TENTH EDITION

Craven & Hirnle's Fundamentals of NURSING

Concepts and Competencies for Practice

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Concepts and Competencies for Practice

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DEDICATION

To Ruth Craven and Constance Hirnle, who envisioned a fundamentals nursing textbook that would be comprehensive yet readable, current and rich with history, and forward-thinking: Your passion for nursing and for nursing students shines on every page of this text.

—Chris and Renee

To all the students who have taught me so much over the years: Your dedication to learning the art and science of nursing has and continues to inspire me. With every sentence of this book, I consider, "Does this make sense to the beginning student, and does this add to those students who come to nursing with so much experience in healthcare?" It is a privilege to enter into the lives of students and walk beside them as they achieve their dream of being a nurse. Nursing is all I have ever wanted to do, and I would do it all over again!

—Chris

To my husband, Shawn Bomers, and children, Isabella, Shawn Junior, Wyatt, and Viviana: I am so grateful for your love and support, caring for me when I was caring for others. To my mentors Kristen Swanson and Margo Bykonen: Thank you for demonstrating authentic leadership and teaching me how to embrace challenges with innovation and compassion. And finally, to all the nurses who showed up, fought tirelessly, and served patients during the COVID-19 pandemic: This book is dedicated to your courage, as the fundamentals of nursing are truly the skill, clinical judgment, and heart that you bring to our profession every day.

—Renee

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PREFACE

WHY THIS BOOK?

The COVID-19 pandemic has changed the world nursing. During that period, nurses were on the front lines of healthcare, leading teams and the community through a global crisis. Recovery postpandemic further demonstrated the importance of nurses as central and critical leaders in healthcare delivery, policy design, and innovation for the future. Nursing is poised to drive the future of healthcare, due to its historical roots in population health, ensuring the health and well-being of individuals, families, and communities. *Craven & Hirnle's Fundamentals of Nursing: Concepts and Competencies for Practice*, Tenth Edition, provides a framework for the foundations of nursing practice that is critical for continued navigation in a dynamic environment.

Preparing nurses for the responsibility to support and restore patients to functionality and wellness across a multitude of settings requires resources that help students develop strong critical thinking and clinical judgment, clear communication, and sound clinical skills. This text leverages research, evidence-based best practices, clinical scenarios, and contemporary and emerging healthcare trends to provide students with a strong foundation on which to build their practice.

MAKING KNOWLEDGE WORK FOR YOU

As healthcare evolves and clinical knowledge, research, and innovation grow exponentially, having a strong foundation of nursing practice is important. The pandemic demonstrated this fact; response to an emerging and changing virus required nurses to apply historical experience and to incorporate current and new research while at the same time maintaining the flexibility to modify practice when information changed. Nursing students, regardless of background or experience, must develop a strong framework of nursing practice and a system for acquiring knowledge and putting it to work. This approach streamlines the process of clinical thinking and supports better judgment when you are faced with clinical scenarios. In addition, an effective framework enables you to work in a logical sequence and to process data calmly and efficiently, so prioritizing becomes natural. Such a framework teaches you to think about each case in a meaningful, systematic way, and it builds intuition, so you can instantly grasp the kinds of problems you need to solve.

This textbook supports excellent decision-making and improved safety and outcomes for you and your patients. The book still covers the basics—how to promote health, differentiate between normal function and dysfunction, use scientific rationales, and follow the nursing process using clinical judgment. However, considerations from the clinical environment are also included, with input from nurses who are currently practicing in a range of settings and situations. Our aim is to help you ease the transition from school to your first nursing job. This book will give you a mastery of critical healthcare knowledge as well as something just as valuable: an understanding of how successful nurses think and act.

Finally, it is important to remember that today more than ever, a nurse is a player in a collaborative process. To provide the best care for patients and their families, you must hone your communication skills, learn how to use reputable healthcare sources for evidence, and know how to put your research into practice. Exercises throughout the chapters offer opportunities to practice these skills and to demonstrate how evolving knowledge is applied to contemporary care.

HOW THIS BOOK IS STRUCTURED

Related concepts are grouped into seven units. Each unit contains chapters that address the overarching topic of the unit.

Unit 1: Professional Concepts

Although beginners may view nursing as a set of skills to learn and perform, nursing is much more than that—it is a way of thinking about patients and healthcare. The professional concepts of nursing are the essential underpinnings of the role, and without them, any task a nurse performs is meaningless. This unit introduces vital concepts that are woven throughout the book, such as safety, values, ethics, legal concepts, and research. Together, this material forms the basis for professional nursing practice.

Unit 2: The Nursing Process and the Clinical Judgment Measurement Model

In this unit, you will be introduced to the nursing process: a way of thinking—a framework for acquiring and processing information—that provides the basis for nursing practice and clinical judgment. This framework allows you to stay on track while customizing care for each patient. You will learn to identify

normal function, assess risk for altered function, envision potential outcomes, plan and provide for interventions, and evaluate the effectiveness of care. The nursing process is the conceptual basis for nursing care. Clinical judgment is the application of critical thinking in the clinical setting. The nursing process gives you the tools to reason through clinical scenarios and make good decisions about the care you provide to patients.

Unit 3: Healthcare Delivery Concepts

In this unit, you will learn about concepts related to nursing in a variety of settings. Integrative healthcare, culture and diversity, communication, and patient education are applicable in all nursing scenarios. This unit also addresses healthcare in the community and home, and caring for older adults. The information you will learn in this unit forms an essential part of a nurse's toolkit, teaching you how to offer safe, individualized care in various clinical settings.

Unit 4: Clinical Care Competencies

Keeping patients safe is critical to nursing. Skills such as health assessment, vital signs, and asepsis are used in every setting. This unit also addresses medication administration, intravenous therapy, and perioperative nursing. Whether you perform these skills or work in a perioperative setting, understanding these topics is essential to assisting patients who may be experiencing these therapies.

Unit 5: Concepts Involving Protection and Movement

The human body has an amazing capacity for function and healing. When these mechanisms are hindered or fail, the nurse must know how to support or protect the body. In this unit, you will learn about some of these protection mechanisms, such as hygiene and self-care, mobility, skin integrity and wound healing, infection prevention and management, pain management and sensory perception, and how to support patients experiencing challenges in these areas.

Unit 6: Concepts Involving Homeostasis and Regulation

Each body system and function presents unique challenges to the patient and the nurse. In this unit, you will learn about care for patients experiencing issues related to respiratory, cardiac, urinary, or bowel functions. Fluid, electrolyte, acid–base balance, nutrition, and sleep are integrating concepts essential for homeostasis.

Unit 7: Psychosocial Concepts

This unit discusses content related to those aspects of personhood that are less visible but that are essential to the overall health of the person. Self-concept, cognition, sexuality, and spiritual health are integral to each person's being. How the person interacts with families and others, and how the person copes and adapts to stressful situations, may be altered by the person's health issue and can be supported by the nurse. Loss and grieving are a part of life, and the nurse can be instrumental in helping people navigate difficult times.

UNIFYING CONCEPTS

Safety is the overarching concept of nursing care in this text. The features in this book promote safety in every aspect of nursing and encourage students to think independently about best practices for a particular patient.

- **Critical Thinking and Clinical Judgment:** Many interactive features assist students in developing critical thinking and clinical judgment. All chapters open with a patient Case Scenario with critical thinking questions; in many chapters, this case also forms the basis for the concept map, the PICO display, and the Essential Nursing Competencies feature. The Think Like a Nurse and Concept Mastery Alert displays help the student dig deeper into the content. The Safety Alerts highlight key safety information. The NCLEX questions at the end of each chapter, including Next Generation NCLEX style questions in some chapters, allow students to test their understanding of chapter concepts. Ethical/Legal Issue boxes present significant topics that arise in nursing practice and ask challenging questions for the student to consider.
- **Communication:** Learning effective communication skills can be difficult. The Therapeutic Dialogue displays present options for communicating and ask the student to evaluate which option is best. Collaborating with the Healthcare Team displays introduce students to standardized communication among team members (SBAR).
- **Nursing Process and the Clinical Judgment Measurement Model:** The nursing process is fundamental to nursing care. The concept map, care plan, and teaching plan features provide the beginning nursing student with a framework for how to think about nursing and how to deliver care using clinical judgment. The Clinical Judgment Measurement Model identifies the steps used in applying critical thinking and the nursing process to clinical judgment and serves as a tool to assess students' learning of clinical judgment.
- **Evidence-Based Practice:** The practice of nursing is based on research and the application of that research to practice (evidence-based practice). PICO displays and evidence-based bundles encourage the student to learn about nursing evidence and to understand how to apply that evidence to daily work.

WHAT MAKES THIS BOOK UNIQUE?

This textbook uses a concept-based approach to healthcare knowledge. Content is organized in a way that makes the information accessible and usable. The material is based on available evidence and presented in a readable and student-friendly

way. Throughout the text, case studies, scenarios, and features provide you with real-life examples of how to make the information applicable to current practice. This book has been thoughtfully designed to help you practice with confidence and offer the best care for your patients right from the start.

BUILDING CLINICAL JUDGMENT SKILLS

Nursing students are required to obtain nursing knowledge and to apply foundational nursing processes to practice effective clinical judgment. Being able to apply clinical judgment in practice is critical for patient safety and optimizing outcomes. The content provided in this text includes features such as Case Scenarios, Therapeutic Dialogues, Think Like a Nurse, Collaborating With the Healthcare Team, Ethical/Legalal Issues, and Unfolding Patient Stories that strengthen students' clinical judgment skills by giving them opportunities to apply knowledge and to practice critical thinking. Additionally, accompanying products CoursePoint+ and Lippincott NCLEX-RN PassPoint provide an adaptive experience that allows students to build confidence by answering questions like those found on the Next Generation NCLEX (NGN) examination.

INCLUSIVE LANGUAGE

A note about the language used in this book. Wolters Kluwer recognizes that people have a diverse range of identities, and we are committed to using inclusive and nonbiased language in our content. Please note that whenever "male" is used in this book, it refers to a person assigned male at birth, and whenever "female" is used, it refers to a person assigned female at birth. In line with the principles of nursing, we strive not to define people by their diagnoses, but to recognize their personhood first and foremost, using as much as possible the language diverse groups use to define themselves and including only information that is relevant to nursing care.

We strive to better address the unique perspectives, complex challenges, and lived experiences of diverse populations traditionally underrepresented in health literature. When describing or referencing populations discussed in research studies, we will adhere to the identities presented in those studies to maintain fidelity to the evidence presented by the study investigators. We follow best practices of language set forth by the *Publication Manual of the American Psychological Association*, 7th Edition, but acknowledge that language evolves rapidly, and we will update the language used in future editions of this book as necessary.

SPECIAL FEATURES

Many features appear throughout the text to help students grasp the important content. Refer to the "How to Use This Book" section immediately following this preface to learn more about them.

A COMPREHENSIVE PACKAGE FOR TEACHING AND LEARNING

To further facilitate teaching and learning, a carefully designed ancillary package has been developed to assist faculty and students.

Resources for Instructors

Tools to assist you with teaching your course are available upon adoption of this text at http://thepoint.lww.com/Craven10e.

- The **Test Generator** lets you put together exclusive new tests from a bank containing more than 1,000 questions to help you in assessing your students' understanding of the material. Test questions link to chapter learning objectives.
- An extensive collection of materials is provided for each book chapter:
  - **PowerPoint Presentations** provide an easy way for you to integrate the textbook with your students' classroom experience, either via slide shows or handouts. Multiple choice and true/false questions are integrated into the presentations to promote class participation and allow you to use i-clicker technology.
  - **Guided Lecture Notes** walk you through the chapters, objective by objective, and provide you with corresponding PowerPoint slide numbers.
  - **Discussion Topics** (and suggested answers) can be used as conversation starters or in online discussion boards.
  - **Assignments** (and suggested answers) include group, written, clinical, and web assignments.
  - **Case Studies** with related questions (and suggested answers) give students an opportunity to apply their knowledge to a patient case similar to one they might encounter in practice.
- An **Image Bank** of all the images in the book allows you to use the photographs and illustrations from this textbook in your PowerPoint slides or as you see fit in your course.
- Sample **Syllabi** provide guidance for structuring your nursing fundamentals course.
- An **American Association of Colleges of Nursing (AACN) Essentials Competency Map** identifies book content related to the AACN Essentials.
- **Learning Objectives** from the textbook.

Contact your sales representative for more details and ordering information.

Resources for Students

An exciting set of free resources is available to help students review material and become even more familiar with vital concepts. Students can access all these resources at

http://thePoint.lww.com/Craven10e using the codes printed in the front of their textbooks.

- **Multimedia Resources** appeal to various learning styles:
  - **Watch & Learn Videos** reinforce skills from the textbook and appeal to visual and auditory learners.
  - **Concepts in Action Animations** bring physiologic and pathophysiologic concepts to life and enhance student comprehension.
- **Procedure Checklists** walk through skills from the book step by step and can be used to help evaluate mastery of skills.
- **Journal Articles** offer access to current research available in Wolters Kluwer journals.
- A table of **Medical Terminology: Prefixes, Roots, and Suffixes** provides clues to deciphering many medical terms students will encounter.
- Plus **Heart and Breath Sounds**.

VSIM FOR NURSING

vSim for Nursing, jointly developed by Laerdal Medical and Wolters Kluwer Health, offers innovative scenario-based learning modules consisting of web-based virtual simulations, course learning materials, and curriculum tools designed to develop critical thinking skills and promote clinical confidence and competence. vSim for Nursing | Fundamentals includes 10 cases from the Simulation in Nursing Education—Fundamentals Scenarios, authored by the National League for Nursing. Students can progress through suggested readings, pre- and postsimulation assessments, documentation assignments, and guided reflection questions and will receive an individualized feedback log immediately upon completion of the simulation. Throughout the student learning experience, the product offers remediation back to trusted Lippincott resources, including Lippincott Nursing Advisor and Lippincott Nursing Procedures—two online, evidence-based, clinical information solutions used in healthcare facilities throughout the United States. This innovative product provides a comprehensive patient-focused solution for learning and integrating simulation into the classroom.

Contact your Wolters Kluwer sales representative or visit wltrsklwr.com/vsimfornursing for options to enhance your fundamentals nursing course with vSim for Nursing.

LIPPINCOTT DOCUCARE

Lippincott DocuCare combines web-based academic electronic health record (EHR) simulation software with clinical case scenarios, allowing students to learn how to use an EHR in a safe, true-to-life setting, while enabling instructors to measure their progress. Lippincott DocuCare's nonlinear solution works well in the classroom, simulation lab, and clinical practice. Contact your Wolters Kluwer sales representative or visit wltrsklwr.com/DocuCare for options to enhance your fundamentals nursing course with DocuCare.

A COMPREHENSIVE, DIGITAL, INTEGRATED COURSE SOLUTION: LIPPINCOTT® COURSEPOINT+

Lippincott® CoursePoint+ is an integrated, digital curriculum solution for nursing education that provides a completely interactive experience geared to help students understand, retain, and apply their course knowledge and be prepared for practice. The time-tested, easy-to-use and trusted solution includes engaging learning tools, evidence-based practice, case studies, and in-depth reporting to meet students where they are in their learning, combined with the most trusted nursing education content on the market to help prepare students for practice. This easy-to-use digital learning solution of *Lippincott® CoursePoint+*, combined with unmatched support, gives instructors and students everything they need for course and curriculum success!

Lippincott® CoursePoint+ includes the following:

- Leading content provides a variety of learning tools to engage students of all learning styles.
- A personalized learning approach gives students the content and tools they need at the moment they need it, giving them data for more focused remediation and helping to boost their confidence and competence.
- Powerful tools, including varying levels of case studies, interactive learning activities, and adaptive learning powered by PrepU, help students learn the critical thinking and clinical judgment skills to help them become practice-ready nurses.
- Preparation for Practice tools improve student competence, confidence, and success in transitioning to practice.
  - vSim® for Nursing: Co-developed by Laerdal Medical and Wolters Kluwer, vSim® for Nursing simulates real nursing scenarios and allows students to interact with virtual patients in a safe, online environment.
  - Lippincott® Advisor for Education: With over 8,500 entries covering the latest evidence-based content and drug information, Lippincott® Advisor for Education provides students with the most up-to-date information possible, while giving them valuable experience with the same point-of-care content they will encounter in practice.
  - Unparalleled reporting provides in-depth dashboards with several data points to track student progress and help identify strengths and weaknesses.

Unmatched support includes training coaches, product trainers, and nursing education consultants to help educators and students implement CoursePoint+ with ease.

HOW TO USE THIS BOOK

Craven & Hirnle's Fundamentals of Nursing: Concepts and Competencies for Practice, Tenth Edition, includes many features to help you gain and apply the knowledge that you'll need to meet the challenges of today's nursing profession.

FEATURES THAT SET THE STAGE FOR THE REST OF THE CHAPTER

- **Key Terms** listed at the beginning of each chapter and bolded in text highlight important vocabulary. A glossary provides definitions of all the key terms in the book.

KEY TERMS

adaptation
allostasis/allostatic load
appraisal
coping
coping mechanisms
homeostasis
hypothalamic–pituitary–adrenal axis
inflammation
plasticity
resilience
resistance
stress
vulnerability

- **Learning Objectives** help readers identify important chapter content and focus their reading.

LEARNING OBJECTIVES

Upon completion of this chapter, the student will be able to do the following:

1. Identify physiologic signs and symptoms of stress.
2. Identify psychological responses to stress.
3. Discuss pathophysiologic processes of stress.
4. List examples of biophysical and psychosocial stressors.
5. Give examples of variables that affect a person's ability to cope with stress.
6. Describe various types of coping patterns people typically use to handle stress.
7. Identify stress management techniques that nurses can use to help patients adapt to stress.

FEATURES THAT STRENGTHEN CRITICAL THINKING AND CLINICAL JUDGMENT

- **Think Like a Nurse** features in every chapter provide real-life examples that guide students to explore concepts and situations more deeply. Answers provided in Appendix B allow students to check their thinking.

THINK LIKE A NURSE

You are giving heparin subcutaneously for the first time. Your patient has heparin 7,500 units ordered, and the available heparin vial contains 10,000 units/mL.

Calculate how much (in milliliters) you need to administer to give 7,500 units.

What type of syringe would you select to give the heparin?

Discuss specific administration guidelines to safely give this heparin.

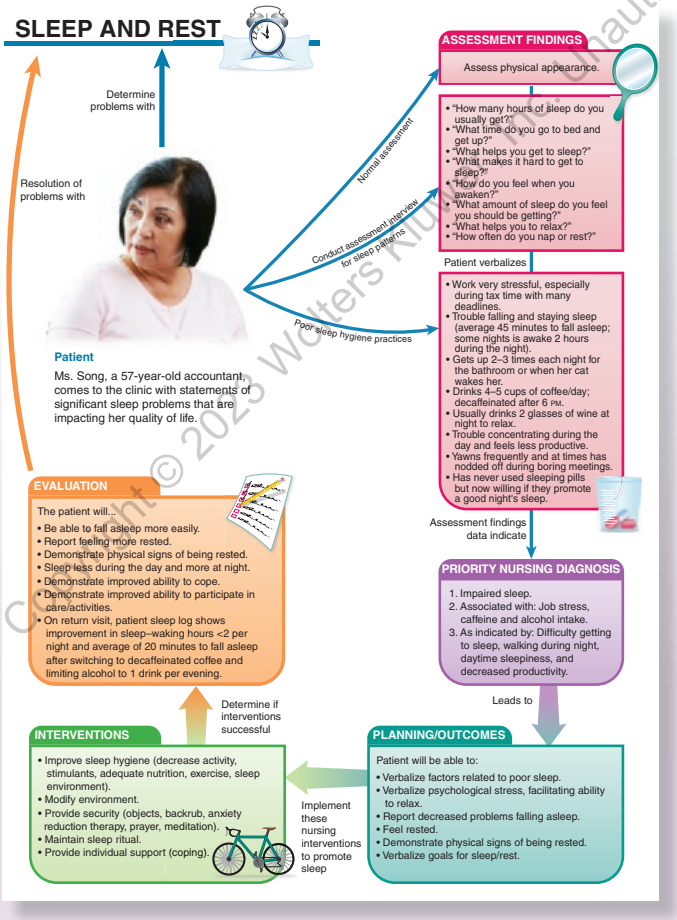
Check your answer in Appendix B.

Unfolding Patient Stories: Mona Hernandez • Part 2

Recall Mona Hernandez from Chapter 9, the 72-year-old admitted with pneumonia. She has a history of hypertension controlled with hydrochlorothiazide 25 mg PO daily, continues to smoke a half pack of cigarettes per day, and is 20 lb overweight. The provider has ordered moxifloxacin 400 mg IV as a secondary line infusion (piggyback) daily to treat the pneumonia. What factors affecting drug action and potential adverse effects will the nurse consider before administering the antibiotic to Mona?

Care for Mona and other patients in a realistic virtual environment: ***vSim*** *for Nursing* (thepoint.lww.com/vSim-Funds). Practice documenting these patients' care in DocuCare (thepoint.lww.com/DocuCareEHR).

- **Case Scenarios** that open each chapter show nurses working in a variety of settings with diverse clients. The scenarios include questions that encourage students to think holistically and to reflect on broader issues related to the scenario.



FEATURES THAT STRENGTHEN CRITICAL THINKING AND CLINICAL JUDGMENT (continued)

- **Unfolding Patient Stories**, written by the National League for Nursing, are an engaging way to begin meaningful conversations in the classroom. These vignettes, which appear throughout the text near related content, feature patients from Wolters Kluwer's vSim for Nursing | Fundamentals (codeveloped by Laerdal Medical) and DocuCare products; however, each Unfolding Patient Story in the book stands alone, not requiring purchase of these products.

Sleep

Diana Taibi Buchanan

Case Scenario

Ms. Song, a 57-year-old accountant, comes to see you in the clinic stating she is having significant problems with sleep that are impacting her quality of life. During your interview, you collect the following information:

- Work has been very stressful, especially during tax time when she has many deadlines.
- She has trouble getting to sleep (average 45 minutes; some nights up to 2 hours).
- She wakes up two to three times a night to go to the bathroom or when her cat wakes her.
- She drinks four to five cups of coffee a day but decaffeinated after 6 PM.
- She usually has two glasses of wine at night to relax her.
- She has trouble concentrating during the day and feels less productive.
- She yawns frequently and at times has nodded off during boring meetings.
- She has never used sleeping pills but now is willing if they will help her get a good night's sleep.

Once you have completed this chapter and have incorporated sleep and rest into your knowledge base, review the above scenario and reflect on the following areas of Critical Thinking:

1. What poor sleep hygiene practices are influencing Ms. Song's sleep quality?
2. Script questions that could help her analyze factors that might have a negative impact on her sleep.
3. Identify nonpharmacologic interventions that could improve her sleep.
4. Discuss the advantages and disadvantages of pharmacologic use of hypnotics to treat Ms. Song.

- **Richly illustrated concept maps**, ideal for visual learners, apply the nursing process and critical thinking to the Case Scenarios that begin each chapter.

FEATURES THAT STRENGTHEN CRITICAL THINKING AND CLINICAL JUDGMENT (continued)

Critical Thinking Using Essential Nursing Competencies

Now that you have completed this chapter, reread the opening Case Scenario. Ms. Song is now hospitalized and continues to have sleep problems. Develop a plan for how you can best fulfill the essential nursing competency involving interprofessional collaboration.

Interprofessional collaboration: Participate effectively in interprofessional teams, using effective communication and collaborative decision-making to achieve optimal patient outcomes.

- You are working on the day shift. What conversation would you have with your night shift colleagues in planning Ms. Song's care?
- How would you approach a difference of opinion between shifts regarding Ms. Song's care?
- Ms. Song is willing to try a sleeping medication, but the provider decides to wait to order medication. Ms. Song really wants to try a medication due to the effects of not sleeping well. How might you approach the provider about her decision to wait to order sleeping medication for Ms. Song?

- **Critical Thinking Using Essential Nursing Competencies** at the end of each chapter apply an essential nursing competency to the opening Case Scenario. Thought-provoking questions allow the student to synthesize the chapter content in light of that competency.

Features That Focus on Evidence-Based Practice

- **PICO (patient/problem, intervention, comparison, outcome) displays** illustrate examples of a structured, evidence-based way to find an answer to a clinical question related to the chapter-opening Case Scenario.

Sleep and Rest PICO

Ms. Song from the chapter-opening scenario discloses to you that one of her doctors had diagnosed her with OSA. She indicates that she is supposed to be using a CPAP machine at night. She states, "I hate that thing" "I can't sleep with it on… it's too big on my face. Isn't there some other treatment that will do the same thing?" Unsure about the answer, you turn to PubMed for evidence. The PICO question you decide to use is: *What are next steps to take for a patient with OSA who is interested in no therapy versus use of a poorly fitted CPAP mask?*

P = patients with obstructive sleep apnea
I = continuous positive airway pressure
C = no therapy
O = improve breathing at night

You find several reviews review articles on sleep apnea in PubMed. A clinical practice guideline published by the American Academy of Sleep Medicine catches your eye because it provides updated recommendations on treating OSAS with positive airway pressure (Patil et al., 2019). The Good Practice Statements emphasize the importance of follow-up care to monitor treatment efficacy and promote adherence. Practice recommendations 7 to 9 state that education, behavioral interventions, and telemonitoring should be used during the initial period of adjustment to PAP. Although the guideline task force did not compare PAP to other treatments, it strongly emphasized the efficacy of PAP as the only first-line treatment for OSA. The guideline summarizes findings from several randomized controlled trials (RCTs) showing that education and behavioral intervention for starting PAP improved adherence and was desired by patients. A limited number of RCTs showed improved adherence with telemonitoring. You share your findings with Ms. Song and discuss what follow-up she has received. She admits that she did not follow through with scheduling follow-up appointments because she was tired and busy. You emphasize the efficacy of PAP and recommend follow-up consultation with the sleep medicine provider before considering second-line treatments. Ms. Song agrees, and you send an electronic SBAR message to the provider.

REFERENCE

Patil, S. P., Ayappa, I. A., Caples, S. M., Kimoff, R. J., Patel, S. R., & Harrod, C. G. (2019). Treatment of adult obstructive sleep apnea with positive airway pressure: An American Academy of Sleep Medicine clinical practice guideline. *Journal of Clinical Sleep Medicine, 15*(2), 335–343. https://doi.org/10.5664/jcsm.7640

FEATURES THAT STRENGTHEN CRITICAL THINKING AND CLINICAL JUDGMENT (continued)

Features That Focus on Evidence-Based Practice (continued)

- **Evidence-Based Bundles to Improve Patient Care** boxes focus on bundles, which are structured methods of improving patient care. For a specific problem, a bundle recommends a set of evidence-based practices, which when performed collectively and reliably improve patient outcomes.

EVIDENCE-BASED BUNDLES TO IMPROVE PATIENT CARE:
Prevention of Catheter-Associated Urinary Tract Infections (CAUTIs)

BACKGROUND

UTIs account for approximately 40% of all hospital-acquired infections annually, and fully 80% of these can be attributed to indwelling urethral catheters. In the United States, up to 5 million urinary catheters are placed annually. Between 12% and 25% of all hospitalized patients will receive a urinary catheter during their hospital stay, and up to half of these do not have an appropriate indication.

It is well established that the duration of catheterization is directly related to risk for developing a UTI. With a catheter in place, the daily risk of developing a UTI ranges from 3% to 7%. When a catheter remains in place for up to a week, the risk increases to 25%; at 1 month, this risk is nearly 100%.

RISK FACTORS

- Prolonged catheterization greater than 6 days
- Female gender
- Catheter insertion outside operating room
- Other active sites of infection
- Diabetes
- Malnutrition
- Azotemia (creatinine greater than 2.0 mg/dL)
- Ureteral stent
- Catheter in place solely for monitoring of urine output
- Drainage tube below level of bladder and above collection bag
- Antimicrobial drug therapy

KEY RECOMMENDATIONS

1. **Avoid unnecessary urinary catheters.**

NURSING IMPLICATIONS

- Catheters are appropriate in patients with acute urinary retention or bladder outlet obstruction or in patients undergoing prolonged surgeries or are anticipated to receive large-volume infusions or diuretics during surgery. Catheters are also indicated for patients with stage 3–4 decubitus ulcers with incontinence or for patients receiving palliative care if they request an indwelling catheter.
- Catheters are *inappropriate* if used as a substitute for nursing care of the patient with incontinence, as a means of collecting serial urine specimens, or for prolonged postoperative duration without appropriate indications (which include structural repair of the urethra or other contiguous structures or prolonged effect of epidural anesthesia).

ETHICAL/LEGAL ISSUE

HEALTH ASSESSMENT

Bob Ellis is the nursing student assigned to Mrs. Androni, a 73-year-old widow who was recently admitted for observation after a fall. Bob introduces himself and explains that he needs to ask her some questions and perform a physical examination. Mrs. Androni states, "I just don't feel comfortable having a man examine me. I feel just fine, so you go along and find someone else to practice on."

CRITICAL THINKING CHALLENGE

- How would you feel if you were the student in this situation?
- Explain factors that might contribute to Mrs. Androni's feelings.
- Can the healthcare facility provide safe care to Mrs. Androni if Bob avoids performing the physical examination?
- Brainstorm advantages and disadvantages of switching the patient assignment so that Mrs. Androni receives care from a female student or nurse.

Feature That Incorporates an Understanding of Ethical/Legal Issues As Well As Critical Thinking and Clinical Judgment

- **Ethical/Legal Issue** boxes, which are included in many chapters, incorporate critical thinking questions to help students think about complex situations in nursing.

FEATURES THAT STRENGTHEN CRITICAL THINKING AND CLINICAL JUDGMENT (continued)

COLLABORATING WITH THE HEALTHCARE TEAM
Calling the Home Health Nurse Concerning Care Issues in the Home

Mr. House, age 78 years, has advanced Alzheimer disease with occasional wandering at night.

Situation: Mrs. House needs her sleep in order to do all the things she needs to do, so she ties Mr. House in bed at night so that he'll stay put.

Background: Mrs. House, age 74 years, provides care for her husband, holds a part-time child day care job because their income is limited, and is getting increasingly fatigued but is adamant about not finding another care situation for her husband. Mrs. House has no other family close by.

Assessment: Mrs. House needs the home health nurse to spend time with her, assess her situation, and help her to understand what other options she may have to assist her with Mr. House's care as well as her own well-being.

Recommendation: Could you go as soon as possible and talk with Mrs. House and support her in her caregiving responsibilities? I am quite concerned about her mental and physical state.

CRITICAL THINKING CHALLENGE

- Discuss the rationale for requesting that the home health nurse be called instead of another professional colleague.
- Which other members of the collaborative team could be called on to help provide some advice?
- What support does Mrs. House need in this situation? Mr. House?

Features That Focus on Communication As Well As Critical Thinking and Clinical Judgment

- **Collaborating With the Healthcare Team** demonstrates examples of effective communication using the SBAR technique. These displays enhance students' abilities to more effectively communicate information accurately and safely. Challenging questions ask students to consider the content of the SBAR and also the nurse's role in the healthcare team, ethics, and clinical judgment.

- **Therapeutic Dialogues** offer side-by-side comparisons of communication with patients, demonstrating how close listening and a few well-chosen questions can enhance communication and provide important information for the nurse while supporting and acknowledging the patient.

THERAPEUTIC DIALOGUE: RESPIRATORY CARE

SCENE FOR THOUGHT

Marvin Ottaway is a 60-year-old man in the hospital for treatment for his pneumonia. He's sitting up in bed with the O_2 nasal prongs lying on his chest and is somewhat short of breath, but smiles when he sees the nurse at the door.

LESS EFFECTIVE

Marvin: Hello, Nancy, it's good to see you again today! I haven't seen you for a week! *(Smiles broadly and breathes rapidly.)*

Nurse: Hello, Mr. Ottaway. *(Speaks slowly and clearly.)* My name is Betsy, actually, and this is the second time I've met you. Who is Nancy?

Marvin: *(Looks confused and somewhat alarmed.)* But … you're Nancy, my sister-in-law!

Nurse: (*Gently replaces the O_2* prongs.) I'm Betsy, your nurse, Mr. Ottaway. You really need to keep this oxygen on. If you don't have enough oxygen, you're going to get confused. That's why you think I'm Nancy. *(Smiles and speaks in a gentle tone.)*

Marvin: But you are! I know my own kin! Why are you telling me you're not?! *(Becomes agitated and frightened.)*

Nurse: Quiet down, now. The oxygen will start to work soon, then you'll recognize me. *(Still speaks quietly, putting hand on his arm.)*

Marvin: No, I want Nancy! What have you done with her?! *(Becomes more agitated. Finally calms down after nurse administers oxygen and a mild sedative.)*

MORE EFFECTIVE

Marvin: Hello, Nancy, it's good to see you again today! I haven't seen you for a week! *(Smiles broadly and breathes rapidly.)*

Nurse: Hello, Mr. Ottaway. *(Speaks slowly and clearly.)* My name is Betsy, actually, and this is the second time I've met you. Who is Nancy?

Marvin: *(Looks confused and somewhat alarmed.)* But … you're Nancy, my sister-in-law!

Nurse: *(Stands quietly by the bed with hand on his arm. Gently replaces the O_2 prongs.)* I'm Betsy, your nurse, Mr. Ottaway. Tell me a little about Nancy.

Marvin: *(Still breathes somewhat quickly but begins to warm to the subject.)* Oh, she's lovely; been married to my brother for 30 years and always treats me like one of the family. I miss her. She hasn't been to see me lately. *(Looks worried.)*

Nurse: You really like her, don't you? *(Still stands next to the bed.)*

Marvin: *(Looks at Betsy with sudden recognition.)* Oh, now, I remember you. I'm sorry. Sometimes, my mind isn't clear. I can't remember things like I used to. *(Looks embarrassed.)*

Nurse: No need to apologize. Sometimes, lack of oxygen from pneumonia can play tricks with your memory. It's important to keep the oxygen in place so you can get the benefit.

Marvin: Okay, I'll try to remember.

CRITICAL THINKING CHALLENGE

- Explain the relationship between oxygen deprivation, confusion, and anxiety.
- Compare and contrast how the nurse presented reality differently in each scenario.
- Identify dialogue that caused Mr. Ottaway's anxiety level to increase or decrease.

USING THE NURSING PROCESS TO INDIVIDUALIZE PATIENT CARE

PATIENT PLAN OF CARE
The Patient With Impaired Ability to Bathe and Impaired Dressing and Grooming

NURSING DIAGNOSIS
Impaired ability to bathe associated with right-sided weakness as indicated by impaired ability to wash most body parts.

PATIENT GOAL
Patient will be able to participate in care planning and be able to bathe.

PATIENT OUTCOME CRITERIA
- During care, patient states need for assistance to perform hygiene activities that can't be performed alone.
- After teaching session, patient demonstrates bathing face, trunk, and upper extremities with verbal cuing.
- Before discharge, patient verbalizes a realistic plan for bathing at home.

NURSING INTERVENTION	SCIENTIFIC RATIONALE
1. Assist the patient to identify self-care deficits in hygiene.	**1.** Maximum self-participation can occur with improved self-esteem.
2. Encourage the patient to communicate needs and concerns to nursing staff and significant others.	**2.** Communication reduces energy-consuming stressors such as isolation and worry.
3. Permit and encourage the patient to accept some dependency and verbalize feelings.	**3.** A degree of dependence is a necessary part of recovery and rehabilitation for most people.
4. Ensure safety through monitoring and assistance during bathing and hygiene activities.	**4.** Safety measures reduce the possibility of increased injury due to falls.
5. Schedule hygiene self-care 1 hour after breakfast when the patient feels rested.	**5.** Hygiene self-care is a tiring procedure; fatigue can produce confusion.
6. Lay out objects for hygiene care in the order to be used and place them within the patient's reach and sight. Don't hurry patient.	**6.** Nurse gives support and conserves the patient's energy. Placement enables easy access with decreased energy expenditure.
7. Provide for the greatest amount of privacy possible.	**7.** Privacy enhances feeling of dignity and self-worth.
8. Assist the patient to use unaffected hand to wash self, comb hair, and brush teeth within the limits of ability.	**8.** Activities enhance independence while providing help and support as needed. Some programs encourage use of affected side to strengthen and regain function.
9. Evaluate frequently for indications of fatigue by checking pulse and respiratory rate.	**9.** Ability to sustain concentrated effort may be limited until endurance is developed.
10. Coordinate self-care rehabilitation with OT, PT, and any other involved health professionals.	**10.** A team approach is often needed to develop an individualized plan. Represent patient in negotiations and making arrangements for care.

EVALUATION

9/17/2024: 08:30—Mr. Shannon achieved his care goals by demonstrating willing participation in hygiene measures. He asked for assistance with some hygiene activities, demonstrated bathing of the upper body, and verbalized his bathing plan at home.

—D. Callum, RN

- **Patient Plan of Care** features "put it all together" for students. Scientific rationales are included to build knowledge.

OUTCOME-BASED TEACHING PLANS

When Nicole Travis, mother of an 11-month-old child named Jessie, comes to the clinic for a routine well-child visit, you learn that Jessie is not paying attention when spoken to. Her mother reports that Jessie frequently ignores her when she tries to get her attention. Ms. Travis states, "I'm not sure what kind of discipline or punishment I should use." You review Jessie's health record and learn that the expected newborn hearing screening 11 months ago was not completed.

OUTCOME

Ms. Travis will verbalize a realistic plan to determine whether Jessie is ignoring her on purpose or is truly not hearing her.

STRATEGIES
- Discuss with Ms. Travis the common methods of determining adequate hearing in an infant.
- Suggest a referral to an audiologist.
- Provide education on diagnosis and treatment of newborn/infant hearing loss.
- Have Ms. Travis observe Jessie's response to sounds that are out of her vision.
- Instruct Ms. Travis to record Jessie's reactions to sounds and her facial expressions.
- Encourage Ms. Travis to record and describe the verbal sounds and words that Jessie says, including listening for inflections in Jessie's voice.
- Urge Ms. Travis to bring these observations to the next appointment and to the audiologist for a more detailed discussion.
- Encourage Ms. Travis to avoid discipline about not responding until Jessie's hearing is thoroughly evaluated.

EVALUATION

- 3/29/2024: 13:00—Nicole Travis can identify resources to evaluate Jessie's hearing.
- Nicole Travis has utilized strategies appropriately to determine if Jessie has a hearing deficit.

—J. Woodman, RN

- **Outcome-Based Teaching Plans** provide clear examples of patient teaching. Focusing on the outcome of the teaching facilitates clear evaluation of learning that occurred.

Table 25-4 SELECTED ICNP NURSING DIAGNOSES INVOLVING MOBILITY

Nursing Diagnosis	Associated Considerations	Diagnosis Statement
Impaired mobility	Pain; decreased strength, muscle control, or endurance; joint stiffness; malnutrition; physical deconditioning	Impaired mobility associated with pain, joint stiffness, and malnutrition as indicated by slow, uncoordinated movement, shortness of breath with ambulation and discomfort
Activity intolerance	Immobility, physical deconditioning, imbalance between oxygen supply/demand	Activity intolerance associated with deconditioned state as indicated by abnormal BP and HR response to activity, fatigue, and exertional dyspnea
Risk for fall-related injury	Cluttered environment, insufficient lighting, decrease in lower extremity strength, urinary urgency, impaired mobility	Risk for fall-related injury as indicated by decreased lower extremity strength and impaired mobility

- **Selected ICNP Nursing Diagnoses Tables** identify common nursing diagnoses related to the chapter topic and the factors leading to the diagnosis ("associated factors"). The table then provides a full diagnostic statement that includes the diagnosis, associated factors, and the signs and symptoms that may be seen ("as indicated by").

FEATURES THAT FOCUS ON SAFETY

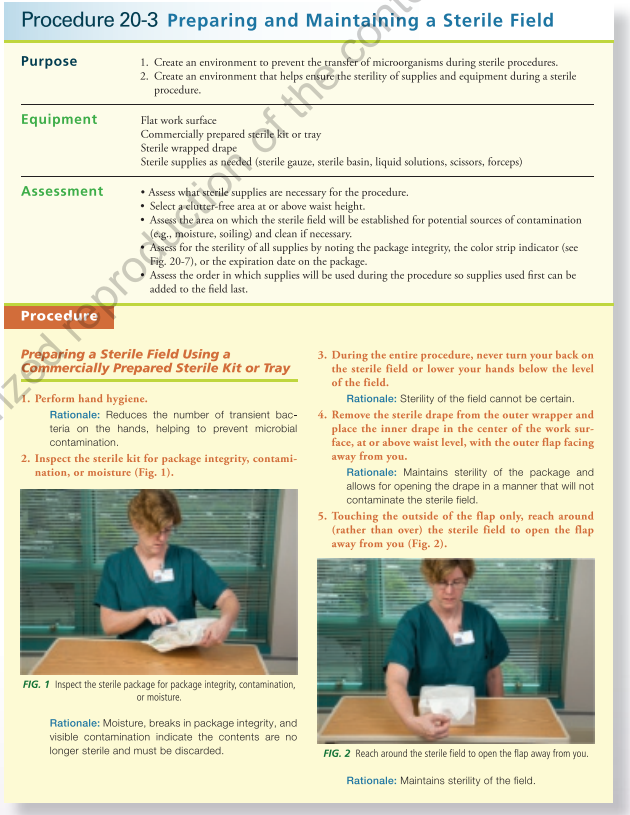
SAFETY ALERT

Add stimulation slowly so that patients are not overwhelmed. Include various stimuli, and keep the amount of sensory input at a moderate level.

- **Safety Alerts** appear close to related text issues and address specific safety concerns for students.

FEATURES THAT TEACH SKILLS AND CONCEPTS

- **Procedures** use clear descriptions, rationales, and pictures to assist students in learning important nursing care skills. Each procedure focuses on patient safety and comfort and includes the latest evidence-based practice and technology.



Procedure 20-3 Preparing and Maintaining a Sterile Field

Purpose

1. Create an environment to prevent the transfer of microorganisms during sterile procedures.
2. Create an environment that helps ensure the sterility of supplies and equipment during a sterile procedure.

Equipment

Flat work surface
Commercially prepared sterile kit or tray
Sterile wrapped drape
Sterile supplies as needed (sterile gauze, sterile basin, liquid solutions, scissors, forceps)

Assessment

- Assess what sterile supplies are necessary for the procedure.
- Select a clutter-free area at or above waist height.
- Assess the area on which the sterile field will be established for potential sources of contamination (eg., moisture, soiling) and clean if necessary.
- Assess for the sterility of all supplies by noting the package integrity, the color strip indicator (see Fig. 20-7), or the expiration date on the package.
- Assess the order in which supplies will be used during the procedure so supplies used first can be added to the field last.

Procedure

Preparing a Sterile Field Using a Commercially Prepared Sterile Kit or Tray

1. Perform hand hygiene.
   Rationale: Reduces the number of transient bacteria on the hands, helping to prevent microbial contamination.
2. Inspect the sterile kit for package integrity, contamination, or moisture (Fig. 1).

FIG. 1 Inspect the sterile package for package integrity, contamination, or moisture.

   Rationale: Moisture, breaks in package integrity, and visible contamination indicate the contents are no longer sterile and must be discarded.
3. During the entire procedure, never turn your back on the sterile field or lower your hands below the level of the field.
   Rationale: Sterility of the field cannot be certain.
4. Remove the sterile drape from the outer wrapper and place the inner drape in the center of the work surface, at or above waist level, with the outer flap facing away from you.
   Rationale: Maintains sterility of the package and allows for opening the drape in a manner that will not contaminate the sterile field.
5. Touching the outside of the flap only, reach around (rather than over) the sterile field to open the flap away from you (Fig. 2).

FIG. 2 Reach around the sterile field to open the flap away from you.

   Rationale: Maintains sterility of the field.

FEATURES THAT PREPARE STUDENTS FOR THE NCLEX

- **Concept Mastery Alerts** clarify fundamental nursing concepts to improve the reader's understanding of potentially confusing topics, as identified by Lippincott's Adaptive Learning Powered by PrepU. Data from thousands of actual students using this program in courses across the United States identified common misconceptions to be clarified in this feature.

Concept Mastery Alert

When providing oral care for a patient who is unconscious, the patient should be positioned side-lying, with the head of the bed lowered. This position best minimizes the patient's risk of aspiration when providing oral care because it allows fluids to drain easily.

- **NCLEX review questions**, the kind you can expect to see on your licensing examination, are included in each chapter. This edition includes Next Generation NCLEX style questions in some chapters. Appendix A provides answers, with rationales for correct and incorrect answers. These questions and answers allow you to test your clinical thinking skills and can jump-start discussions with your instructors.

PRACTICING FOR THE NCLEX

...

12. Which interventions included in the plan of care for a patient recuperating from an above-the-knee surgical amputation of the left leg are focused on preventing contractures? Select all that apply:

a. Limit spending long periods in a sitting position, either in bed or in chair.
b. Place patient on abdomen as part of regular positioning schedule.
c. Provide patient education regarding proper use of bed trapeze.
d. Have patient perform isometric exercises three times a day.
e. Have patient avoid elevating stump on pillows.

Next Generation NCLEX Style Question

Nurse's Note

13. Mrs. Golden, the retired, widowed woman introduced earlier in this chapter who recently underwent knee replacement surgery, continues to be reluctant to engage in physical rehabilitation exercises. Her son reports that Mrs. Golden spends most of her time sitting on the couch in the living room watching television or napping in bed. She has not been eating or drinking much so that she can avoid frequent trips to the bathroom. Mrs. Golden demonstrates appropriate use of a walker, and the home environment is without safety hazards. She reports taking 1 tab oxycodone 5 mg/acetaminophen 325 mg PO every six hours. Surgical staples removed per order without complication.

Vital Signs

BP 168/86 mm Hg, HR 92 BPM, RR 18/min, T 37.8°C (100°F)
Physical Assessment
Heart sounds are within normal limits. Lung sounds are clear. Bowel sounds are hypoactive. Patient reports last bowel movement was four days ago. Patient states her urine pattern is unchanged from prior to surgery. Pulses are 1+ in all extremities. Patient is oriented to person, place, and time. Skin is warm, dry, and intact with the exception of the surgical incision; however, Mrs. Golden declined skin assessment of her buttocks. Her surgical incision has slight edema but is without redness or exudate, and the wound edges are well-approximated.

➢ **Complete the following sentence by selecting the correct options from each list.**

The priority problem for this patient is _____(list 1)_____ as indicated by _____(list 2)_____.

List 1	List 2
Nonadherence to therapeutic regime	T 37.8°C (100°F)
Constipation	Reluctance to perform prescribed exercises
Infection	Edema of surgical incision
Impaired skin integrity	No bowel movement for 4 days
	Declined skin assessment of buttocks

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CASES FEATURED IN EACH CHAPTER

CHAPTER 15

Patient Education and Health Promotion

Trena Redman

Case Scenario

Mrs. Hussein, accompanied by her husband, presents to the clinic for a blood pressure check. As they enter the office, the nurse hears the husband speaking rapidly in a language the nurse does not understand, and he appears upset. The wife does not respond but looks down and appears to withdraw. Because her blood pressure is elevated for the second consecutive visit, the provider decides to prescribe a blood pressure medication and a low-sodium diet. The nurse has 15 minutes to teach the couple about hypertension and its management.

Once you have completed this chapter and have incorporated patient education and health promotion into your knowledge base, review the above scenario, and reflect on the following areas of critical thinking:

1. Prioritize important assessment data to collect from the couple so you can determine their readiness to learn and individualize your health promotion teaching.
2. Describe factors that might hinder or facilitate the family's learning.
3. Role play how you might individualize teaching, focusing on three realistic goals.
4. Identify how you will evaluate learning and use your findings to revise future teaching.

KEY TERMS

adherence
affective
cognitive
compliance
determinant of health
disease prevention activities
health literacy
health promotion
health promotion activities
health protection activities
learning
motivation
motivational interviewing
noncompliance
psychomotor
return demonstration
role playing
simulation
teach-back
telehealth

LEARNING OBJECTIVES

Upon completion of this chapter, the student will be able to do the following:

1. Identify four purposes of patient education.
2. Give examples of health promotion and disease prevention behaviors.
3. Explain the domains of learning and how knowledge is acquired differently in each.
4. Describe important qualities of a teaching–learning relationship.
5. Discuss important assessment data used to individualize patient teaching.
6. Recognize major factors that affect motivation and health maintenance.
7. Define factors that inhibit and facilitate learning.
8. Describe individualized teaching methods and evaluation strategies for patients of different ages or abilities.

Patient education is an important function of the nursing profession. Providing patients and their families with knowledge and understanding about their health improves clinical outcomes and health. Patient education is aimed at assisting patients in gaining skills and knowledge to promote and maintain their health and well-being. Historically, healthcare professionals viewed patients as passive receivers of care, and education meant telling patients what to do. Patient education has moved beyond this approach and is now focused on involving patients in decisions about their health to develop a plan that fits with the patient's values and healthcare goals. Patient education plans are individualized to align with the abilities, preferences, and life circumstances of each person. Today's patients are more likely to be active participants in decision-making about their care and treatment. Patients and their families work collaboratively with healthcare professionals to achieve their healthcare goals. This collaborative teaching–learning process empowers patients to achieve increased wellness through health promotion activities or to manage specific healthcare needs. Nurses are often the primary teachers for patients as well as coordinators of information from other healthcare professionals.

Patient and family education is an integral part of any comprehensive healthcare delivery system. The American Nurses Association's *Nursing*: *Scope and Standards of Practice* includes a standard of practice that describes a competent level of nursing care for health teaching and health promotion: "The registered nurse employs strategies to promote health and a safe environment" (ANA, 2021). The purpose is to deliver patient-centered care. Patient and family engagement, in which hospitals, healthcare providers, patients, and families actively partner with one another, leads to improved healthcare quality and patient activation.

Today, the cost of healthcare remains a continuing concern and is driving healthcare reform. The importance of education to prevent illness has been promoted by the Affordable Care Act, federal legislation enacted in 2011, which guarantees preventive services for most patients, including counseling on weight loss, tobacco and alcohol use cessation, treating depression, and healthy eating (ASPA, 2021). Healthcare facilities are now discharging patients more quickly, and the federal government requires healthcare organizations to provide patients with discharge plans. The Institute for Healthcare Improvement encourages patients to become more active participants in their healthcare and to ask specific questions to increase understanding of their health conditions and what to do to improve health (IHI, n.d.). Readmissions can be prevented when patients understand their discharge plans.

Patient education and health promotion will continue to be a primary focus for nurses, regardless of the setting. School nurses talk with adolescents about contraception and safe sex practices. Occupational health nurses may conduct classes on workplace safety. Ambulatory or clinic-based nurses discuss normal childhood development and age-appropriate activities with parents. Ambulatory surgical center nurses discuss postoperative care with patients before discharge. Clinical nurse specialists review choices in menu planning and policies for patients who have diabetes. Nurse practitioners, when prescribing drugs for treatment, describe medication side effects to patients. Public health nurses stress the importance of keeping immunizations current to prevent the spread of illness. Those are just a few examples.

Although nurses can influence and promote positive healthcare outcomes, they cannot control the patients' actions after education has been delivered. Despite best intentions, patients may not follow the recommendations of healthcare providers, and it is important for the nurse to understand the factors that affect a patient's ability to access health information and follow said guidelines. Gaining knowledge and changing behaviors are voluntary actions; however, nurses can act as health coaches to effect positive behavior changes based on patients' motivation and readiness for change. No matter how important a nurse believes certain actions and attitudes to be, the choice is always that of the patients.

Patient education is seldom the process that most people experienced in formal education. When a teachable moment occurs during routine nursing care, it is appropriate to offer unplanned education if the patient is receptive. During any patient care activity, a patient or family member may ask questions. This curiosity indicates a degree of motivation that nurses should act on. During these moments, patient education can be extremely effective. Simply being knowledgeable about the patient's health status and care, however, is not enough. To take advantage of these spontaneous opportunities for teaching, nurses must know the teaching and learning processes, possess teaching skills, be able to define the patient's learning needs quickly and accurately, and know how best to include the patient's family in the process. Part of this understanding is realizing that patient education consists of more than handouts, pamphlets, and videos. It requires a therapeutic relationship in which the nurse empowers the patient and family, facilitating autonomy and self-care (Champarnaud et al., 2020).

PURPOSES OF PATIENT EDUCATION

Patient education has long been considered an independent role for nurses, so it is important for nurses to gain not only subject matter knowledge but also specific knowledge and skills for patient education. Nurses must educate patients in a way that meets the patient's learning needs and actively engages them (Oh et al., 2021). The goals of patient education are to promote health and wellness (primary prevention), prevent or diagnose illness early (secondary prevention), restore optimal health and function if illness has occurred (tertiary prevention), and assist patients and families with coping with alterations in health status. Education plays a role in each level of prevention. Levels of disease prevention are outlined in Table 15-1. Patient teaching at each level encompasses all areas of function, as reflected in Table 15-2.

TABLE 15-1 THREE LEVELS OF DISEASE PREVENTION

Level	Description	Examples
Primary prevention	Seeks to prevent a disease or condition at a prepathologic state; to stop something from ever happening	Immunizations, fluoride supplements, car seat restraints, oral contraceptives, education in elementary schools about substance use disorder
Secondary prevention	Seeks to identify specific illnesses or conditions at an early stage with prompt intervention to prevent or limit disability; to prevent catastrophic effects that could occur if proper attention and treatment are not provided	Physical assessments, developmental screening, vision screening, breast and testicular self-examinations, pregnancy testing
Tertiary prevention	Occurs after a disease or disability has occurred and the recovery process has begun; intent is to halt the disease or injury process and assist the person in obtaining an optimal health status	Rehabilitation for people with impaired mobility, support groups such as reach for recovery and alcoholics anonymous, cardiac rehabilitation, health education for a patient with newly diagnosed diabetes

Nurses have a professional, ethical, and social responsibility to assist individuals, families, and communities to maintain and improve health. Nursing interventions should focus on enhancing the abilities of patients and families to engage in safe, effective, and efficient health behaviors.

Health Promotion

The importance of health promotion is an essential element of healthcare reform in the United States, Canada, internationally, and globally. **Health promotion** helps reduce excess mortality, address the leading risk factors and underlying determinants of health, and helps strengthen sustainable health systems (WHO, 2022a, 2022b). **Determinants of health** are factors that, combined, affect the health of individuals, families, and communities. The context of people's lives determines their health, so blaming individuals for having poor health or crediting them for good health is inappropriate (WHO, 2022b). The state of health of an individual or family is affected by these determinants of health, which include the patient's social and economic environment, such as income and education; physical environment, such as clean water, air quality, and working conditions; and the person's individual characteristics, such as gender, and behaviors, such as lifestyle choices (WHO, 2022a). Nurses who are knowledgeable about the determinants of health enable all people to achieve their fullest health potential.

Health promotion activities seek to expand the potential for health and are often associated with lifestyle choices, increasing the level of wellness. Put simply, people use health promotion activities to feel better. Health promotion behaviors enhance overall well-being. **Disease prevention activities** involve efforts to avoid or prevent specific diseases or conditions. Both health promotion and disease prevention share the goal of improving health. A difference between them is that health promotion activities may be more general and concern improving someone's overall well-being.

TABLE 15-2 EXAMPLES OF HEALTH PROMOTION AND PATIENT EDUCATION

Concepts	Example of Possible Teaching
Health promotion	Importance of regular physical examinations and immunizations
Mobility	Importance of regular exercise, how to use ambulation devices (e.g., crutches, walker)
Nutrition	Healthy diet, dietary restrictions, total parenteral nutrition at home
Elimination	How to maintain regular bowel function, pelvic floor muscle training to decrease stress incontinence, self-catheterization
Sleep	Importance of getting adequate rest, aids to promote sleep
Self-concept	Normal body changes, methods of promoting self-esteem
Roles and relationships	Assertiveness training, parenting classes
Coping–stress tolerance (self-care)	Biofeedback, relaxation techniques, meditation
Sexuality–reproductive	Prenatal classes, contraception
Value–belief	Patient rights, "do not resuscitate" options

Concept Mastery Alert

Disease prevention (illness prevention) activities address ways of reducing the risk of a particular health problem. Health promotion often has a more general focus, including strategies for enhancing overall wellness and quality of life.

Disease prevention concentrates prevention efforts on one specific illness. Another distinction is that health promotion activities may be more inclusive of community, seeking the input of others about health concerns and their priority in a community. Disease prevention is more likely to stem from

THINK LIKE A NURSE

A patient returns to the clinic 1 week after the nurse holds a teaching session with them. The following is a diary of activity and food intake for a day that the patient shares with the nurse.

Breakfast
Orange juice
Large chocolate chip muffin
Coffee

Lunch
Ham and Swiss cheese on rye with mayo
Potato chips
Pickles
Salad with blue cheese dressing
Donut

Dinner
Hamburger
French fries
Salad with blue cheese dressing
Ice cream

Exercise
Walking with a friend in the neighborhood

Identify healthy aspects of the patient's diet and exercise pattern to provide positive feedback. What are some important changes that can promote optimal health? What further teaching measures could the nurse indicate for this patient?

Check your answers in Appendix B.

outside information that suggests a significant health need in a community, such as rates of a particular disease as collected by a local health department. Together, health promotion and disease prevention efforts can improve and maintain the health of people in a community.

Health protection activities are environmental or regulatory measures that seek to protect the health of a community or large population. Examples of health protection activities include air and water quality regulations and food and drug regulations enforced by federal, state, and local governments.

Focus on health promotion has gained much momentum in recent decades. Nurses, regardless of their practice arena, are involved in patient education to promote optimum health and function. Knowledge, values, and access to healthy food and safe places to participate in physical activity are important when determining choices people make daily. Such things as food, rest, coping abilities, and hygiene and safety practices may influence optimal wellness. When health choices are under the control of patients, they still may lack the motivation to change comfortable, unhealthy habits when they are feeling well. Nurses often aim health promotion at young people to encourage positive health choices from a young age, with the hope that the positive choices will continue through the life span.

Behavior change and breaking long-established habits are required for health promotion. Health behavior change is complex, and nurses can best support these changes by basing their education and health promotion efforts on theoretical models of behavior change. The Health Belief Model is an established framework that has been used to predict behaviors and helps explain interpersonal processes that lead to decision-making (Lau et al., 2020). This model is heavily utilized and consists of six constructs: perceived benefits, barriers, susceptibility and severity, self-efficacy, and the presence of reminders to action (Lau et al., 2020). For example, COVID-19 vaccination rates were influenced by perceived benefits; lowered barriers, such as accessibility and cost; and reminders to get vaccinated from the Centers for Disease Control and Prevention (CDC), local government, healthcare workers, and even social media.

THE HEALTHY PEOPLE INITIATIVE

In the United States, the Healthy People initiative is a national health promotion and disease prevention initiative whose objectives are updated every decade. The mission of the initiative is to ensure improvement of health and well-being of all people through the promotion, strengthening, and evaluation of national health promotion activities (Office of Disease Prevention and Health Promotion, n.d.).

The five goals of Healthy People 2030 are to assist the people of the United States to achieve the following (Office of Disease Prevention and Health Promotion, n.d.):

- To attain healthy, thriving lives and well-being free of preventable disease, disability, injury, and premature death.
- To eliminate health disparities, achieve health equity, and attain health literacy to improve the health and well-being of all.
- To create social, physical, and economic environments that promote attaining full potential for health and well-being for all.
- To promote healthy development, healthy behaviors, and well-being across all life stages.
- To engage leadership, key constituents, and the public across multiple sectors to take action and design policies that improve the health and well-being of all.

INTERNATIONAL AND GLOBAL CONCERNS

Key to addressing health promotion is action not only on a local level but also at an international and global level. This will require an integrated approach to health promotion. The World Health Organization (2022b) has described pillars of health promotion: good governance, strengthening policies to make healthy choices accessible to all, healthy cities that enable people to live and work in good health, and health literacy to increase knowledge, helping people make healthy choices. The increasing emphasis on community partnerships places responsibilities on nurses to work cooperatively with all levels

of government, college programs, community and business organizations, and neighborhoods to improve the health of groups as well as individuals.

Disease Prevention

Patient education also focuses on teaching patients the knowledge and skills for early detection or prevention of disease and disability. As research increases, the understanding of risk factors for disease improves. For example, studies have demonstrated the link between some types of cancer and obesity. This knowledge enables nurses to focus on weight reduction to help decrease cancer risk. Studies also have proven the importance of early detection and support teaching about regular screening. Research has better identified people at risk for specific illnesses, so resources and teaching programs can be directed at high-risk groups. For example, patients with diabetes are at risk for cardiovascular problems, so frequent blood pressure and cholesterol screening with appropriate prescribed medication can prevent myocardial infarction or stroke.

Restoration of Health or Function

When illness or dysfunction occurs, patient education is important to help limit disability or restore function. In the home, community, and rehabilitation center, much teaching focuses on helping people deal with chronic health problems such as heart disease or diabetes (Fig. 15-1). In the acute care facility, teaching also focuses on restoring health. Patients who are admitted for surgery receive instruction during the preoperative and postoperative periods to help prevent complications and to ensure optimal recovery. In the ambulatory care setting, nurses explain medications or diagnostic procedures to patients to reduce anxiety and to assist them in making informed healthcare decisions. Important patient teaching opportunities are outlined in Table 15-3.

FIGURE 15-1 The nurse teaches the patient about medications as one method to help the patient manage chronic health problems.

TABLE 15-3 IMPORTANT TEACHING OPPORTUNITIES

Opportunity	Possible Learning Need
Clinic visit	Immunization record, routine screening, weight reduction and diet, medications
Hospital admission	Unit policies, how to work call light and bed, specific treatments that have been ordered and why
Beginning of each shift	Review plan of care; explain any new treatments, tests, or medications
New medication	Action of drug, possible side effects, frequency, and any special considerations or interactions
Diagnostic procedure	Necessary preparations, what will be experienced during the procedure, any restrictions or special considerations after the procedure
Surgery	Preoperative preparation, postoperative protocols (e.g., deep breathing, leg exercises), pain control, how to get out of bed and turn easily
Discharge	Limitations on activity or diet, procedures such as wound care, when to call the provider

Promotion of Coping

Patient education is important for individuals and families who must cope with new and frightening procedures or adjust and continue to live with chronic illness or new limitations. Adjusting to a loss of function can be difficult for patients and their families. Teaching may assist people to adapt to using new devices (e.g., a walker to assist with ambulation) or to alter diet or activity. Some teaching assists with changes in body image (e.g., a mastectomy) or role expectations (e.g., grocery shopping for someone who can no longer drive). Teaching may be necessary to prepare caregivers for the technical and psychological challenges of caring for loved ones who have impaired functioning. Patient education also is important for helping both patients and their families deal with grief and loss.

TEACHING–LEARNING PROCESS

Learning is the acquisition of a skill or knowledge by practice, study, or instruction. Learning theory has changed over time. According to an early, teacher-centered theory, learning required a disciplined mind, and the goal was to memorize many facts. Later, student-centered theorists believed that learning could be completely intuitive; by encouraging self-direction, an active unfolding of knowledge would occur. Still others claimed that learning must build on prior knowledge and experience with the teacher actively imparting new ideas and the learner passively associating them with related ideas

to grasp principles. Different conceptual models of the learning process also viewed the teacher's role differently—director, designer, programmer, or producer. More recent views suggest that the core of effective teaching is to produce capable self-learners, who continue their learning well past teaching–learning encounters. Nursing students have experienced all these theories at work. For example, to learn anatomy, one must memorize facts. Dealing with people, especially patients, always requires a level of emotional intelligence and an intuitive component. Pharmacology builds on the student's previous knowledge of pathophysiology, chemistry, anatomy, physiology, and mathematics.

Adult learning theory addresses how adults learn best. Malcolm Knowles developed this theory, which explains how adults learn. Adults need to know why they are learning something; they need to know the reason and rationale (Norman, 1999). Learning is best when it is experiential, and the learner is actively engaged in the activity, especially when involving practice of a skill. Effective instruction entails adults in problem-solving situations that are meaningful to them (Forbes et al., 2021).

Domains of Learning

Learning can be acquired in three different domains: cognitive, affective, and psychomotor. Although the following section discusses each domain separately, the nurse should remember that learning does not occur in one domain without affecting the other domains and frequently involves interdependent processes that include all three domains (Bloom, 1956).

COGNITIVE

Cognitive learning may involve learning facts, reaching conclusions, solving problems, making decisions, or using critical thinking skills. Nurses frequently participate in teaching–learning experiences in which patients must use new information to promote optimal health. Moving from the simple to the complex is likely to yield the best results during a cognitive teaching session. Depending on the patient and after assessing their baseline knowledge on the topic, it is often most effective to start with basic facts and concepts and then move to discussing how the topic is meaningful to the patient. As patients learn to apply the material correctly in various situations, the nurse can add more information and offer in-depth explanations when the patient or family asks questions. Short, specific learning sessions and limiting teaching to essential information allow for patients to learn effectively.

Teaching a new birthing parent, the physiology of the breast and its role in milk production is an example of cognitive learning. After the patient understands the physiology of the milk supply, the letdown reflex, and how these two factors work together, they have demonstrated cognitive knowledge.

AFFECTIVE

Affective learning refers to emotions or feelings. Affective learning changes beliefs, attitudes, or values. Sensitivity and emotional climate influence all types of learning but are especially important in the affective domain. Affective learning is more difficult to measure than cognitive or psychomotor learning because it focuses on thoughts and feelings. When working with patients to change beliefs, values, or attitudes, the nurse must understand their own feelings and emotions related to the topics being discussed; create an atmosphere in which patients can honestly and freely discuss their feelings and emotions; and situate the changes within the reality of the patients' lifestyle environment. Finally, for affective learning to occur, the nurse must allow sufficient time for exploration of feelings and emotions within a nonjudgmental environment. An example of affective learning is helping a new parent explore the possible benefits of breast-feeding for the health of the baby.

PSYCHOMOTOR

Psychomotor refers to the muscular movements learned to perform new skills and procedures. This type of knowledge is easiest to measure because it can be physically demonstrated. Teaching a new birthing parent to breast-feed is an example of psychomotor learning. When the patient can successfully and independently breast-feed the infant to the physical satisfaction of both, the patient has demonstrated psychomotor learning.

Nurses are frequently responsible for teaching patients to perform certain skills independently (e.g., effective hand hygiene, good body mechanics). Nurses teach principles and demonstrate skills, patients practice these skills, and nurses answer any questions and identify further resources.

An important consideration in the psychomotor domain is that patients demonstrate the dexterity to manipulate the body parts, tools, or objects needed to perform the skill or procedure. A **return demonstration**, by which the nurse observes the patient performing the new skill, is critical and essential for evaluating psychomotor learning.

Qualities of a Teaching–Learning Relationship

In nursing, the relationship between teacher and learner is special, characterized by mutual sharing, advocacy, and negotiation. Unlike some traditional views, nurses are not experts who generously bestow knowledge upon patients, nor do nurses barter knowledge for compliance. Both images represent the relationship as a power imbalance in which nurses, because of their knowledge and expertise, control the situation. Effective learning occurs when patients and healthcare professionals are equal participants and partners in the teaching–learning process. This requires that nurses explore the types of learning strategies that best help patients to learn during any teaching–learning situation. The nurse must promote health and teach in

a way that considers patients' "beliefs, health practices, developmental level, learning needs, readiness and ability to learn, language preference, spirituality, culture, and socioeconomic status," (ANA, 2021). Developing rapport with the patient and family is important prior to any teaching. Often, it may be best to delay the teaching until the patient demonstrates readiness to learn and actively participate.

PATIENT FOCUS

Patient education is a therapeutic relationship that should focus on the patient's specific needs. Patient educational needs can differ due to many factors, including whether the patient's condition is acute or chronic. Nurses must actively engage patients to ensure their individual educational and learning needs are met (Oh et al., 2021).

Patients also have unique values, beliefs, cognitive abilities, and preferential ways of learning that affect involvement and educational outcomes. Allowing patients to share their beliefs and preferences enables nurses to better understand this uniqueness and to individualize teaching to the patient's needs.

HOLISM

The teaching–learning relationship should consider the whole person rather than focusing on the specific content. Nurses use the patient's individual needs and their own experiential knowledge to provide meaningful information to the patient. For example, a nurse teaching insulin injection to a patient with newly diagnosed diabetes anticipates problems or questions based on previous patient's experiences and questions.

NEGOTIATION

Together, nurses and patients determine what is already known and what is important to learn. Decision-making is a shared process between the patient and the nurse, and a plan is developed with input from both parties. Sometimes, negotiation is a more formalized process with a written contract that guides the learning experience, such as when changes in attitude or behavior are needed. More often, the process is informal and ongoing, with continual checking and validating to guide the learning process. Remember a patient nodding their head may not mean agreement; it is best to ensure understanding by having both parties verbally state the plan.

INTERACTION

The teaching–learning relationship is a dynamic, interactive process that involves active participation from both the nurse and patient. Nurses learn from patients, and patients learn from nurses as they discuss content, clarify and revisit specific points, or determine new needs. This interactive, nonlinear model differs from the simplistic model that many texts describe: presentation of content, learning, and evaluation of learning.

ASSESSMENT FOR LEARNING

Assessing Learning Needs

The educational assessment begins with determining what the patient needs to know or do to function more independently. It is important to know the purpose of the teaching and to identify the expected result (patient outcome or goal). New knowledge or skill acquisition may need to occur before a patient leaves a clinic or is discharged from the hospital or home care. For example, parents with a newly inserted feeding tube must demonstrate the ability to feed their infant via the new feeding tube before the infant can be discharged home. Along with the assessment of learning needs, the nurse must also assess the patient's access to necessary resources, such as the medication that the nurse will be teaching the patient how to take, or access to insulin needles if the patient is learning self-injection. It is easy to assume that patients have access to necessary resources, but this is not always the case. If patients need supplies, medications, transportation, or other resources, other professionals, such as social workers, may be contacted to assist the nurse in accessing these resources for the patient.

BASELINE KNOWLEDGE

Many times, patients articulate specifically what information is important to them and why. Other times, requests for knowledge are less direct. For example, a patient may say, "I'm just not sure about all these new medications." Compare the patient's knowledge, attitudes, and skills with those necessary for independent functioning. "Tell me what you know about (relevant topic)" is a useful opener to discover the patient's knowledge (or gaps in knowledge) on the subject. This information is essential to build trust and to start the education in an engaging place. If the nurse does not do this first, they may risk disengagement from the patient. Additionally, determining other factors that may impede learning is an important part of this assessment; for example, being in a public place when teaching may discourage a patient who prefers privacy.

CULTURAL AND LANGUAGE NEEDS

Culture, values, and beliefs influence health maintenance practices, including preventive care, diet, childbearing and childrearing customs, self-medication, and alternate therapies. To improve individual health and build healthy communities, healthcare providers need to recognize and address the unique cultures, languages, and health literacy levels of diverse consumers and communities. Assess the patient's ability to understand and speak English; an interpreter (other than a family member) may need to be arranged for any significant teaching session. Both in-person and electronic or virtual interpreters are available in many healthcare settings.

Nurses also need to consider components of diversity such as race and ethnicity, religion, health beliefs, language, and gender role beliefs when planning patient education. In general, the more the nurse educator can learn about the

patient, including lifestyle, occupation, affiliations, and where the patient gets their health information, the more likely it is that educational interventions will be successful.

Spiritual beliefs and personal or family values also affect health maintenance. Some people place great value on physical health to achieve spiritual health. Others may have religious beliefs that prohibit certain medical practices and treatments or any medical treatment at all. Not all people who share a group identity share certain healthcare norms and values.

If a patient from a culture different than that of the nurse needs to be educated about nutrition, a registered dietitian may be able to help. Registered dietitians often are familiar with cultural food beliefs and can tailor a plan for individual patient needs. In some cultures, family members assigned female at birth are the only ones to prepare food or care for the sick. (Please note that hereinafter in this chapter, "female" refers to a person assigned female at birth, and "male" refers to a person assigned male at birth.) Therefore, identify and include these family members or significant others in any dietary or health teaching for the patients.

ETHICAL/LEGAL ISSUE

LITERACY

The provider writes discharge orders for a patient who is an English language learner and does not speak English fluently. They include a complex medication regimen and self-management of an indwelling catheter. When the nurse calls for an interpreter, one is not available until tomorrow. Due to staffing and insurance coverage, the patient is due to be discharged today.

CRITICAL THINKING CHALLENGE

- Legally, should an interpreter be provided to this patient during the teaching session?
- Role play how you might respond to the provider who may be upset when you call to let them know the patient hasn't been discharged yet.
- Brainstorm other alternatives to help provide the patient with the teaching required for safe discharge.

PRIORITIES

Patients usually have many learning needs; therefore, nurses, the patient, and involved family members must set priorities to help ensure that teaching will prove effective. Priority setting may involve teaching patients the basic skills in the hospital and arranging home nursing visits for follow-up teaching. It is important to begin assessment and priority setting early in the patient–nurse interaction because time for teaching may be limited. Hospital lengths of stay are often 3 days or less, while in other settings, appointment times are brief. The Institute for Healthcare Improvement has a campaign called *Ask Me 3* for patients to better understand their health and obtain key information that is important for each patient to know (IHI, 2022). The three questions can serve as a standard guide for teaching when time is limited. The questions are as follows:

1. What is my main problem?
2. What do I need to know?
3. Why is it important for me to do this?

Ask patients to identify their learning needs; assess what is important to them. Patients may perceive learning needs when they wish to learn more to maintain or promote health or to fix a perceived problem that has occurred. For example, a routine physical examination may reveal an elevated cholesterol level. This information can increase a patient's need and desire to learn about lifestyle changes that can prevent heart disease. Teaching should occur when learning is a high priority for the patient. Seizing teachable moments when patients and their families are invested in learning enables them to be active participants. Sometimes, the perceived need for health teaching comes from a patient's personal reflection (e.g., a desire to exercise more and to lose weight after the winter).

REALISTIC APPROACH

Nurses who take a realistic approach with the patient set priorities. Teaching too much to patients and families when they are not ready will only result in little or no learning. The most effective approach is to interpret cues from the patient and family about readiness and willingness to learn. Consider the following:

- *The patient's energy/comfort level*: Physical weakness, pain, discomfort, and fatigue can affect attention span and decrease learning.
- *The patient's age*: Educational goals for children, adolescents, and adults differ, and patients require different teaching styles at different ages.
- *The patient's emotional state*: Patients may be too anxious or depressed to learn. It is not uncommon for those who have received a new diagnosis, suffered a loss, or experienced trauma to have difficulty learning.
- *The patient's cognitive ability and developmental level*: Patients with dementia, short-term memory deficits, or altered mental status may be unable to retain information or learn new skills. It may be necessary to identify another person (a caregiver or family member) to include in the teaching.

Assessing Learning Readiness

MOTIVATION

Motivation provides the incentive for learning. Often, nurses associate noncompliance or lack of adherence to a treatment plan as an indication that patients do not possess the necessary knowledge, are lazy, are resistant to change, or are unmotivated. The notion that a patient sufficiently motivated will "comply" with the provider's or nurse's instructions belies the complexity of motivating factors and incentives. Motivation for learning starts with the patient's recognition of the need to know. Remembering Maslow's Hierarchy of Needs may affect

one's ability to adhere to treatment plans such as housing or financial problems, inconvenience, denial, lack of social support, nonacceptance of the disease, anxiety, fear, shame, and negative self-concept (Xu et al., 2021). Motivating factors can change daily. For instance, a patient starting antihypertensive medications to control blood pressure may show less motivation to continue taking the medications and learn more about treatment options if a close friend confides that they experienced erectile dysfunction when taking a similar medication. In addition, patients may be ambivalent about making a change, experiencing mixed feelings or having contradictory ideas about the change. This ambivalence can lead to feelings of anxiety, resulting in procrastination, which is often perceived as resistance. They may be labeled "noncompliant" by healthcare providers without finding the root cause of the lack of adherence to the previous plan. Good adherence to treatment plans have positive outcomes and lower rates of hospitalization and morality; therefore, health providers must have effective strategies to help improve a patient's adherence to the plan of care (Wilhelmsen & Eriksson, 2019).

Because motivation is complex, often involving several different incentives (or disincentives), discovering factors that promote adhering to healthcare regimens and those that create barriers to achieving success may be difficult. Often, patients are not aware of all the motivating factors involved in their actions. There may be verbal cues (e.g., a patient who says, "My partner takes care of all that!") or nonverbal cues (e.g., lack of attention, missed appointments) that point to decreased motivation to learn. An important part of assessing what motivates any patient is to learn what the patient values and especially what has resulted in past successes. Patients who associate healthcare goals with something they already value will probably be more motivated to adhere to healthcare regimens.

Motivational interviewing (MI) is an evidence-based communication style that is collaborative and goal oriented, designed to strengthen an individual's motivation. MI is focused on the individual's reasons for change while the interviewer is committed to providing a safe, accepting, and compassionate environment (Gagneur, A., 2020; Prescott, 2020). Key concepts include the following:

- Guiding communication that has minimal interventions from the provider while keeping the patient's best interest in mind while the provider avoids assuming the expert role
- Promotion of change by drawing out the individual's own meaning for the change and for the provider to recognize that the individual's perspective includes the best ideas for them
- Based in curiosity and respect while honoring the natural process of change as well as recognizing the patient's own strength and autonomy

To successfully practice MI, the nurse must begin the conversation with empathy and lack of judgment, must elicit the patient's experiences, and must respect the patient's autonomy (Prescott, 2020). Specific skills that can be used in MI along with examples can be found in Table 15-4.

COMPLIANCE VERSUS ADHERENCE

Issues of **compliance** or **noncompliance** (i.e., following or not following the recommended plan) are losing favor as authoritarian and rigid terms to describe why patients do or do not follow healthcare regimens. In the past, compliance implied that the nurse dictated what the patient must do, and that the patient had to follow through or risk being labeled "noncompliant," or unwilling or unable to follow the recommendations.

TABLE 15-4 MOTIVATIONAL INTERVIEWING SKILLS

Skills	Explanation	Implementation
Open-ended questions	Avoid traditional questions about the behavior such as "How much alcohol do you drink per day?" Do not use questions that can be answered with a "yes" or "no" answer.	Encourage the patient to express thoughts and feelings by asking open-ended questions; avoid leading toward a specific agenda. Ask questions like "How are you feeling?" or "What role do you feel alcohol plays in your life?"
Affirmation	Positive statements about anything. Encourages the patient by praising strengths.	Encourage the patient's self-confidence. Say, "You were successful changing in the past." Or "You've worked very hard."
Reflection	Hearing the feelings and thoughts that a patient is experiencing and restating them. This involves listening to understand their perspective.	Convey empathy and see the situation from the patient's perspective. Patient: "I've been like this so long that I think it's just my personality." Nurse: "This all seems normal to you."
Summaries	Synopsis of multiple ideas expressed by the patient. Allows the patient to know the nurse was listening.	Select ideas to summarize reasons that the patient has expressed for change. Patient: "I enjoy having drinks with my friends. I am worried about my partner's statements about my drinking." Nurse: "You enjoy drinking alcohol, but you're concerned it's impacting your relationship."

Adapted from Arnett, M. C., Blue, C. M., Ahmann, L., Evans, M. D., & Reibel, Y. G. (2022). Impact of brief motivational interviewing on periodontal clinical outcomes: A randomized clinical trial. *Journal of Dental Hygiene*, *96*(5), 13–22; Palmer, D., & Miedany, Y. L. (2018). Incorporating motivational interviewing into rheumatology care. *British Journal of Nursing*, 27(7), 370–376.

The original intention of judging (and labeling) patients negatively when they do not follow a healthcare provider's medical advice conflicts with the prevailing view of developing partnerships with patients for optimal healthcare success. Instead, a more collaborative patient–nurse relationship involving respect, trust, mutuality of goals, and, most importantly, an understanding of the complexities involved in changing health behaviors and promoting **adherence** is suggested.

As previously mentioned, it is important for nurses to realize that following even mutually agreed-upon goals and recommendations may be difficult when patients are experiencing pain, anxiety, financial constraints, social isolation, and loss of independence. Identifying the reasons for nonadherence, either purposeful or unintentional, is important. For example, the nurse's intervention to address nonadherence to taking daily antihypertensive medications would be different for a patient whose antihypertensive medication was not covered by insurance than for a patient who was simply struggling to remember to take the medication. For those patients who are having difficulty making lasting changes in their health behaviors, understanding that the process of change will involve backsliding and failures will help patients identify the obstacles to following treatment goals and develop strategies to achieve success. For instance, asking supportive, open-ended questions such as "People often find it hard to take blood pressure pills twice a day, every day. Has this ever been a problem for you?" is a useful lead when assessing a patient's ability to follow treatment guidelines. Giving patients an agenda ("As I listen to you, it sounds as if we need to talk about wound care and diet. What do you think?") may also be useful. Suggesting follow-up with support groups to continue success with smoking cessation, healthy eating, or regular exercise can help promote long-term compliance. People may decide not to follow conventional medical advice for various reasons. This is often frustrating to nurses and other healthcare providers, but the choice to follow advice belongs to the patient, and the nurse must respect it as such.

SENSORY AND PHYSICAL STATE

The patient's sensory abilities and physical state affect learning readiness, and the teaching plan must be modified accordingly. For example, patients with poor vision or compromised fine motor skills may be unable to give themselves subcutaneous injections safely. Patients who receive pain medication postoperatively may have difficulty concentrating.

LITERACY LEVEL

One major barrier to optimal healthcare outcomes and successful patient education is literacy, especially among marginalized populations. Literacy is the ability to read and write and the ability to use language, numbers, and images to understand the written and spoken word. Poor literacy causes individuals to have trouble finding pieces of information or numbers in a lengthy text, integrating multiple pieces of information in a document, or finding two or more numbers in a chart and performing a calculation. Patients and families with poorer literacy skills are believed to have greater difficulty navigating the healthcare system and to be at risk for experiencing poor health outcomes.

Low levels of literacy also affect patients' abilities to understand communication provided by nurses and providers, further complicating the ability of patients to follow healthcare regimens, navigate healthcare systems, and follow healthcare instructions. It is possible to find people with low literacy in every occupation, among all races, at all ages, and at all socioeconomic levels. Appearance does not indicate a person's literacy; a roughly dressed person may be able to read well, but a professionally dressed person may be unable to read at a functional level. Use of spoken language also does not indicate a person's literacy; many people with low literacy levels have average or above average intelligence and speak articulately. Educational level gives only a rough estimate of literacy; a correlation between literacy and the number of grades completed in school does not always exist. The ability to interpret clocks and calendars is not universal, and this can also contribute to the inability to follow instructions and keep appointments.

The U.S. Department of Health and Human Services (DHHS) has action plans to improve health literacy, knowing that reading levels widely vary and materials are often confusing to patients (U.S. Department of Health and Human Services, 2010). Additionally, patients may be ashamed to admit their difficulty reading and understanding complex information. The action plan by the DHHS is based on two core principles:

1. All people have the right to health information that helps them make informed decisions.
2. Health services should be delivered in ways that are easy to understand and that improve health, longevity, and quality of life.

As such, it is important to determine a patient's literacy level. Tools to determine literacy level include reading tests, such as the Wide Range Achievement Test (WRAT) and Rapid Estimate at Adult Literacy in Medicine (REALM). Direct testing is the most accurate way to assess literacy, but observation of behaviors may be helpful when testing is impractical (Box 15-1). Here are some less accurate, but expedient, methods:

- Check the level of the patient's pleasure reading. This will present a measure of literacy level but not of functional health literacy (ability to read and understand healthcare information).
- Give the patient something to read, and later request a description of the contents in their own words.
- If possible, offer the patient several options (reading, watching, or listening) for learning.
- When in doubt and when time may be limited, use the lowest-grade literacy information material available. Even with high functional literacy ability, when patients are stressed by illness and teaching, it is better to start with simpler material and add complexity later.

BOX 15-1 Behaviors and Responses That May Indicate Limited Literacy

Behaviors
- Incompletely or inaccurately filled out forms
- Checking "no" for yes/no questions to avoid follow-up questions
- Demonstrating confusion, agitation, frustration; avoiding situations in which complex learning is required
- Frequently missed appointments
- Lack of follow-through with instructions

Responses to Written Information
- Lifting text closer to eyes or following text with the finger.
- "I forgot my glasses. I'll read this when I get home."
- "I'm too tired to read."

Responses to Questions About Medications
- Unable to name medications; may identify medications by color or shape if unable to read the medication label
- Unable to explain what medications are for

Adapted from Cornett, S. (2018). Assessing and addressing health literacy. *OJIN: The Online Journal of Issues in Nursing*, 14. Retrieved from http://www.who.int/global-coordination-mechanism/activities/working-groups/Assessing-and-Adressing-Health-Literacy.pdf

It may seem that these kinds of assessments take too much time. Nevertheless, nurses have an ethical and legal responsibility to make sure that the patient receives information in a manner that they understand.

HEALTH LITERACY LEVEL

Compounding the dilemma of low literacy is the need to consider health literacy levels. "**Health literacy** is the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions" (U.S. Department of Health and Human Services, 2022). Without fully understanding health information, it may be difficult for patients to complete health forms; manage follow-up care, such as attending appointments; or act on instructions regarding health behaviors, such as self-administering medications. To ensure patients can manage their chronic conditions and avoid hospital readmissions, it is imperative that health information be provided in a way that can be understood by patients. The problem of health literacy is a national focus in healthcare today because many studies have shown that patients often do not understand the information given to them. Culture and language must also be considered when providing information to patients. "Culture affects how people communicate, understand, and respond to health information; healthcare providers must recognize the health effects of cultural beliefs, values, attitudes, traditions, language preferences, and health practices of patients" (U.S. Department of Health and Human Services, 2022).

THINK LIKE A NURSE

An 84-year-old patient with chronic heart problems is being discharged with three new heart medications, a stool softener, and an as-needed (PRN) pain medication for arthritis. The patient is pleasant and is always patting your hand and saying, "Oh, you are so smart. I will try my best to follow all your instructions." The patient lives alone and has weekly visits and daily calls from family members.

What additional information should you collect to individualize this patient's teaching?

Describe some principles that might guide your teaching.

How might you evaluate the patient's learning?

Check your answers in Appendix B.

NURSING DIAGNOSES

Select nursing diagnoses associated with health promotion and patient teaching include lack of knowledge, adequate knowledge, impaired cognition, and literacy problem.

OUTCOME IDENTIFICATION AND PLANNING

The planning phase of patient education involves working with patients to develop a teaching plan, identifying appropriate teaching strategies, and developing a written plan to coordinate teaching among healthcare team members. Factors to consider in planning include the patient's assessed learning needs and motivation level, learning style preference, language translation needs, literacy level, health literacy level, inclusion of family member or support persons, timing, and the appropriate amount of information to cover.

Outcome Identification

Person-centered, patient-involved goals are most effective. Including patients in the planning process helps show clearly what patients are willing or unwilling to do, and it clarifies goals.

Be brief and realistic when writing goals and outcome criteria. Do not promise overly optimistic outcomes. Create measurable goals with time frames. A possible form for writing patient outcomes is as follows:

Who + Does + What + How + When = Goal

For example:

Patient + will demonstrate + dressing change without cueing + before discharge = to achieve goal

Evaluate and revise learning goals as necessary. If learning has been successful, new learning goals may be formulated. If outcomes have not been met, the time frame may be changed, or based on additional assessment data, the outcomes may be revised.

Planning Teaching Strategies and Methods of Delivery

There are many methods to deliver patient information to patients and families. Availability of resources, learning style preference, literacy level, and health literacy level affect planning effective teaching strategies. Teaching sessions can be individual, small-group, or large-group sessions. One-to-one teaching can be individualized, so it is usually most effective, but it is also most expensive in terms of money and time. Box 15-2 lists key points to remember for various teaching sessions.

Choosing the right strategy or method for patient education can make the experience more enjoyable for both the nurse and patient. If possible, use several strategies to enhance learning and retention. Combining modalities such as seeing, hearing, and touching promotes better learning than does using only one modality. The use of electronic teaching materials such as computer-assisted programs, videos, and internet-based tools can enhance learning.

DEMONSTRATION

Demonstrations are particularly useful for psychomotor learning. Explaining a skill while slowly demonstrating it leads to talking patients through the procedure for the first few times. Recordings can be used, but human contact is almost always preferable when teaching. Repeated practice can help patients move toward independent functioning. Return demonstration for skills is critical to help nurses evaluate learning. Reinforcement in the form of specific praise ("You're doing a great job of pushing up from the chair with your hands when you stand up"), correction ("Try leaning a bit more on the cane as you walk"), or constructive feedback ("I see you've figured out how to use your glucometer for glucose testing") is particularly important for identifying and continuing appropriate actions and behaviors.

DISCUSSION AND VERBAL TEACHING

Discussion and verbal teaching is an opportunity for patients to focus learning through exchange of ideas by sharing information, clarifying feelings, or asking questions. It can be useful with individual patients or groups. Discussion involves learners more deeply in the process because it requires participation. This strategy can enhance cognitive and affective learning. During the discussions, your role is to be a facilitator. Use positive comments and open-ended questions to promote further discussion, clarification, and understanding. Clarification and assessing understanding is key, as only 60% of patients report that they always understand the information that their healthcare providers explain (Office of Disease Prevention and Health Promotion, n.d.). For instance, the nurse may say, "I hear you saying this medication is your 'water pill.' I am curious to know what that means to you."

WRITTEN INFORMATION

Access to written materials can assist nurses in planning teaching–learning sessions. Agencies such as the American Cancer Society, Canadian Cancer Society, American Heart

BOX 15-2 Key Points for Teaching Sessions

- Focus on the patient's perspective—what they need to know. Avoid general background information.
- Emphasize behaviors or actions. Focus on what to do and why, *not* what to know.
- Avoid medical terminology whenever possible. If you must use it, limit the amount and find a comparable everyday word to substitute (e.g., shortness of breath for dyspnea).
- Keep it simple:
  - Offer small yet vital bits of information *one* at a time.
  - Keep to the main objectives.
  - Add information *only* when you have determined that the previous information was thoroughly understood.
  - Use short sentences in concrete language. For example, "Take your water pill at dinner time. This gives you time to pee before bedtime. You can then sleep through the night" versus "Make sure to take your diuretic at least 2 hours before you go to bed to ensure that you do not get up during the night to urinate."
  - Use words without double meanings. For example, "positive" can mean good (in the form of praise) or bad (disease finding, as in positive for cancer).
  - Repeat and emphasize main topic points at the end of each session as a summary (remember: *not* too many).
  - Ask the patient to restate what you have said or what they have read or heard.
- Highlight specific phrases of information if using print materials.
- Give educational materials that promote the patient's active involvement, such as short quizzes, checklists, questionnaires, diaries, or medication records.
- Use photos and graphics that enhance the message, *not* compete with it.
- Use positive words, phrases, and messages. Avoid scare tactics.
- Evaluate and test the message and materials for effectiveness (such as focus groups).

Association, American Diabetes Association, and other health-related groups frequently prepare written materials. Some are prepared within agencies by clinical nurse specialists or other nurses with a specialized teaching role. Being familiar with available written resources is important. Material should pertain to the patient's concerns and be written clearly with up-to-date information. Written material and verbal information must be consistent.

When providing written materials, consider the capabilities and needs of the patient. The reading level of the material must be screened for appropriateness for the individual patient; when evaluating educational material for the person with low literacy, look for materials that contain short sentences and words with few syllables. Large print is important for patients with visual difficulties.

Frequently, nurses provide written materials in advance of a teaching session to give patients time to assimilate information and formulate questions or concerns. Whenever possible, encourage patients to make use of such materials immediately by circling or highlighting important information to review before the teaching session. It is best to select a few well-written materials rather than to overwhelm patients with dozens of pamphlets (Fig. 15-2).

ROLE PLAYING

Role playing, or acting out feelings or knowledge, is especially useful for teaching effective behavior to adults or children. Most children and adults enjoy role-playing sessions as a form of education. Role playing can be helpful in decreasing anxiety during learning. It can be used to work through past, present, or anticipated feelings or new situations. Patients react based on their experiences, while nurses offer guidance and feedback. Dolls can be used, especially with children. For example, a child may be asked to demonstrate how a parent's illness has affected the family by using dolls to represent each family member.

FIGURE 15-2 The nurse provides an instructive, well-written pamphlet to the patient to support teaching regarding asthma management.

LECTURES

A lecture is a formal presentation of information by a teacher to a group of learners. This format is most effective when communicating facts (cognitive learning), but it can be used for psychomotor or affective learning. A simple lecture (a one-way communication from teacher to learner) is much more effective when combined with discussion, question and answer sessions, or short interactive and hands-on activities. A lecture may stifle learners who are eager to contribute. Determine whether patients appear bored, anxious, or easily distracted. Limit how much information is given verbally; have supportive printed materials that include additional information. Informational overload is common when using the lecture method.

Teaching Aids and Resources

Teaching aids assist learning but are not substitutes for human contact. They are best used to supplement or reinforce face-to-face teaching.

AUDIOVISUAL AIDS

Videos, audio recordings, and computer-assisted instruction can be useful for subjects taught often, such as insulin injections or breast-feeding. Visual aids often increase learning during formal lectures. Audio recordings can be especially useful for instructing patients with low literacy skills and allow for later review of health information. Some healthcare facilities have a special television channel with programming to provide health education on various topics. Let patients decide which aid might be helpful if more than one form is available. Do not use audiovisual aids in isolation but instead combine them with discussion or one-on-one teaching (Fig. 15-3). The most effective audiovisual education materials are short, no more than 10 to 15 minutes total.

FIGURE 15-3 Combining audiovisual aids with discussion and patient participation will lead to more effective learning.

THE INTERNET

The internet has become an extremely broad and valuable source of information and advice for patients. Access to computers at home, the office, and in libraries is available for many individuals. Learning via the internet encompasses learning primarily in the cognitive and affective domains. It can be entertaining, informative, and accessible at any time; is relatively anonymous; and offers much diversity and variety of available information. For instance, internet message boards offer counseling and support, allowing patients to connect with other individuals to share information and experiences to gain insight. For patients who are homebound, the internet can offer ways to communicate, relieve boredom, and elevate mood. However, evaluation by various researchers regarding the quality of information retrieved from the internet found the following:

- Although many healthcare educational materials were available, most were above the recommended reading level for patients with low literacy skills.
- Few health information sites provided evaluative information regarding their materials.
- Problems with keeping sites current and up to date were reported.
- Multi-focused sites, such as those targeting audiences, including care providers, professions (including nurses), and patients and families, were less individualized and made it difficult to generalize to any given person accessing the site.
- Lack of stability for site continuation or locations created confusion and frustration, and good sites sometimes were discontinued or lost.
- Patients may not have the experience or ability to critically evaluate the information found on the internet (Schnitman et al., 2022).

Despite these challenges, the internet can be a valuable resource for patients and family members. The role of the nurse is to guide patients toward reliable, evidence-based sites and to clarify misunderstandings that patients may have based on online information.

Another use of the internet is telehealth for education and patient care management. **Telehealth** is "the use of electronic information and telecommunication technologies to support and promote long-distance clinical healthcare, patient and professional health-related education, public health and health administration," (Health Resources and Services Administration, 2021). Methods include the internet, video conferencing, streaming media, and terrestrial and wireless communications. Telehealth phone links, often with 24-hour nursing coverage, provide health education, address patient questions, and help patients determine what level of healthcare they may require (Farias et al., 2020). Such links are especially important in rural and remote areas where people may live an hour or more away from the nearest hospital. This service and use of technology was amplified during the COVID-19 pandemic, because there were restrictions to accessing healthcare facilities. Postpandemic, the demand for telehealth services has grown, and such services are more readily available to patients and their families.

EQUIPMENT AND MODELS

To promote effective learning, create situations for patients to see and practice on equipment. Whenever possible, obtain the equipment that a patient will *actually* use for practice. For instance, when teaching glucose monitoring to a patient with diabetes, use the type of monitor that the patient will use in the future. Models can be used to simulate actual conditions. For example, models of spinal vertebrae can assist in teaching what various spinal conditions look like. When using models of the human body, be sensitive to cultural considerations and gender roles if anatomy is directly visible, such as genitalia or reproductive organs. Some patients are more comfortable using and handling these materials in the presence of only the nurse (without family members in the room). It is important to be sensitive to these possibilities and to ask patients their preferences *before* models are taken out and displayed.

Use of Interpreters and Translators

If a patient, family member, or caregiver cannot speak English, an interpreter is necessary during the teaching session. A 2000 law requires all federally run programs to make accommodations for people with limited English proficiency. Medical interpreters receive special training in the use of medical language and terms and are certified to provide translation services. When the nurse needs a medical interpreter, the teaching session will take longer because each message must be repeated twice. In addition to speaking the language, the interpreter must be aware of the patient's culture and be able to interpret medical information clearly and objectively. Doing so is difficult when a family member or friend acts as interpreter. Better choices for interpreters are bilingual staff members or other professionals who may be available in large medical centers. Additionally, sex may affect the ability to communicate; for instance, a female interpreter may be able to communicate more freely than a male interpreter with female patients without encountering cultural prohibitions. Return to the opening scenario and see the SBAR in the "Collaborating With the Healthcare Team" box, which the nurse uses for making a referral to an interpreter.

When using an interpreter, remember to continue to talk to and look at the patient. Keep information simple and direct. Instruct the interpreter to translate word for word as much as possible. Keep the name and phone number of the interpreter in the patient's record. A nod or "yes" from the patient does not always indicate understanding because some people agree just to be polite. Having a verbal teach-back is always best. Be sure to also provide written translated material. See Box 13-2 for more detailed information about communicating through an interpreter.

COLLABORATING WITH THE HEALTHCARE TEAM
Making a Referral for an Interpreter

The nurse's teaching session with Mrs. Hussein, the patient in the opening scenario, was unsuccessful due to limited time and a language barrier. The nurse convinced the patient and her husband to agree to return next week for a follow-up so that more teaching can be done. Since communication was challenging, the nurse put in a consult for an interpreter, providing the following SBAR report.

Situation: Mrs. Hussein, an Iranian Persian–speaking woman, has recently been diagnosed with hypertension and started on blood pressure medication and a low-sodium diet.

Background: I attempted medication and diet teaching, but Mr. Hussein was upset and said "no more." Mrs. Hussein sat quietly and did not maintain eye contact. They talked rapidly in a language I did not understand. I did get them to agree to return on Monday for a follow-up visit and more teaching.

Assessment: For my teaching session to be effective, I will need an interpreter. It would be helpful if the interpreter was male because Mr. Hussein seems more comfortable with the male staff here at the clinic. He is important in managing his wife's care and the primary family decision maker.

Recommendation: Please let me know if an interpreter speaking Iranian Persian is available next Monday at 0900 for 1 hour to interpret.

CRITICAL THINKING CHALLENGE

- Did the nurse provide essential information in this referral for the interpreter?
- Is an SBAR report necessary when requesting a consult?
- Does it make a difference whether the interpreter is male or female?
- What might you discuss with the actual interpreter before the session with the Husseins? Refer to Box 13-2 after you have answered this question for additional ideas.

Many phone companies now offer a language line service whereby the patient and healthcare provider talk on the phone with a bilingual operator who provides translation. This service is cost-effective and provides 24-hour coverage in most languages. It is valuable for small agencies and for agencies located in remote areas. One disadvantage is the inability to see nonverbal communication. Many smart phones can translate select languages.

Another option for interpretation is the use of computer technology. Using a computer that is equipped with cameras allows the interpreter and patient to interact "face to face." Using this emerging technology offers the ability to see both verbal and nonverbal communication. Try to avoid translation applications as there is no way to vet that the information being delivered and received is accurate.

Timing and Amount of Information

When planning a teaching session, consider factors such as the amount of time available and the amount of material that needs to be covered. The times when patients are most receptive to teaching is often referred to as a "teachable moment." For example, if the patient asks questions when you administer medications, take a few minutes to explain each newly ordered medication and its possible side effects. Reinforce this informal teaching whenever the medication is administered until the patient can verbalize this information to you. When a more formal teaching session is necessary, planning the best time possible can help ensure teaching effectiveness. Consider the following principles when planning a good time to teach:

- The patient should not be tired.
- The patient should be comfortable.
- Family members or caregivers may be present.
- Uninterrupted time must be available so that meals or necessary treatments do not interrupt the teaching session.
- Teaching should not occur just before an event (e.g., discharge, surgery).

Hospital teaching sessions should be limited to no more than 20 to 30 minutes (or less) to avoid tiring patients. Approximately half the session time should be allotted for the nurse to deliver information; the other half should be allotted for the patient to take in information (i.e., ask questions and give comments). Warn patients about any time restraints. Saying "I have 20 minutes to talk" communicates clearly the nurse's time limit, minimizing the chance that patients will feel slighted when the nurse has to leave.

While one fifth of discharged patients experience adverse events within the first month after discharge, hospitalization is not the best time for teaching (Oh et al., 2021). Plan to cover essential material, but do not expect patients to learn all

that is necessary while anxiety or pain is present. Combining the teaching session with one or two informational pamphlets with highlighted portions for later review helps ensure that the patient can remember and use information later. Outpatient education is usually more effective than inpatient education for several reasons. Patients are usually less stressed and, therefore, better able to learn when they are no longer in the hospital. Following hospital discharge, they have lived at home with the condition and bring practical, everyday questions to the session. Simply attending an outpatient education session indicates a willingness to learn, and motivation is a strong indicator of educational success. To reduce readmission rates, various patient education programs should be provided to patients to help decrease repeat hospitalizations (Oh et al., 2021).

Appropriate Family and Friend Involvement

Whenever possible, with the patient's permission, plan to include family members and friends in patient education. Their support strongly affects patient success. A statement such as "I'm here because my partner made me come" may indicate denial on the patient's part and tells the nurse about the partner's attitudes and influence. Never assume that because someone is a blood relative, they automatically want to participate in patient education or care. Friends are often as supportive as family members. When a family member or friend assumes the caregiver role, it may be necessary for that person to attend teaching sessions and demonstrate mastery of important skills and knowledge (Fig. 15-4).

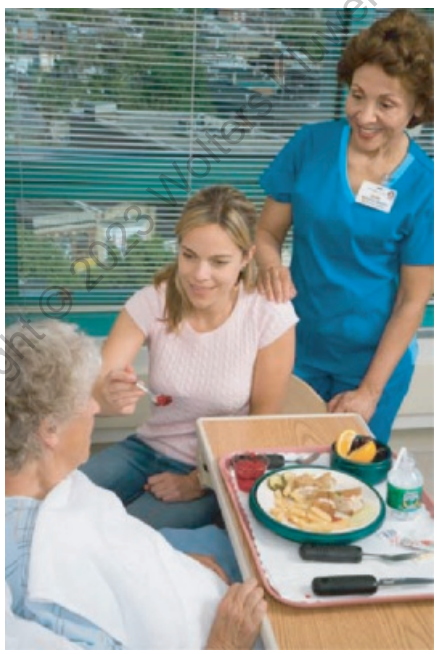


FIGURE 15-4 Involving family members in patient education helps improve outcomes after discharge.

Written Teaching Plan

The written teaching plan guides the teaching process and coordinates teaching among members of the healthcare team. Without a written plan, teaching is likely to be haphazard and ineffective. A written plan clearly stating expected outcomes also serves as a useful reference for evaluation and fosters communication with other professionals so that they may participate. A written teaching plan may be incorporated into critical pathways, indicating at what point specific teaching should occur. The Fracture Recovery Pathway developed at Virginia Mason Medical Center (Fig. 15-5) illustrates a patient-focused pathway that can be used for patient teaching. Box 15-3 shows the format for an outcome-based teaching plan, examples of which are provided in each clinical chapter in this text.

IMPLEMENTATION OF PATIENT TEACHING

Meeting Priority Needs First

Before any teaching, the patient should be comfortable. Easing acute symptoms, such as pain, hunger, thirst, nausea, or dyspnea, allows the patient to focus on learning. Give the patient a chance to use the toilet. Offer pain medication, and determine whether the patient is comfortable. Ask, "Is this a good time for us to talk?"

Anger, fear, anxiety, worry, grief, and guilt block learning. Nurses who are sensitive to distress can modify the plan accordingly. Supportive body language and statements are useful. No matter how thorough planning has been, last-minute changes may be needed.

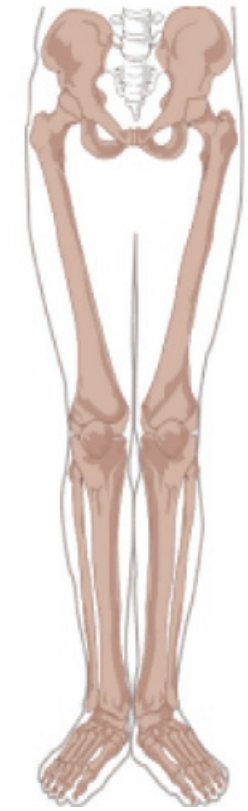
Comfortable Environment

Anyone who has tried to study in a room that was too hot, cold, dim, bright, noisy, or distracting knows that the environment affects learning. During patient education sessions, try to make the environment conducive to learning. If necessary, send visitors who are not caregivers away temporarily. Privacy is important; closing the curtains in a semiprivate room, sitting near the patient, and speaking quietly, slowly, and facing the patient all contribute to a greater sense of privacy.

Individualized Teaching Sessions

Trying to teach too much at once can block learning. Likewise, teaching will not be as effective if the nurse does not address topics that the patient has identified as priorities, or if the nurse does not attend to nonverbal communication from the patient demonstrating disinterest or confusion. Listening to the patient's response gives excellent feedback about their progress. Always allow time for patient questions.

Fracture Recovery Pathway



My Fracture		Before Surgery →	Day of Surgery →	After Surgery	Checklist for Discharge
	My Recovery Plan	My Care Team will help prepare me for surgery, including blood work, x-rays, heart testing and other tests as needed.	My nurses will do my pre surgery checks, both in my room and in the pre-op room. I will have blood tests done and will have my vitals monitored.	My vital signs are stable. My medical team will manage my medical conditions. My surgical team will see me every day.	☐ I am medically stable. ☐ My pain is controlled with oral medications. ☐ My family and I understand my medications. ☐ I understand my activity limitations. ☐ My family and I understand where I am going next. ☐ My family and I know my follow-up plan. ☐ All of our questions and concerns have been addressed.
	What About My Pain?	I will be seen by the Pain Team about pain management, including pills, shots and possibly a procedure to block my pain.	My Pain Team will manage my pain during surgery. After surgery, I will take pain medication by mouth but may still need I.V. pain medication. I may still have my pain block in place.	I may still have some pain, but I will be taking medication to manage it so I can get out of bed.	
	When Can I Eat?	I cannot eat after midnight before my surgery.	After surgery, I can start to eat and drink as I am able.	I can eat what I want within my diet guidelines.	
	When Can I Get Up?	For safety, I cannot get out of bed, but my nurses will help turn me for comfort.	After surgery, with help, I am able to sit on the edge of bed. My nurses will help turn me so I don't get sore.	I will be seen by physical and occupational therapy to help me get back on my feet. Nursing will help me get up to the bathroom.	
	What Happens Next?	I will meet briefly with a social worker to start talking about what will happen after I leave the hospital.	My urinary catheter is removed as soon as possible after surgery. I may have an I.V. line for fluids and medications.	The social worker will help my family and I finalize my discharge plan.	

FIGURE 15-5 The Fracture Recovery Pathway is a patient-focused pathway that can be used for patient teaching. (©2019 Virginia Mason Medical Center.)

People have different learning styles. Some prefer to do, and others prefer to watch. When teaching a psychomotor skill, be sensitive to those who like to do. A demonstration may have been planned, but if the patient reaches out to touch the materials, consider talking the patient through the skill instead. Children learn through play and are usually energetic and eager doers. However, if a child prefers to watch, a demonstration instead of instructive play may be best.

Communication

Good communication is necessary for effective patient teaching. Chapter 14 discusses communication in the nurse–patient relationship in more detail. Active listening requires the nonverbal communication techniques of silence, attending, and observing. If a patient is comfortable and believes that they have the nurse's undivided attention, learning is greatly enhanced. If rapport between the nurse and the patient is not established before the teaching session, learning is negatively impacted.

Participation is the best measure of involvement. Getting a person to participate can occur by leading—making a pointed, specific statement. The patient who rambles may need to be focused.

To clarify understanding, repeat what you hear the patient saying and ask whether it is accurate. Reflecting or restating (repeating the patient's words) also can be a valuable communication tool.

BOX 15-3 Example of an Outcome-Based Teaching Plan

Outcome/Deadlines: Patient will demonstrate blood glucose testing independently by discharge.

Teaching Plan	RN Initials	Date/Time
Assess patient's fears and readiness to learn.	CH	7/15/24
Assess patient's preferred learning style.	CH	7/15/24
Assess what patient knows about blood glucose testing.	CH	7/15/24
Verbalize steps in procedure as it is performed by nurse.	CH	7/15/24
Ask if patient has any questions and/or feels comfortable trying procedure.	CH	7/15/24
Verbally cue patient as they complete blood glucose testing.		
Include family and significant others.		
Have patient practice and demonstrate glucose testing three times or until they verbalize comfort.		

Documentation

7/15/24 13:00: Blood glucose testing teaching session completed in patient's room without family members present. Patient verbalizes nervousness about needles and sticking themselves but started to read pamphlet they were handed. Watched demonstration and asked questions. Stated they wanted to wait until parent arrived for return demonstration.

—Cindy Howles, RN

Repetition

The realities of today's healthcare system—including short hospital stays, limited home care opportunities, and very ill patients—provide less time for patient teaching. Setting priorities and repeating information are imperative. When cognitive or psychomotor learning is the goal, try repeating the information in various ways. For example, if the patient has been learning a therapeutic diet, ask about appropriate food choices in different restaurants, on a picnic, or at a party. Have patients repeat information several times. Ask patients how new learning will affect their daily routines, and check to see whether they are integrating new routines into daily activities. Ask patients to practice and demonstrate psychomotor skills several times before discharge. Repetition may point out deficits in learning that would not be evident in a single session.

Because discharge instructions can be overwhelming, clarify important concepts, provide written instructions, review factual information, and have patients repeat the knowledge and practice the skills. Most healthcare agencies have discharge forms that are printed, so nurses can give a copy of the specific discharge teaching to patients as they document it. These forms also help alert nurses to essential information that they must provide before discharge.

Teaching Methods

Methods of teaching differ in the three domains of knowledge. Principal teaching methods are listed in Box 15-4.

COGNITIVE

Because the cognitive domain of learning involves expanding knowledge, the material must be organized from the simple to the complex. Introduce patients to the basic concepts and give definitions. Then help patients integrate these concepts into something meaningful and beneficial to health. People do not learn isolated facts well. Learning is enhanced when information builds on previous knowledge, and the reason and rationale are included. The most common error is trying to teach too much

BOX 15-4 Principal Teaching Methods

Cognitive (Knowledge)
1. Lecture
2. Discussion (factual questions and answers)
3. Simulation (application of knowledge in different contexts)
4. Independent study

Affective (Values)
1. Discussion and values clarification
2. Role playing
3. Simulation
4. Discussion

Psychomotor (Skill)
1. Skill demonstration
2. Talking the learner through the skill
3. Repeated practice

in a single session. It is better to teach some basic ideas well than to overload patients with many hard to remember facts.

AFFECTIVE

When trying to modify an attitude or emotional response, keep a nonjudgmental, nonthreatening attitude. Acknowledging the patient's ability to accept or reject the material can empower the patient and lead to more healthy decision-making. The nurse who states emphatically the rightness of their position and the wrongness of the patient's position loses all credibility and influence. Listen carefully to what the patient values, and work from there. For example, a nurse is trying to encourage a patient with paraplegia and depression who is struggling with adherence to join a support group. The patient's depression is limiting self-care but does seem to have a strong sense of contributing as a family member. The nurse gently approaches the patient with the idea that better physical and mental health would enable them to better contribute to the family's well-being. The patient may begin to assign a higher value to health when it is tied to better family functioning.

PSYCHOMOTOR

Psychomotor methods involve the muscular motions needed to learn a skill. Assemble the appropriate equipment (e.g., dressings, syringes); having the necessary supplies at hand can save time and prevent interruptions. Written material with a step by step guide acts as a reference during the session and as a reminder to patients the first few times they practice the skill independently. Allow patients to ask questions and make comments. Many adults are intimidated by learning a new skill, so encouragement and praise almost always improve performance. Comments such as "Lots of people have that same concern" or "I've had many patients with that same problem" help patients feel less isolated. Positive corrective feedback such as "You've just about figured out how to give yourself an injection; now, angle the syringe a little more this way" acknowledges and reinforces learning accomplishments but at the same time provides significant correction to facilitate a better performance.

Unfolding Patient Stories: Rashid Ahmed • Part 2

Recall from Chapter 10 Rashid Ahmed, a 50-year-old admitted to the medical unit with a diagnosis of dehydration from severe nausea, vomiting, and diarrhea. What factors should the nurse consider when planning patient education for Rashid? How can the nurse create an environment conducive to learning? What teaching methods can be used to enhance the clarity and retention of information? Why is it important for the nurse to evaluate learning after education is provided, and what evaluation methods can be used?

Care for Rashid and other patients in a realistic virtual environment: ***vSim*** *for Nursing* (thepoint.lww.com/vSimFunds). Practice documenting these patients' care in DocuCare (thepoint.lww.com/DocuCareEHR).

EVALUATION OF LEARNING

Evaluation of learning is most effective when it is systematic, practical, and ongoing. Measurable, clearly stated outcomes streamline evaluation. When patients actively participate in outcome formation, they can likely do much of the evaluation.

This final phase depends heavily on what has preceded it. If evaluation becomes unclear, review the outcomes. Were they realistic for the patient's abilities, time frame, and resources? Were they clearly stated and measurable? Elicit the patient's feedback in this process at each step.

Evaluation occurs continually as teaching proceeds rather than after teaching is completed. In this way, the teaching session can be continually adjusted to meet the patient's needs. Feedback from nurse to patient is most effective when it enhances the patient's self-concept and motivates the patient to higher learning. Asking patients to repeat or demonstrate what they have learned to family members is one way to accomplish this, especially with children. Remind patients of the progress they have made rather than what still needs to be done. Evaluation can take several forms, including written tests and questionnaires, oral tests, "teach-back" techniques, return demonstration, check-off lists, and simulations.

"Teach-Back"

An effective strategy to evaluate learning is to use the **teach-back** technique. Teach-back techniques are reported to improve patient outcomes by encouraging patient engagement, which generally leads to improved understanding (Oh et al., 2021). After the teacher (nurse) teaches information to the learner (patient), the learner (patient) teaches back to the teacher (nurse) what they have learned. It is most effective when the learner can reword the information in a way that makes sense to them, rather than regurgitating the information word for word. This closes the communication loop and helps ensure that not only the learner retained the knowledge but understood it as well. Teach-back, which is low-cost and does not require additional resources, helps decrease admission rates of patients discharging from the hospital by increasing health knowledge and self-care (Oh et al., 2021). Using this technique is a quick way to evaluate the effectiveness of your instruction. An area for growth among healthcare providers is to increase the percentage of people who "report that their healthcare provider always asked them to describe how they will follow instructions." The proportion of people who currently report this is only 25.6% (Healthy People 2030). The teach-back technique utilizes open-ended questions or statements to elicit responses from patients and their families. For example, "I want to be sure that I've explained everything correctly to you. Will you please explain to me how you will take your medication?" If a patient is unable to teach back the information, it may not have been provided in a way that was well understood by the patient. The information or the educational

approach may need to be evaluated and teaching may need to be reattempted.

Return Demonstration

As previously stated, return demonstration is an effective way to test skill performance. A patient's degree of accuracy and independence in performing a skill is almost always a clear indication of learning. Psychomotor skills can be evaluated with this method. Give feedback about parts done well, along with areas for improvement. Figure 15-6 shows how a nurse uses return demonstration to evaluate the patient's skill in using a metered-dose inhaler.

Checkoff Lists

Checkoff lists have the advantage of highlighting accomplishments while showing whether the patient has performed each step in a particular learning process. For instance, checkoff lists work well when documenting whether a patient can perform activities of daily living or identifying gaps in organizational skills. Most patients find checkoff lists helpful and achieve a sense of pride and fulfillment when they complete one. Patients can also use checkoff lists effectively with psychomotor evaluation, such as return demonstrations.

Simulation

Simulation evaluates whether the patient can apply learning in different situations. Offer a scenario to the patient and ask what the best choice or choices would be. For example, the nurse could evaluate dietary learning by asking the patient about the best choices in various restaurants, or the nurse could evaluate diabetic sick-day care (diet choices and considerations when a patient with diabetes is sick or ill) by posing various sick-day scenarios. Simulation is becoming an effective way to teach complex information.

Written Tests and Questionnaires

Written tests are time-consuming, intimidating, and not always specific to the patient. They are useful only when the following conditions have been met:

- The patient is literate (do not take this for granted).
- Clear educational objectives have been mutually decided.
- It is necessary to measure a broad sample of factual information.
- A skilled test writer has prepared the test.
- The test has been beta tested with a subset of patients to determine effectiveness.

As in the classroom, written tests are most useful for evaluating cognitive learning. Affective learning cannot be tested this way because no answer is right or wrong. Written test questions may be useful as assessment tools (pretests) or as evaluation tools to check a patient's progress. A questionnaire may be used to evaluate how helpful an educational program has been for a group of learners so that positive changes can be made if the program is offered again.

Oral Tests

Oral tests are usually more expedient and less intimidating than written ones. Questions can be informally phrased, and patients usually give immediate, specific, and useful feedback. Stay as casual as possible because the greater the patient's anxiety about being tested, the less likely it is that the evaluation will be accurate. Evaluation of the patient's verbal response can be useful in testing cognitive learning, but affective learning in the form of an attitude change is more difficult to measure.

A

B

FIGURE 15-6 **A.** The nurse teaches the patient how to use a metered-dose inhaler. **B.** In the return demonstration, the patient demonstrates skill performance.

Documentation of Learning

Documenting patient education is as important as documenting any other aspect of patient care. Documentation of patient education serves several purposes:

- It communicates the plan and progress to other healthcare professionals.
- It fulfills the nursing job description as delineated by local, state, and national licensing agencies.
- It provides a legal record.
- It may be required for financial reimbursement of care.

Documentation must contain the subject matter, the patient's response to teaching, and any necessary break in the process (e.g., if, after evaluation, the nurse found it necessary to return to the planning stage). Well-documented patient education is a record of methods that did or did not work, and it can give some indication of patient accomplishments and adherence to healthcare regimens over time.

Documenting the patient's response to teaching should include statements like the following:

1. Patient is able to verbalize understanding by teaching back the information about their medications.
2. Patient is able to demonstrate skills for wound care by following instructions for irrigation and dressing application.

LIFE SPAN CONSIDERATIONS

Newborn and Infant

Newborns and infants learn by interacting with their environments. During this period of rapid development, infants learn a great deal (e.g., how to recognize their parents, how to follow objects as they move, how to hold toys). Encourage an environment rich in appropriate stimuli to foster normal cognitive development.

During this stage, infants are not ready for formalized teaching; instead, direct any necessary teaching at parents and caregivers. Health promotion teaching for the caregiver may include providing information about immunizations, normal growth and development, and car seat safety. Teaching about various aspects of child care, demonstrating capabilities of newborns and infants, and modeling appropriate and effective interactions help support and promote positive parent–child relationships.

Toddler and Preschooler

Because toddlers and preschoolers are accustomed to learning from and communicating with their parents, the parents are usually the most effective teachers. Teaching parents about safety practices, well-child visits, and proper sleep and nutrition are important for health promotion of this age group (Fig. 15-7). Children learn through play, so using dolls or toys as models can enhance learning.

FIGURE 15-7 Routine checkups help protect the child's health and ensure continued healthy growth and development. (Shutterstock/Black-Photography.)

Children 2 to 5 years old like to be addressed with their parents listening. Trust is vital. If you tell a preschooler that a procedure will not hurt but it does, you have lost credibility with the child and learning is hindered. Children of these ages are likely to have many questions and may ask the same ones many times. Answer their questions immediately, directly, and in language they can understand. Sometimes, this means checking with a parent or caregiver about words that a child uses to describe body functions or important things. Preschoolers are generally energetic and restless, so try to limit the session to 5 to 10 minutes. Let children handle equipment or supplies as soon as possible. Children of this age can understand some anatomy, so when possible, use models and correct anatomic names.

Evaluate learning frequently to ensure that children understand. Preschoolers usually enjoy displaying new knowledge, giving nurses the chance to praise them repeatedly and to offer rewards such as stickers, picture books, or rubber stamps.

Child and Adolescent

School-age children are usually eager to learn. Including health promotion teaching about proper nutrition, sleep, exercise, safety, and learning how to deal with stress and frustration assists in their understanding of their role in maintaining their own health.

Development of concrete thinking, an increased understanding of their bodies, and continuing curiosity about how things work contribute to the school-age child's understanding of the healthcare experience (Fig. 15-8). They can understand cause and effect ("If I don't stay off my leg, it won't heal as quickly, and it'll be longer before I can play outside at recess"). Include children in educational planning, allowing them to

THERAPEUTIC DIALOGUE: PATIENT TEACHING

SCENE FOR THOUGHT

Jennifer Cohan is 14 years old and identifies as female. She has a new diagnosis of diabetes mellitus and wants to learn to give herself insulin injections. The diabetes nurse specialist comes to the clinic to talk to her.

LESS EFFECTIVE

Nurse: Hi, Jennifer. I'm Laurel Mandrake, the diabetes nurse. I'm here to teach you how to give yourself your shots.

Jennifer: *(Looks doubtfully at the equipment but doesn't say anything.)*

Nurse: I see you're looking at the equipment I brought. It's okay to be nervous. I'll show you how to do it, and then you can ask me questions.

Jennifer: Can I see it first? I know I need this insulin stuff so I don't get sick like I did at school. That was so embarrassing! But I hate needles, so I don't know how good I'll be at this. *(Begins to take out syringes, alcohol swabs, vials, etc.)*

Nurse: It will be easier if you just let me show you what to do. I have to cover a lot of information in a short amount of time. I'll give you some pamphlets to take home after you are done. I'll go over all this stuff with your mom too so she'll be able to help you. It will be fine.

Jennifer: Okay. *(Mumbles the word. Bites her lip to keep from crying.)*

MORE EFFECTIVE

Nurse: Hi, Jennifer. I'm Lorraine Morris, the diabetes nurse. Your doctor told me you wanted to learn how to give yourself your shots. Is that right? *(Makes sure information is accurate.)*

Jennifer: Yeah, I said that, but I don't know now. *(Looks doubtfully at the equipment.)*

Nurse: It's okay to be unsure. I see you're looking at the equipment I brought. Do you want to see it or talk about it first? *(Assesses Jennifer's learning readiness and gives choices.)*

Jennifer: Can I see it first? I know I need this insulin stuff so I don't get sick like I did at school. That was so embarrassing! But I hate needles, so I don't know how good I'll be at this. *(Begins to take out syringes, alcohol swabs, vials, etc.)*

Nurse: *(Sits and watches Jennifer explore.)*

Jennifer: Look at those needles. They're so little!

Nurse: They do look small, don't they?

Jennifer: Do we have to do this today? *(Looks pleadingly.)*

Nurse: I have a suggestion. How about if we go over the equipment today, and I'll give you a few pamphlets to take home and read. We can reschedule the actual teaching when we meet next week. How does that sound?

Jennifer: I like that better. Maybe if I read this for a week, I'll get more courage. *(Looks relieved.)*

Nurse: That means your mom will have to give you the insulin until next week. Is that okay with you?

Jennifer: Yeah, if it's okay with Mom. She hates needles too! *(Laughs. Lorraine and Jennifer look at the equipment together and make plans for next week. Jennifer's mother comes in and learns how to give insulin as Jennifer watches.)*

CRITICAL THINKING CHALLENGE

- Determine how many of the three domains of learning Jennifer will use to acquire knowledge.
- Evaluate what kind of learner Jennifer might be.
- Examine how the first nurse approached Jennifer's learning style. What actions contributed to a less effective teaching session?
- Detect what the second nurse did that makes you think she knew the principles of teaching adolescents.
- Develop additional options the nurse might consider for teaching Jennifer.

FIGURE 15-8 Allowing the child to participate and handle equipment to demonstrate procedures are effective methods for educating children about healthcare. (Shutterstock/Wavebreak Media.)

help set goals. Being accustomed to a classroom atmosphere, they understand the scheduling of work and play.

Answer all questions quickly and truthfully. Trust is vital to learning and establishing a relationship in which children feel comfortable enough to express fears and concerns.

Educational content can be more sophisticated for this group than for preschoolers. Coloring books for teaching anatomy work well. Written material is acceptable at the proper reading level. Keep in mind that hospitalized children may regress. Explain procedures directly to these children with the parents in the background. Sessions should be no longer than 20 minutes.

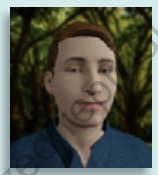
"Winning" may be important for school-age children, so they often value success highly. Use of charts with stickers to mark progress is often an effective motivating tool with this group.

Adolescents usually appreciate complete, open, and honest explanations to their questions. Their peers are usually more influential than their parents, teachers, or nurses. If given permission, it is fine to include peers in a teaching session; in fact, general healthcare information may be included for the benefit of these visitors. Take the opportunity to include health promotion education when possible. Adolescence is a time for experimenting, so providing information about smoking, safe driving, preventing sexually transmitted infections, and avoiding drugs and alcohol may influence their choices. A sensitive, caring attitude is essential to educate adolescents effectively. To maintain the adolescent's trust, keep their confidence; if confidence must be broken, explain to the patient whom you must tell and why.

Include adolescents in any educational planning, because their struggle for independence makes them averse to having anything imposed on them. They are more likely to comply when provided with alternatives and consequences. It is also helpful when working with adolescents to give them the reason and rationale behind your information. Ask them what they need to know. Find out the value system an adolescent associates with an illness, and work from their point of view. For example, an adolescent may value friends and academics, which may change their perspective of self-care and addressing sickness. Adolescents are generally sophisticated learners, able to understand broad concepts and assimilate much information. They frequently access and get information from the internet. They are oriented to the present, however, and are more in tune with immediate advantages than with long-term results.

This age group is accustomed to teaching sessions of 45 to 50 minutes in school, but this is unrealistic in a healthcare setting. It may be better not to include parents (unless requested by the adolescent) in the session to encourage patient autonomy and heighten self-concept; parents can be informed later as appropriate. Literature, audiovisual, and computer-related educational materials to review between sessions can be useful with this group.

Unfolding Patient Stories: Christopher Parrish • Part 1



Christopher Parrish, age 18, is hospitalized for management of cystic fibrosis with weakness and weight loss. What areas of health promotion should the nurse discuss with Christopher? How can the nurse help an adolescent with a chronic illness avoid feelings of isolation? (Christopher Parrish's story continues in Chapter 24.)

Care for Christopher and other patients in a realistic virtual environment: ***vSim*** *for Nursing* (thepoint.lww.com/vSimFunds). Practice documenting these patients' care in DocuCare (thepoint.lww.com/DocuCareEHR).

Adult and Older Adult

Adults tend to be motivated by activities that enhance or maintain their self-concept. Self-direction and achievement generally boost self-concept; dependence and error generally decrease it. Adults may take errors personally, thinking poorly of themselves if they believe they are taking too long to grasp a concept.

Adult learners respond well to a straightforward teaching approach and can apply knowledge immediately. Try to provide a comfortable, informal, friendly learning environment in which the patient can feel appreciated. Adults may become at risk for lifestyle-related chronic conditions, so when possible, incorporate health promotion behaviors such as exercise, nutrition, self-examinations, health screening, stress management, and reduction or cessation of smoking and alcohol consumption.

Young adults may have plenty of energy and take good health for granted, potentially leading to risky behaviors. Learning must be practical because young adults often lead busy lives. When setting educational goals with patients from this group, take a practical approach, if possible, explaining how the change will improve daily life. Young adults may often

be motivated by maintaining their health in order to care for any children they may have.

Middle-aged adults may be more aware of health problems and take good health for granted less often. People in this age group may sometimes lack the self-confidence to try something new. Middle-aged adults should be involved in all aspects of a teaching plan because they are usually familiar with the concepts of goal setting and achievement. These individuals have a broad base of life experience, and teaching goals will more likely be met if they are given time to assimilate new knowledge into old. Approach learning directly, explaining all rationales fully. Try to keep sessions to less than 45 minutes, allowing time for patients to practice skills in private. Middle-aged people also enjoy praise. Evaluate patients in a supportive atmosphere, stressing how much progress they have made. Gently correct misconceptions and be sensitive to fears and anxieties.

Older adults are the fastest-growing segment of the U.S. population. General adult learning principles apply to this group; however, some special considerations are required. Motivation to learn may be decreased if patients believe life is near its end. Two motivational strategies may be tried:

- Show patients how new knowledge will improve their quality of life regardless of its length.
- Show how the new knowledge could improve the patient's independence.

Physiologic changes that normally occur with aging may hinder learning. Vision may decrease because of cataracts; smaller, less reactive pupils; or a decrease in color perception. The ability to hear high-pitched sounds usually decreases, although low-pitch hearing may be intact. Rapid speech may become unintelligible because older adults often take longer to process what they hear. Hearing loss can be a source of shame and frustration for the older learner, causing withdrawal and worsening feelings of isolation.

Older adults may also experience short-term memory loss. Do not assume that memory loss is always present but be sensitive to it. When it does exist, it is usually associated with meaningless learning, complex learning, or new information that has required a reassessment of old learning.

The older learner has large stores of information, so scanning for recall may take longer. Generally, older learners need more time to learn psychomotor skills. Often, they compensate by putting a great deal of effort into accuracy.

Box 15-5 lists guidelines for assisting older adults with learning.

BOX 15-5 Teaching the Older Adult Learner

Teaching Tips

- Use a brightly lit, glare-free room.
- Use visual aids with large, well-spaced letters and primary colors.
- Eliminate extraneous noise.
- Face the learner.
- Speak in low, slow tones.
- Limit sessions to 20 to 30 minutes.
- Watch for cues indicating inadequate hearing, such as leaning forward, cupping an ear, frowning when trying to hear, or starting a separate conversation.
- Relate new material to past experiences in a meaningful way.
- Supply one idea at a time. Use frequent summaries and positive feedback.
- Provide a written or recorded summary of the session.

Medication Teaching

- Be sure that the patient is the one who manages their medications.
- Be sure that the patient knows what each medication does, how many pills to take, and when.
- Discuss what to do if the patient misses a dose. (Containers that hold a week's worth of medications improve accuracy and consistency.)
- Be sure that the patient has written medication instructions in appropriate size, form, and language.

* Critical Thinking Using Essential Nursing Competencies

Now that you have completed this chapter, reread the opening Case Scenario and develop a plan for how you can best demonstrate the essential nursing competency involving person-centered care.

Person-centered care: Acknowledge the patient or designee as the key member of the healthcare team, providing care based on respect for the patient's needs, values, and preferences.

- Consider how you might develop rapport with both Mrs. Hussein and her husband before any teaching occurs.
- Explore your own feelings regarding how both Mrs. Hussein and her husband have responded during this office visit. Will your feelings impact your ability to deliver compassionate person-centered care and effective teaching?
- What cultural factors may influence how Mr. and Mrs. Hussein respond to your teaching?
- How do time restraints during an office visit impact your ability to effectively provide compassionate person-centered care?

KEY POINTS

- Patient education is a dynamic process used to empower the patient toward autonomy and high-level wellness.
- In patient education, the nurse can influence but cannot control. Education must be person centered.
- Individualize teaching strategies and evaluation methods for each type of learning (cognitive, affective, or psychomotor).
- Knowing the patient's literacy level and ability to comprehend oral and written English is important in choosing methods and content.
- Patient education is a process that considers the patient's health literacy as well as their literacy level.
- The nurse, in collaboration with the patient, assesses the patient's learning needs and readiness to learn; they then form a teaching plan. The plan is implemented, the learning is evaluated, and the process is documented.
- People have varying learning styles, and different age groups require different approaches.

PRACTICING FOR THE NCLEX

Check your answers in Appendix A.

1. A nurse is teaching a patient following surgery how to change a leg bag prior to discharge. This skill demonstration by the patient displays which type of learning?

a. Cognitive
b. Affective
c. Psychomotor
d. Auditory

2. A nurse is assisting a patient following surgery with effective use of an incentive spirometer (IS). The nurse states that using the IS 10 times every hour while awake will help prevent atelectasis, enabling the patient to regain their baseline health and return home sooner to be with their children. They ask the patient how they would like to learn, and the patient expresses a need to have a schedule and reminders. Together, the patient and nurse develop a practice schedule that allows the patient to take a break for visitors in the afternoon. Then, the patient verbalizes to the nurse what they have learned and demonstrates their skill with the IS. Which patient education practices are evident in this scenario? Select all that apply:

a. Developing patient rapport
b. Assessing patient's learning preference
c. Individualizing education to the patient
d. Negotiation of plan of care
e. Interactive education technique

Next Generation NCLEX Style Question

Nurse's Notes

3. A patient has just received a new cancer diagnosis after being hospitalized for fatigue and anemia (low red blood cell levels). The nurse has built a good rapport with the patient and has information about how to improve red blood cell counts through appropriate nutrition. Identify the top four most important pieces of information the nurse should know prior to conducting the conversation.

Information	Top four pieces of information
Patient's current level of fatigue	
Patient's gender	
Patient's cognitive status	
Patient's emotional status	
Patient's knowledge about anemia	
If family will be present for education	

4. During shift handoff, a patient is described as being noncompliant with their diabetes management. The past medical history includes bipolar disorder, depression, chronic back pain, and kidney failure with hemodialysis. Upon talking to the patient, the nurse learns that the patient is from the Philippines, has no family locally, and has high levels of chronic pain. Which statement by the nurse is the most appropriate?

a. "No wonder they are depressed, they're ruining their life by not following medical advice."
b. "I get so frustrated with noncompliant patients; we treat them, and they just come right back."
c. "It seems that the patient has a lot of issues that may be related to their psychological state and may be impacting their ability to be adherent."
d. "I think there may be some cultural issues that are leading the patient to be noncompliant."

5. A nurse sees a patient in the cardiology office for coronary artery disease and congestive heart failure. It has been recommended that the patient eat a diet low in sodium, but they confess that they have not consistently modified their diet, though they do understand that sodium intake increases fluid retention. Which of the following nursing diagnoses is most appropriate for this patient?

- **a.** Nonadherence to dietary regime
- **b.** Impaired ability to manage dietary regime
- **c.** Impaired ability to participate in care planning
- **d.** Lack of knowledge of dietary regime

6. The nurse is teaching a patient who has a new diagnosis of adult-onset diabetes the facts regarding sick days. After 10 minutes of explanation, the nurse asks the patient to answer some questions to ensure understanding. Which learning domain is the nurse using?

- **a.** Affective
- **b.** Cognitive
- **c.** Independence
- **d.** Psychomotor

7. The nurse is planning to teach a patient who has three chronic illnesses the importance of influenza immunization. How will the nurse evaluate the patient's understanding?

- **a.** Ask the patient to explain the information back to the nurse.
- **b.** Elicit permission from the patient to administer the vaccination.
- **c.** Demonstrate how the injection is given.
- **d.** Request that the patient's family get shots.

REFERENCES

American Nurses Association (ANA). (2021). *Nursing: Scope and standards of practice*. Nursesbooks.org.

Arnett, M. C., Blue, C. M., Ahmann, L., Evans, M. D., & Reibel, Y. G. (2022). Impact of brief motivational interviewing on periodontal clinical outcomes: A randomized clinical trial. *Journal of Dental Hygiene*, *96*(5), 13–22.

Assistant Secretary for Public Affairs (ASPA). (2021, April 29). *Preventive care*. https://www.hhs.gov/healthcare/about-the-aca/preventive-care/index.html

Bloom, B. (1956). *Taxonomy of educational objectives: The classification of educational goals*. David McKay.

Champarnaud, M., Villars, H., Girard, P., Brechemier, D., Balardy, L., & Nourhashémi, F. (2020). Effectiveness of therapeutic patient education interventions for older adults with cancer: A systematic review. *The Journal of Nutrition, Health & Aging*, *24*(7), 772–782. https://doi.org/10.1007/s12603-020-1395-3

Cornett, S. (2018). Assessing and addressing health literacy. *OJIN: The Online Journal of Issues in Nursing*, *14*. http://www.who.int/global-coordination-mechanism/activities/working-groups/Assessing-and-Adressing-Health-Literacy.pdf

Farias, F., Dagostini, C. M., Bicca, Y. A., Falavigna, V. F., & Falavigna, A. (2020). Remote patient monitoring: A systematic review. *Telemedicine journal and e-health: the official journal of the American Telemedicine Association*, *26*(5), 576–583. https://doi.org/10.1089/tmj.2019.0066

Forbes, R., Clasper, B., Ilango, A., Kan, H., Peng, J., & Mandrusiak, A. (2021). Effectiveness of patient education training on health professional student performance: A systematic review. *Patient Education and Counseling*, *104*(10), 2453–2466. https://doi.org/10.1016/j.pec.2021.02.039

Gagneur, A. (2020). Motivational interviewing: A powerful tool to address vaccine hesitancy. *Canada communicable disease report = Releve des maladies transmissibles au Canada*, *46*(4), 93–97. https://doi.org/10.14745/ccdr.v46i04a06

Health Resources and Services Administration. (2021). *Telehealth programs*. Retrieved March 10, 2022, from https://www.hrsa.gov/rural-health/telehealth/index.html

Healthy People 2030: Increase the proportion of adults whose health care provider checked their understanding—HC/HIT-01—Healthy People 2030 | health.gov. Retrieved November 27, 2022, from https://health.gov/healthypeople/objectives-and-data/browse-objectives/health-communication/increase-proportion-adults-whose-health-care-provider-checked-their-understanding-hchit-01

Institute for Healthcare Improvement (IHI). (2022). *Ask Me 3* Retrieved November 27, 2022, from http://www.ihi.org/resources/Pages/Tools/Ask-Me-3-Good-Questions-for-Your-Good-Health.aspx

Institute for Healthcare Improvement (IHI). (n.d.). *Ask Me 3*. Retrieved March 10, 2022, from http://www.ihi.org/resources/Pages/Tools/Ask-Me-3-Good-Questions-for-Your-Good-Health.aspx

Lau, J., Lim, T. Z., Jianlin Wong, G., & Tan, K. K. (2020). The health belief model and colorectal cancer screening in the general population: A systematic review. *Preventive Medicine Reports*, *20*, 101223. https://doi.org/10.1016/j.pmedr.2020.101223

Norman, G. R. (1999). The adult learner: A mythical species. *Academic Medicine: Journal of the Association of American Medical Colleges*, *74*(8), 886–889. https://doi.org/10.1097/00001888-199908000-00011

Office of Disease Prevention and Health Promotion. (n.d.). *Healthy People 2030*. U.S. Department of Health and Human Services. https://health.gov/healthypeople

Oh, E. G., Lee, H. J., Yang, Y. L., & Kim, Y. M. (2021). Effectiveness of discharge education with the teach-back method on 30-day readmission: A systematic review. *Journal of Patient Safety*, *17*(4), 305–310. https://doi.org/10.1097/PTS.0000000000000596

Palmer, D., & Miedany, Y. L. (2018). Incorporating motivational interviewing into rheumatology care. *British Journal of Nursing*, *27*(7), 370–376.

Prescott, D. S. (2020). Motivational interviewing: As easy as it looks? *Current Psychiatry Reports*, *22*(7), 35. https://doi.org/10.1007/s11920-020-01158-z

Schnitman, G., Wang, T., Kundu, S., Turkdogan, S., Gotlieb, R., How, J., & Gotlieb, W. (2022). The role of digital patient education in maternal health: A systematic review. *Patient Education and Counseling*, *105*(3), 586–593.

U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (2022). *Health Literacy in Healthy People 2030*. Retrieved April 24, 2023, from https://health.gov/healthypeople/priority-areas/health-literacy-healthy-people-2030

U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (2010). *National Action Plan to Improve Health Literacy*. Retrieved March 12, 2022, from https://health.gov/our-work/national-health-initiatives/health-literacy/national-action-plan-improve-health-literacy

U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (2022). *Health Literacy in Healthy People 2030*. Retrieved April 24, 2023, from https://health.gov/healthypeople/priority-areas/health-literacy-healthy-people-2030

Wilhelmsen, N. C., & Eriksson, T. (2019). Medication adherence interventions and outcomes: An overview of systematic reviews. *European Journal of Hospital Pharmacy: Science and Practice*, *26*(4), 187–192. https://doi.org/10.1136/ejhpharm-2018-001725

World Health Organization. (2022a). *Health impact assessment (HIA)*. Retrieved March 12, 2022, from https://www.who.int/health-topics/health-impact-assessment#tab=tab_1

World Health Organization. (2022b). *Health promotion*. Retrieved March 12, 2022, from https://www.who.int/health-topics/health-promotion#tab=tab_1

Xu, J. X., Wu, L. X., Jiang, W., & Fan, G. H. (2021). Effect of nursing intervention based on Maslow's hierarchy of needs in patients with coronary heart disease interventional surgery. *World Journal of Clinical Cases*, *9*(33), 10189–10197. https://doi.org/10.12998/wjcc.v9.i33.10189