Every Nurse is a Leader: Book Club Improves Health Literacy for Homeless Veterans

by Joan Jenkins, RN, BSN

The following story debuts the Nursing 2015 Red Team’s Every Nurse is a Leader series, which highlights how nurses make a difference, take actions and deliver care in ways that demonstrate leadership.

I am a Registered Nurse/Case Manager, in the Comprehensive Homeless Center’s Outreach Program, at a Veteran Affairs (VA) medical center. As a member of the Outreach team, I am responsible for providing skilled nursing and care coordination services to veterans that are currently experiencing homelessness. In this capacity, I provide physical and psychiatric assessments, medication education, crisis intervention services, transportation assistance, place consults for healthcare, dental, and other appointments, advocate for the veterans, assist with housing, etc… These services are provided on an outpatient basis, and are offered at various homeless centers, drop-in centers, campsites, and other locations where homeless veterans may be encountered. The goal of the Outreach Program is to begin to identify the factors that have contributed to the individual becoming homeless, and then to adequately address each issue.

In order to best meet the needs of the homeless veterans, I have found it necessary to work collaboratively with other VA health professionals from a variety of disciplines. However, I have found it to be just as important to develop collaborative partnerships with non-VA healthcare professionals. One such collaboration which has developed is between myself the program manager of a community agency that provides no cost/low cost healthcare to the homeless. We often work together at a men’s homeless shelter which houses 350 people each night. During one such instance, after having seen patients, we discussed different ideas for improving the attendance at our perspective health promotion groups. The agency program manager told me about one of her past groups, at our perspective health promotion groups. The agency program manager told me about one of her past groups, at our perspective health promotion groups. The agency program manager told me about one of her past groups, at our perspective health promotion groups. The agency program manager told me about one of her past groups, at our perspective health promotion groups. The agency program manager told me about one of her past groups, at our perspective health promotion groups. The agency program manager told me about one of her past groups, at our perspective health promotion groups. The agency program manager told me about one of her past groups, at our perspective health promotion groups. The agency program manager told me about one of her past groups, at our perspective health promotion groups. The agency program manager told me about one of her past groups, at our perspective health promotion groups. The agency program manager told me about one of her past groups, at our perspective health promotion groups. The agency program manager told me about one of her past groups, at our perspective health promotion groups. The agency program manager told me about one of her past groups, at our perspective health promotion groups. The agency program manager told me about one of her past groups, at our perspective health promotion groups. The agency program manager told me about one of her past groups, at our perspective health promotion groups. The agency program manager told me about one of her past groups, at our perspective health promotion groups. The agency program manager told me about one of her past groups, at our perspective health promotion groups. The agency program manager told me about one of her past groups, at our perspective health promotion groups. The agency program manager told me about one of her past groups, at our perspective health promotion groups. The agency program manager told me about one of her past groups, at our perspective health promotion groups. The agency program manager told me about one of her past groups, at our perspective health promotion groups. The agency program manager told me about one of her past groups, at our perspective health promotion groups. The agency program manager told me about one of her past groups, at our perspective health promotion groups. The agency program manager told me about one of her past groups, at our perspective health promotion groups.

After determining why the book club would be significant, and what issue it would be addressing, we learned that we had been awarded grant money. We then developed the remainder of the program. The name of our innovative group is The Homeless Veteran’s Health Literacy Book Club, and it meets once a week. This group allows the veteran to have meaningful conversations with the VA nurse/community agency nurse. It provides a safe, and confidential arena in which health teaching is done while discussing parallel life experiences & lifestyle behaviors exhibited by characters in the books being read. We kicked off our first meeting on September 1st, and plan to expand our program to the men’s homeless shelter soon.

Tell us your story! Think of a time when you felt especially proud of the role you played in a situation that affected the outcome for a patient, a student, a colleague, or a community. Submissions should be insightful, encouraging, or inspirational. We are looking for stories that have a strong beginning, middle and end and are ideally no longer than 500 words.

Terms and Conditions: All stories must be true. Names of patients, clients, colleagues, students and facilities must be changed to protect their identity. Please include your contact information; name, address, phone number and email address. There is no monetary prize if your story is selected for print and you retain all rights. Please send your story to Shannon Richmond at shannon.richmond@ohnurses.org

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Editor’s Notes

All independent studies published in the Ohio Nurse are free to ONA members and can be completed online through our CE4Nurses website. Non-members can also complete the studies published in this issue online for $12.00 per study. See page 5 for more details. Non-members: think about joining ONA! See page 3 for membership information and five reasons for joining the only professional organization in Ohio for registered nurses.

Ohio Nurses Association

Get your copy of Legal Regulations and Professional Standards for Ohio Nurses

The third edition of Legal Regulations & Professional Standards for Ohio Nurses is available for purchase from the Ohio Nurses Foundation. Much has changed in the health care environment since the initial publication of this resource ten years ago and this new, updated edition will enable students and registered nurses alike to become more familiar with the law, rule, and professional standards that define nursing practice.

This resource is available as an Adobe® PDF available via email for $18.00. To order your copy, please visit www.ohnurses.org > Practice > Legal Regulations Guide. Please allow seven to ten business days for delivery.

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To help Ohio’s RNs and LPNs meet their obligation to stay current in their practice, three independent studies are published in each issue of the Ohio Nurse.

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1. Go to www.ohnurses.org and click on the CE4Nurses logo.
2. Click on “Ohio Nurse Independent Studies”.
3. Click on each study you want to take and add it to your cart. (ONA members will see a price of $0.00 after they are logged in).
4. Complete the check-out process. You will receive a confirmation email with instructions on how to take the test.
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7. Please read the independent study carefully.
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Questions
Contact Sandy Swearingen at 614-448-1031 (sswearingen@ohnurses.org) or Zandra Ohri, MA, MS, RN, Director, Continuing Education at 614-448-1027 (zohri@ohnurses.org).

Disclaimer: The information in the studies published in this issue is intended for educational purposes only. It is not intended to provide legal and/or medical advice. The authors and planning committee members of these studies have declared no conflict of interest.

The Ohio Nurses Foundation (OBN-001-91) is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center’s Commission on Accreditation.
Nursing Law and Rules in Ohio: An Overview

Developed by: Carol Roe, JD, RN, Centers for Dialysis Care.

OBJECTIVES

(1) To explain the difference in the role of the Ohio Board of Nursing and professional nursing associations in Ohio.

(2) To describe the role of the Ohio General Assembly in establishing the Nurse Practice Act in Ohio.

(3) To describe selected functions of the Ohio Board of Nursing.

(4) To describe selected portions of the Nurse Practice Act and Board rules.

The Role of the Ohio Board of Nursing

The purpose of the Ohio Board of Nursing (OBN) is to protect the public. Nursing is regulated because it is one of the professions, if done by unqualified persons that could be detrimental to public health and safety. The law defines the scope of nursing practice, which regulates the practice of nurses, like that of physicians, pharmacists, and other health care professionals, is within the purview of the state government. State government overturns the State Constitution. Thus, the OBN is a structure of state government.

The OBN is financially supported by the individual license fees which are paid by those who are regulated by the OBN. The payment of those fees support the department who wish to practice in Ohio. Because the OBN is a public body, its meetings are open to the public. The OBN's authority to establish regulations or rules making is defined by the law. The main purpose of the law is to protect the public from the unsafe practice of nursing and dialysis care.

The Nurse Practice Act of 2000 led to the inclusion of dialysis technicians and in 2003, community health workers. The law defines nursing practice and establishes standards for licenses in each state. It is the most definitive legal statute or legislative act regulating nursing practice. A list of the Nurse Practice Act of Ohio can be found in Title 47 of the Ohio Revised Code (ORC), specifically at Chapter 4723. ORC.

The OBN seeks public input into the rule making process. The CPG develops recommendations regarding the practice and education, as had been the approach, the practice issues. Rather than maintaining an advisory group which decisions are made are open to only those who are licensed, the committee, the Committee on Continuing Education (CPE) is comprised of a CNM, a CNP, a CNS, a registered nurse member be elected to serve as supervising registered nurse (Section 4723.491, ORC). This committee is to the practice of all licensed nurses, that is, registered nurses (RN), licensed practical nurses (LPN), certified nurse practitioners (CNP), certified registered nurse anesthetists (CRNA), clinical nurse specialists (CN), and the role of the OBN in the creation of rules.

The OBN annually elects a President and Vice-President and the OBN as a whole meets every two months for two days. The term of office is four years with terms expiring at the end of the calendar year. Board members may be appointed to one additional four-year term. The expiration date is four years after all board members’ terms do not expire at the same time.

The Governor appoints board members. Individuals who will be appointed to the Board must have demonstrated an interest in the delivery of or financing of health care.

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Nursing Law and Rules continued on page 7

June 2011 Ohio Nurse Page 5

Nursing Law and Rules continued from page 4

According to section 4723.17 or 4723.171 of the Revised Code. Medications may be administered by a licensed nurse or a certified medical assistant who has completed a course in medication administration approved by the board of nursing.

(4) Administration to an adult of intravenous therapy authorized by an individual who is authorized to practice in the facility and is within the course of the individual’s professional practice, on the condition that the licensed practical nurse is authorized under section 4723.17 or 4723.171 of the Revised Code to perform intravenous therapy and performs intravenous therapy only in accordance with those provisions in the chapter.

(5) Delegation of nursing tasks as directed by a registered nurse.

(6) Teaching nursing tasks to licensed practical nurses, individuals to whom the licensed practical nurse is authorized to delegate nursing tasks as directed by a registered nurse.

A frequently asked question relates directly to the legal differences in the scope of practice of the RN and LPN. As can be seen by words of the law, the most fundamental difference is that of independent versus dependent functioning. The definition of the practice of nursing by the RN outlines six broad functions, five of which are independent functions meaning they can be initiated solely at the discretion of the RN after assessment of the situation and the client’s response to treatment. Conversely, all the functions set forth in the law for the LPN are dependent functions, performed in accordance with the orders of the RN. The RN is not required to obtain a certificate to prescribe in ORC) and does not require a standard care arrangement. A nurse practitioner, physician assistant, or physician (Section 4723.43 (B), ORC) by a physician, podiatrist, or dentist (Section 4723.43 (B), ORC). Both the RN and the LPN have authority to practice with a physician (or podiatrist) (Section 4723.43 (F)(3), ORC). Both the RN and LPN can administer intravenous normal saline; equivalent local anesthetic; and (F)(3), ORC. Both the RN and LPN working with those practitioners need to ascertain whether or not the medical direction is consistent with their practice. LPNs may administer medications under orders issued by a physician, podiatrist, or dentist (Section 4723.43 (B), ORC). Both the RN and LPN can administer medications under orders issued by a physician, podiatrist, or dentist (Section 4723.43 (B), ORC). Both the RN and LPN can administer medications under orders issued by a physician, podiatrist, or dentist (Section 4723.43 (B), ORC). Both the RN and LPN can administer medications under orders issued by a physician, podiatrist, or dentist (Section 4723.43 (B), ORC). Both the RN and LPN can administer medications under orders issued by a physician, podiatrist, or dentist (Section 4723.43 (B), ORC). Both the RN and LPN can administer medications under orders issued by a physician, podiatrist, or dentist (Section 4723.43 (B), ORC). Both the RN and LPN can administer medications under orders issued by a physician, podiatrist, or dentist (Section 4723.43 (B), ORC). Both the RN and LPN can administer medications under orders issued by a physician, podiatrist, or dentist (Section 4723.43 (B), ORC). Both the RN and LPN can administer medications under orders issued by a physician, podiatrist, or dentist (Section 4723.43 (B), ORC). Both the RN and LPN can administer medications under orders issued by a physician, podiatrist, or dentist (Section 4723.43 (B), ORC). Both the RN and LPN can administer medications under orders issued by a physician, podiatrist, or dentist (Section 4723.43 (B), ORC). Both the RN and LPN can administer medications under orders issued by a physician, podiatrist, or dentist (Section 4723.43 (B), ORC). Both the RN and LPN can administer medications under orders issued by a physician, podiatrist, or dentist (Section 4723.43 (B), ORC). Both the RN and LPN can administer medications under orders issued by a physician, podiatrist, or dentist (Section 4723.43 (B), ORC). Both the RN and LPN can administer medications under orders issued by a physician, podiatrist, or dentist (Section 4723.43 (B), ORC). Both the RN and LPN can administer medications under orders issued by a physician, podiatrist, or dentist (Section 4723.43 (B), ORC). Both the RN and LPN can administer medications under orders issued by a physician, podiatrist, or dentist (Section 4723.43 (B), ORC). Both the RN and LPN can administer medications under orders issued by a physician, podiatrist, or dentist (Section 4723.43 (B), ORC). Both the RN and LPN can administer medications under orders issued by a physician, podiatrist, or dentist (Section 4723.43 (B), ORC). Both the RN and LPN can administer medications under orders issued by a physician, podiatrist, or dentist (Section 4723.43 (B), ORC). Both the RN and LPN can administer medications under orders issued by a physician, podiatrist, or dentist (Section 4723.43 (B), ORC). Both the RN and LPN can administer medications under orders issued by a physician, podiatrist, or dentist (Section 4723.43 (B), ORC). Both the RN and LPN can administer medications under orders issued by a physician, podiatrist, or dentist (Section 4723.43 (B), ORC). Both the RN and LPN can administer medications under orders issued by a physician, podiatrist, or dentist (Section 4723.43 (B), ORC). Both the RN and LPN can administer medications under orders issued by a physician, podiatrist, or dentist (Section 4723.43 (B), ORC). Both the RN and LPN can administ...
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For more information visit www.chamberlain.edu/ohionursesassociation or call ONA’s designated line at 877-295-5016. To join ONA, visit www.ohnurses.org and click on “Join.”

For information on upcoming 2011 Events, go to www.ohnurses.org and click on Events
Individuals who enter this program must submit to the terms of the program, which include temporary voluntary surrender of the license or certificate issued by OBN and ongoing monitoring, for the duration of participation in the program. Non-compliance with the terms and conditions will result in referral for disciplinary action by the OBN. The other alternative to discipline is the Practice Intervention and Improvement Program (PIIP) (Section 4723.282, ORC). The OBN may refer individuals who have an identified practice deficiency that can be corrected through remediation to this program. Individuals who enter this program must complete the terms of remediation or be referred for disciplinary action.

Please note, under current law, MA-Cs are not eligible to participate in either of the alternative programs. The OBN can only take disciplinary action in relationship to licensed nurses, dialysis technicians, and CHWs and MA-Cs. The OBN cannot discipline employers of nurses who may be coercing nurses to inappropriately delegate, nor can the OBN mandate staffing ratios. The OBN can, however, investigate complaints and, in some instances, the process of investigation provides an opportunity for education about nursing law.

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### Post Test and Evaluation–Nursing Law and Rules in Ohio: An Overview

**DIRECTIONS:** Please complete the post-test and evaluation form. There is only one answer per question. The evaluation questions must be completed.

**Name:** __________________________ Final Score: ___________

1. The purpose of the Ohio Board of Nursing is to protect the jobs of nurses and dialysis technicians.  
   a. True  b. False

2. The nurse practice act does not apply to advanced practice nurses.  
   a. True  b. False

3. Individual nurses and dialysis technicians voluntarily pay dues to belong to the Ohio Board of Nursing.  
   a. True  b. False

4. The Ohio General Assembly enacted the Nurse Practice Act.  
   a. True  b. False

5. The Governor appoints the members of the Ohio Board of Nursing.  
   a. True  b. False

6. The scope of practice for the RN and LPN is essentially the same.  
   a. True  b. False

7. Nurses may take “orders” for diagnostic tests from CNMs, CNPs, CNs, and CRNAs.  
   a. True  b. False

8. Dialysis technicians provide care if it has been delegated by either a physician or registered nurse.  
   a. True  b. False

9. Both nurses and dialysis technicians have a duty to delineate, establish, and maintain professional boundaries with patients.  
   a. True  b. False

10. Nurses may delegate medication administration to unlicensed assistive personnel in hospitals.  
    a. True  b. False

11. Once a task is delegated by a nurse to an unlicensed assistive person, the nurse is no longer accountable.  
    a. True  b. False

12. The OBN can take away a license or certificate based upon a complaint being filed and a nurse might never have a chance to tell his/her side of the story.  
    a. True  b. False

13. The OBN can discipline an employer if the staffing is inadequate.  
    a. True  b. False

14. The OBN has a range of disciplinary actions available to utilize in the discipline of a nurse or dialysis technician.  
    a. True  b. False

15. The Board deliberates in executive session but actually makes disciplinary action decisions in public.  
    a. True  b. False

16. Individuals who have substance abuse problems can avoid discipline if they enter the Alternative Program for Chemical Dependency and abide by all the conditions of participation.  
    a. True  b. False

17. Unlicensed assistive personnel may assist patients with self-medication if the setting is one where the substantial purpose is NOT the provision of health care.  
    a. True  b. False

18. The OBN writes the laws for nurses and dialysis technicians.  
    a. True  b. False

19. One of the reasons for the establishment of the Ohio Nurses Association was to lobby the state legislature to pass a Nurse Practice Act.  
    a. True  b. False

20. One of the 13 Board members is either a CNM, CNP, CRNA, or CNS.  
    a. True  b. False

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**Evaluation**

1. Were the following objectives met?  
   a. Describe the difference in the role of the Ohio Board of Nursing and professional nursing associations in Ohio.  
      __ Yes  __ No
   b. Describe the role of the Ohio General Assembly in establishing the Nurse Practice Act in Ohio.  
      __ Yes  __ No
   c. Describe selected functions of the Ohio Board of Nursing.  
      __ Yes  __ No
   d. Describe selected portions of the Nurse Practice Act and Board rules.  
      __ Yes  __ No

2. Was this independent study an effective method of learning?  
   If no, please comment:

3. How long did it take you to complete the study, the post-test, and the evaluation form?  
   ______________

4. What other topics would you like to see addressed in an independent study?  
   ______________

**SEND WITH REGISTRATION FORM ON PAGE 3**
The Development of Palliative Care Programs

Though hospice care originated in the 1800’s in Ireland, it was after St. Christopher’s Hospice opened in 1890 in England, that the world began to develop a more formal approach to end-of-life care. The first Palliative Care program was developed in Canada in 1975, by Dr. Balfour Wilson at the Royal Victoria Hospital in Montreal, Quebec, Canada after Saunders’ hospice model. He coined the term ‘palliative’, a derivative of the Latin word ‘pallium’, which is meant to convey the concept of reducing the severity of a situation. Dr. Mount is considered the father of palliative care in the United States.

In spite of the rapid growth in programs, in 2011, there is still much confusion about what really constitutes ‘palliative care’. Many definitions are similar and embody key components of care. Several health organizations have offered a definition of palliative care including the World Health Organization (WHO) (5) and the Center to Advance Palliative Care (CAPC) (6) among others. The definition put forth by Mount focuses on the quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, psychological, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice. (7)

The Eight Domains of Palliative Care: The Framework for Palliative Care Practice

The Eight Domains of Palliative Care continue on page 9
based upon the best available evidence, which is skillfully the importance of the psychological and psychiatric Practice Guidelines for Quality Palliative Care (4) have protocols for managing end-stage dyspnea and treated appropriately and aggressively, or if treatment is Constipation is a significant effect of opioid therapy, often usually are due to preservatives, antioxidants, dyes, or other require the addition of an opioid. When available and inflammatory drugs (NSAIDs) are useful for many pain adaptation can be affected by the trajectory of the illness. If such as cancer had been ‘cured,’ they may experience a period of profound disappointment or shock when a They have not all been fully standardized, some assessment of infants are complicated, and symptoms may have multiple difficulty, and without adequate energy to face the last stages of the illness. If the illness trajectory is short and the disease a mental health problem arising from significant loss, such people believe that a disease, illness, or other may experience poor mood, inability to concentrate, loss of enjoyment activities may also be signs of a major depression. The treatment of symptoms includes pharmacologic and functional limitations, requires different adaptive responses from the individual makes meaning of their disease relative to their knowledge of these definitions is important to quality 2) be on the lookout for signs that any member of the patient and family's wishes, preferences, hopes and fears emotional pain, a need to explore spiritual pain, and a discussion any features of concern. Palliative Care teams are ideally placed to recognize those at greater risk of poor outcome and initiate referrals to prevent bereavement. Palliative care is ideally placed to identify situations where a palliative care referral is appropriate.

Bereavement—the state of loss resulting from death

Grief—the emotional response associated with loss

Anticipatory Grief—precedes the death and results from the expectation of that event

Complicated Grief—represents a pathological outcome involving psychological, social, or physical morbidity and its treatment. Palliative care is ideally placed to identify those at greater risk of poor outcome and initiate referrals to prevent bereavement. Palliative care is ideally placed to identify situations where a palliative care referral is appropriate.

Key Components of Palliative Family Meeting

When possible, the patient should determine who he or she would like to participate in the meeting. If the patient is not able to participate in the meeting and clinical decisions will be made, it is important that the patient’s legal decision-maker, i.e., the agent or attorney in fact as identified in the Durable Power of Attorney for Healthcare (DPOAH), document a legal guardian, if applicable, which Palliative Care teams are likely to be called to participate in the family meeting. Regular meetings with the patient and family can anticipate and resolve problems and obstacles to quality care. The non-palliative care nurse can and should facilitate palliative care if the palliative care team is not available. Other members of the interdisciplinary team, such as social workers, chaplains, can also convene or assist with family meetings.

Key Components of Palliative Family Meeting

When possible, the patient should determine who he or she would like to participate in the meeting. If the patient is not able to participate in the meeting and clinical decisions will be made, it is important that the patient’s legal decision-maker, i.e., the agent or attorney in fact as identified in the Durable Power of Attorney for Healthcare (DPOAH), document a legal guardian, if applicable, which Palliative Care teams are likely to be called to participate in the family meeting. Regular meetings with the patient and family can anticipate and resolve problems and obstacles to quality care. The non-palliative care nurse can and should facilitate palliative care if the palliative care team is not available. Other members of the interdisciplinary team, such as social workers, chaplains, can also convene or assist with family meetings.

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team that can respond to the spiritual and existential dimensions that patients with life-threatening illnesses are facing. We must confront these issues. The exploration of concerns includes an assessment of religious background and beliefs, the necessity of providing support for spiritual and existential questions, and the importance of a referral to a chaplain or local clergy as desired. The importance of a spiritual assessment cannot seem to affirm what human beings seek when dealing with serious, life-threatening illness, i.e., attention to their entire being that includes their physical being, the soul.

Important distinctions can be drawn between religion and spirituality. For example, religion typically includes organized religious practices, figures such as priests, rituals & other devotional acts, as well as sacred literature. It functions to offer a system of thought to organize a life view related to the perceived presence of an existence beyond the physical self, and gives rise to the beliefs that explain suffering or dying. On the other hand, spirituality has been described as a creative and integrating element that transcends the self and provides a capacity for transcending and giving meaning while supporting a person's coping with life. While religion often serves this integrative function, this non-religious perspective can lead to situations where spiritual processes may be prioritized. Patients in palliative care need a way to access spiritual resources to help them during this time. Religion can help in the spiritual understanding of existential meaning.

The Eight Domains of Palliative Care continued from page 9

Domain 6: Cultural Aspects of Care

Much of healthcare is driven by a problem-oriented approach following a critical incident or disease process that drives a specific and non-negotiable treatment, e.g., a fractured femur requiring surgery and setting of the bone for healing to occur. With the seriously ill patient who is seeking treatment, it is important to consider the goals of care that may be very different from patient to family. As a result, palliative care is more imbued with the need for cultural understanding and the importance of cultural differences and values. It is helpful to engage with the patient in an attitude that exhibits respect and an eagerness to learn. Some helpful questions include:

• Do the patient maintain a strong ethnic or cultural affiliation?
• Who are the healthcare decision makers and cultural boundaries?
• What are the patient's primary and secondary languages?
• What are the patient's religious or spiritual focus?
• Are there current practices or rituals observed?
• Are there food restrictions or preferences to be aware of?
• Re: death rituals: Are there any preferred practices as death approaches? For the care of the body after death, cremation or burial or only one? Does the family wish to be involved?

These are all questions that can help to guide the practice of a cultural perspective, an important and sensitive issue.

Domain 7: Care of the Imminently Dying Patient

The guidelines related to Domain 7 outline that signs and symptoms of impending death are recognized and managed. The role of the nurse in this case includes the consideration of any special needs for their understanding, and that care appropriate for this phase of life is provided. It is also important to acknowledge the importance of the phase of dying and the cultural understanding of important aspects of this phase of palliative care. The role of the nurse during this phase of life has been likened to the role of the midwife at childbirth. Like the midwife, the nurse assists patients and families in making critical decisions, in this case about care before, during and after death. It requires great skill and continuous care over the process of dying. Approaching this time of life with holistic presence requires knowledge of excellent symptom management, a calm and reassuring demeanor, critical assessment skills, and competent and compassionate communication skills.

It is important that the nurse knows what to look for as death approaches and actively manages symptoms in accord with the patient and family wishes. The nurse may initiate the conversation about goals for this time of life has taken place. This can include the possibility of hospice or comfort care, if necessary, in putting a plan in place that takes into consideration the needs and desires of the patient and family. If no such conversation has taken place, the nurse may be a helpful resource in putting an interdisciplinary team caring for the patient should address this conversation and education.

At this time, the most significant areas of concern for patient and family are:

• Receiving adequate management of pain and other symptoms
• Managing the appropriate prolongation of dying
• Retaining control over their end-of-life decisions
• Releasing possible burdens that their dying would impose on loved ones

Strengthening relationships with their loved ones:
• Addressing spiritual and cultural needs—Contacting and updating patient's personal clergy or the chaplain may be helpful at this time.

Communicating the expectation of death is an important skill that patients and families typically expect from the healthcare team. A family meeting with key medical personnel to discuss the patient's condition and share their wishes with the patient and family would be helpful to families. The meeting can ensure that questions are answered and will provide an opportunity for the patient to identify caregivers who can coordinate this type of communication. The communication may also provide the opportunity for patients and their family to ask about and express their needs related to work of forgiveness, acceptance, and life closure which we would not want to be missed. Often there are patient/ family communication的愿望 and values that will be expressed which may be important to these important topics. Also at this time, communicating the goals of care to the other healthcare team members is vital to patient care.

If possible, offering opportunities to honor patient traditions and preferences by arranging for the closing of the room may be discerned in advance. A hospice referral in advance of the dying process may make the difference of whether that care is desired to return home again or dies in a medical unit or ICU.

Symptom assessment and management is a critical skill that nurses must use to help achieve a peaceful death. It is important to ensure that:

• Patient and family treatment goals have been clearly documented, and can easily be followed by other staff members. The goal may include symptom management, i.e., the overall goal of care is comfort.
• The setting for the dying experience includes a calm and quiet environment, with enough room to accommodate the patient and family, and a private room if possible and desired.
• Symptom follow-up, care, and resources, are observed, reported, managed in a timely fashion, and documented.

Close monitoring of the patient’s comfort level should include adjusting schedules for vital signs and other routine nursing/medical interventions and should include only the care for that phase of life. It is also important to reassure patients and their families that common symptoms that occur during the dying phase are pain, dyspnea, and anorexia. Delirium, multi-system organ failure and terminal delirium may also occur. Any, or all of these symptoms/syndromes may arise during the dying process.

The role of the nurse, and other care-providers, is to ensure that these symptoms are managed as effectively as possible and that their needs are met, i.e., the overall goal of care is comfort. It is also important to help the patient and family to maintain their sense of control over their emotional and physical needs. It is helpful simply to hear the experience as the patient is living through the dying process or the patient and family might be able to make the experience more meaningful.

As a patient dies, typically they become more Bradycardic and have lower respiratory rates. Eventually, one may experience restlessness and increased agitation, and the patient may have seen or are experiencing. Many times, these may be important transition visions and families may be enriched by these experiences. It is important to be sure these are not missed.

Symptom management and relief for the dying patient should be carried out in a manner that respects the patient's and family's cultural and religious
practices. Ceremonial washing, body positioning, jewelry, or readings (scriptures or prayers) are examples of these rituals. In the event of a patient’s death, the registered nurse should ask the significant other if any of these needs exist. If so, it is important that they are carried out to the best of the healthcare team’s ability. A plan for documentation and communication is needed to make sure that these rituals are carried out as desired by the patient. Contacting the patient’s personal clergy or the chaplain may be helpful. Family members or significant others should be given the opportunity to view the body after death. For some persons, this type of participation may be an important part of healthy grieving and part of the process of saying goodby to the loved one.

Care immediately after death should also be delivered in accordance with institutional policies and procedures and the specific terms of local laws. Ideally, a member of the palliative care team, or the nurse or physician caring for the patient at the time of death, should discuss with families of significant others whether they want to view the body in this area, such as documents they will be required to complete, decisions about organ donation and autopsy, and logistics of choosing and notifying a funeral home. All caregivers involved in the care of the imminently dying patient need to be aware of organizational procedures and policies related to these topics, particularly in regard to who on the team bears responsibility for such things as reporting the death to the local Organ Procurement Organization (OPO).

Holistic palliative care does not end when a patient dies. It continues in the preparation for the phase of grieving. If the patient has been a hospice patient, a bereavement plan for the family is an important structural element of hospice care. If the patient, for whatever reason, did not have hospice care and preparation for the phase of grieving has been made, the bereavement follow-up is equally important. The palliative care team may want to refer the bereavement to a grief counselor or other bereavement care provider. If there are no such resources available, the plans should be made for that care to come through another source. Many hospital-based palliative care teams establish a partnership with a local hospice to provide bereavement follow-up for their families. They also provide information to families about local bereavement support groups in their community.

There are many good teaching materials that can help educate families about the idea that the person one is actively dying and during the bereavement period. For more specific suggestions, see the resources listed at the end of this section.

Domain 8: Ethical and Legal Aspects of Care

Domain 8 of the Clinical Practice Guidelines emphasizes that processes and procedures must be in place to assure that the patient’s goals, preferences and choices form the basis of the care plan and that patient rights are protected within the limits of applicable state and federal law and within current accepted standards of medical care. Palliative Care team members or interdisciplinary team members must be knowledgeable about legal and regulatory aspects of palliative care and aware of, and prepared to address, the complex ethical issues arising in the care of people with life-threatening illnesses.

Many commonly occurring legal and regulatory issues in palliative care relate to surrogate decision-makers and the presence or absence of documents outlining the patient’s wishes. A hallmark of quality palliative care is to ensure that the patient’s wishes are respected and that patient’s wishes are respected. This may involve an ethical dilemma and then to seek out the resources necessary to assure that questions are resolved in the way that is most respectful of the patient’s interests. The example of such resources is the ANA Code of Ethics for Nurses. (14) This professional code identifies nine individual provisions, which, among other things, direct nurses to “practice with compassion; respect an individual’s inherent dignity, worth and uniqueness; and promote, advocate for and strive to protect the health, safety and rights of the patient.” These guidelines are particularly important in quality palliative care.

Another resource for resolving ethical dilemmas is the institutional ethics committee. All nurses, not just palliative care specialists, should understand and utilize the process of ethical decision-making for their own practice and their organizations. “Ethical decision-making” is the ability to recognize that, while these are essentially legal documents, real ethical issues in palliative care can be but are certainly not limited to: goals of care, treatment options, and religious preferences. The knowledge of principles of ethical decision-making is also an important resource for addressing ethical dilemmas. Two principles that are particularly helpful in ethical decision-making in palliative care are the principles of beneficence and non-maleficence. These terms have different connotations. In both cases, the assessment of decisions or actions in terms of their benefits or burdens.

The Principle of Double Effect

Occasionally, dying patients may put the nurse or physician in the uncomfortable position of providing the last intervention before the patient actually dies. The nurse or physician administers an opioid a few moments before the patient takes his or her last breath, may be haunted by fears that she or he has hastened that patient’s death. Nurses and physicians attending the patient as they remove a ventilator may have the same concerns, i.e., that by removing the ventilator they have caused the patient to die.

In both of these situations, an important ethical consideration is the intent behind the specific action or intervention. Will the medication administered to relieve the patient’s pain and keep them comfortable as they continue the journey of actively dying, a process that cannot be reversed? Or was the intent of the medication to make them die faster? Is the ventilator being removed to allow death to occur? Or to deprive the patient of the oxygen they need to survive and get well? In both of these situations, one outcome is the intended effect and the other an unintended consequence. An action is ethically acceptable if the intent is morally good, even if it may have undesirable consequences. This is called the principle of double effect.

The Principle of Do Good and Do No Harm

For the patient with chronic, life-threatening illness, the quality of that person’s everyday life is always a major consideration. Poorly managed pain and other symptoms that can negatively affect the patient’s ability to function and carry out their desired activities of daily living. Healthcare professionals, in partnership with the patient and family, should consider benefit versus burden when making the determination about interventions. In other words, is a particular treatment doing mostly good for the patient (benefit)? Or is the ‘harm’ experienced by the patient greater than the good that will result (burden)?

For instance, a decision about ordering a diagnostic test should consider both the good that will result from having those test results (the benefit for the patient) and also the amount of pain, discomfort or even expense that the patient must endure in order to complete the test (the burden). Will the test results definitely contribute to changing the plan of care that will benefit the patient? Or will those results mostly be interesting information for the care team without likely altering the plan of care? The patient’s goals for care and their perspectives on quality of life should always be primary considerations in care planning. When the burdens of a treatment or situation seem to be greater than the benefit that the patient receives, it is ethically appropriate to re-consider the plan of care.

Summary

Many factors, including advance elimination of numerous decisions, on energy, in the development of treatment technology, and an aging population, have changed how people die in America today. Rather than dying quickly as happened often in the period before the introduction of antibiotics, patients today most often die of chronic, life-threatening illnesses that progress over long periods, often many years. In response to the needs of this population of patients, palliative care programs have developed rapidly across the US.

The challenges facing palliative care programs include the lack of standardization among programs and the need for partnerships across the continuum, since patients and their families receive the seamless array of comprehensive, interdisciplinary services when and where they are needed. The Eight Domains of Palliative Care outlined by the National Consensus Project, and the Preferred Practices defined by the National Quality Forum serve as a framework in which these challenges can be successfully addressed. All nurses providing care for patients and families experiencing chronic illness, including patients who have a role in expanding patients’ access to quality palliative care.

References

**Post Test and Evaluation—The Eight Domains of Palliative Care: The Framework for Palliative Care Practice**

**DIRECTIONS:** Please complete the post-test and evaluation form. There is only one answer per question. The evaluation questions must be completed.

**Name:** ___________________________ **Final Score:** ____________

1. Which of the following statements about palliative care is not true?
   - a. Palliative care makes it possible for people with life-threatening illnesses to receive the comprehensive, interdisciplinary care typical of hospice before they would be eligible for the hospice benefit.
   - b. The first palliative care program was started in Canada in 1975.
   - c. Palliative care programs are all very similar because they all follow the same definition and standards of palliative care.
   - d. Palliative care is not always hospice, but hospice is always palliative care.
   
2. Palliative care is only delivered to patients who die in the acute hospital setting:
   - a. True
   - b. False

3. One factor contributing to the growth of palliative care in the US is that causes of death are different than they were at the beginning of the 20th century.
   - a. True
   - b. False

4. Which of the following are among the eight domains of palliative care as identified by the National Consensus Project on Quality Palliative Care? (Mark all that apply)
   - a. Care of the imminently dying patient
   - b. Cultural aspects of care
   - c. Spiritual, religious, and existential aspects of care
   - d. All of the above

5. Which of the following is/are true about the Ohio Durable Power of Attorney for Healthcare (DPOAHC) and the Living Will? (Mark all that apply)
   - a. The Living Will is a document for the patient to identify a surrogate decision-maker.
   - b. Conditions outlined in the DPOAHC override conditions outlined or stated in the patient's Living Will.
   - c. The surrogate or attorney-in-fact designated in the DPOAHC does not become the decision-maker until the patient has lost capacity to make his or her healthcare decisions.
   - d. Ohio's Living Will provides for withholding or withdrawing nutrition and/or hydration

6. The most important aspect of good advance care planning means that the patient has completed both the Living Will and the Durable Power of Attorney for Health Care documents.
   - a. True
   - b. False

7. Significant ‘triggers’ to engage patients in advance care planning include:
   - a. Emergency room visits
   - b. Hospital admissions
   - c. When patient and/or family express that the current quality of life is poor
   - d. All of the above

8. Which of the following situations would be appropriate for a referral to the Palliative Care team?
   - a. Your patient has just been diagnosed with lymphoma.
   - b. Your patient's Living Will states that she does not wish to be intubated, but her son is talking to the doctor about whether intubation would be a good intervention.
   - c. Your patient with late stage cancer of the esophagus is complaining that his pain isn't really acceptable, but he doesn't want to take any more medication because he doesn't want to be sleeping all the time.
   - d. All of the above

9. One of the National Quality Forum preferred practices is that patient symptoms should be assessed using standardized and validated assessment tools.
   - a. True
   - b. False

10. Patients with chronic, life-threatening illnesses often present with complicated pain scenarios. Which of the following are helpful approaches to good pain management for these patients?
    - a. Assessment of each pain complaint to determine what might be the most effective treatment regimen
    - b. Using NSAIDs as a first line treatment, particularly if there are symptoms of inflammation
    - c. Including an order for a stool softener whenever opioids are ordered
    - d. All of the above

11. Allergic reactions to opioids are extremely rare and usually are due to preservatives or additives, rather than the opioid itself.
    - a. True
    - b. False

12. The Principle of Double Effect means
    - a. Opioid-based medication may relieve pain as well as treat other symptoms.
    - b. An action of medication may have more than one negative result.
    - c. An action is ethically acceptable if the intent is morally good, even if it may have undesirable consequences.
    - d. All of the above

13. A primary goal of assessment and treatment of psychosocial distress associated with a terminal illness is to:
    - a. Identify all family history of psychosocial or psychiatric problems
    - b. Distinguish between the normal symptoms of adjustment to an advanced illness and a major psychiatric disorder
    - c. Determine when it's necessary to begin prescribing anti-anxiety medication
    - d. None of the above

14. Undiagnosed depression frequently increases the number of inpatient admissions.
    - a. True
    - b. False

15. Support for the grieving process in both patients and their caregivers begins during the palliative care process, rather than waiting until after death has occurred.
    - a. True
    - b. False

16. The nurse who is not a palliative care specialist should still be able to identify signs that any member of the family unit is struggling with psychological issues.
    - a. True
    - b. False

17. Which of the following are necessary components of a productive meeting between the patient and family and the care-giving team?
    - a. Key team participants are the physician, nurse, social worker, and if possible a chaplain or counselor.
    - b. Patients and families should be allowed to do most of the talking.
    - c. Team members should determine the patient and families wishes, preferences, hopes and fears and provide emotional and social support.
    - d. All of the above

18. Which of the following is the best definition of bereavement?
    - a. The state of loss resulting from death
    - b. A pathological outcome involving psychological, social, or physical morbidity that may have an impact on daily life
    - c. The hidden sorrow of the marginalized individual who has less opportunity to express their loss
    - d. None of the above

19. Exploring patients' participation in activities such as meditation or the creative arts can reveal important insights into their sources of spiritual strength.
    - a. True
    - b. False

20. Which of the following statements about the assessment of spiritual, religious and existential aspects of care are true?
    - a. It is important to assess matters of potential stress as well as possible sources of strength and centeredness.
    - b. Asking patients about their religious background and practices is an important part of an assessment but it is not adequate in determining the patient's spiritual and existential needs.
    - c. "Do you consider yourself to be a religious or spiritual person?" would be an appropriate question to ask a patient experiencing a chronic, life-threatening illness.
    - d. All of the above

21. If the nurse learns in the cultural assessment that the patient and family wish to follow specific, elaborate rituals for care of the body after death, what would be an appropriate response from the nurse?
    - a. Make a note in the care plan that the family has specific requests regarding care of the body after death.
    - b. Identify a family member who will work closely with nursing staff to identify the family's needs and plan for after-death care.
    - c. Consult the Palliative Care team for assistance in supporting the family during this ritual.
    - d. All of the above

22. Which of the following organizations developed the first edition of the Clinical Practice Guidelines for Quality Palliative Care?
    - a. National Quality Forum
    - b. Centers for Medicare and Medicaid Services
    - c. National Consensus Project
    - d. Joint Commission for Accreditation of Healthcare Organizations

23. The nurse who is not a palliative care specialist should be able to recognize and teach families about the physical signs of imminent death.
    - a. True
    - b. False

24. FICA is:
    - a. An acronym to help the nurse in completing an assessment of a patient's religious and spiritual needs.
    - b. Stands for Faith, Importance, Community, and Assessment.
    - c. Stands for Faith, Inspiration, Commitment and Affirmation.
    - d. An acronym that can be used to determine level of cognitive functioning

25. In the state of Ohio, the order of priority for individuals to be appointed as surrogate decision-makers for a patient who cannot make healthcare decisions for himself/herself is as follows:
    - a. Legal guardian, spouse, adult children, parents, children
    - b. Spouse, adult siblings, parents, children
    - c. Legal guardian, person(s) listed in HCPOA document, spouse, adult children
    - d. None of the above

26. From an ethical perspective, when the burdens of a treatment seem to be greater than the benefit the patient derives, the treatment plan should be re-considered.
    - a. True
    - b. False

27. All nurses providing care for patients and families experiencing chronic, life-threatening illnesses have an important role to play in expanding access to quality palliative care.
    - a. True
    - b. False

28. Resources for nurses who encounter ethical dilemmas in caring for patients with terminal life-threatening illnesses include:
    - a. Institutional Ethics Committees
    - b. Nurses Code of Ethics
    - c. Palliative Care teams
    - d. All of the above

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**Evaluation**

1. Were the following objectives met?
   - a. Describe the eight domains of palliative care.
   - b. Outline the role of the nurse who is not a palliative care specialist in assuring patients have access to palliative care.
   - c. Was this independent study an effective method of learning?
   - d. How long did it take you to complete the study, the post-test, and the evaluation form?
   - e. What other topics would you like to see addressed in an independent study?

SEND WITH REGISTRATION FORM ON PAGE 3
**Interpreting Common Lab Values**

**Developed by:** Deborah A. Hague, MS, RN, C.

This independent study has been developed for nurses who wish to learn more about interpreting common lab values. 0.96 contact hours will be awarded. The author and planning committee members have declared no conflict of interest.

**Sponsored by an unrestricted educational grant from the AstraZeneca Foundation.**

**Objectives**

Upon completion of this independent study, the learner will be able to:

1. Identify the normal and abnormal values for four of the most common lab tests used to diagnose hematologic disorders, electrolyte disorders, and urinary disorders.
2. Interpret arterial blood gas findings.

**DIRECTIONS:** Read the following case studies. Answer the questions regarding each case study and then review the correct answer and its explanation. At the end of the program, complete the post-test by circling the one correct answer for each multiple-choice question.

**HEMATOLOGIC LAB STUDIES**

Mrs. J. has brought her 4 year old son, Todd, to the office with complaints of persistent nose bleeds. She states he has a nose bleed at least once a day and she has noticed that he seems to have more bruises on his arms than usual. Your physical exam reveals several ecchymotic areas on both arms in various stages of healing. He denies any trauma to the areas, stating that they “just happen.” His last nose bleed was yesterday around noon. He denies nose picking or other trauma. He states, in fact, that he was just “watching TV” when his nose began to bleed yesterday. His bleeding is always profuse, usually from both sides of the nose and it generally takes about 15 minutes to get it stopped. His vital signs are: T 98.6, B/P 80/60, HR 100, R 22. Ht 42 inches, wt 45 lbs.

**CBC**

- **RBC** 4.0 million
- **MCV** 80
- **MCH** 27
- **Hgb** 9.4
- **Hct** 31%
- **Platelets** 80,000
- **WBC** 75,000

**Differential:**

- Neutrophils 65%
- Lymphocytes 32%
- Monocytes 3%
- Eosinophils 3%
- Basophils 5%

1. In light of your findings and the patient’s history, what blood studies would you expect the physician or APN to order?

**Discussion**

If you answered CBC with diff, PT, PTT, and platelets, you are right on target! Let’s take a look at why these tests would be ordered.

By definition, epistaxis is bleeding from the nose caused by irritation, trauma, coagulation disorders, or chronic infection. The history that you have gotten from the patient and his mother rules out trauma and irritation, leaving coagulation disorder and infection as strong possibilities. He also has several bruises which may hint at some hematologic problem. His lab results are:

- **CBC**
  - **RBC** 4.0 million
  - **MCV** 80
  - **MCH** 27
  - **Hgb** 9.4
  - **Hct** 31%
  - **Platelets** 80,000
  - **WBC** 75,000

**Differential:**

- **Neutrophils** 65%
- **Lymphocytes** 32%
- **Monocytes** 3%
- **Eosinophils** 3%
- **Basophils** 5%

2. Identify which of the above lab values are normal or abnormal.

**Discussion**

Let us now review your answers about whether or not these are normal lab values.

- **RBC**
  - 4.0 million: This is a low normal value for a child 4 years of age. Normal value is 4.5-5.2 million, although values for all lab findings may vary slightly

- **MCV**
  - 80: The mean corpuscular volume of the red blood cell determines the size and volume of each red blood cell. The normal for this patient would be 80. If you marked it 70, you were right!

- **MCH**
  - 27: This is the mean corpuscular hemoglobin and determines the hemoglobin content in RBCs. (Hemoglobin of 100 ml of RBCs). Todd’s value is normal.

These corpuscular tests are helpful when diagnosing certain types of anemias, hepatic disease, iron deficiency, malaria and many other disorders that affect the hematologic system.

- **Hgb**
  - 9.4: This determines the amount of hemoglobin in a given volume of blood. A four year old child should run between 9.4 and 15.3.

- **Hct**
  - 31%: The hematocrit determines the percentage of blood composed of RBCs. Todd should fall between 31% and 44%.

- **Platelets**
  - 80,000: The platelet count determines the number of platelets in 1 mm3 of blood. Normal count for Todd would be about 250,000.

- **WBC**
  - 75,000: The WBC gives us the number of white blood cells in 1 mm3 of blood. Normal for Todd should be 5700-13,000. His WBC is extremely elevated, more than would be expected if he just had an infection. Our next step is to look at the differential to see if it will tell us more about Todd’s problem.

In a WBC differential, 100 or more white cells are classified into two major types of leukocytes: granulocytes (neutrophils, eosinophils, basophils) and nongranulocytes (lymphocytes and monocytes). Neutrophils play an important role in fighting bacterial infection in the body. Large numbers of neutrophils can be produced by the bone marrow in response to infection. Soon, however, our body runs out of mature neutrophils and begins pushing immature ones into our system. Immature neutrophils (called blasts, bands or stab) are not as effective as mature neutrophils. An increase in the immature neutrophils is called a “shift to the left.” Normal neutrophil count for Todd would be about 56-68. His is elevated, indicating either a ferocious infection or a problem with the white cells themselves.
Eosinophils 3% Eosinophils elevate in times of allergic reaction, immune system response, and parasitic infections. Normal is 1-3% of the WBC. Todd is normal here.

Basophils 5% Basophils work in hypersensitivity reactions and enhance the inflammatory response. Normal value is 0-0.75%. Todd falls within normal limits.

Lymphocytes 32% Usually about 30% of the total white blood cell count is lymphocytes. They play a major role in cell-mediated and humoral immunity and are divided into T-cell and B-cells. This is an abnormal elevation for Todd.

Now let us put all this information together. Todd has a grossly elevated WBC with a pronounced "shift to the left." The lymphocyte count stands out as well. His platelet count is decreased and his H/H is borderline low. All of this data may indicate that Todd is experiencing acute leukemia. However, further testing would be indicated, especially a blood smear which would show numerous blast (immature) cells. A bone marrow biopsy might also be scheduled and would also reveal massive blast cells.

BLOOD CHEMISTRIES
Ms. S. is a 24 year old female who presents to the office with complaints of severe diarrhea. She states she has been having at least ten bowel movements per day. She describes them as watery brown, somewhat mucousy and in large volumes. She also states she has severe cramping and bloating with them. She claims she has never experienced this in the past. Your physical examination reveals a very thin, pale woman with dry mucous membranes and poor skin turgor. She is 5'7" tall and weighs 105 pounds. She states this is ten pounds below her ideal weight.

She is on no medications and states she thought she just had the "flu" but became concerned when it did not clear up in a few days.

Vital signs are T 99, HR 100, RR 24, BP 90/60 in the upright position.
1. Given this information, what blood chemistries would you expect to be ordered?

Discussion
Most of you would agree that the physician or APN probably would order at least serum electrolytes, BUN and creatinine in addition to a stool culture.

Ms. S's blood chemistries were:

<table>
<thead>
<tr>
<th>Test</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Na</td>
<td>150</td>
</tr>
<tr>
<td>Cl</td>
<td>92</td>
</tr>
<tr>
<td>K</td>
<td>3.0</td>
</tr>
<tr>
<td>CO₂</td>
<td>22</td>
</tr>
<tr>
<td>Cr</td>
<td>1.0</td>
</tr>
<tr>
<td>BUN</td>
<td>20</td>
</tr>
</tbody>
</table>

2. Take a moment now to write N for normal or A for abnormal next to each of the values.

Let us now take a look at each value and see what information it gives us.

Na 150 If you labeled this as abnormal, you are right. Normal serum sodium for adults is about 135-145. Again, it is important for you to familiarize yourself with the values used at your lab since they may vary slightly from lab to lab.

Cl 92 This is abnormally low. The normal range is 97-107.

CO₂ 22 This falls within the normal limits of 22-30.

Cr 1.0 A normal creatinine is 1-1.1.

BUN 20 This is an elevated level since the normal is about 5-18.

You probably had no problem recognizing the abnormal values with this patient. Now let us put all the values together so that we can draw some conclusions about Ms. S's problem.

Your examination of the patient revealed signs of dehydration. She has dry mucous membranes and poor skin turgor. Her heart rate is 100 and her BP 90/60. She also has a recent weight loss of ten pounds. As we look at the lab values to validate our assessment, we see that she has a low Na and Cl level and an elevated BUN. These can be indicators of dehydration.

There are several subgroups of water-sodium imbalances: osmolar imbalances, which have to do with the amount of water in the body in relation to the number of solutes, and volume imbalances, in which sodium, chloride and water work together as a team. This patient has a typical hypovolemia characterized by fluid shifts of Na, Cl, and water together. The BUN also reveals some information. An elevated BUN unaccompanied by an elevation in the creatinine can often be seen when patients are hypervolemic or in a starvation state where protein begins to be catabolized (broken down) for energy. Our patient fits this picture as well.

A low serum potassium can be accounted for by the large volumes of diarrhea. Clα-Clβ+ diarrhea causes at least three major fluid and electrolyte imbalances: dehydration, Na deficit, and K deficit. The body has compensatory mechanisms such as fluid shifts of Na, Cl, and ADH secretion which attempt to deal with the fluid and electrolyte disturbances caused by diarrhea. In this patient’s case, these mechanisms were not enough to correct her problems.

Our initial lab values show dehydration, hypotension, hypochloremia, and hypokalemia. These are the results of the patient’s problem but do not give us the full picture. More information is needed to further identify the cause of her diarrhea. She may be suffering from her first episode of ulcerative colitis. In the meantime, you could expect the physician or APN to treat the fluid and electrolyte disturbances because further depletion could result in severe complications such as cardiac dysrhythmias and renal failure.

ARTERIAL BLOOD GAS VALUES
Mr. M. is a 59 year old male who has been under the care of your physician group for several years. He has recently been diagnosed with diabetes. His current HbA1c is 7.5% and his current HbA1c is 7.8%. He reports a history of smoking 50 pack yr. smoker. During the last year he has been hospitalized twice for respiratory failure, the last time resulting in a stay in the intensive care unit on a ventilator. For the last two months, Mr. M. has been relatively healthy. He has presented himself to the office for a routine check-up. He is 5'9" and weighs 180 pounds. Vital signs are T 98, HR 100, RR 38, BP 150/90. He denies shortness of breath but appears to be working hard at his breathing, using all of his accessory muscles. His lips and nailbeds are slightly cyanotic. The physician orders a set of arterial blood gases. You accompany Mr. M. to the lab next door and await the results.

His ABGs were:

<table>
<thead>
<tr>
<th>Test</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>pH</td>
<td>7.30</td>
</tr>
<tr>
<td>PaCO₂</td>
<td>32</td>
</tr>
<tr>
<td>PaO₂</td>
<td>90</td>
</tr>
<tr>
<td>PaCO₂</td>
<td>40</td>
</tr>
<tr>
<td>HCO₃</td>
<td>20</td>
</tr>
</tbody>
</table>

1. What is your interpretation of these values?

Discussion
There are four major acid-base disorders: respiratory acidosis, respiratory alkalosis, metabolic acidosis and metabolic alkalosis. Typically, when interpreting blood gases, a simple process. The chart below gives you a "quick look" method:

Respiratory acidosis:
- PaCO₂ rises
- pH falls
- Metabolically normal

Respiratory alkalosis:
- PaCO₂ falls
- pH rises
- Metabolically normal

Metabolic acidosis:
- PaCO₂ normal or falls
- pH falls
- PaCO₂ normal or rises

Note that the PaCO₂ does not play a role in delineating acid-base imbalances. However, it is an important indicator of oxygenation and should be evaluated within the context of the acid-base balance.

2. Interpret the following blood gases.

<table>
<thead>
<tr>
<th>Test</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>pH</td>
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<td>90</td>
</tr>
<tr>
<td>HCO₃</td>
<td>20</td>
</tr>
</tbody>
</table>

Here are the answers:

- a) metabolic acidosis
- b) metabolic alkalosis
- c) respiratory acidosis
- d) respiratory alkalosis

Of course, blood gas interpretation is not always so easy since the body has compensatory mechanisms which try to maintain the body to a normal pH. These mechanisms do not always work, especially in patients who have been in chronic acid-base imbalance.

Let us go back now and look at Mr. M. Did you interpret his blood gases as respiratory acidosis? If you did, you were correct. Patients with emphysema have lost their gas-exchange surface because of the loss of the elastic tissue of the alveolar wall. These patients usually compensate over time by increasing the PaCO₂ retention through ventilation and they breathe more shallowly. However, in this case the value members of what is often called the 50/50 club. This means that their bodies adjust to a 50 PaCO₂ and a 50 PaCO₂. It is when the PaCO₂ begins to rise above the PaCO₂ that respiratory failure ensues. Even though Mr. M. is denying any shortness of breath, his ABGs indicate that soon his respiratory status will degenerate. He requires immediate intervention such as low flow oxygen therapy and breathing treatments which will help him blow off some of this excess CO₂.

URINE STUDIES
Mrs. H. is a 50 year old owner of a small business. She presents at the office with complaints of a burning, stinging pain in her lower pelvis that is only relieved when she urinates. She says she drinks up frequently at night to go to the bathroom because the pain awakens her. During the day she states she has to go to the bathroom ten or fifteen times a day. She states she takes fluids and drinks to try to alleviate the problem but believes that it has just gotten worse. She claims to have had this problem for about two years now.

As you would expect, the physician orders a urinalysis and urine culture and sensitivity. Here are the results of these tests.

Urine C/S reveals more than 100,000/ml bacterial colonies.

Urinalysis
- Color: Dark Yellow
- Appearance: Cloudy
- Albumin: Negative
- Bilirubin: Negative
- Glucose: Negative
- Ketones: Negative
- Nitrite: Positive
- Occult blood: Negative
- pH: 7.5
- Odor: Fetid
- Protein: 1+
- Specific gran: 1.029
- Urobilinogen: Negative Cells:
- Erythrocytes: 5
- Leukocytes: 7
- Epithelium: 8
- Casts: Moderate
- Crystals: Small amount
- Bacteria: Large amount
- Parasites: None

1. Next to each finding, place an N for normal or an A for abnormal.

Discussion
Now let's take a look and see how many you marked correctly.

Urinalysis
- Several of the tests included in the urinalysis are normal. Those that are abnormal are: appearance, nitrite, odor, protein, leukocytes, and bacteria.

Urine C/S
- As you know, more than 100,000/ml bacterial colonies indicate a severe infection and possibly cystitis.

Let's now take a look at each of Mrs. H's abnormal findings.

Appearance
Normal appearance of urine is clear to faintly yellow. Mrs. H's urine is obviously cloudy, indicating that perhaps she has bacteria and/or protein in it.

Nitrite
Normally we oxidize ingested nitrite and excrete it as nitrate. The presence of nitrite in the urine is a valuable indicator of urinary tract infection with organisms that change nitrate back to nitrite.

Protein
Most labs will state that there should be no protein in the urine. However, some sources state that a small amount of protein in the urine can be regarded as normal. If protein is present, it should be quantified whenever the random urine sample is positive since the presence of protein suggests renal disease. Mrs. H has 1+ protein which would indicate some urinary tract disease. With her accompanying bacteria this is another piece of data to support severe cystitis.

Leukocytes
The presence of leukocytes in the urine is abnormal. Their presence indicates inflammation and/or infection.

Bacteria
Normally there should be no bacteria or at most a small number of bacteria present. This finding, along with all the other abnormalities, requires that a urine C/S be done.

As we put together both the lab data and the clinical signs, we realize that Dr. M. has probably suffered from a severe case of cystitis.

We have now covered common lab tests and ABGs. Proceed to the post-test to complete this self-study packet.

Interpreting Common Lab Values continued on page 15
**Post Test and Evaluation—Interpreting Common Lab Values**

**DIRECTIONS:** Please complete the post-test and evaluation form. There is only one answer per question. The evaluation questions must be completed.

Name: ______________________ Final Score: _________

1. Which of the following sets of lab tests would be ordered when trying to identify a bleeding problem?
   a. Na, Cl, CO2
   b. K, Ca, BUN
   c. PT, PTT, platelets
   d. MCV, MCH, MCHC

2. Which of the following sets of lab tests would be ordered when a patient has been experiencing fluid loss through diarrhea or vomiting?
   a. PT, PTT, platelets
   b. Na, Cl, K, BUN
   c. arterial blood gases
   d. SGOT, SGPT, LDH

3. The presence of many immature neutrophils in a WBC differential is called:
   a. a shift to the right
   b. thrombocytopenia
   c. a shift to the left
   d. leukocytopenia

4. A normal serum sodium (Na) for an adult is:
   a. 135-145
   b. 5,000-10,000
   c. 2-5
   d. 20-60

5. An elevation in the BUN without an elevation in the serum creatinine can indicate:
   a. kidney disease
   b. cardiac dysfunction
   c. protein breakdown
   d. hypervolemia

6. Which of the following blood gas values indicate respiratory acidosis?
   a. pH 7.40, PaCO2 40, HCO3 24
   b. pH 7.48, PaCO2 28, HCO3 16
   c. pH 7.32, PaCO2 40, HCO3 16
   d. pH 7.30, PaCO2 50, HCO3 25

7. Which of the following blood gas values indicate metabolic acidosis?
   a. pH 7.40, PaCO2 40, HCO3 24
   b. pH 7.48, PaCO2 28, HCO3 16
   c. pH 7.32, PaCO2 40, HCO3 16
   d. pH 7.30, PaCO2 50, HCO3 25

8. In a random urinalysis, which of the following values is considered normal?
   a. trace of albumin
   b. positive for nitrites
   c. specific gravity of 1.020
   d. positive for ketones

9. The presence of leukocytes in the urine may indicate:
   a. urinary tract infection
   b. poor glomerular filtration
   c. inadequate fluid intake
   d. dysfunction of the bone marrow

10. A urine culture and sensitivity indicates clinically significant bacteriuria when there are how many bacterial colonies grown?
    a. 20,000/ml
    b. 50,000/ml
    c. 75,000/ml
    d. 100,000/ml

---

**Evaluation**

1. Were the following objectives met?
   a. Identify the normal and abnormal values for four of the most common lab tests used to diagnose hematologic disorders, electrolyte disorders, and urinary disorders. ___ Met ___ Not Met
   b. Interpret arterial blood gas findings. ___ Met ___ Not Met

2. Was this independent study an effective method of learning? ___ Yes ___ No
   If no, please comment:

3. How long did it take you to complete the study, the post-test, and the evaluation form? ______________________

4. What other topics would you like to see addressed in an independent study?

SEND WITH REGISTRATION FORM ON PAGE 3