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FIVE STAR GUIDE

MEDICAL-SURGICAL CARE PLANNING

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- PATIENT OUTCOME CRITERIA
- DOCUMENTATION
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THIRD EDITION

Nancy M. Holloway, RN, MSN

MEDICAL-SURGICAL CARE PLANNING

Third Edition

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Dedication

This book is dedicated to D. Michael Holloway, my husband, for championing my dreams, and to Jason and Willow Holloway, my son and daughter, for making it all worthwhile.

Preface

Medical-Surgical Care Planning, Third Edition, is essential. Why? Because it integrates three major factors in nursing — care planning, nursing diagnoses, and diagnosis-related groups (DRGs) — and provides information nurses need to meet the 1992 Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) Nursing Care Standards. Focusing on care of the adult medical-surgical patient, this book:

- distinguishes clearly between nursing's collaborative functions (those shared with medicine) and its independent functions (those unique to nursing)
- offers the bedside nurse, nursing student, and nursing educator comprehensive, realistic clinical plans to meet their educational needs.

Why are plans of care important?

Clinically, plans of care offer a way to plan and communicate appropriate patient care. Legally, they offer a framework for establishing the standard of care for a given situation. Financially, they can validate the appropriateness of care and justify staffing levels and patient-care charges.

If plans of care are so important, why don't more nurses use them?

Most nurses are first exposed to plans of care as students. They soon learn that writing out individual plans can be frustrating and time consuming. After graduation, most nurses practice in a hectic, complex environment that allows little time for thoughtful care planning.

Even nurses who would like to use written plans of care may be at a loss when trying to integrate nursing diagnoses into their planning. Overwhelmed, they may turn to previously published books for guidance, only to find the information too general or too theoretical, that common medical problems are renamed in nursing diagnosis terminology, or that nursing diagnoses are not matched to medical disorders.

Yet *clinically relevant* plans of care can help nurses answer many of the questions they ask daily:

- "What are the most important points to cover during a physical assessment when I haven't got time to check everything?"
- "Which laboratory tests and diagnostic procedures should I anticipate, and what do they typically show?"
- "What are this patient's nursing priorities?"
- "Which problems is this patient most likely to experience?"
- "Why are certain interventions important?"
- "Which complications can occur with this disorder?"
- "How long is this patient likely to be in the hospital?"
- "Realistically, how much patient teaching can I accomplish?"
- "From a nursing standpoint, how will I know when this patient is ready for discharge?"

The solution: This book

Medical-Surgical Care Planning, Third Edition, provides clinically relevant answers to common questions about patient care because it targets the needs of the "hands-on" nurse clinician through standardized plans of care. Distinguishing features include:

- 11 general plans of care covering conditions nurses encounter daily, such as impaired physical mobility and knowledge deficit
- 71 plans of care, organized by body system, covering various medical-surgical conditions and procedures (including critical care disorders)
- 8 clinical pathways
- nursing diagnoses (using selected terminology from the North American Nursing Diagnosis Association) and collaborative problems (using familiar medical terminology such as shock) arranged in order of importance.

This approach will help you see the total picture of patient care; differentiate between collaborative and independent nursing responsibilities; apply the latest official nursing diagnoses; and avoid forcing all planning under nursing diagnoses, a process that only renames medical diagnoses and fosters confusion between nursing and medicine.

Each plan presents the latest clinically relevant DRG information, including DRG numbers, principal diagnoses, and mean length of stay, to help you understand the reimbursement system responsible for today's cost-conscious health care environment and to help you anticipate the patient's recovery and plan patient teaching. Common historical and subjective findings are presented according to Gordon's functional health patterns, a widely accepted format that blends both traditional and contemporary methods of nursing assessment; objective findings are listed by body system. This assessment information will help you recognize pertinent signs and symptoms and understand how the nursing diagnoses and collaborative problems were identified.

The plans of care build on a goal-directed, action-oriented approach to care planning that ranks problems and interventions in order of importance and identifies specific outcome criteria. This approach will help you determine the most important patient problems, decide

what to do first, and recognize when a problem has been resolved.

JCAHO standards' impact on nursing

The 1992 update represents the first major revision of the Nursing Care Standards since 1978. The JCAHO Nursing Standards Task Force, which included 23 representatives from various nursing services and educational programs, adopted the new standards after circulating two drafts and considering feedback from more than 50,000 nurses.

Where the former Nursing Services Standards focused on the process of care to determine if the nursing organization could provide quality care, the new Nursing Care Standards focus more on the patient and the outcomes of care to determine the quality of care provided. In addition, the new standards emphasize patient-family education and discharge planning. Consequently, nurses will play an even more important role in helping hospitals maintain accreditation. Such accountability is likely to *increase* interest in care planning.

The revised standards also place increased emphasis on documentation, requiring that nursing information involving assessment, nursing diagnoses or patient needs, interventions, and outcomes become a permanent part of the medical record. Care may be documented directly in the patient's record or indirectly through references to other documents. However, this documentation does not have to be the handwritten, complex, case-study approach to care planning that educators find helpful, or the routine, repetitive handwritten plan that many hospital nurses rightly dismiss as irrelevant and time consuming. Instead of being required to provide handwritten plans of care for all patients, nursing departments now have more flexibility in documenting care. Nurses may now choose to document care planning through standards of care, clinical practice guidelines, critical paths, or preprinted plans of care.

When individualized as recommended, the standardized plans in this book can help nurses meet all of the JCAHO's requirements. The plans cover all the elements required for documentation of care planning and also include useful information about patient outcomes, patient-family education, and discharge planning.

Standardized vs. individualized plans

Major differences of opinion exist in nursing concerning standardized and individualized plans of care. Opponents of standardization argue that it equals depersonalization. Advocates argue that standardization promotes efficiency, by limiting planning time without sacrificing quality, and fosters quality assurance. This disagreement cannot be resolved easily; however, this book combines the advantages of standard plans of care with unusual features that help minimize their disadvantages:

- The plans blend standardized and individualized aspects of care. Standardization works better in some areas of care planning than others: problems, priorities, and interventions usually can be standardized, but outcome criteria, timing of interventions, and discharge criteria require significant individualization. This book takes these factors into account and encourages flexibility in areas that vary significantly among patients.
- Space is provided at the end of each problem for the nurse to add additional interventions and rationales specific to the individual patient's needs.

These unusual features challenge the nurse to think creatively. Because the resulting plan is pertinent and individualized, its clinical usefulness is ensured.

However, the most important point to remember in the debate over standardized versus individualized plans of care is that a plan of care does not cause depersonalized care; rather, the nurse's attitude is the culprit. The nurse who appreciates patients as individuals will use a standard plan as a starting point, staying attuned to the individual patient's responses while applying the art and science of nursing.

Why nurses will continue to use plans of care

Plans of care provide a valuable way to organize care, meet JCAHO's requirements for documentation, and prepare for site visits. In addition, many institutions have invested substantial time and money to develop systems of care planning appropriate for their patients. Before abandoning such systems, they would need to identify a better one and find the funds, time, and expertise to implement it—a difficult undertaking in this era of scarce resources. Finally, instructors in schools of nursing will continue to use plans of care as a method for teaching patient care because of the plans' comprehensiveness.

Ultimately, any plan of care is only as good as the nurse who provides the care. Conscientious nurses find plans of care a resource for learning new information quickly, refreshing their knowledge, and focusing their energy on the most important problems their patients may encounter. The contributors to *Medical-Surgical Care Planning,* Third Edition, have based their plans on a blend of clinical expertise, nursing diagnosis, and care planning — always keeping in mind the nurse on the front line. This book will provide welcome help for nurses facing the daily challenge of providing quality patient care.

Nancy M. Holloway

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Part 1

Introduction

Trends and issues in health care and nursing

Major developments in American society and the health care industry are producing revolutionary changes in health care delivery. The most significant developments include our aging population (also known as the "graying of America"), chronic care, and restricted access to care. Other critical issues include the evolution of health care, its impact on the patient and on nursing, and opportunities for advanced practice.

Population trends: The graying of America

By the year 2000, about 35 million Americans will be age 65 or older, with those age 85 or older constituting the fastest growing age-group. The percentage of elderly patients with disabilities is declining, partly due to the decline in diseases that cause disability in the elderly, such as stroke and heart disease. Despite this decline, however, the sheer number of people who are aging means that long-term disability will continue to be a major problem in our health care system.

Only about 5% of elderly citizens live in nursing homes; patients are usually discharged to their homes from the acute care hospital. Unfortunately, shorter hospital stays mean the nurse often doesn't have enough time to educate caregivers. Additionally, a patient over age 85 may have an elderly caregiver who also requires medical care or assistance with daily living.

Elderly patients require a range of services; the most important include home health care, homemaker or chore services, transportation, assistance with activities of daily living, nutrition services, and an emergency response system. Integration of these services is important but in many cases doesn't exist; nurses could help bridge this gap. The Program of All-Inclusive Care for the Elderly (PACE) is a good example of a program that delivers comprehensive care for the elderly. With 11 sites nationwide, PACE focuses on preventive care and maintaining function to avoid the need for costly inpatient care.

Chronic care

The intersection of an aging population and a health care system focused on acute care creates another trend: the increasing importance of chronic care. Chronic care consists of medical care, rehabilitation, and assistance with activities of daily living.

Several factors affect the health status of older Americans. These patients commonly have multiple chronic disorders. According to the American Association of Retired Persons, the most common disorders in those over age 50 are hypertension, arthritis, heart disease, hearing disorders, cataracts, sinusitis, orthopedic disorders, and diabetes — all chronic conditions that last for years. In addition, older people are at risk for receiving inadequate medical care because of poverty, forgetfulness, hearing or vision impairments, and transportation problems, among other factors. Finally, older people are at risk for experiencing unexpected adverse effects associated with complex drug regimens.

Access to care

About 41 million Americans (17.4% of the population) are uninsured, making access to care a major issue in our current health care system. Our nation's economic restructuring means that many higher-paying manufacturing jobs have been replaced by low-paying service sector jobs that don't offer benefits. Of all uninsured children, about 89% are in working families. Over the next 3 to 5 years, the working poor probably will have less access to care, and the safety net will continue to deteriorate.

"The whole issue of the uninsured is the Achilles' heel of the reshaping of our health care system by market forces," says Kathryn Duke, a researcher from the University of California, San Francisco, Institute for Health Policy Studies. The uninsured are less likely to seek care, so they are usually seriously ill when they finally do. Although some steps have been taken to achieve wider access to health care, the goals of universal coverage, a single-payer system, and a national health insurance plan will remain unrealized.

Doctors and nurse practitioners will increasingly control access to the health care system. However, their efforts to refer patients for specialized services will be hampered by spending caps and a limited number of specialists participating in insurance plans.

Evolution of health care

The evolution of health care will be characterized by reduced spending, increased governmental regulation, and changes in the site of health care delivery.

Reimbursement issues

Enrollment in managed care plans will continue expanding, especially among Medicaid recipients. Health care providers and plan administrators will continually seek the most cost-effective ways to deliver care. Prevention, case management, and rehabilitation will be emphasized.

The health care system will continue to reel from the reduced rate of Medicare and Medicaid spending. Medicare spending will be reduced by $115 billion over the next 5 years, with most of the savings coming from reduced payments to providers, hospitals, and health maintenance organizations (HMOs). Even more troublesome is the change in the payment system for home health care, until recently a fee-for-service system. As of January 1, 1998, Medicare (and to a lesser extent Medicaid) began using a prospective payment system to pay for home care. In response to this system, the home care field is likely to experience the same belt-tightening that has become common in many hospitals.

Government regulation

Government regulation will play an increasing role in the health care field. Already, state regulators are becoming more involved in policing managed care organizations (for example, by citing hospitals for violating federal laws against patient dumping). Pressure from lawmakers and consumer groups will continue to eliminate objectionable practices, such as excluding benefits for preexisting conditions or canceling the policies of patients with catastrophic illnesses. Managed care organizations will likely respond to consumer backlash and temper their approach primarily to avoid more restrictive legislation. Ongoing consolidation and mergers among health care facilities will form large hospital chains that will be monitored closely by the federal government for violations of antitrust laws. Vigorous federal prosecution of Medicare fraud will continue.

Site of care

Outpatient care and community programs — as opposed to inpatient acute care — have become popular sites of care. In the largest survey ever conducted of nurses' views on health care and nursing practice, the *American Journal of Nursing (AJN)* polled more than 7,000 nurses nationwide about patient care. This survey provides the best picture so far of the state of health care and nursing practice. More than half of the respondents reported that their health care organization had reduced the number of beds or closed units in the last year. Managed care is the major factor driving down hospital stays, with HMOs using an average of 34% less inpatient care. More community hospitals are likely to close, and job prospects for RNs in hospitals across the country are dwindling.

Outpatient services are taking greater responsibility for complex care regimens previously managed by inpatient services. For example, AIDS patients today receive more of their care in ambulatory facilities. The trend toward same-day and outpatient surgery — driven by managed care, improved anesthesia, and advances in pain management — means that patients are commonly back home a few hours after a procedure or treatment.

Professionals caring for these patients need a different approach and greater range of skills than they did a few years ago. The demands of maintaining quality care within a shorter period of time present a daunting challenge for nurses. These conditions require more critical thinking; the nurse needs an ability to establish relationships quickly as well as excellent patient assessment skills.

A patient's satisfaction with his care is directly related to his expectations of the experience. Preparation is one of the keys to achieving patient satisfaction. As one nurse notes, "Patients need to know that they're going to move through quickly. Patients think they're there for a day, but it's really a piece of a day; rarely is someone there 8 to 12 hours. That's information patients need to know up front — that they are being moved through not because we're rushing them but rather because criteria have been met and they are ready for discharge."

Consumers also are likely to see increased growth of long-term facilities. According to a survey by the National Center for Health Care Statistics, there has been a significant drop in the proportion of elderly people entering nursing homes.

"What we're seeing now is the diversification of long-term care," says David Kyllo, a spokesman for the American Health Care Association, which represents two-thirds of the nation's nursing homes. "Twenty-five years ago you had nursing homes doing the lighter care as well as the heavier care. Today, nursing homes have evolved to become the provider of more complex medical care. Lighter care has gone to assisted living or in-home care."

Nurses are likely to see an explosion of community-based programs, which are popular because most people want to live at home and because home care is cost-effective. Most nursing jobs will be in the community because of the increased need for health professionals in ambulatory care, home health, schools, and prisons. According to the American Medical Association, more than 80% of all health care takes place in the home. This shift in the site of health care requires a corresponding shift in the attitudes of health care professionals.

"Our hospital system in the past several decades has been built on an illness model: If you're sick, you go to the hospital," says Susan Odegaard Turner, a nurse who helped develop a guide for health care providers to assist nurses in making the transition to the new charac-

teristics of health care. "Managed care is based on a wellness concept: You try to keep somebody out of the hospital and manage them in an off-site environment — an alternative site."

The shift of focus to ambulatory facilities is having a great impact on nurses, especially critical care nurses. Gloria McNeal, a critical care RN who has studied the role of critical care nurses in caring for patients beyond traditional institutional boundaries, found that "about 2 years ago...it became very clear to me that critical care was going to expand into the realm of high-tech home care." Patients are either bypassing the intensive care unit or leaving more quickly; the average length of stay is down from 3½ days to 1½ days.

Other opportunities for nurses are expanding. Nurses have more opportunities to provide care in nontraditional settings such as nurse advice lines; as independent contractors or employees of case management firms, such as workers' compensation, disability, or health insurance carriers; or as legal consultants for attorneys.

Impact on the patient

Reduced spending, increased governmental regulation, and shifts in the site of care will impact the patient. Health care providers will need to focus more attention on patient satisfaction and patient education. The alternative health care trend will continue as patients seek relief from stress and pain.

Patient satisfaction

Paul Schyve, a senior vice president of the Joint Commission for the Accreditation of Health Care Organizations (JCAHO), says that "ten years ago, JCAHO based its assessments of the quality of care on standards like staffing and a facility's resources. Now JCAHO looks at other things, such as how healthy and satisfied patients are and how much their care costs." Patient satisfaction was evaluated in the American Hospital Association's "Eye on Patients," which surveyed 37,000 patients about the care they received in 1996 at 120 hospitals, clinics, or doctor offices. Among the significant concerns patients mentioned were having little say in their treatment, receiving inadequate information, and experiencing posthospital "abandonment." As Sharon Ostwald, director of the Center on Aging at the University of Texas-Houston Health Science Center, commented, "The focus is on getting the patient out of the hospital, and we've sort of lost track of who's going to take care of them the day they walk out the door."

Patient education

The last decade has brought three major changes in patient education: the increasing impact of technology, change in the site of health education, and the increasing sophistication of health care consumers.

The Internet has improved access to health information for millions of people and is bringing together people with similar health issues in forums and chat rooms. Hospital-associated learning centers are providing "one stop" education for patients and family. One example, the Beth Israel Learning Center in Boston, provides printed material, videotapes, a consumer health database, and free access to the Internet. A growing number of hospitals now have web sites on the World Wide Web, delivering health care information through cyberspace. Ask-A-Nurse at St. Francis Hospital and Medical Center in Topeka, Kansas, allows users to E-mail questions to RNs.

Technology also is impacting the way care is delivered. Increasingly, phone-nursing experts are providing patients with information, advice, coaching and referrals to specialists, and in some cases providing care similar to case management. Employee Managed Care Corporation (EMC^2) in Seattle, Washington, provides several types of nurse phone services:

- CareWise, a 24-hour-a-day service that covers decision support in areas of health and medicine
- CareSupport, which provides detailed teaching and support for those with chronic disorders
- Living Wise, which provides lifestyle management support
- CareWise Stat, which provides triage services.

State-of-the-art telemedicine systems (which use ordinary phone lines to transmit video, audio, and diagnostic information), such as the Personal Telemedicine System developed by American Telecare in Eden Prairie, Minnesota, allow nurses in an office to check a patient's blood pressure, pulse, and temperature; evaluate heart or lung sounds; and examine wound sites of a patient at home.

In many cases, the site of patient education has changed dramatically. Whereas most patient education previously occurred in the hospital, education now is occurring in doctors' offices, patients' homes, and cyberspace.

"Most hospitals are seeing 50% to 60% actual outpatients (those staying less than 23 hours). Another 20% of patients stay in the hospital a few days, and many of those are admitted following surgery," says operating room nurse Denise Geuder, Director of Cardiovascular and Surgery Services for St. Francis Hospital in Tulsa, Oklahoma. Because of the shortened stays, almost all preoperative teaching has to be done on an outpatient basis. Most nurses use a combined approach of a preadmission phone call or visit, instruction before and after the procedure, and a follow-up call 24 hours after discharge. The teaching process now begins earlier, in many cases in the doctor's office.