to another person who accepts that responsibility and authority.
- Delegator remains accountable for tasks delegated.

Assignment versus Delegation of Nursing Care

Delegation (cont'd)

- Delegatee is accountable to delegator (and patient) for responsibilities that are assumed and carried out.
- Use caution when asking another staff member to perform a task that is one of your responsibilities.

Assignment versus Delegation

Definitions

Responsibility – obligation to accomplish delegated task.

*In **delegation** the responsibility is **transferred**.*

Accountability – accept ownership for results or lack of results.

*In **accountability** the responsibility is **shared**.*

Assignments and Delegation

An RN can only delegate those tasks which a staff member is legally able and responsible to perform. This is determined by the:

1. Nursing Practice Act
2. California Code of Regulations, Business & Professions Code
3. Job description
4. Policy statement

Assignments and Delegation

What *not* to do

Do not:

- Assign tasks to UAPs for patients who are unstable or medically fragile
- Assign tasks to UAPs if the task could pose potential harm to the patient
- Assign tasks to UAPs which require a substantial amount of scientific knowledge and technical skill

Assignments, Delegation and the NCLEX Exam

- When answering questions relating to assigning or delegating of nursing care, refer to the general guidelines found in authoritative documents such as the Nursing Practice Act.
- This supporting document will provide information regarding what a health care provider can competently and legally perform.
- Avoid using local health care agency policies and procedures or agency position statements unless the question directs you to give this information.



Assignments, Delegation and Time Management

- Always provide directions that are clear, concise, accurate, complete and validate the person's understanding of the directions and expectations.
- Maintain continuity of care as much as possible. It is best for the patient to be cared for by a nurse with whom the patient has developed a therapeutic relationship.

Assessing Skills of Members of the Health Care Team

- Should take place at the **beginning** of the work relationship and **prior** to making patient assignments.
- A **remediation plan** should be developed if the team member can't perform all areas of the job description.
- Assignments should be make with staff member's **limitations in mind**.

Communication and Delegation

- When making assignments, consider the language skills of the patient and health professional.
- When English is a second language for health care professionals, give consideration to listening, speaking, reading, writing and comprehending skill level.
- This may affect an assignment and the understanding of individualized patient care instructions.

Communication and Delegation

- Delegatee must be able to **meet** most of the **work demands** with confidence and function effectively in work situations that require interaction with the public.
- They should be able to **follow written** technical **information**.
- If pronunciation inhibits fluency and communication, these health care providers should be able to **adjust their language** to be understood.

Steps for Delegation

- Define task to be delegated.
- Identify constraints for completing task and risks involved.
- Identify variables that would change authority and responsibility.
- Obtain feedback from delegatee regarding assignment.
- Reach mutual agreement on task(s) to be performed.

Steps for Delegation (cont'd)

- Monitor performance and results according to the established goals.
- Give constructive feedback to delegatee.
- Confirm that delegated tasks are performed as agreed.
- Delegator must remain accessible during the performance of the task(s).

What Is **NOT** Delegation

- Assignment of tasks that are **outside** an individual's **scope** of practice.
- Assignment of overall responsibility for the **safe and effective** clinical outcomes of patients.

Delegation: Legal and Quality of Care Considerations

- Many nursing functions can legally be performed by CNAs and LVNs.
- Be certain to clearly understand the differences of each team member's scope of practice.
- Failure to recognize differences among the role functions of other members of the health care team can result in legal and patient care problems.

Delegation **Pros** and **Cons**

- Delegation **increases staff satisfaction**, RN **efficiency** and overall **productivity** of the health care team.
- Delegation of care may be beyond the **scope**, **competence** and **legal practice**
- LVNs have their own licenses, but practice under the direction of the RN and MD.
- If team **worker expresses doubt** about an assignment, if there is a **failure to assume responsibility**, or the worker questions the appropriateness of care to be provided.

California Board of Registered Nursing on Delegation

- Consider the **legal scope** of practice of licensed and unlicensed workers.
- A license authorizes the same scope of practice but not all licencees have the same **level of education and experience**.
- Evaluate **preparation and capability** needed in the tasks to be delegated.
- Evaluate if **clinically competent** to perform the functions delegated to them.
- **Supervise** nursing care being performed.



California Code of Regulations, Title 16

Curriculum Requirements for Nursing Schools

- Communication skills shall include principles of verbal, written and group communication.
- Legal, social, ethical aspects of nursing
- Nursing leadership and management

Barriers to Effective Delegation

- Need for **control** limits effective delegation.
- Believing that supervising others takes **more work time** than it actually does.
- **Anxiety** about being able to assure **safe and effective clinical outcomes**.
- **Failure to understand** the roles of others.
- **Anxiety** about taking on **responsibility** without adequate support.

Unlicensed Assistive Personnel (UAP)

- Includes aides, orderlies, nursing care assistants, patient care attendants and technicians.
- Considered to be nurse extenders.
- Must be supervised when given responsibility and are accountable to RN.
- Includes direct and indirect care.
- Must protect patients/staff from harm.
- Assignment must be within scope of practice and compatible with skills and education.



Unlicensed Assistive Personnel (UAP)

Noninvasive tasks and basic patient care activities:

Ambulation

Specimen collection

Client transport

Range of motion exercises

Chore services

Stocking tasks

Assist with ADL care

Positioning

Bathing

Grooming

Companion care

Housekeeping

Maintenance activities

Unlicensed Assistive Personnel (UAP)

The term “unlicensed assistive personnel” does not include members of the client’s immediate family, guardians, or friends; these individuals may perform nursing care without specific authority from a licensed nurse [as established in Section 2727(a) of the Nursing Practice Act]

<http://www.rn.ca.gov/pdfs/regulations/npr-b-16.pdf>



Unlicensed Assistive Personnel (UAP)

For more information regarding assigning tasks to UAPs, see the Board of Registered Nursing, California's document titled, *Unlicensed Assistive Personnel*. This document can be found online at:

<http://www.rn.ca.gov/pdfs/regulations/mpr-b-16.pdf>

Medical Assistant (MA)

- Broad definition: an unlicensed person who provides administrative, clerical and technical support to the physician (most commonly in clinics and doctor's offices).
- The MA scope of practice governed by the Medical Practice Act, Business & Professions Code
- The licensed physician, surgeon or licensed podiatrist is required to be physically present in the treatment facility when the medical assistant is performing procedures.

Medical Assistant (MA)

- If a physician provides written instructions regarding supportive tasks for the MA in writing, a registered nurse or physician's assistant may then assign (delegate) those tasks to the MA. The RN must first:
 - 1) assess the MA's competence at performing the assigned task;
 - 2) verify an order concerning the task has been written in the patient's medical record;
 - 3) confirm that performance of the procedure or task by the MA was documented in the patient's medical record.

Medical Assistant (MA)

- RNs may train MAs to perform technical support services.
- With appropriate training, an MA may administer medications and draw blood.
- The law prohibits an MA from providing technical support in an acute care hospital.
- For more information related to assigning tasks to MAs including a list of approved procedures an MA may perform refer to:

<http://www.rn.ca/gov/pdfs/regulations/npr-b-12.pdf>

Licensed Vocational Nurse (LVN)

In addition to the tasks that unlicensed personnel can perform, an LVN can perform the following:

- Administering oral medications
- Administering intramuscular injections
- Administering subcutaneous injections
- Changing dressings

Registered Nurse (RN)

Some of the tasks that only the registered nurse can perform are:

- Administering intravenous medications
- Leading others and managing the client care environment
- Teaching (LVNs and MAs may review instructions with patients that are provided in writing such as hospital-approved patient teaching materials or instructions written by a healthcare provider).
- Using the nursing process

Registered Nurse (RN)

- The following aspects of the nursing process shall be performed **only** by registered nurses:
 - 1) performance of a comprehensive assessment;
 - 2) validation of the assessment data;
 - 3) formulation of the nursing diagnosis for the individual client;
 - 4) identification of goals derived from nursing diagnosis;
 - 5) determination of the nursing plan of care, including appropriate nursing interventions derived from the nursing diagnosis; and
 - 6) evaluation of the effectiveness of the nursing care provided.

Delegation Sample Question

A RN is planning patient assignments for the day with a LVN and a nursing assistant. The nurse most appropriately assigns which patient to the LVN?

1. A patient with a tracheostomy who requires frequent suctioning.
2. A patient who requires the collection of urine for a 24-hour period.
3. An older patient who requires turning and repositioning every 2 hours and range-of-motion exercises every 4 hours.
4. An older patient recovering from pneumonia who requires ambulation every 3 hours.

Delegation and Time Management

- Time Management is the ability to manage time efficiently to complete tasks and patient care activities within a reasonable time frame.
- Identify tasks, obligations, and patient care activities, and write them down.
- Identify which tasks and patient care activities must be completed in specified time frames.
- Prioritize patient needs.

Delegation and Time Management

- Keep a daily hour-by-hour **log** to assist in providing structure to the tasks that must be accomplished, and cross tasks off the list as they are accomplished.
- Use hospital and agency **resources** efficiently, anticipating resource needs and gathering the necessary supplies before beginning the task.
- Provide **time** for unexpected and unplanned tasks.
- **Delegate** tasks when appropriate.
- Organize paperwork and continuously **document** task completion and necessary client data throughout the day.

Time Management

Sample Question

A home care nurse is planning visits for the day and will visit her first patient at 8:00 a.m.

- List in order of priority how the nurse will plan the day's visits. All patients live within a 5-mile radius.
- (Number 1 is the first patient that the nurse would visit and 4 is the last home care visit for the day).



Time Management Question Options

1. A patient with pneumonia who was discharged from the hospital 1 day ago; the patient's spouse lives with the client, and the patient will need to be admitted to home care.
2. A patient who requires a daily dressing change on the foot.
3. A patient who requires a fasting blood glucose draw before self-administering insulin.
4. A patient who will be cared for by a home health aide for the first time, with the aide scheduled to arrive at the patient's home at 9:00 am.



Delegation

Sample Question

An RN assigns the care of a new post-operative mastectomy patient to an LVN. The RN reminds the LVN not to take the blood pressure on the operative side. Later in the shift, the RN discovers the BP cuff deflated but still on the arm of the patient's affected side.

How should the RN handle this situation?



Delegation

Sample Question Options

1. Talk to the LVN in private after the shift is over.
2. Call the LVN in for counseling to determine why she did not follow directions.
3. Find the LVN and review with her the importance of not taking the blood pressure on the affected side.
4. Write up a report regarding the incident and place it in the LVN's personnel file.



Delegation

Sample Question

The nurse demonstrates an understanding of appropriate delegation when she assigns which patient care to the LVN?

1. A psychotic patient
2. A patient receiving chemotherapy
3. A patient in Buck's traction
4. A patient receiving a blood transfusion



Delegation

Sample Question

The RN is making patient assignments including several patients who have AIDS. One of the nursing assistants states, “I’m not going to take care of anyone who has AIDS.” What is the best action for the RN to take regarding the assignment?



Delegation Sample Question Options

1. Tell the NA that when she was hired, she was advised about caring for AIDS patients and she does not have a choice.
2. Respect the NAs request and assign others to care for the AIDS patients.
3. Determine her knowledge regarding Standard Precautions and her ability to follow them correctly.
4. Privately discuss with the NA that it is necessary for her to provide care to AIDS patients and then determine the source of fear.



Time Management Sample Question

Two days after admission a patient's sputum culture is reported as positive for TB. While awaiting orders from the physician, the nurse should:



Time Management Sample Question Options

1. Initiate measures to transfer the patient to a TB unit.
2. Institute measures to initiate respiratory isolation.
3. Arrange for all of the patient's personal effects to be decontaminated.
4. Notify the family that they have been exposed to a highly contagious disease.



Time Management Sample Question

Several patients are admitted to the medical unit at the same time. Each patient has an order to initiate IV therapy. Which patient should receive care first?

1. Abdominal pain
2. Vaso-occlusive cell crisis
3. Mild dehydration
4. Surgery scheduled for the next day



Supervision Sample Question

A patient is admitted and the lab technologist arrives to draw blood. After the technician leaves, the RN finds dried drops of blood on the floor and the wall adjacent to the needle container. When considering safety issues, what is the best nursing response?



Supervision

Sample Question Options

1. Call the lab supervisor and report the poor technique used by the technologist.
2. Make a note for the unit manager to discuss the break in aseptic technique with the lab supervisor.
3. Call housekeeping to come immediately to clean the area.
4. Have the lab technologist return and clean up the area.



Prioritizing Sample Question

A 5-year-old is admitted after sustaining a closed head injury as well as numerous lacerations and abrasions to the head and neck.

Three hours after admission to the hospital, the child is assessed to be unconscious and minimally response to painful stimuli.

Which assessments should the nurse report to the physician?



Prioritizing Sample Question Options

1. Her obtunded state (level of consciousness or LOC).
2. Clear fluid draining from her right ear.
3. Slight withdrawal of extremities in response to painful stimuli.
4. The condition of the lacerations on her face.



Supervision

Sample Question

A nursing unit is implementing a project involving changes in the way the unit is managed. The RN manager continues to have problems with a team member that has been disruptive regarding the implementation of this project.

What is the best approach for the nurse manager to take when handling this situation?



Supervision

Sample Question Options

1. Call the unit supervisor and advise her of the problems observed with the team member and ask her how to handle the situation.
2. Privately meet with the team member, review her behavior and determine if she is aware of the impact her behavior has on the nursing unit.
3. Involve other members of the team in an attempt to discourage the team member's disruptive behavior.
4. Counsel the disruptive team member and ask her why she is not happy working on this unit.



Delegation

Sample Question

The nurse is making an assignment for the evening shift. In a shared semi-private room, patient A has neutopenia.

Patient B has a tracheostomy with purulent drainage and a pending C & S.

Which nursing care assignment is most appropriate?



Delegation

Sample Question Options

1. Assign an experienced nurse to care for both patients in the same room.
2. Assign 2 nurses: one for patient A and one for patient B in the same room.
3. Transfer patient A to a private room and assign the same nurse to care for both patients.
4. Transfer patient A to a private room and assign a different nurse to care for each patient.



Leadership in Nursing Practice

- Giving feedback to members of the health care team is a vital role nursing leaders assume.
- Positive feedback if given frequently will help motivate staff to excel in their work and may increase job satisfaction.
- Negative feedback if given without criticism, is essential for course correction and quality improvement.



Leadership in Nursing Practice

Qualities held by effective leaders include:

Integrity

Initiative

Optimism

Influence

Respectful of others

Problem solving skills

Handles stress

Courage

Energy

Critical thinking

Informal designation

Good listening skills

Perseverance

Balance

Leadership in Nursing Practice

Qualities held by effective leaders include:

- Good listening and communication skills
- Setting goals
- Having a vision
- Good coach
- Good evaluator
- Self-development
- Self-awareness
- Encouraging exchange of information

Management Role

- A **formal** designation of a role
- An assigned job or position
- Based on authority and influence
- Includes budgetary responsibilities
- Has hiring, firing and evaluation duties
- Good managers demonstrate use of leadership traits.



Effective Managers

- Clinical expertise
- Business sense
- Networking
- Conflict resolution skills
- Employee development
- Rewards and punishment

Managers or Leaders

- Managers have employees.
- Leaders have followers.
- Leaders empower and inspire.
- The manager's position is legitimized by position or title.
- The leader's position is legitimized by a vision and the ability to communicate the vision to followers.
- Managers seek stability, predictability and to be in control.
- Leaders seek flexibility and change.



Mc Gregor Leadership Styles

X leader is a controlling, rule driven, micro-manager; threats of punishment such as loss of raise or job and reprimands are driving forces.

Y leader motivates by producing a supportive environment, focusing on guidance, rewards for performance, development versus supervision.

Power Can Be

- Legitimate/ Authority
- Reward
- Coercive
- Expert

Management Styles

Autocratic

- Bureaucratic
- Makes and announces decisions without input
- Focuses upon selling decision

Management Styles

Democratic

- Presents problems
- Solicits solutions
- Tests feasibility of solutions
- Consults and collaborates
- Defines limits

Management Styles

Laissez Faire

- Asks group to make decisions
- Sets some parameters
- Joins as a colleague
- Lets go of role constraints
- Gives total responsibility to group
- Maximum group freedom
- Minimum leader control



The Management Process

- **Assessment**

- Needs

- Resources available

- Planning

- Establish goals

- **Identify, write, revise policies and procedures**

Leadership Styles: **Directing**

- Focuses communication on **goal achievement**
- Gives instructions on what goals to achieve and how to achieve them
- Spends a limited amount of time on supportive behaviors

Northhouse, 1997

Leadership Styles: Coaching

- Focuses communication on both goal achievement and individual's needs
- Gives encouragement
- Asks for input
- Ultimately the leader still makes the final decisions

Northhouse, 1997

Leadership Styles: **Supporting**

- Does not focus on goals
- Focuses on tasks to be accomplished
- Uses **supportive behaviors** to bring out others' skills

Listening

Praising

Asking for input

Giving feedback

Leadership Styles: **Delegating**

- Offers less input and social support
- Facilitates other's confidence and motivation to do tasks
- Leader not as involved in planning, details or goal clarification

Northouse, 1997



Comparing and Contrasting Leadership Styles

Directing

High directive and low supportive

Coaching

High direct and high supportive

Supporting

High supportive and low directive

Delegating

Low supportive and low directive



Leadership and Giving Feedback

- Everyone **NEEDS** it!
- Reinforces behavior
- Provides recognition of achievement
- Provides correction
- Supports development of strengths

Providing Feedback:

What to do:

- Provide both positive and negative.
- Be constructive rather than critical.
- Be objective and fair.
- Give feedback in a private setting.
- Seek first to understand then be understood.
- Include suggestions for change.

Providing Feedback

What NOT To Do

- Avoid issues of concern
- Be vague
- Show favoritism
- Correct individuals in public
- Demonstrate bias
- Assume you know the whole story
- Include threats

Feedback Case Discussion

As team leader you notice that an RN co-worker is frequently 5-10 minutes late for her shift. The RN has again arrived late which has caused a disruption of end-of-shift report. During the report the RN complains about traffic and asks for a census report.

- What would you do in this case?
- What feedback would you provide?
- How would you go about providing feedback?

Evaluation Case Discussion

You are the nurse manager for a busy inpatient unit. You have the task of writing a performance evaluation for a marginally performing staff RN. Staff have met with you regularly complaining about sloppy and inaccurate information documented by this RN. During the evaluation the RN becomes angry, hostile and accuses you of “discrimination.”



Evaluation Case Discussion

- What would you do to diffuse the angry response?
- How would you provide feedback to this individual?
- Should this RN get a “satisfactory” rating on her evaluation?

Documentation

Multiple purposes exist for thorough and timely documentation

- Promotes communication among health professionals.
- Maintains a legal record of patient care.
- Meets requirements of regulatory agencies.
- Required for third-party reimbursement for services rendered.



Documentation

Characteristics of Good Documentation

1. Legible
2. Accurate
3. Timely
4. Thorough
5. Well-organized and concise
6. Confidential
7. Proper grammar and spelling
8. Approved abbreviations



Documentation

Changes in a patient's condition are noted as follows:

1. Assessments of a patient's condition is compared with previous evaluations over time.
2. Notification of a physician is documented if a patient's physiological or psychological condition changes significantly.



Documentation

Changes (cont'd)

3. Notification of members of the interdisciplinary team if changes are noted in a patient's medical condition.
4. Notification of family or significant others about changes in patient's condition and plan of care.
5. Document performed in timely manner which records urgent or acute changes in a patient's condition.



Summary

- Critical thinking is an integral part of our practice as RNs.
- Understanding the components of the nursing process, which utilizes elements of critical thinking, is fundamental to our role as RNs.
- The patient is central to our utilization of critical thinking and the nursing process.
- Role functions of delegation, assignment and time management skills are integral to the roles and responsibilities of RNs.



Summary

- Effective leaders and managers are critical to ensure the provision of high quality care.
- Leadership styles can affect the functioning of the health care team.
- Feedback given with consideration to the individual receiving feedback can be a valuable experience.



Expected Role Outcomes and Competencies of the Professional Nurse

- Critical Thinker
- Communicator
- Care Provider
- Manager of Care
- Member of the Profession
- Lifelong Learner



Practice Makes Perfect!

- The more one uses critical thinking, the more skilled they will become.
- Critical thinking is one of the educational nursing outcomes required by the National League for Nursing Accrediting Commission.
- Being able to distinguish between fact and opinion is critical to highest level of nursing functioning.




Photo Acknowledgement:

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