

CHAPTER

1

Introduction to Medical-Surgical Nursing

OBJECTIVES

In this chapter you will review:

- The function and purpose of the medical-surgical unit.
- The scope and role of the medical-surgical nurse.
- The impact of culture on the provision of care in the medical-surgical setting.
- Patient safety in the medical-surgical setting.
- Utilization of the nursing process in the medical-surgical setting.
- Documentation of care in the medical-surgical setting.

THE MEDICAL-SURGICAL UNIT



Here's the Deal

Hospital admissions are necessary when a sick person needs a nurse around the clock.



Factoid

Specialized units (pediatrics, intensive care, obstetrics) have sick patients with more predictable needs, but the nurse on a medical-surgical unit must be prepared to take care of adult patients across the life span who have all kinds of acute and chronic health issues, many of which can deteriorate into emergency situations.

Hospitals organize patients in order to create the optimal healing environment. The medical-surgical unit has often been described as a “catch-all” for different types of patients. This is not to be confused with patients who are uncomplicated or do not require specialized care. Patients who are hospitalized in today’s health care environment are most likely experiencing a serious acute illness or the exacerbation of a chronic illness. This patient mix includes surgical patients, cardiac patients, cancer patients, renal patients, and everything else that doesn’t fit into one of the specialized categories.

The medical-surgical unit is a conglomeration of all kinds of nonpregnant adults having all sorts of health problems; therefore, nurses on such a unit must be versatile and on their toes at all times! Emergency Department nurses (who expect emergencies) are well equipped to deal with emergency situations because they deal with life-and-death emergencies on a daily basis, and they are always looking for complications secondary to trauma. Nurses on a medical-surgical unit must be careful not to develop a “ho-hum” attitude toward routine nursing care, as their patients can experience rapid changes in condition and quickly become unstable even though they were admitted for the predictable kinds of conditions commonly seen on a medical-surgical unit.

The largest percentage of medical-surgical nurses are employed by acute care facilities; however, there are opportunities for provision of care by medical-surgical nurses in other settings. These settings include but are not limited to clinics, outpatient surgery centers, physician offices, long-term care facilities. In other words, patients require medical-surgical care across a wide expanse of the health care spectrum.

+ The nursing process

The nursing process is how we do what we do! The nurse has a scientific knowledge base from all nursing research and other disciplines (anatomy and physiology, psychology, nutrition, chemistry, etc.), and uses the nursing process to provide evidence-based nursing care. A sound understanding of the nursing process is mandatory for all nurses in any practice area.

The nursing process is the organizing framework for all nursing care. The phases of the nursing process are:

- Assessment
- Diagnosis
- Planning
- Implementation
- Evaluation

Assessment

Nursing assessment is the initial and most important phase of the nursing process. If you miss something, how can the best nursing diagnosis

be assigned? It can't! The RN always has to complete the admission assessment, because this is the time when the patient is assessed from head to toe, just to make sure that something important is not being missed.

CASE IN POINT What if the patient is admitted with an ingrown toenail and all that we focused on was the toe? If I missed night sweats, remittent fever, and a chronic cough, then I could possibly spread TB all over the surgical unit! The admission nursing assessment and history is too important to delegate to non-nurses! Does this mean that the CNA cannot get your admission vital signs and weigh my patient? Certified nurse aides are supposed to be able to correctly perform these tasks; however, since drug dosing is based on weight and comparisons of vital signs refer back to baseline, the RN obtains these initial data. Does this mean that the RN has to go through every pill bottle in a 10-pound grocery sack of medications to write down every dosage and schedule, plus when it was taken last? No, it does not. The LPN is a licensed staff member who is perfectly capable of filling out the medication reconciliation record! But the RN is required to sign the admission form verifying all data. And the RN oversees all aspects of care; but we will discuss this more with principles of management and delegation.

Subjective Versus Objective Data

Some aspects of physical assessment can be seen by the nurse, and other aspects of physical assessment must be based on what the patient tells you.

Nursing diagnosis

The second phase of the nursing process requires what your nursing instructors call “critical thinking.”

- First, you assess your patient and differentiate normal versus abnormal findings.
- Then, determine what is normal for your patient depending on the history and disease process.
- Next, analyze data from your complete nursing assessment, and interpret what the data mean.
- Once you determine the patient's problem, you're ready to go to the list of patient problems that NANDA (North American Nursing Diagnosis Association) put together for us, and pick out the appropriate nursing diagnosis! Now we are ready to roll!

Planning

If you miss the boat on the nursing diagnosis, your planning isn't worth a “toot!” That's why your data (objective and subjective) needs to be



Factoid

The admission physical assessment and nursing history are only performed by the registered nurse!



Factoid

Objective data=can be observed
The big “O”= Observed
Anything that can be observed (seen by the nurse, such as moist rales in a lung, lesions on the body, vital signs, or lab tests) are always objective data.



Factoid

Anything that the nurse cannot detect independently is subjective data, because the patient will have to tell you about the complaint. The nurse can see the patient grimacing and limping with each step (objective data because the nurse can see this), but the nurse must share these observations with the patient and ask if pain is present (subjective feeling experienced by the patient).



Factoid

Subjective = Has to be stated (said) by the patient
The big “S” = Stated (by the patient)



Here's the Deal

When performing patient assessments, the first step is to compare everything you see with normal physical assessment findings. Then, based on patient history, consider what is normal for that particular patient.



Here's the Deal

Now you see why “thinking” is critical! All those notes you have written down, the patient lab work and X-rays, plus the subjective data obtained from the patient are all pieces of the puzzle that you put together with the processes of analysis and interpretation to come to a conclusion about the patient’s problem.



Factoid

Sometimes you will find that you need additional data in order to come to a conclusion about your patient’s problem. That’s when you go back to the drawing board!



Factoid

The ABC method is always good to use when setting priorities, but don’t pick airway as the priority if your patient does not have an airway problem!

- A = airway
- B = breathing
- C = circulation



Marlene Moment

If your diabetic patient has an airway problem, but you decide to do foot care first, nobody except the mortician will see what a good job you did because they don’t usually open the lower half of the casket for viewing.

complete and verified with the patient. Planning always starts with deciding which patient problems need attention first!

In addition to setting priorities, the planning phase of the nursing process is also a time for setting realistic, attainable patient goals that provide the direction for selecting interventions to accomplish the desired patient outcomes.

Implementation

Now we are ready to carry out the planned actions (nursing interventions) during this caregiving phase of the nursing process.

- These interventions can be independent, interdependent, or dependent actions.
- A large portion of nursing interventions come from the nursing domain: things that nurses have been taught to do that are based on scientific, outcome-based, nursing knowledge.

As nurses we cannot do everything independently, so we collaborate with other members of the health care team to carry out interdependent nursing interventions. For example, you know (independently) your patient who has an endotracheal (ET) tube needs mouth care and a lemon-glycerin swab will not suffice. Here’s what to do:

- Collaborate with the physician for a peroxide-based oral solution.
- Wait for the respiratory therapist (RT) to change the mouth piece/bite block and the Velcro strap holding the ET tube.
- Enlist assistance of the RT to secure and stabilize the endotracheal tube.
- Clean, suction, and rinse the patient’s mouth during a time when everything is out of the mouth and you can see what you are doing!
- We all work together (interdependently); because none of us want the patient to develop a lung infection from a yucky, bacteria-filled mouth!

We aren’t finished with the implementation phase until we do the paperwork! We have to document the patient response (during and after the intervention) and share this information with other health care team members.

Charting (documentation) may be done using pen-and-paper; nurse’s notes or flow sheets, or may be computerized charting, done at the bedside. Regardless of how you chart, institutional guidelines for use of accepted abbreviations must be followed to the letter! Because so many errors are preventable, abbreviations are changing to protect the patient.

Evaluation

During the evaluation phase of the nursing process, you have to determine whether or not the plan is working. You ask yourself:

- Have goals been met?
- Are the short-term goals being met with progress toward long-term goals?

- Is this plan of care working to accomplish the patient's highest possible level of wellness?

The nurse has to reassess whether the plan of care is accomplishing the expected outcomes! Notice that we have to assess again!

- We are always assessing and reassessing the patient's response to everything!
- And we are always evaluating and re-evaluating everything too!

The evaluation phase is never ending.

- Some patient issues resolve and are no longer priority.
- Other problems change or new problems present themselves!

That's why nursing is so FUN! Nothing is ever the same (static)! Patient needs and related nursing care are constantly changing (dynamic) from minute to minute and day to day.

SBAR form of communicating the patient status in terms of recovery, risk reduction, or rehab concerns. This format originated with commanders in the armed forces, and was used when one commander "handed-off" to another:

S = Situation: Describe the current problem.

B = Background: Give the doctor a rundown on the patient (admission diagnosis and vital signs, treatments, previous lab results, or whatever is relevant).

A = Assessment: Share conclusions (based on assessment) about the patient's problem.

R = Recommendation: Offer a statement of what you believe would be helpful to remedy the patient's problem.

+ Therapeutic communication

Therapeutic communication is sending, receiving, and interpreting information necessary for all interactions with patients, families, and health care personnel. Communication is verbal, which includes the written and spoken word, as well as nonverbal, which includes tone, gestures, body language, and physical presence when silence is used. All therapeutic communication is "for good" and is goal oriented rather than just "shooting the breeze" (talking to be talking) about trivia, or making social conversation.

- Beginning with the birth cry, communication is a basic human need: the ability to make needs known, to understand, and respond.
- Therapeutic communication is powered by the need to know, understand, and validate.
- Therapeutic communication facilitates acceptance of health care offered.
- Information must be elicited from patients and family members in order to understand and prioritize needs for planning care.
- Continuation of care demands effective goal-directed communication.



Factoid

Thorough assessments are required, especially in emergencies, taking all relevant data into consideration.



Factoid

Independent nursing intervention=based on nursing knowledge



Factoid

Dependent nursing intervention= based on a specific physician order



Marlene Moment

Not all nurses are as smart as you are! Abbreviations used improperly have been identified as a major source of medical errors. For example, od (right eye) and os (left eye) may not be acceptable abbreviations, because one "not so smart" nurse squirted eye drops into a patient's mouth (per os) rather than his left eye! This is why certain things need to be written out clearly!



Factoid

The Joint Commission which provides accreditation to health care facilities released a list of "Do Not Use" abbreviations in 2001 in an effort to reduce medical errors and increase patient safety.



Here's the Deal

With experienced nurses reaching retirement age, and existing nurses leaving the profession sooner, the nursing workforce is experiencing change.¹ What factors will impact the future of nursing and the quality of medical-surgical nursing the most? New nurses meet the challenge with these essential attributes:

- Nursing knowledge
- Nursing skills
- Clinical judgment
- The ability to analyze assessment findings
- The ability interpret clues from the patient.¹



Here's the Deal

The introduction sets the tone, whether you are a new graduate meeting with a nurse recruiter, or you are meeting your patient for the first time.



Marlene Moment

Always select the proper PLACE. Never correct a coworker in front of another health care worker, in the hallway or in the patient's presence. And always shut the door and wait until the patient is alone before discussing personal stuff!

- Information must be communicated to other members of the health care team for integrated and uninterrupted patient care.

Therapeutic communication is for the purpose of enabling health care providers to:

- collect data necessary for creating a diagnosis.
- formulate the patient treatment plan.
- enhance understanding and acceptance of the plan of care.
- obtain feedback that the patient understands his or her role in the plan.

You must use communication skills while conducting the admission interview, completing the patient history, and performing the admission assessment. This may be challenging because you are talking with a sick patient who may be:

- frightened of a “bad diagnosis.”
- anxious about health care costs and missing work.
- intimidated by white coats.
- feeling vulnerable in a peek-a-boo gown!

The “Four Ps” is a good place to start:

- Always be POLITE and show respect for the individual.
- Always select the PROPER time. Don't ask about personal information in the presence of visitors.

In addition to communicating with your patient, you will be required to communicate with everyone else too: family members, visitors, physicians, and other members of the health care team. You cannot conduct a patient interview or perform any management or delegation function without using therapeutic communication. Here are some other basic principles:

- Always be nonjudgmental.
- Use active listening: Don't be thinking about what YOU are going to say next, or what else you have to do. Focus on the patient and what he or she is saying!
- Keep all patient communication and patient data confidential. If it is not relevant to the nursing care needs, you don't share this communication with others. Even computer screens and assignment boards in hospitals are not available for public viewing.
- If the patient is in pain or distress or distracted by other issues, don't attempt any interview, patient teaching, or long conversations requiring patient attention or input.
- Don't use big words to let people know how smart you are! If they can't understand what you are saying, then your message will not be received. And don't use slang terms, either! You want to make sure that your message is clear, so avoid any terms that can be misunderstood.

Be sure to use all of the above basic principles of therapeutic communication and refer to Table 1-1 for specific communication techniques.

Table 1-1 Techniques of therapeutic communication

Communication technique	Description and examples of how used
Silence	Keep your mouth shut! But make sure the patient knows that you are actively listening to every word and constantly engaged. Face the patient and use nonverbal communication (relaxed, open body language, with facial expressions) to demonstrate interest in what the patient is saying or NOT saying. Sometimes patients need more time to process information and respond. Silence gives the patient time to formulate his or her thoughts. Don't let yourself feel uncomfortable or hurried: stay focused on the goal of therapeutic communication! Sometimes just being with a patient is what he or she needs. Maybe the surgeon has just returned a bad verdict on a biopsy and the patient is alone with this "ton of bricks." Ask for permission if it seems appropriate. For example, "May I just sit with you?" Or show that you value the patient by saying, "I'd like to be here with you (during this time, or until family member or clergy arrives)."
Sharing observations	Make a note of patient behaviors, and share observations. For example, "You seem angry ... or ... you seem tense today." Make note of congruence between verbal and nonverbal communication (ie, do they match). For example, the patient may tell you that the biopsy showed invasive cancer, and yet he or she is laughing. Share the observation this way: "Sometimes when people are really nervous, or don't know how to respond, they laugh at really bad news." Then ask for validation (see technique below).
Broad opening statements	This technique lets the patient lead the conversation and select topics of personal concern. For example, "How are you doing with your hospitalization today?" opens the door for just about anything from health concerns, to family or job issues secondary to hospitalization.
General leads	This technique keeps the patient on track by directing the patient to an area that the nurse wishes to explore. For example, "I would like to hear more about.... (whatever)."
Open-ended questions	This technique allows the nurse to gather more information while keeping the patient focused. For example, "And then you...."? Or, "And then he responded by...."
Validating	This technique allows the nurse to gain feedback from the patient to make sure that both parties (sender and receiver) are interpreting the message the same way. For example, the nurse might say, "I hear you saying that you are unhappy with your treatment plan."
Restating	Repeat what the person said (in his or her own words), allowing the patient to hear what he or she said for the purpose of seeking clarification and/or keeping the patient focused on the topic. You may feel like "Polly Parrot," but this technique really works! Just don't overuse this technique or you may find yourself on the roost with other pigeons!

(Continued)**Hurst Hint**

Silence. If you're one of those kinesthetic (hyped-up) people who always have to be moving, twisting your hair, or thumping a pencil, this will help you to be able to sit still and quiet: With your mouth SHUT, rub the tip of your tongue back and forth across your teeth (front, bottom works well and your need to move doesn't bother anybody).

Table 1-1 Techniques of therapeutic communication (*Continued*)

Communication technique	Description and examples of how used
Giving information	Providing factual information to replace myths and “old wives’ tales” or misconceptions. The nursing diagnosis “Fear of the unknown related to knowledge deficit” can be effectively dispelled with factual information presented in language that the patient can understand.
Direct questioning	This technique is commonly used when filling out the admission history. (Check all that apply.) For example, “Are you a diabetic, or do you have any diabetes in your family?” Direct questioning is mandatory when you must get straight to the point and elicit an immediate answer, such as is necessary when your patient expresses suicidal ideation. For example, you MUST say, “Are you thinking of killing yourself”? Yes, you have to be just that abrupt; otherwise, you may not get another chance to ask.
Summarizing	This wraps up a conversation/interview by stating briefly what has been discussed. For example, “During the past few minutes we’ve talked about...blah, blah, blah.” ²

*This table uses concepts from *Hurst Reviews: NCLEX-RN Review*, 2008.

+ Cultural considerations

The concept of culture is derived from anthropology, the study of human beings and how they live, customs, practices, and patterns of behavior. All patients have beliefs handed down by families that influence their behavior and health-seeking practices.

Culture is a population’s specific set of values, beliefs, traditions, social norms, and patterns of behavior that are passed down over generations from one family to the next.

Growing up in a particular family, in a particular neighborhood, and locale exposes the individual to different patterns of behavior, speech, and belief systems. Your patients have different cultures and respond to illness and hospitalization in ways that vary because:

- Patients come from many different cultural backgrounds.
- Depending on cultural orientation, health and illness have different meanings.
- Persons from different cultures may experience communication based on the impact a specific culture has on communication.
- Many patients experience culture shock, and demonstrate anxiety and confusion when facing the many stressors of hospitalization.
- Communication styles, appropriateness of eye contact, touch, and particular health care belief systems are specific factors that demand cultural competence to prevent a negative impact on communication and the nurse–patient relationship.

Table 1-2 contrasts communication styles, the dos and don'ts of touch and eye contact, and some cultural beliefs about health, health care, and health care providers. Please note that the term "Black" refers to a highly diverse group of Americans coming to the United States from all over the world (rather than solely from Africa). Therefore, this cultural term is used in Table 1-2 rather than African American.³ Refer to Table 1-2 for specific guidelines.

Table 1-2 Cultural barriers to communication

Culture	Communication patterns/methods	Eye contact and touch	Orientation to values and beliefs
Black Americans: from Caribbean, Haiti, Dominican Republic, and Africa	Have a need for solidarity and seek refuge in family, church, and community especially in times of illness. Bonds of kinship are strong. Self-identity is tied to the group and from an early age they are socialized to be in control and independent. Condescending attitudes will NOT be tolerated! Personal questions may feel like an invasion of privacy. Blacks tend to be highly expressive, and emotion is expressed freely and naturally. Communication may be expressed in "Black" English even though they are competent and articulate in the formal English language.	Some cultures maintain eye contact while speaking to a person, but look away while listening to that same person. Most African Americans born in America are comfortable with eye contact, viewing it as a sign of respect. African immigrants view eye contact as rude behavior. Touch is acceptable with family members and close personal friends.	Some use prayer for healing, and laying on of hands for anointing power. Some hold on to ancestral beliefs of illness as a state of disharmony with nature and use folk remedies and supernatural healing rituals. Some have a fatalistic view of illness and pain. Folk healers are "Grannies," Voodoo Priests, or Root Doctors depending on the country of origin. Self-treatment with use of over-the-counter medications is usually a first-line health care practice.
Asian Americans: from China, India, Japan, Philippines, Korea, Laos, Cambodia, Vietnam, Thailand, and Pacific Islands	Family hierarchy must be respected, and health care providers can do so by recognizing and addressing the oldest male in the family or group first, before addressing or greeting the patient. When an elderly parent is the patient, children have a moral obligation to protect them and care for them, which means that the nurse must recognize this and involve grown children in all planning and implementations of nursing care. Problems are kept within the family and confidentiality is critical.	Do not like to be touched by members of the opposite sex. Touch is avoided during conversations, and touching the head is particularly disrespectful because the head is considered sacred.	Respect elders and those in authority such as health care providers. Hold to the belief system that life is a cycle of suffering and rebirth, so suffering is natural and to be endured. Many delay seeking health care and believe that healing is spiritual as well as scientific. Karma as well as biology causes illness. Chinese medicine integrates body, mind, and spirit, and a balance of yin and yang (hot and cold) is essential to achieve health. Herbalists and shamans are healers. Ayurveda (means knowledge of life) is the traditional approach to healing for Asians. India's holistic approach calls for balance in body and mind through yoga, meditation, and herbal medicine.

(Continued)

Table 1-2 Cultural barriers to communication (*Continued*)

Culture	Communication patterns/methods	Eye contact and touch	Orientation to values and beliefs
European American: A conglomeration from all over Europe! Whites and Caucasians!	Silence can show respect or disrespect for someone, depending on the situation. Consumers of health care expect explanations in language they can understand, and they ask questions freely, expecting answers.	Direct eye contact is an indicator of trustworthiness, honesty, and attentiveness. Touch is acceptable with permission and respect for privacy. Handshakes are customary as formal greetings.	Increasingly health conscious and seeking alternative medicine. Desire to be active participant in health care and informed decision maker. Depending on subculture, many use preventive health care practices. The uninsured and underinsured delay health care because of financial hardship. Most respect health care professionals, but some degree of bias is present in mainstream society.
Hispanic American (H) from Caribbean, Mexico, Puerto Rico, and Central and South America; and Italian American from Italy! (I)	Both cultures are very gregarious and sociable. Behavior is demonstrative, with dramatic nonverbal communication, gestures/facial expressions, and verbal expressiveness, especially when pain or pleasure is experienced. An audience of family members and friends are welcomed and expected during times of illness. (H) Hispanics respect health care professionals and will verbally express disagreement or doubt, so nurses must ask questions and seek validation.	(H) Averting the eyes to avoid a direct gaze is common and is a sign of respect and attentiveness. If the patient is older than the nurse, the gaze should be directed below eye level. (I) Eye contact is appropriate and expected. Both cultures are very tactile and are comfortable with close physical contact and touch. Hugs and handshakes are welcome and socially appropriate among friends and family members. (I) Kissing on the cheek among men and women is appropriate when the relationship is close.	(H) Older women who serve as health practitioners are called curanderos, and they provide health care information. Recovery from illness is a result of the skill of the doctor and God's power and will. Some Hispanics believe that illness results from witchcraft, the "evil eye," or is punishment for sins. Some Hispanic cultures may not value preventive health care, and miss appointments, showing up an hour or a day late, still expecting to see the doctor. (I) See European Americans.
Native American: from North America, not immigrants (they were here first!)	Speaking in a quiet tone shows respect. Loud talk is considered rude, so keep the tone down! Wait and be patient, as members from different tribes may require extra time to mull over explanations. Silence is a communication technique that works well.	Direct eye contact is rude and may be considered confrontational. Touch may be considered unacceptable unless the persons know each other very well. Light touch in greeting is acceptable by some tribes. Health care professionals should ask permission before any touch just to be sure! Touching the dead is prohibited.	Believe that wellness and health occur when a person is in harmony with nature and natural laws of the universe. Illness is thought to occur when the person is in a state of disharmony or dis-equilibrium. Evil spirits, fear, and jealousy of other nations as well as failure to live according to the native code of life promote disharmony and can also cause illness. Shamans are sought out as holistic healers, and folk medicine and rituals are used. Hospitalization is a last resort when other approaches fail. Tribal practices to induce healing may include: <ul style="list-style-type: none"> • Prayer • Chanting • Smudging (brushing smoke from herbs or incense over the patient) • Herbalism • Laying on of hands³

Source: Young C, Koopsen C. *Spirituality, Health and Healing*. Mississauga, Ontario: Jones & Bartlett Learning; 2006.

The nurse who is culturally insensitive may cause the patient to refuse needed health care. Other adverse outcomes include:

- Lack of respect for health care providers.
- Misunderstanding of concepts necessary for promotion of wellness.
- Low self-esteem and feelings of rejection because a belief system and way of behavior is not valued or respected.
- Impaired communication between the patient and health care providers.

The only way to “diagnose” potential cultural problems is to include “those” questions on the admission form:

- “Do you have any religious beliefs or needs that we can assist you with during this hospitalization?”
- “Do you have any cultural beliefs that we should discuss so we can provide appropriate care during this hospitalization?”
- “Do you have any cultural needs that we need to incorporate into your plan of care?”

All patients need to feel valued, regardless of race, creed, and cultural and religious preferences. My patient needs to have access to the shaman, curanderos, or voodoo priest as desired, and healers are to be respected and welcomed. If practices require a special setting (such as smudging, in which smoke from fire is used), the nurse can assist in making arrangements for a satisfactory room within the hospital.

PATIENT TEACHING

You will be required to teach patients about all aspects of their unique health care needs from the disease process, to medications, treatments, risk reduction, and self-care monitoring associated with discharge teaching. In doing so, you will use principles of therapeutic communications with cultural considerations:

- To determine the patient’s learning needs and preferred learning style.
- To conduct teaching sessions with the patient and/or family member(s).
- To deal with conflict when teaching is contrary to what “grannie” believes.
- To show respect for grannie (never belittling) and find culturally acceptable ways to accomplish identified teaching goals.

When creating your plan for any patient teaching, please refer to the Hurst 5 Rights for patient teaching:

- Right time: Pick a time when the patient is pain free and not experiencing distress or distraction.
- Right setting: If the patient does not have a private room, it might be best to accompany the patient to a classroom, depending on the nature of the material to be taught.



Factoid

Culturally competent care opens the door to effective cross-cultural communication.



Factoid

Talk is NOT cheap! Communication is basic to everything that we do!



Here’s the Deal

First and foremost: Respect for religious practices and acceptance of cultural beliefs are priority for establishing the nurse–patient relationship. Patient’s cultural beliefs must be identified to provide direction for nursing care planning.



Here’s the Deal

It would be totally inappropriate to give the patient written instructions about home care if he or she is illiterate!

- **Right method:** Depending on the material to be taught and your assessment of the patient’s preferred method for learning, select from videos, brochures, one-to-one question-and-answer, or group teaching. Psychomotor (hands-on) techniques (example, an orange and an insulin syringe) would be appropriate for teaching skills.
- **Right material:** The content must match what the patient needs to learn about his or her medical condition, self-care and monitoring, risk reduction, and recovery. Keep it simple and in terms that the patient can understand.
- **Right evaluation:** Just because you taught something, it doesn’t necessarily mean that the patient has learned. You must get feedback from the patient to make sure that learning has occurred. If teaching nutrition, it might be appropriate to allow the patient to select items from a menu that are to be included or avoided in a prescribed diet.

Standards for care have been established for cultural competence, and agencies that accredit hospitals look for evidence that patients are receiving this consideration. Mandatory in-service education requires that health care providers fulfill the agency objectives for periodically reviewing guidelines for culturally competent care.

A recent study using community lay educators and patient navigators to deliver culturally tailored health information showed positive outcomes in terms of increased knowledge about self-care and decreasing barriers to health care, and had the added benefit of improving the cultural knowledge base of the health care providers!⁴

THE MEDICAL-SURGICAL NURSE TODAY

The medical-surgical nurse was once considered an entry-level or “starter” position. In the past a new nurse had to “pay his or her dues” on the medical-surgical unit before moving on to a specialty unit. Today, however, medical-surgical nursing is considered an adult health specialty.

The Academy of Medical-Surgical Nurses refers to this group as “the backbone of every adult-care clinical agency,” which is an accurate description. The organization also goes on to outline the scope of this increasingly specialized group of caregivers (Table 1-3).

Table 1-3 Academy of Medical-Surgical Nurses: description of the medical-surgical nurse today

Skill set	<ul style="list-style-type: none"> • Knowledge related to all aspects of adult health; • Excellent assessment, clinical, organization, and prioritization skills; and • Educator for patients, families, peers, and other health professionals.
Patient advocate	<ul style="list-style-type: none"> • Participates in the measurement and improvement of the quality of care delivered; • Is dedicated to making patient safety a top priority; and • Supports patients in identifying and meeting their interests and needs.

(Continued)

Table 1-3 Academy of Medical-Surgical Nurses: description of the medical-surgical nurse today (*Continued*)

Diversity	<ul style="list-style-type: none"> • Provides care for patients of all ages; • Manages the care of patients with multiple medical, surgical, and/or psychiatric diagnoses as well as diagnoses across all medical specialties; • Embraces opportunities to learn new skills; and • Can practice across a wide array of health care settings, both inpatient and outpatient.
Making a difference	<ul style="list-style-type: none"> • Provides comfort and care to people who, at that moment, need someone genuinely interested in their lives and well-being; • Heals patients physically and emotionally through intuitive experiences that rely on observation and touch; • Assists patients in reaching the goal of returning to their highest level of functioning; and • Provides dignity and respect in end-of-life decision making and care.

Data from Academy of Medical-Surgical Nurses web site: <http://www.amsn.org>

PRACTICE QUESTIONS

1. A medical-surgical nursing unit suddenly becomes short staffed when a nurse scheduled to work 7 a.m. to 7 p.m. does not report to work. Which option by the nurse manager offers the LEAST effective solution for providing safe effective care for the existing patients?
 - A. Employ a PRN agency nurse whose salary is double that of the regular staff nurse.
 - B. Request that the nursing supervisor pull a float nurse from another area of the hospital.
 - C. Take the patient assignments that would have been given to the absent nurse.
 - D. Call the nursing administrator to temporarily suspend any additional admissions to this nursing unit.
2. A Spanish-speaking patient who can speak, read, and understand very little English has just signed a permit for surgery after receiving preoperative information in English. Which priority action by the nurse best exemplifies the role of the nurse as a patient advocate?
 - A. Refuse to sign the operative permit as a witness to the signature.
 - B. Notify the hospital ethics committee of this breach in standards for informed consent.
 - C. Delay surgery until arrival of a Spanish interpreter who can translate all previous preoperative information.
 - D. Report the physician/surgeon to the Peer Review Organization (PRO) for illegal/unethical action.



Nurses on a medical-surgical unit must be able to provide a wide variety of specialized care and be ready for emergencies too!



On a “routine” day, the nurse may have a patient with gastroenteritis (diarrhea, diarrhea, diarrhea) in one room and another with pneumonia in the other room. It is easy to get lulled into complacency when everything is so “routine,” isn’t it? People don’t just come in and DIE with routine stuff! Better think again! Unexpected occurrences can and do occur on all patient care units.



When things change on a medical-surgical unit, they usually change fast!



Always assume the worst!

**Factoid**

Your patient should never be worse off AFTER a procedure than he or she was before! Something is wrong!

**Deadly Dilemma**

Because of the effect of illness on diabetes, your patient in room 210 who appears sound asleep is now breathing rapidly and is very lethargic! Metabolic acidosis (ketoacidosis, we call it because he is a diabetic)! This is a medical emergency! The medical-surgical nurse has to be continuously observant for these types of patient care emergencies.

**Factoid**

Illness + diabetes = diabetic ketoacidosis

3. Upon completion of a nursing history when the patient is scheduled for excision and biopsy of a breast nodule, which of the following is of greatest and most immediate concern to the nurse?
 - A. An aunt and two cousins have had cancer of the breast.
 - B. An uncle had a febrile response during surgery and “almost died.”
 - C. A previous surgery was complicated by postoperative nausea and vomiting.
 - D. A latex allergy was discovered during a previous hospitalization.

4. After an above-the-knee amputation on a diabetic patient, which postoperative intervention is the priority?
 - A. Keep a tourniquet clearly visible at the head of the bed.
 - B. Medicate the patient as needed for phantom pain with PRN analgesia.
 - C. Administer prescribed antibiotics IVPB (intravenous piggy back) as ordered.
 - D. Allow ample time for the patient to discuss concerns about body image change related to the amputated limb.

5. An elderly adult develops watery foul-smelling diarrhea after bowel surgery. After notifying the physician, which next nursing implementation is the priority?
 - A. Administer prescribed antidiarrheal agents.
 - B. Monitor cardiac output and blood pressure.
 - C. Caution the patient not to strain with stools.
 - D. Place the patient in protective (reverse) isolation.

6. Which of the following items is most important to keep at the bedside following an above-the-knee (AK) amputation when the patient is an African American pastor in the rural south?
 - A. A Bible.
 - B. A tourniquet.
 - C. A bedside commode.
 - D. A blood pressure cuff.

7. On the third postoperative day after a vaginal hysterectomy, a middle-aged woman verbalizes all of the following subjective complaints. Which one would be of most concern to the nurse?
 - A. Numbness and tingling from left knee to ankle.
 - B. An uncomfortable feeling of lower pelvic fullness.
 - C. Pain in the calf when ambulating to the restroom.
 - D. Nausea occurring 30 minutes after a codeine-based oral analgesia.

8. A nurse is reviewing the admission history of an elderly woman who has adult onset diabetes (Type II) and is NPO for a radiologic procedure using iodine-based dye for contrast. Which lab results are the most critical to report to the physician?
- A. BUN 26 mg/dL
 - B. Serum creatinine 2.8 mg/dL
 - C. Urine specific gravity 1.027
 - D. Blood sugar 2-hour postprandial 120 mg/dL
9. Which of the following lab tests would assist the med-surg nurse to evaluate both the preoperative patient's nutritional readiness for surgery and unexplained ankle edema on a medical patient who has been on prolonged bed rest?
- A. Serum glucose
 - B. Serum sodium
 - C. Serum albumin
 - D. Serum magnesium
10. A patient is receiving a nitroglycerin drip, and the primary nurse is titrating the IV flowrate to maintain blood pressure. To which, if any, licensed or unlicensed assistive personnel could the task of monitoring blood pressure readings be delegated?
- A. Another RN (registered nurse).
 - B. The UAP (unlicensed assistive personnel).
 - C. The LPN/LVN (licensed practical or vocational nurse).
 - D. The primary RN may not delegate blood pressure monitoring.

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