Professional Practice in Nursing: Part I

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Welcome to the supplementary document and resources for Professional Practice in Nursing: Part I

INTENTIONAL NURSING PRACTICE

Learning Objectives:

By the end of this case study, you will be able to:

1. Consciously examine your current "habit of knowing" in your nursing practice.
2. Think reflectively about the sources of your knowledge used in your practice.
3. Use the Doane and Varcoe (2021) Framework of relational inquiry in your nursing practice.

Case Study

Lily Petrov is 71 years old and lives in a rural town in Ontario. She never married and has no children. She lives alone in a small two-story townhome. She prefers to be called Lily.

After working as a registered nurse for 35 years, Lily retired 6 years ago when she was diagnosed with chronic kidney disease (CKD). The diagnosis came as a surprise to Lily as she did not have any symptoms. A yearly physical exam and blood work at that time revealed that her GFR was 28. Since her diagnosis, her GFR has fallen to 23. Lily has told her physician that she will refuse dialysis when her kidneys are no longer able to function, and she does not wish to go on a kidney transplant list.

Two weeks ago, Lily was discharged from the local community hospital post-operation for gallbladder surgery. While hospitalized, the nurses learned that Lily eats a diet rich with dairy, meat, and pastries (foods known to contribute to gallbladder disease). They also learned she prefers not to follow a CKD dietary regime as she finds the foods to be bland. Her decline in kidney function and the appearance of new symptoms (itchiness, some sleep problems) associated with renal decline were attributable to her choice not to follow her prescribed CKD diet of low potassium, low sodium and low purine foods. The team decided to refer her for follow up by a CCAC nurse as they felt her declining health could be enhanced with some nutritional education. With more knowledge, the team believed that Lily would implement the dietary regime to prolong her health.

The CCAC nurse met with Lily one week after her discharge. She provided lots of health literature and pamphlets about advanced kidney disease. The nurse found Lily in her backyard pulling up weeds in her garden and feeding the birds. Lily served the nurse some orange juice and bagels – both not ideal foods for CKD diet. The CCAC nurse was surprised to learn that Lily felt her health was

excellent, despite feeling tired on occasion. When the nurse probed Lily more about her health, the nurse learned that Lily believes that health is being well enough to garden, visit with friends, and enjoy good food. Without those things, Lily felt her quality of life would decline. It was clear to the visiting nurse that Lily did, in fact, know a great deal about her prescribed diet but her understanding about health and well being was driving her lifestyle choices and not her CFR values. Lily declined to take the pamphlets but said she would look forward to another visit by the nurse and stated, "I will have some nice fresh baked cake when you visit next".

Questions

Questions

1. Where do you spend most of your time when you are providing nursing care?
2. What is your definition of health?
3. Do you think most people have the same definition of health as you do? Please explain.

CHRONICITY

By the end of this chapter, you will be able to:

1. Identify the unique needs of the older adult and their family living with chronic illness.
2. Analyze the role of the nurse in the planning of care of clients/ families living with chronic illness.
3. Assess the range of approaches and strategies for supporting health in the adult and older adult populations.

Case Study

Javeed Akhtar is a 69-year-old and presenting to the emergency department with a right foot ulcer affecting the 3rd, 4th and 5th toes. Mr. Akhtar prefers to be called Javeed and identifies as a cis-gender man. Javeed states that he thinks the ulcer was caused by him stubbing his 5th toe while climbing into his truck a week ago and now noticed two days ago that it was spreading to his other toes. As his nurse, you note that Javeed can ambulate without any gait aids and when you ask his pain score, he states it is a 5/10 in his right foot. According to Javeed, he has been a truck driver for about 40 years. He is divorced, lives alone, and has one estranged son.

When you ask Javeed about his medical history he laughs and states, "Well I've been here a few times, I have a bit of diabetes and high blood pressure, I take pills for that". He is unable to recall all the medications, but he is taking them regularly. When you review Javeed's chart, you note that his past medical history includes diabetes with diabetic neuropathy, atrial fibrillation, coronary artery disease, peripheral vascular disease, and hypertension. His last visit was three months ago. His primary issue at that time was chest pain in which investigations were found to be negative, and he was discharged with follow up appointments with the cardiologist that he missed.

As you remove Javeed's shoes and socks, you notice a foul smell and see necrotic lesions on his right 3rd, 4th and 5th toes extending up to the dorsum of his foot. In palpating his pedal pulse, you assess that his skin is cool to touch. He has limited range of motion in his toes due to swelling but he is able to ambulate. His vital signs are: blood pressure is 90/45, heart rate is 110, respiration rate is 20, oxygen saturation is 97% on room air, and temperature is 37.9 °C.

After you complete your assessment the physician enters the

room and completes his own assessment. The doctor then orders septic blood work (CBC, electrolytes, lactate, vbg, & blood cultures x 2), chest and right foot x-rays, and a 1 Liter of normal saline bolus over one hour. When the orders are complete Javeed is reassessed by the physician, he is then ordered to have ceftriaxone 1 grams IV and piperacillin-tazocin 4.5 grams IV, preoperative blood work collected and to be assessed by an orthopedic surgeon. When reviewing his results, you note that he has a white blood count of 28.9 × 109/L (with 83% neutrophils), hemoglobin A1C of 12%, random glucose level of 18.8 mmol/L, and the x-ray impression of his right foot shows acute osteomyelitis. As you collect additional blood work the surgeon enters the room, introduces herself and proceeds to explain to Javeed that he has an infection in his right foot that extends into his bone. The surgeon then states that due to the history of his uncontrolled diabetes and peripheral vascular disease she recommends he consents to having a below the knee amputation. After thoroughly explaining the procedure and its associated benefits and risks, the surgeon asks Javeed if he understands and consents to the procedure. Javeed states that while he understands, he needs to think about it before signing the consent form. When the surgeon leaves, you speak wih Javeed and discover that although he understands his diagnosis and the required treatment, he feels guilty for continuing to eat fast food meals while working. You also discover that Javeed is concerned that after the procedure he would no longer be able to work as a truck driver and financially support himself. You decide to then advocate for Javeed to be consulted to see a social worker so that Javeed can explore what assistive devices will available post-surgery as well as discuss financial supports. After meeting with the social worker Javeed feels comfortable with proceeding with the surgery and signs the consent form.

Question

Questions:

1. How is the experience of chronic illness affected by acute sickness treated within the acute care system?
2. How can the client be supported through both the acute and chronic clinical context within the acute healthcare system?
3. What are the elements of self-management for Javeed's chronic illness?

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THE ILLNESS EXPERIENCE

Learning Objectives:

By the end of this chapter, you will be able to:

1. To utilize a relational practice perspective to understand the needs of clients and families living with chronic illness
2. Analyze the role of the nurse in the planning of care for clients and families living with chronic illness
3. Identify valid assessment tools to determine the functional, physical, cognitive, psychological, spiritual and social needs of the older adult

Case study

Rose Silva is an 84-year-old cis-gender woman presenting to the emergency department after having an unwitnessed fall. She prefers to be called Rose. Her only son found her lying on her left side on the floor next to her bed during one of his biweekly visits and is unsure how long she has been on the floor. Rose's native tongue is Portuguese and the nurse obtains most of her medical history from her son during assessment. According to her son, Rose was unable to stand after the fall. Rose is usually able to shower, groom and dress independently; however, she needs help with laundry, grocery shopping and meal prepping, which is what her son helps with during his biweekly visits.

Rose has a past medical history of osteoporosis, and colon cancer treated in 2013 and 2015, she has been in remission since her last treatment. She recently had her colonoscopy screening postponed due to the COVID-19 pandemic. Upon physical assessment, Rose has a cachexic appearance, alert and oriented to person, place and time, pain is 7/10, has a purplish bruise to her left hip, and a distended and firm abdomen. After the Nurse Practitioner assesses Rose, she orders blood work (CBC, electrolytes, calcium, magnesium, phosphate, CK), a bladder scan with insertion of Foley if over 300 ml, brain, neck and abdominal CT scan, and a left hip x-ray. A bladder scan shows 650 ml, you then insert a Foley catheter. Rose is diuretic; however, her abdomen remains distended and when asked Rose states she has not had a "good" bowel movement in 1 week (as translated by her son).

The results of the diagnostic tests are a hairline left hip fracture and a mass in her right colon. Rose is admitted to the hospital for further investigations, nutritional and hydration support, conservative management, and potential rehabilitation of her left hip.

After admission, additional investigations show that she has

metastases to her liver and kidneys. Rose's oncologist proposed a plan of care, which was translated by her son, including chemotherapy and resection with a likely chance of the insertion of a permanent ileostomy. Rose denies treatment and states to her son, "I can't do any more chemo and if I have to learn how to deal with the ileostomy…I just can't…I don't want to die lying in a hospital bed". Rose's son then translates this to the oncologist. The oncologist believes that Rose may feel overwhelmed and may not fully understand the plan due to language discordance. He also believes that she may not understand the intention of treatment. The oncologist then decides to use the hospital-designated translation line to explain further by stating that the chemotherapy and ileostomy will not cure cancer rather it will extend her life expectancy and improve her nutritional status. Rose replies to the hospital translator that she understands, but still does not wish to move forward with treatment and the oncologist suggests Rose meet with the palliative care team. Rose's son then intervenes and asks for time to consider the treatment plan. As Rose's son objects to her decision, she then expresses to her son and the hospital translator that she has "lived her life", accepted her diagnosis and is at peace with God. The oncologist ends his conversation with Rose and leaves the room. Rose assures her son that this is her final decision; however, she is apprehensive about meeting with the palliative care team as she believes they only assist in speeding up the process of dying and seeks more information. After her son translated the information from the medical-surgical nurse on the services provided by palliative care, Rose decides to move forward with meeting the palliative care team. After completing bedrest, Rose is then discharged to a rehabilitation center for her left hip with palliative support in place to follow her care.

Questions

Questions:

1. How does the nurse consider intrapersonal, interpersonal and contextual phenomena related to the provision of nursing care for Rose near the end of her life?
2. What are the unique needs of the older adult living with a chronic illness?
3. How do various sources of information influence nursing actions?

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SELF MANAGEMENT

Learning Objectives

By the end of this chapter, you will be able to:

1. Analyze the role of the nurse in the planning of care for clients and families living with chronic illness.
2. Through the process of relational practice, identify appropriate therapeutic nursing strategies that embrace the client's diverse history and life story.
3. Understand the scope of practice for the nurse in caring for clients with chronic illness.

Case Study

Jamal Phiri is a Canadian-born 17-year-old diagnosed with asthma at the age of 9. He identifies as a transman and uses the pronouns he/him. Since then he has had four pediatric ICU admissions for acute asthma exacerbation, one in which he was intubated. He has no other past medical history and is currently taking Breo Ellipta daily with occasional use of rescue inhaler Ventolin. Jamal recently decided to go back to school as opposed to virtual schooling during the COVID-19 pandemic against his mother's advice. He is an only child and lives in a single parent home with his mother who works 2 jobs. Jamal's father blamed the mother for their "daughter's" gender identity and abandoned the family. He has been following up with his family doctor, however, Jamal has rescheduled his consultation with the respirologist 3 times. He asks the healthcare team to use the preferred name of Jamal.

For the past 3 days he has been having increased shortness of breath not completely relieved by his rescue or maintenance inhaler. Jamal was sent to the emergency department by the principal when he was found to be short of breath after participating during the gym class. Presenting to the emergency department he has a temp of 37.9°C, 2-3 word dyspnea, audible wheezes, and accessory muscle use. Jamal's past medical visits are well documented within his medical record and after the physician assesses Jamal, he orders an urgent consultation with the ICU physician while Jamal is stabilized by the nurse and respiratory therapist. Jamal had a septic diagnostic tests completed (CBC, electrolytes, blood cultures x 2, lactate level, venous blood gas, urinalysis, chest x-ray and a COVID-19 swab) and is placed on Bilevel Positive Airway Pressure (BiPAP) by the respiratory therapist. Jamal is being administered steroids, bronchodilators, and antibiotics when the ICU physician assesses and admits him to the ICU.

You are Jamal's ICU nurse and are receiving a report from the emergency nurse who states that Jamal's blood chemistry and venous blood gas are pending as the first samples sent where hemolyzed and could not be analyzed by the lab. The emergency nurse states he attempted to call his mother three times with no answer and left two messages with call back information. After receiving the report, you assess Jamal and get him settled into his bed as the respiratory therapist adjusts the BiPAP mask. While putting his belongings away you noticed that Jamal's medications were last refilled about two months ago. At this time, you note the following in his blood work: pH 7.30, PaCO2 39 mmHg, HCO3 19.5 mmol/L, lactate 15, potassium-2.8 mmol/L, and magnesium 0.51 mmol/L. You call the physician and inform her of the lab values, and she orders for electrolyte correction and repeat blood work 1-hour post administration.

After administering ordered medications, you call Jamal's mother again and she answers. When speaking to her you realize that she is often not home and most of the responsibility of filling his prescriptions, taking daily medications, and getting to and from appointments falls on Jamal. She was also upset to find out that Jamal had returned to school as she received a call from the principal as well. Furthermore, she states she will not be able to come in until she is finished her shift in 2 hours.

As Jamal stabilizes and is down-graded to 40% FiO2 face mask you start asking him about his medications and triggers leading up to exacerbation. He believes that exercise could have been a factor of this exacerbation as he has not been able to renew any of the prescriptions due to his lost health card. He states that due to being busy with finishing up his last school year he has not had time to see his respirologist of renew his health card. As Jamal is answering your questions, his mother arrives and begins to engage in the conversation.

When Jamal is stabilized enough and ready to be transferred to the medicine unit you give a report to the medicine nurse and suggest that before discharge home there is a family meeting with

the interprofessional healthcare team to review his current plan of care, medications and follow up appointments to identify areas that need adjustment due to his asthma.

Case Study Expert Reviewer: Dr. Erin Ziegler

Questions

Questions:

1. What are some strategies that can be implemented for effective self-management of a chronic illness?
2. Highlight the systemic barriers and facilitators of self-management as it relates to this case.
3. Identify personal and familial barriers and facilitators of self-management in this case.
4. What social determinants of health impact Jamal's self-management with asthma?

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UNCERTAINTY AND SOCIAL ISOLATION

Learning Objectives:

By the end of this chapter, you will be able to:

1. Identify the unique needs of the older adult and their family living with chronic illness.
2. Analyze the role of the nurse in developing a plan of care for clients and families living with chronic illness.

Case Study

Ms. Katsitsanéron Tehya is an 85-year-old woman who has been living on her own in a large urban city since her partner died one-and-a-half years ago. She identifies as Two-Spirit, prefers to be called Katsitsanéron, and her pronouns are she/her. She has no children; however, she has a niece that lives about two hours away. Her niece calls to check in on her aunt twice a week and visits occasionally. Lately, while speaking to Katsitsanéron her niece has noticed some slightly odd behaviours and lapses in her memory. Starting about two weeks ago she noticed a gradual worsening of Katsitsanéron's ability to remember certain things, forgetting what time of day it was and misplacing items, she also noticed that at times her aunt had difficulty finding words when they would speak. Concerned that these behaviours were progressing, Katsitsanéron's niece decided to visit her. When she arrived, Katsitsanéron stated that she was surprised to see her niece despite the arrangements they made together. When visiting Katsitsanéron's niece is surprised to notice that Katsitsanéron appeared as though she has not showered in several days and her home had several dirty dishes including pots with burn marks. In trying to assist her to bathe and change into clean clothes, her niece notices that Katsitsanéron has difficulty changing positions from sitting to standing and walking. Her niece then asked her if she is having pain and she states, "Yes in both of my hips…my arthritis is acting up again…".

In a medical clinic, you are the nurse registering Katsitsanéron. You complete her initial assessment and document the observation from Katsitsanéron's niece as the primary presenting concern. Katsitsanéron's vital signs are as follows: blood pressure 145/69, heart rate 82, temperature 36.7, oxygen saturation 97% on room air, and respiration rate 18. When asking Katsitsanéron about her past medical history she answers, "I am pretty healthy". Her niece then interjects and states that she has a history of high blood pressure

and osteoarthritis. You complete her neurological examination and note that she is alert but disoriented to time. Katsitsanéron is able to tell you her name, however, she is unable to recall her age and states an incorrect birth month initially and then corrects herself. Katsitsanéron has diminished grip strength bilaterally in her hands due to Heberden and Bouchard nodes from her osteoarthritis. The primary care provider orders blood work and a CT scan after assessing Katsitsanéron. When you ask about her social networks, her niece states that Katsitsanéron has been living alone since her partner died and she seemed to be coping well until recently. She also explained that she has no children, two of her close friends recently passed away, and she does not attend any social groups.

After Katsitsanéron's evaluations were complete, she is diagnosed with both middle-stage Alzheimer's disease and a flare-up of her osteoarthritis. The primary care provider states that she needs around-the-clock supervision, assistance with daily personal care, and increased social interaction. This can be achieved through a change in her living circumstances and becoming a part of social support groups. Although very conflicted due to her own responsibilities and financial constraints, Katsitsanéron's niece eventually decides to move Katsitsanéron into her home and assume the role of primary caregiver.

After about a month, during the home visit, the nurse asks Katsitsanéron and her niece, "How are you managing? How are you dealing with daily life?" Katsitsanéron's niece states, "Everything is generally okay". The nurse notices that Katsitsanéron's niece appears uneasy and fatigued, and decides to inquire further and asks: "At this point what do you think we can put in place that would help support you?". After some encouragement, she states "I need help during the daytime for someone to watch her. My husband works two jobs and I can't run errands if I need something. The other day I ran to the store to pick up a few items while she was having a nap and when I returned home, I saw her walking down the street in her nightgown…every day I am in constant fear

that she will wander, misplace something or fall". The nurse continues to listen to all of Katsitsanéron's niece's concerns and begins to coordinate some support and resources to address each concern.

Case Study Expert Reviewer: Suzanne Ezekiel

Questions

Questions:

1. What does "good" practice with family look like to you (from Family Nursing as discussed by Doane and Varcoe (2014) in Relational Inquiry, p 285)?
2. Consider the empirical information given in this case. What other types of knowledge would you need to care for Katsitsanéron and her niece? How would this inform your nursing practice (p. 285)?
3. What are the sources of uncertainty in this case?
4. What is the role of social isolation within the concept of uncertainty?

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COLLABORATIVE PRACTICE

Learning Objectives:

Beginner questions to test knowledge and reflect:

1. What is the difference in meaning between interprofessional, intraprofessional, and interdisciplinary?
2. What hinders interprofessional collaboration in providing care for Mr. Burgess?
3. What strategies can be used to improve communication between the interprofessional team? Reflect on all the different social and healthcare professionals that provide care to clients on a given day in the following settings: day surgery, medicine floor, intensive care unit, primary care office, community healthcare, and mental healthcare setting.
4. How do their roles and responsibilities influence and complement each other in order to achieve care goals?

Case Study

Daniel Burgess is a 65-year-old male with chronic kidney disease. Mr. Burgess lives at home alone. He often forgets to take his medications. Mr. Burgess previously had an acute episode of kidney failure requiring hemodialysis.

Mr. Burgess develops end-stage kidney failure and is admitted to the hospital. The nephrologist tells him that he requires a peritoneal dialysis catheter. Later, a surgeon explains to him the reason for the procedure along with the risk and complications. Mr. Burgess reluctantly agrees. The operating room (OR) nurse prepares him for the procedure and performs a pre-procedure questionnaire. After the procedure, Mr. Burgess is transferred to a nephrology unit. You are the nephrology nurse who will be providing care for Mr. Burgess. You receive a detailed report from the OR nurse.

You introduce yourself to Mr. Burgess, take his vital signs and perform an initial head-to-toe assessment. You demonstrate the first peritoneal dialysis exchange and educate Mr. Burgess about exchanges at home. You also educate him on being aware of the signs and symptoms of infection. After a few days in the nephrology unit, Mr. Burgess is ready to be discharged home with homecare services and support. You discharge him home on Friday afternoon and assure him that the hospital will set up the homecare service to perform the next peritoneal dialysis exchange for him. Usually, the social worker makes this referral to a home care service. You place a note on the social worker's desk and write "Please set up home care services for Daniel Burgess MRN #1220932 for Saturday, November 16th".

Saturday afternoon arrives, and Mr. Burgess still has not heard from the homecare service or the hospital. He gets worried that they forgot about him. He calls the homecare service agency and they state "Sorry we don't have your information on record". He

calls the hospital to follow up. The nurse from the previous day and the social worker were not back at work. The charge nurse is unaware of the circumstances. They have no choice but to call you, on your day off, to find out whether the referral was made. You reply, “Yes, I put a note on the social worker’s desk”. The unit finds that the note was not received by the social worker, as she had to leave work early. Due to the miscommunication, and the referral not being made, Mr. Burgess did not receive his peritoneal exchange on the Saturday when it was supposed to be due.

Questions

Questions

1. What hinders interprofessional collaboration in providing care for Mr. Burges? What were some aspects that went wrong with the interprofessional collaboration? How will this impact the quality of care for Mr. Burgess?
2. What strategies can be used to improve communication between the interprofessional team?
3. Reflect on all the different social and healthcare professionals that provide care to clients on a given day in the following settings: day surgery, medicine floor, intensive care unit, primary care office, community healthcare, and mental healthcare setting.
4. How do the social and healthcare professionals' roles and responsibilities influence and complement each other in order to achieve care goals?

ADHERENCE AND CONCORDANCE

Learning Objectives:

By the end of this chapter, you will be able to:

1. Identify the ideologies that are dominant in this case (those of Mr. Levy, the team, and the nurse). (Family Nursing as Relational Inquiry, p. 280)
2. Identify your own ideologies of adherence and identify how they might influence your nursing practice and care of Mr. Levy and his family (Family Nursing as Relational Inquiry)
3. Analyze the role of the nurse in the planning of care for clients and families living with chronic illness.
4. Assess the range of approaches and strategies for supporting the health of the adult and older adult populations.

Case Study

Mr. Jeremy Levy is an 89-year-old cis-gendered man with a past medical history of uncontrolled hypertension, a myocardial infarction with the placements of two stents, high cholesterol, diabetes, and gastroesophageal reflux disease. He has currently been prescribed a variety of medications, including lasix, amlodipine, metformin, sitagliptin, aspirin, pantoprazole and rosuvastatin. His primary care provider has connected with his cardiologist and endocrinologist and discovered that he has missed appointments with them. In the times that he has shown up to his appointments his blood pressure and point-of-care blood glucose have consistently been elevated and when asked whether he was taking his medications as prescribed Mr. Levy responded, "There are too many to keep track of" and admitted that he took the blood pressure medications but not every day.

Today Mr. Levy shows up to the clinic hoping to be seen by the primary care provider, although he has no scheduled appointment. You are the nurse completing Jeremey's intake forms, he states that he is feeling weak and drowsy for the past three days with muscle cramps in his arms and legs, and some intermittent abdominal pain. You document his presenting concerns and assess his vital signs noting BP 93/59 and HR 115 bpm. You noticed the A-72994 tattoo on his arm and try to be friendly and state, "Cool tattoo" and instruct Mr. Levy to wait while you speak with the primary care provider to determine if he can be seen and he interrupts you and states firmly "well am I going to be seen or not? Don't waste my time". You repeat yourself and ask him again to wait while you speak with the primary care provider. You inform the doctor of Mr. Levy's presenting signs and symptoms. The doctor agrees to assess Mr. Levy right away and instructs you to arrange for a transfer via ambulance to the emergency department. As you wait with Mr. Levy, you discover he has recently travelled and forgotten his

medications and then decided to double up on his medications two days ago.

The ambulance arrives and transports Mr. Levy to the nearest emergency in which he is brought into the subacute area after being triaged. Mr. Levy is then assessed by the emergency physician who also reads the note that was sent by Mr. Levy's family doctor. Mr. Levy is then ordered to have blood work including a blood glucose level, electrocardiogram and Normal Saline 0.9% 1L IV bolus. The emergency doctor diagnosed Mr. Levy with mild hyperglycemia and severe electrolyte imbalance presumably due to the double dosing of his medications. He is then ordered electrolyte replacement of his potassium, magnesium, and calcium.

Mr. Levy is given a referral to be assessed by the pharmacist, endocrinologist, diabetic nurse educator and nutritionist. When the doctor explained the extreme seriousness of the situation to Mr. Levy, he was then agreeable to meeting other members of the healthcare team. After each team member's individual assessment, the team collectively agreed that Mr. Levy has difficulty with his medication regimen. The interprofessional team discussed changes needed to address his current medical issues and decided to admit him to the hospital. Mr. Levy was apprehensive about being admitted to the hospital and he decided to contact his two daughters for assistance. One daughter informs you, "Papa is a holocaust survivor so he is often fearful of being admitted to the hospital." As he informs both of his daughters of the situation, they meet with their father and the healthcare team to collectively generate a plan to support Mr. Levy once he is discharged home.

Questions

Questions

1. What factors and health beliefs can influence adherence to a medical regimen?
2. How does Mr. Levy's behaviour influence the therapeutic nurse-client relationship?
3. What individual and systemic biases exist about Mr. Levy?

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EMPOWERMENT

Learning Objectives:

By the end of this chapter, you will be able to:

1. Analyze the client's sources of power and disempowerment.
2. Identify and explain key values found in client empowerment.

Case Study

Liang Wong is 42 years old and presenting to the mental health clinic after a hospitalization for an altered level of consciousness due to fentanyl poisoning. He has been cleared by the psychiatrist and referred to the clinic for follow-up. Mr. Wong has a past medical history of bipolar disorder, depression, a spinal cord injury leading to paraplegia in bilateral legs and a history of ethanol and fentanyl substance use disorder. Mr. Wong uses a power scooter for mobility.

As Mr. Wong's nurse, you complete an initial assessment to identify Mr. Wong's current needs and any resources that may be beneficial for him. When completing his assessment, Mr. Wong informs you that he has no permanent housing as he was living with his partner who broke up with him 2 weeks ago. Since then he has been living temporarily in shelters and on the streets. He was asked to leave a shelter due to his drug use, and he has been searching for another shelter. Mr. Wong states that he was coping well and was clean for 8-months prior to his partner breaking up with him and kicking him out of their apartment. You ask him about any additional familial and social support; he states that he has one brother and one sister, and both are uncomfortable with him living with them because they have young children. When asked how he financially supports himself, he states that he applied for disability support, however, received a denial letter about 3 months ago. He states that he was denied due to expired status documents that had to be renewed in addition to omitting a document from his family doctor, which he has been unable to acquire due to transportation issues. Additionally, Mr. Wong admits that he has not been taking his medications regularly or attending his narcotic support group meeting since the breakup. He states, "I was feeling depressed and embarrassed… I just need help now to get back on track".

As you complete his assessment you highlight several needs for Mr. Wong and note his motivation to get better with the individualized support in place. In an interprofessional meeting, you collaborate with the physician and the social worker (SW) to coordinate a feasible plan of care. The SW suggests a detox shelter for Mr. Wong and also joining the clinic's street health identification support program so that he can get the documents he needs to apply for the disability program. The SW finds Mr. Wong a nearby primary care provider and books his initial appointment. Mr. Wong states he is willing to go to detox and he will attend his follow-up appointments.

Mr. Wong visits the clinic for his one-month follow-up. You interview him to assess his current status. Mr. Wong states that he had a minor setback when he relapsed once in rehabilitation and had to go to the hospital to be medically cleared so that he could return to rehabilitation. He attended his primary care provider appointment and is continuing with his Opioid Agonist Treatment program.

Questions

Questions

1. What is your current understanding of the nursing role within the context of empowerment?
2. What are some of the macro, meso and micro sources of power that influence both the nurse and the client?
3. What is the role of power within the concept of stigma?

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FAMILY CAREGIVING, COMPASSION FATIGUE, ELDER ABUSE

Learning Objective:

By the end of this chapter, you will be able to:

1. Explain the 5 types of abuse as defined by the CNO and understand its implications for clients (neglect, physical, verbal/emotional, financial, sexual).
2. Discuss compassion fatigue and its implications for safe, quality care delivery.
3. Discuss the role of the nurse as a client advocate.
4. Describe the mandatory reporting requirements for health professionals in Ontario.

Case Study

You are a new graduate Registered Nurse who recently started working at your first job in a long-term care facility. You oversee 25 patients and delegate to a few Registered Practical Nurses and Personal Support Workers. In the last month, you have been noticing some strange behaviour between a patient and their family member. Mr. Joshua Cordova is a 78-year-old resident that recently came to the long-term care (LTC) facility. His daughter used to be his main caregiver at home however, she brought him in because she stated she could no longer care for him. Mr. Cordova has multiple sclerosis and is quadriplegic. He requires total care with all his activities of daily living, including incontinence care, feeding, bathing, dressing, physiotherapy exercises and mental stimulation. Mr. Cordova is unable to communicate his needs verbally. Sometimes the staff can communicate with him through his blinking. When he arrived at the facility, he was malnourished, covered in bedsores and had incontinence dermatitis. Some staff members suspected that he was not properly taken care of at home. When you approached Mr. Cordova's daughter and questioned her about the bedsores and dermatitis, she stated that "He was too much to care for", and "I couldn't do it anymore".

Mr. Cordova's daughter visits her dad once or twice a month. You notice that each time Mr. Cordova's daughter visits, he seems frightened, withdrawn and emotional. You notice that his daughter stands over him, and always speaks to him in a loud and forceful tone. Her visits are often very short. One day, as you are making your way through the unit when you overhear Mr. Cordova's daughter yelling at her father about finances. In anger, she slams her hand down on his bedrail and pinches the skin on her father's arm. His arm instantly starts to bleed and the daughter, in frustration, grabs some Kleenex very firmly and holds her father's arm to stop the bleeding. Mr. Cordova grimaces in pain. You

interrupt the scene and replace the Kleenex with some clean gauze. You also ask Mr. Cordova's daughter to step out of the room as you call your manager in to help you. When your manager arrives, you explain what happened and dress the wound on Mr. Cordova's arm. You ask the daughter to leave the facility and indicate that Mr. Cordova should get some rest as he was quite upset. You also bring this information to the healthcare team to discuss the situation that transpired and the next steps.

Questions

Questions

1. Based on your previous clinical and personal experience, reflect on the advantages and disadvantages of the person being cared for at home. List some examples from the perspective of the client and the caregiver.
2. Identify the factors that led to Mr. Cordova's daughter's caregiving burnout and compassion fatigue.
3. How do you advocate for the client's safety as a nurse?
4. What personal and workplace strategies would help prevent the abuse of clients?

DIGITAL HEALTH

Learning Objectives:

By the end of this chapter, you will be able to:

1. Recognize nurses' accountabilities when providing care using digital health technologies.
2. Identify legal and ethical implications related to using digital health technologies in the clinical setting.
3. Discuss the significance of assistive digital health technologies for clients living with chronic diseases.
4. Identify the barriers to accessing and utilizing digital health technologies for some people living with chronic diseases.

Case Study

Tameka Jones is a 37-year-old, Black woman with a diagnosis of Type II diabetes who comes to the Emergency Room (ER) with a 4-day history of nausea, vomiting, polydipsia, and polyuria. She was diagnosed with Type II diabetes three years ago and was started on oral hyperglycemic agents. Ms. Jones wears a device which continually monitors her blood sugar levels. However, Ms. Jones often misses doses of her medications. The ER doctor orders blood work and urine analysis. Ms. Jones' laboratory results show an anion gap, hyperglycemia, and metabolic acidosis. She is admitted to the Intensive Care Unit (ICU) unit for diabetic ketoacidosis. You are her nurse and start to treat her with intravenous fluids and insulin-glucose infusion. You need to check Ms. Jones' blood sugar level every hour to titrate the amount of insulin Ms. Jones receives accordingly. As the ICU is a very busy environment, you did not have the time to explain to Ms. Jones the reasons for the frequent blood glucose checks you are performing.

Ms. Jones is starting to become uncomfortable with being pricked every hour. Ms. Jones asks you, "Why can't you use my blood sugar monitor?". My friend, who was admitted to the ICU last week for a similar issue was allowed to use her blood sugar monitor and share the readings with the nurses and doctor."

You respond that you need to follow the hospital policies and that you must use the hospital's blood glucometer to ensure the accuracy of the readings as you are not familiar with Ms. Jones' device. As well, the value obtained by the hospital blood glucometer is automatically transmitted into the computerized charting system to be accessed by other healthcare providers involved in Ms. Jones' care. Ms. Jones states, "I feel like you are hurting me for no reason. It is clear that hospital policies are set differently for each patient as my friend was allowed to do this on this same unit." You respond

that you will investigate this situation and address the patient's concerns before the end of your shift.

Upon reflection, sitting at the nursing station, you realize that Ms. Jones has not been provided with enough information about the procedure at the beginning. You also are aware that some of your colleagues do not always follow hospital protocols, policies, and best practices. You decide to consult with the nursing educator on the unit about how to best proceed with the patient.

The next hour, when you enter the room again to check her blood sugar, Ms. Jones refuses and states that her fingers are too sore to be pricked again. You pull up a chair beside Ms. Jones's bed and sit down to have a conversation with her. You take the time to explain the hospital policies, share a pamphlet with her on the care protocol the healthcare team needs to follow for a patient with diabetic ketoacidosis and acknowledge that this is the most evidence-based way to provide treatment for a patient with such a clinical presentation. Ms. Jones thanks you for the time you spent communicating this information with her and proceeds to give consent for the continuation of the hourly blood glucose monitoring using the hospital-grade device.

Case Study Expert Reviewer: Dr. Nadia Prendergast

Questions

Questions

1. How can you utilize the client's digital health device to support the delivery of evidence-informed care?
2. How does using a client's personal digital health device create challenges for nurses?
3. What are the legal and ethical implications related to using digital health technologies?
4. How do wearable technologies create further disparities in healthcare?