**Chapter 23 – Legal Implications in Nursing Practice**

**Administrative law** – aka regulatory law. More clearly defines expectations of civil and criminal law

**Battery** – intentional offensive touching without consent or lawful justification.

**Case law** – describes decisions made in legal cases that were resolved in courts.

**Civil law** – protect the rights of individuals and provide for fair and equitable treatment when civil wrongs or violations occur

**Common law** – originates from decisions that were made in the absence of law.

**Constitutional law** – derived from federal and state constitutions.

**Criminal law** – protect society and provide punishment for crimes which are defined by municipal, state, and federal legislation.

**Defamation of character** – publication of false statements that result in damage to a person’s reputation.

**Durable power of attorney for health care (DPAHC)** – written legal document that allows patient to express wishes regarding health care.

**Informed consent** – patient’s agreement to have a medical procedure after receiving full disclosure of risks, benefits, alternatives, and consequences of refusal.

**Intentional tort** – deliberate acts against a person or his or her property that may result in both civil and criminal actions.

**Libel** – written defamation of character

**Malpractice** – type of negligence

**Neglect** – pattern of conduct by a person with a duty of care to provide services that maintain the physical and/or mental health of a child or vulnerable adult.

**Negligence** – conduct that falls below the generally accepted standard of care of a reasonably prudent person.

**Nurse Practice Acts** – civil state laws that define nursing and the standards you must meet within individual states.

**Occurrence report** – incident report

**Professional licensure defense** – expensive. Assists nurse if license is challenged.

**Risk management** – involves several components, including identifying possible risks, analyzing them, acting to reduce the risks, and evaluating the steps taken to reduce them.

**Scope of nursing practice** – defines nursing and reflects the values of the nursing profession.

**Slander** – occurs when one speaks falsely about another.

**Standard of proof** – typically what a reasonably prudent nurse would do under similar circumstances in the geographic area in which the alleged breach occurred.

**Standards of nursing care** – reflect the knowledge and skill ordinarily possessed and used by nurses.

**Statutory law** – derived from statutes passed by the US Congress and state legislatures.

**Torts** – civil wrongful acts or omissions made against a person or property.

**Unintentional torts** – arise when a person is harmed and the person inflicting harm knew, or should have known, that his or her actions were less than the accepted scope and standard of practice.

**Legal Limits of Nursing**

**Sources of Law**

\*Constitutional Law comes from federal and state constitutions. An example would be the right to refuse treatment.

\*Statutory law comes from statutes passed by the US Congress and state legislatures. They can be civil or criminal.

 a. Civil laws: protect our rights and provide for fair and equitable treatment

 1. Nurse Practice Acts are civil laws that define nursing and nursing standards.

 b. Criminal Law come from municipal, state, and federal legislation. Can be classified as a

misdemeanor or felony.

 1. Mistreatment of vulnerable adults is a criminal statutory crime, and can be a misdemeanor or

felony depending on the severity of harm to the patient.

\*Administrative or regulatory law: defines expectations of criminal and civil law.

a. nurses who violate regulatory law knew or should have known their actions could result in patient harm.

\*Common Law – judicial decisions

\*Case law – precedents

**Scope and Standards of Nursing**

\*Standards of nursing care are derived from health care laws, best practice guidelines, EBP.

\*The Joint Commission (TJC) requires written nursing policies and procedures that are accessible on all nursing units.

**Standard of Proof**

In a malpractice suit a nurse had a certain responsibility that she failed to do which caused the patient harm and, in that case, monetary compensation is allowed.

\*Standard of proof is evidence showing that the nurse did not perform her duty causing harm to the patient.

**Federal Statutes Impacting Nursing Practice**

**Patient Protection and Affordable Care Act**

\*PPACA Passed in 2010

\*Renamed Affordable Care Act

\*4 themes

 1. Consumer rights and protections

 2. Affordable health care coverage

 3. Increased access to health care

 4. Quality of care that meets the patient’s needs.

\*Healthcare coverage cannot be denied because of a preexisting condition

\*No limits on the amount of care for said conditions.

\*ACA reduced overall cost by

 1. Providing tax credits

 2. Increasing insurance company accountability for premiums and rate increases

 3. Increasing the number of choices available to patient to select insurers that best meet their needs.

**Emergency Medical Treatment and Active Labor Act**

\*EMTALA passed in 1986

\*Prohibits the transfer of patients from private to public hospitals without appropriate screening and stabilization.

**Health Insurance Portability and Accountability Act**

\*HIPPA passed in 1996

\*Provides rights to patients and protects employees

\*Establishes the basis for privacy and confidentiality concerns

 1. Privacy: The right of the patient to keep personal information from being disclosed

 2. Confidentiality: Protects private patient information once it is disclosed in health care settings

**Health Information Technology Act**

\*HITECH passed in 2009

\*Passed in response to new technology and social media

**Americans with Disabilities Act**

\*ADA passed in 1990 and was amended in 2008

\*Civil rights statute that protects people with physical or mental disabilities.

**Mental Health Parity and Addiction Equity Act**

\*MHPAEA passed in 2008

\*Requires insurance companies to provide mental health and substance use disorder treatment

**Patient Self Determination Act**

\*PSDA passed in 1991

\*Institutions must provide written information to patients concerning their rights to make decisions about their care including the right to refuse treatment and to formulate an advance directive.

**Uniform Anatomical Gift Act**

\*UAGA passed in 1987

\*Foundation for the national organ donation system

\*When a person dies a qualified healthcare provider asks the family about organ donation in the following order

 1. Spouse

 2. Adult son or daughter

 3. Parent

 4. Adult brother or sister

 5. Grandparent

 6. Guardian

\*National Organ Transplant Act (1984) prevents the purchase or sale of organs.

**Omnibus Budget Reconciliation Act**

\*OMBRA passed in 1987

\*Protects older adults

\*Addresses the use of chemical and physical restraints

 \*Must be a last resort

 \*Must be continually monitored to assure they are safe

 \*Must be assessed within 1 hour of applying restraints

 \*Can only be used to ensure physical safety of the patient and others

 \*Used only when other less restrictive interventions are unsuccessful

 \*Can only be used with a written order from a health care provider

**State Statutes Impacting Nursing Practice**

\*Gibbons vs Ogden (1824) – regulations and licensure is to be handled by each state

**Nurse Practice Act**

\*State laws that protect citizens, make nurses accountable and ensure that care is consistent.

\*State boards educate the public and nurses as the profession changes

**Informed Consent and Health Care Acts**

\*Describe and define the minimum standards of care that will be provided within their geographic region.

\*Signed consent forms are required for admission to a health care agency and for invasive procedures

\*Informed consent includes risks, benefits, alternatives, and consequences of refusal.

\*Treating without consent is battery

\*The person responsible for the procedure is responsible for obtaining consent. The nurse can witness the patient’s signature

**Key elements of informed consent include the following:**

* 1. The patient receives an explanation of the procedure or treatment.
* 2. The patient receives the names and qualifications of people performing and assisting in the procedure.
* 3. The patient receives a description of the serious harm, including death, that may occur as a result of the procedure and anticipated pain and/or discomfort.
* 4. The patient receives an explanation of alternative therapies to the proposed procedure/treatment and the risks of doing nothing.
* 5. The patient knows that he or she has the right to refuse the procedure/treatment without discontinuing other supportive care.
* 6. The patient knows that he or she may refuse the procedure/treatment even after the procedure has begun.

**Good Samaritan Laws**

\*Protects health care professionals when assisting in emergency situations.

\*Must only provide interventions that are in scope of practice and trained for.

\*Must stay with the patient until they can be transferred to someone who can provide needed medical care.

**Public Health Laws**

\*Nurses have a legal duty to provide care to protect public health

 \*Report suspected abuse

 \*Neglect of a child, older person, or suspected domestic violence

 \*Report communicable diseases

**Uniform Determination of Death Act**

\*Two standards for determining death

 1. Cardiopulmonary: irreversible cessation of circulatory and respiratory functions

 2. Whole-brain: irreversible cessation of all functions of the entire brain including the brainstem

\*Health care providers can use either the cardiopulmonary or who brain definition to determine death.

**Legal Implications and Issues Associated with Nursing Practice**

**Torts –** Civil wrongful acts or omissions made against a person or property

\*Intentional torts are deliberate acts against a person or his or her property that may result in both criminal and civil actions.

 1. assault – no contact required. Only a threat.

 2. battery – an intentional offensive touching without consent or lawful justification

\*Quasi Intentional Torts are acts in which a person may not intend to cause harm to another but does.

 1. invasion of privacy: releasing a patient’s health care information to an unauthorized person

 2. Defamation of character is the publication of false statements that result in damage to a person’s reputation.

 3. Slander occurs when one speaks falsely about another

 4. Libel is the written defamation of character

\***Unintentional** torts arise when a person is harmed and the person inflicting harm knew, or should have known, that his or her actions were less than the accepted scope and standard of practice.

 1. Negligence: conduct falls below standard of care of a reasonably prudent person.

 i.e., hanging the wrong IV bag

 2. Malpractice is a type of negligence that pertains to a professional.

 a. The nurse owed a duty of care

 b. the nurse did not carry out the duty

 c. the patient was injured because duty was not carried out

 d. patient is entitled to compensation

**Beginning and End of Life Nursing Issues**

\*Termination of pregnancy

 1. Roe V Wade (1973)

 1st trimester – right to terminate

 2nd trimester – the state has an interest in protecting maternal health

 3rd trimester – the interest of the state is to protect the fetus

 2. Webster V Reproductive Health Services (1989)

 -narrows Roe V Wade

 -some states require viability testing before conducting abortions

 -parental consent for minors

 - heartbeat laws

\*Death with dignity or Physician assisted suicide

 -Oregon Death with Dignity Act (1994) first statute that defined “death with dignity”

 -ANA believes that nurses’ participation in “death with dignity” violates the code of ethics for nurses

 -The American Association of Colleges of Nursing (AACN) supports that mandate to an ensure an individual’s peaceful end of life.

**Nursing Workforce Issues**

 \*Nursing Students

 -Nursing students are liable if their actions exceed their scope of practice.

 -Nursing students should perform only tasks that have been delegated to them.

 \*Staffing and Nurse to Patient Ratios

 -California fixed nurse-patient ratios in acute care settings are mandated by law

 -Safe staffing for Nurse and Patient Safety Act of 2018

 a. staffing committees: 55% will be direct care nurses

 b. develop and implement staffing plans for each unit

 c. results will be better care, decrease will occur in adverse events, nurse turnover and

hospital readmission

 \*Nursing assignments

 -If floated and you don’t have the education or experience on the unit you must inform the

supervisor.

-Request an orientation to the unit

 \*Patient Abandonment

 -Occurs when nurse refuses care to a patient after nurse patient relationship has been established.

 -Before establishing a relationship the nurse can refuse an assignment if

 1. The nurse lacks knowledge or skill to provide care

 2. Care exceeds the nurse practice act

 3. Health of Nurse or unborn child of nurse is threatened

 4. Orientation to unit hasn’t been completely

 5. Clearly states and documents conscientious objection on moral, ethical, or religious

Grounds

6. Clinical judgement impaired b/c of fatigue

 \*Nurse Delegation

 -Responsible to educate, observe, and verify non nurse can do a specific task

**Risk Management and Performance / Quality Improvement**

\*Performance improvement focuses on human performance

\*Quality improvement focuses on work processes.

\*Risk Management

 a. identifying possible risks

 b. analyzing them

 c. acting to reduce risks

 d. evaluating steps taken to reduce risks

\*Never events are preventable errors

 a. falls

 b. CAUTI

 c. pressure injury

**Nurse experts**

\*Testifies on nursing standard of care

\*Darling V Charleston Community Memorial Hospital (1965)

 a. advocate for your patient

 b. escalate to charge nurse if need be

**Review Questions**

**1. A nurse is planning care for a patient going to surgery. Who is responsible for informing the patient about the surgery along with possible risks, complications, and benefits?**

1. Family member

2. Surgeon

3. Nurse

4. Nurse manager

**2. A woman has severe life-threatening injuries, is unresponsive, and is hemorrhaging following a car accident. The health care provider ordered two units of packed red blood cells to treat the woman’s anemia. The woman’s husband refuses to allow the nurse to give his wife the blood for religious reasons. What is the nurse’s responsibility?**

1. Obtain a court order to give the blood.

2. Convince the husband to allow the nurse to give the blood.

3. Call security and have the husband removed from the hospital.

4. Gather more information about the wife’s preferences and determine whether the husband is her power of attorney for health care.

**3. A nurse sends a text message to the oncoming nurse to report that a patient refuses to take medication as ordered. What should the oncoming nurse do? (Select all that apply).**

1. Add this information to the board hanging at the patient’s bedside.

2. Tell the nurse who sent the text that the text is a HIPAA violation.

3. Inform the nursing supervisor.

4. Forward the text to the charge nurse.

5. Thank the nurse for sending the information.

**4. Which of the following actions, if performed by a registered nurse, could result in both criminal and administrative law sanctions against the nurse? (Select all that apply.)**

1. Reviewing the electronic health record of a family member who is a patient in the same hospital on a different unit

2. Refusing to provide health care information to a patient’s child

3. Reporting suspected abuse and neglect of children

4. Applying physical restraints without a written order

5. Completing an occurrence report on the unit

**5. A nurse received bedside report at the change of shift with the night-shift nurse and the patient. The nursing student assigned to 320the patient asks to review the patient’s medical record. The nurse lists patients’ medical diagnoses on the message boards in the patients’ rooms. Later in the day the nurse discusses the plan of care for a patient who is dying with the patient’s family. Which of these actions describes a violation of the Health Insurance Portability and Accountability Act (HIPAA)?**

1. Discussing patient conditions at the bedside at the change of shift

2. Allowing the nursing student to review the assigned patient’s chart before providing care during the clinical experience

3. Posting medical information about the patient on a message board in the patient’s room

4. Releasing patient information regarding terminal illness to family when the patient has given permission for information to be shared

**6. A patient is in skeletal traction and has a plaster cast due to a fractured femur. The patient experiences decreased sensation and a cold feeling in the toes of the affected leg. The nurse observes that the patient’s toes have become pale and cold but forgets to document this because one of the nurse’s other patients experienced cardiac arrest at the same time. Two days later the patient in skeletal traction has an elevated temperature, and he is prepared for surgery to amputate the leg below the knee. Which of the following statements regarding a breach of duty apply to this situation? (Select all that apply.)**

1. Failure to document a change in assessment data

2. Failure to provide discharge instructions

3. Failure to provide patient education about cast care.

4. Failure to use proper medical equipment ordered for patient monitoring

5. Failure to notify a health care provider about a change in the patient’s condition

**7. A man who is homeless enters the emergency department seeking health care. The health care provider indicates that the patient needs to be transferred to the city hospital for care before assessing the patient. This action is most likely a violation of which of the following laws?**

1. Health Insurance Portability and Accountability Act (HIPAA)

2. Americans with Disabilities Act (ADA)

3. Patient Self-Determination Act (PSDA)

4. Emergency Medical Treatment and Active Labor Act (EMTALA)

**8. A home health nurse notices significant bruising on a 2-year-old patient’s head, arms, abdomen, and legs. The patient’s mother describes the patient’s frequent falls. What is the best nursing action for the home health nurse to take?**

1. Document her findings and treat the patient.

2. Instruct the mother on safe handling of a 2-year-old child.

3. Contact a child abuse hotline.

4. Discuss this story with a colleague.

**9. Which of the following statements indicate that the new nursing graduate understands ways to remain involved professionally? (Select all that apply.)**

1. “I am thinking about joining the health committee at my church.”

2. “I need to read newspapers, watch news broadcasts, and search the Internet for information related to health.”

3. “I will join nursing committees at the hospital after I have completed orientation and better understand the issues affecting nursing.”

4. “Nurses do not have very much voice in legislation in Washington, DC, because of the nursing shortage.”

5. “I will go back to school as soon as I finish orientation.”

**10. You are floated to work on a nursing unit where you are given an assignment that is beyond your capability. Which is the best nursing action to take first?**

1. Call the nursing supervisor to discuss the situation.

2. Discuss the problem with a colleague.

3. Leave the nursing unit and go home.

4. Say nothing and begin your work.

Answers:1. 2; 2. 4; 3. 2,3; 4. 1,4; 5. 3; 6. 1,5; 7. 4; 8. 3; 9. 1,2,3; 10. 1.

**Flashcards**

**1. What 4 D’s need to be present for malpractice to occur? Pg. 314**

Duty of care

Duty of care is breached

Breach of Duty of care causes patient harm

Damages awarded to patient for breach of duty of care

**2. What are Good Samaritan Laws? Pg. 313**

Medical workers are encouraged to intervene in emergency situations. They are protected from prosecution as long as they are working in their scope of practice.

**3. Name 2 unintentional torts? Pg. 314**

Libel – written defamation of character

Slander – speaking falsely about someone

**4. What are Nurse Practice Acts? Pg. 311**

Civil laws that protect patients and nurses. They define nursing practice and standard of care.

**5. What is the difference between slander and libel? Pg. 314**

Libel – written

Slander – spoken

**6. What does informed consent mean? Pg. 313**

Patient’s agreement to have a procedure after receiving full disclosure of risks, benefits, alternatives, and consequences of refusal.

**7. Name 2 intentional torts: Pg. 314**

Intentional – deliberate. Assault or battery

Quasi Intentional – not intended to cause harm but does. Defamation of character, libel, slander.

**8. What is EMTALA? Pg. 308**

Emergency Medical Treatment and Active Labor Act. Basically, they have to assess and stabilize you before they discharge you or send you elsewhere.

**9. What is HIPPA? Pg. 308**

Health Insurance Portability and Accountability Act. Basically, it protects patients PHI.

**10. What is a statutory law? Pg. 306**

Derived from statutes passed by the US Congress or state legislatures. Can be criminal or civil.

**Chapter 26 – Informatics and Documentation**

**Accreditation –**

**Acuity rating system –** determines the hours of care and number of staff required for a given group of patients every shift or every 24 hours.

**Case management –** incorporates an interprofessional approach to delivery and documentation of patient care.

**Charting by exception (CBE) –** all standards for normal assessment findings or routine care activities are met unless otherwise documented.

**Clinical decision support system (CDSS) –** computerized program that aids and supports clinical decision making.

**Clinical information system (CIS) –** known as a patient care information system is a large, computerized database management system that is used to access patient data needed to plan, implement, and evaluate care.

**Clinical practice guidelines (CPG –** facilitate the creation and documentation of a nursing and or interprofessional plan of care.

**Computerized provider order entry (CPOE) –** allows health care providers to directly enter standardized, legible, and complete orders for patient care into a medical record from any computer in the healthcare information system.

**Critical pathways –** interprofessional care plans identify patient problems, key interventions, and expected outcomes within an established time frame.

**Diagnosis-related group (DRG) –** classifications based on a hospitalized patient’s primary and secondary medical diagnoses that are used as the basis for establishing Medicare reimbursement for patient care.

**Documentation –** key communication strategy that produces written account of pertinent patient data, clinical decisions and interventions, and patient responses in a health record.

**Electronic health record (EHR) –** an individual’s lifetime computerized record. Improved quality, safety, and efficiency of health care.

**Electronic health record system (EHRS)**

**Electronic medical record (EMR) –** a patient’s record within an integrated health care information system for an individual visit to a health care provider’s office and for an individual admission to an acute care setting that allows for seamless documentation of the progression of care.

**Firewall –** combination of hardware and software that protects private network resources from outside hackers, network damage, and theft or misuse of information.

**Flow sheets –** graphic records that are organized by body system and navigated through use of the computer mouse with a series of tabs or rows.

**Health care informatics –**

**Health care information system (HIS) –** computer hardware and software dedicated to collection, storage, processing, retrieval, and communication in a healthcare organization.

**Health information technology (HIT) –** use of information systems and other information technology to record, monitor and deliver patient care, and to perform managerial and organizational functions in health care.

**Health record –**

**Incident (occurrence) report –** completed whenever an incident occurs.

**Meaningful use –** improves the quality and value of health care.

**Narrative documentation –** is the format traditionally used by nurses and health care providers to record patient assessment, clinical decisions, and care provided; it consists of a story like format to document information.

**Nursing clinical information system (NCIS) –** incorporates the principles of nursing informatics to support the work that nurses do by facilitating documentation of nursing process activities and offering resources for managing nursing care delivery.

**Nursing informatics –** specialty that integrates nursing science, computer science, and information science to manage and communicate data, information, knowledge, and wisdom in nursing and informatics practice.

**Password –** collection of alphanumeric characters and symbols that a user types into a computer sign on screen before accessing a program after the entry and acceptance of an access code or username.

**Protected health information (PHI) –**

**Standardized care plans –** facilitate the creation and documentation of a nursing and or interprofessional plan of care.

**Variances –** unexpected outcomes, unmet goals, interventions not specified within a critical pathway.

\*Documentation is critical to nursing. You must document assessment data, nursing problems or diagnosis, interventions, and evaluation of patient responses in the health record.

\*There are 11 never events that CMS will not pay for. 4 of them are nursing related.

 1. Stage 3 and 4 pressure injuries

 2. Falls with injury

 3. CAUTI

 4. Central line associated blood stream infection - CLABSI

**Purpose of the Health Care Record**

\*Provides a legal record of care

\*Resource for education and research

\*Justification for billing and reimbursement

**Interprofessional Communication Within the Health Record**

\*The health care record is the most current and accurate source of information about a patient’s health care status

\*Health records contain:

 1. patient identification and demographic data

 2. Living will or durable power of attorney

 3. Informed consent for treatment and procedures

 4. Admission data

 5. Nursing diagnosis and care plan

 6. Record nursing treatment and evaluation

 7. Medical history

 8. Medical diagnosis

 9. Therapeutic order (i.e., DNR)

 10. Medical and interprofessional progress notes

 11. Physical assessment findings

 12. Diagnostic study results

 13. Patient Education

 14. Summary of operative procedures

 15. Discharge summary and plan

**Legal Documentation**

\*Accurate documentation is one of the best defenses for legal claims associated with nursing care.

\*Documentation needs to follow organizational standards, clear descriptions, goal directed.

**Reimbursement**

\*Insurance companies use documentation when determining payment

**Auditing and Monitoring**

\*Audits help identify areas for improvement

**Education**

\*Reading the record of a patient is a good way to learn about the patient’s condition and response to treatment.

**Research**

\*Deidentification: a process use the prevent a patient’s identity from being connected with information.

\*Analysis of the data can be used for evidenced based nursing practice

**Electronic Documentation**

\*Use of an electronic health record system results in improved quality, safety and efficiency of health care.

\*Promotes active involvement in their care, increases coordination of healthcare delivery, advances public health, safeguards the privacy and security of personal health records.

**Maintaining Privacy, Confidentiality, and Security of the Health Care Record**

\*Nurses are permitted to use health records for data gathering, researching or continuing education as long as records are used as specified and permission is granted from an institutional review board or appropriate administrative department.

**Privacy, Confidentiality and Security Mechanisms**

\*Safety mechanism: automatic sign off

\*Access to health care records is tracked

**Standards and Guidelines for Quality Nursing Documentation**

\*Health care organizations usually incorporate accreditation standards into policies and revise documentation forms to suite these standards.

\*All patients must be assessed for

 1. Physical

 2. Psychosocial

 3. environmental

 4. self-care

 5. spiritual

 6. cultural

 7. knowledge level

 8. discharge planning needs

**Guidelines for quality Documentation**

\*Important characteristics

 1. Factual

 2. Accurate

 3. Current

 4. Organized

 5. Complete

\*When documenting

 1. Stick to the facts

 2. Write in short sentences

 3. Use simple, short words

 4. Avoid the use of jargon or abbreviations

**Factual**

\*Clear, descriptive, objective

\*Communicate facts not opinion (appears, seems, apparently)

**Accurate**

\*Use exact measurements

**Appropriate us of abbreviations**

\*Every health care institution has a list of standard abbreviations, symbols and acronyms use by all members of the health care team when documenting or communicating patient care and treatment.

**Methods of Documentation**

\*Nursing care can be documented using flow sheets which are graphic records that are organized by body system.

**Progress Notes**

\*Narrative documentation – traditional

\*Focus charting using DAR = Data, action, and response - story like format

\*SOAP notes = identifying interprofessional problems

 1. subjective data

 2. objective data

 3. assessment

 4. plan

\*Notes with a specific nursing focus, identifying nursing problems or diagnosis

**Charting by Exception**

\*The assumption is all standards for normal assessment findings or routine care activities are met unless otherwise documented.

\*WDL = within defined limits

\*WNL = within normal limits

**Common Record-Keeping Forms w/n The Electronic Health Record**

**Admission Nursing History Form**

\*Provides a baseline for comparison when patient condition changes

**Discharge summary forms**

\*Discharge planning begins at admission

\*Discharge summary should include

 1. step by step instructions on how to perform any procedure that the patient or family will be doing independently

 2. Identify precautions to follow when performing self-care or administering medication

 3. List signs and symptoms of complications that a patient needs to report to a health care provider

 4. List name and phone numbers of health care providers and community resources that the patient can contact

 5. Identify any unresolved problems, including plans for follow-up and continuous treatment

 6. List actual time of discharge, mode of transportation, and who accompanied the patient

**Documenting Communication with Providers and Unique Events**

**Telephone calls made to a provider**

\*Document every phone made to a provider

 1. when the call was made

 2. the number called

 3. who made the call

 4. who was called

 5. to whom information was given

 6. what information was given

 7. what information was received

**Acuity Rating Systems**

\*Determines the hours of care and number of staff required for a given group of patients every shift or every 24 hours

\*An acuity system classifies patients on a scale from 1 – 5 with 1 being independent in all but 1 or 2 aspects of care; almost ready for discharge and 5 being totally dependent in all aspects of care; requiring intensive care.

**Documentation in the Long-Term Health Care Setting**

\*RAI – resident assessment instrument

\*MDS – minimum data set

 1. completed on admission and periodically within specified guidelines and time frames for all residents in certified nursing homes.

 2. Determines level of reimbursement.

\*CAA – care area assessment

**Documentation in the Home Health Care Setting**

\*Documentation is the quality control and the justification for reimbursement from Medicare, Medicaid and Private Insurance.

\*Patients 18 and older OASIS is required. Outcome and Assessment Information Set

 1. Comprehensive admission assessment

 2. Allows for calculation of clinical, functional and service scores that provide justification for reimbursement of services.

\*OMAHA system – research based, comprehensive, standardized taxonomy or classification designed to enhance practice, documentation, and information management.

 1. Problem classification scheme

 2. Intervention scheme

 3. Problem rating scale for outcomes

**Case Management and use of Critical Pathways**

\*Interprofessional approach

**Informatics and Information Management in Health Care**

**Flashcards**

**1.What is charting by exception? PG 374**

Assuming that all the standards for care are present and all values are normal unless documented otherwise.

**2. What is nursing informatics? PG 379**

Specialty that integrates nursing science, computer science, and information science to manage and communicate data, information, knowledge, and wisdom in nursing and informatics practice.

 \*Specialty

 \*Requires graduate education

 \*Use of technology enhances bedside care and education

**3. Name 3 purposes that documentation serves? PG. 366**

Education, proof of type and quality of care, record for reimbursement.

**4. Name 3 category of items included in the patient health record? PG. 375**

1. Admission nursing history form

2. Patient care summary

3. Care plans

4. Discharge summary forms

**5. What is narrative documentation? PG. 372**

Story like format

**6. What does the acronym SOAP stand for? PG. 372**

Subjective Data, Objective Data,

**7. What is an incident report? PG. 376**

Describes an incident that occurred outside normal expectations. Example, fall with injury

**8. What is 7 pm in military time?**

1900

**9. Name 2 important points about HIPPA? PG 368**

Protect patient information. Only disclose with patient auth.

**10. Name 5 legal guidelines regarding documentation? PG. 366**

 1. Clear description of individualized and goal directed nursing care based on nursing assessment.

 2. Timely documentation.

 3. Enter objective and factual observations. Quote all patient statements.

 4. Document discussions with providers that you initiate to seek clarification regarding an order that is questioned.

 5. Document only for self

 6. Start with date and time and end with signature and credentials

**Review Questions**

**1. The nurse contacts a provider about a change in a patient’s condition and receives several new orders for the patient over the phone. When documenting telephone orders in the electronic health record, most hospitals require a nurse to do which of the following?**

1. Print out a copy of all telephone orders entered into the electronic health record in order to keep them in personal records for legal purposes.

2. “Read back” all telephone orders to the provider over the phone to verify all orders were heard, understood, and transcribed correctly before entering the orders in the electronic health record.

3. Record telephone orders in the electronic health record but wait to implement the order(s) until they are electronically signed by the health care provider who gave them.

4. Implement telephone order(s) immediately but insist that the health care provider come to the patient care unit to personally enter the order(s) into the electronic health record within the next 24 hours.

**2. The nurse is working in an agency that has recently implemented an electronic health record. Which of the following are acceptable practices for maintaining the security and confidentiality of electronic health record information? (Select all that apply.)**

1. Using a strong password and changing your password frequently according to agency policy

2. Allowing a temporary staff member to use your computer username and password to access the electronic record

3. Ensuring that work lists (and any other data that must be printed from the electronic health record) are protected throughout the shift and disposed of in a locked receptacle designated for documents that are to be shredded when no longer needed

4. Ensuring that the patient information that is displayed on the computer monitor that you are using is not visible to visitors and other health care providers who are not involved in that patient’s care

5. Remaining logged into a computer to save time if you only need to step away to administer a medication

**3. When documenting an assessment of a patient’s cardiac system in an electronic health record, the nurse uses the computer mouse to select the “WNL” statement to document the following findings: *“Heart sounds S1 & S2 auscultated. Heart rate between 80–100 beats per minute, and regular. Denies chest pain.”* This is an example of using which of the following documentation formats?**

1. Focus charting incorporating “Data, Action & Response” (DAR)

2. Problem-intervention-evaluation (PIE)

3. Charting-by-exception (CBE)

4. Narrative documentation

**4. The nurse works at an agency where military time is used for documentation and needs to document that a patient was transported to the operating room for an emergency procedure at 8 in the evening. Point to the area on the clockface below that indicates 8 in the evening in military time:**

**5. The nurse who works at the local hospital is transferring a patient to an acute rehabilitation center in another town. To complete the transfer, information from the patient’s electronic health record must be printed and faxed to the acute rehabilitation center. Which of the following actions is most appropriate for the nurse to take to maintain privacy and confidentiality of the patient’s information when faxing this information? (Select all that apply.)**

1. Confirm that the fax number for the acute rehabilitation center is correct before sending the fax.

2. Use the encryption feature on the fax machine to encode the information and make it impossible for staff at the acute rehabilitation center to read the information unless they have the encryption key.

3. Fax the patient’s information without a cover sheet so that the person receiving the information at the acute rehabilitation center can identify it more quickly.

4. After sending the fax, place the information that was printed out in a standard trash can after ripping it into several pieces.

5. After sending the fax, place the information that was printed out in a secure canister marked for shredding.

**6. The nurse is administering a dose of metoprolol to a patient and is completing the steps of bar code medication administration within the EHR. As the bar code information on the medication is scanned, an alert that states “Do not administer dose if apical heart rate (HR) is <60 beats/minute or systolic blood pressure (SBP) is <90 mm Hg” appears on the computer screen. The alert that appeared on the computer screen is an example of what type of system?**

1. Electronic health record (EHR)

2. Charting by exception

3. Clinical decision support system (CDSS)

4. Computerized physician order entry (CPOE)

**7. The nurse is writing a narrative progress note. Identify each of the following statements as subjective data (S) or objective data (O):**

1. April 24, 2019 (0900)

2. Repositioned patient on left side.

3. Medicated with hydrocodone-acetaminophen 5/325 mg, 2 tablets PO.

4. “The pain in my incision increases every time I try to turn on my right side.”

5. S. Eastman, RN

6. Surgical incision right lower quadrant, 3 inches in length, well approximated, sutures intact, no drainage

7. Rates pain 7/10 at location of surgical incision.

**8. The nurse is discussing the advantages of using computerized provider order entry (CPOE) with a nursing colleague. Which statement best describes the major advantage of a CPOE system within an electronic health record?**

1. CPOE reduces the time necessary for health care providers to write orders.

2. CPOE reduces the time needed for nurses to communicate with health care providers.

3. Nurses do not need to acknowledge orders entered by CPOE in an electronic health record.

4. CPOE improves patient safety by reducing transcription errors.

**9. The nurse is reviewing health care provider orders that were handwritten on paper when all computers were down during a system upgrade. Which of the following orders contain an inappropriate abbreviation included on The Joint Commission’s “Do Not Use” list and should be clarified with the health care provider?**

1. Change open midline abdominal incision daily using wet-to-moist normal saline and gauze.

2. Lorazepam 0.5 mg PO every 4 hours prn anxiety

3. Morphine sulfate 1 mg IVP every 2 hours prn severe pain

4. Insulin as part 8u SQ every morning before breakfast

**10. The nurse is changing the dressing over the midline incision of a patient who had surgery. Assessment of the incision reveals changes from what was documented by the previous nurse. After documenting the current wound assessment, the nurse contacts the surgeon (Dr. Oakman) by telephone to discuss changes in the incision that are of concern. Which of the following illustrates the most appropriate way for the nurse to document this conversation?**

1. Health care provider notified about change in assessment of abdominal incision. T. Wright, RN

2. 09-3-18: Notified Dr. Oakman by phone that there is a new area of redness around the patient’s incision. T. Wright, RN

3. 1015: Contacted Dr. Oakman and notified about changes in abdominal incision. T. Wright, RN

4. 09-3-18 (1015): Dr. Oakman contacted by phone. Notified about new area of bright red erythema extending approximately 1 inch around circumference of midline abdominal incision and oral temperature of 101.5 F. No orders received. T. Wright, RN

**Answers: 1.** 2; **2.** 1, 3, 4; **3.** 3; **4.** 2000; **5.** 1, 2, 5; **6.** 3; **7.** O: 1, 2, 3, 5, 6, 7. S: 4; **8.** 4; **9.** 4; **10.** 4.

**Chapter 31 – Medication Administration**

**Absorption** – occurs when a medication passes into the blood.

**Adverse effects** – undesired, unintended, and often unpredictable responses to medication

**Anaphylactic reactions** – life threatening, characterized by sudden constriction of bronchiolar muscles, edema of the pharynx and larynx, and severe wheezing and shortness of breath.

**Biological half-life** – the time it takes for excretion processes to lower the serum medication concentration by half.

**Biotransformation** – occurs under the influence of enzymes.

**Buccal** – placing solid med in the mouth against the mucous membranes of the cheek until it dissolves.

**Detoxify** – break down and remove biologically active chemicals.

**Idiosyncratic reaction** – patient overreacts or underreacts to a medication or has a reaction different from normal.

**Infusions** – peak concentration occurs quicky, but the serum level also falls quickly.

**Injection**, p. 592

**Instillation**, p. 598

**Intraarticular** – an injection of a medication into a joint.

**Intracardiac** – an injection of a medication directly into cardiac tissue

**Intradermal** (ID) – injection into the dermis just under the epidermis

**Intramuscular** (IM) – injection into a muscle

**Intraocular** – medication delivery involves inserting medication similar to a contact lens into a patient’s eye.

**Intravenous** (IV) – injection into a vein. Produces the most rapid absorption.

**Irrigations** -

**Medication allergy**, p. 594

**Medication error** – any preventable event that may cause inappropriate medication use or jeopardize patient safety.

**Medication interaction** – when one medication modifies the action of another

**Medication reconciliation** – compare medication that a patient is taking currently with what the patient should be taking and any newly ordered medications.

**Medication tolerance** – occurs over time

**Minimum effective concentration (MEC)** – plasma level of a medication below which the effect of the medication does not occur.

**Ophthalmic**, p. 620

**Parenteral administration** – injection

**Peak** – highest level

**Pharmacokinetics** – study of how medications enter the body, reach their site of action, metabolize, and exit the body.

**Polypharmacy** – use of multiple medications, the use of potentially inappropriate or unnecessary medications, or the use of a medication that does not match the diagnosis.

**Prescriptions**, p. 604

**Pressurized metered-dose inhalers (pMDIs) –** deliver medications that produce local effects such as bronchodilation.

**Side effect** – predictable and often unavoidable adverse effect produced at a usual therapeutic dose.

**Solution** – given mass of a solid substance dissolved in a known volume of fluid or a given volume of liquid dissolved in a known volume of another fluid.

**Subcutaneous** – Injection into tissues just below the dermis of the skin.

**Sublingual**, p. 596

**Synergistic effect** – when two meds combined have greater effect than separately.

**Therapeutic effect** – expected or predicted response caused by a medication

**Therapeutic range** – falls between MEC and the toxic concentrations

**Toxic effects –** develop after prolonged intake of a medication or when a medication accumulates in the blood

**Transdermal disk** – patch. Has systemic effects. Secures medicated ointment to skin.

**Trough** – lowest level

**Verbal order** – given in person typically for emergency situations.

**Z-track method** – technique for pulling the skin during an injection recommended for IM injections.

**Scientific Knowledge Base**

**Medication Legislation and Standards**

\*Pure Food and Drug Act – all medications to be free of impure products

\*FDA – enforces medication laws that ensure that all medications on the market undergo vigorous testing before they are sold to the public.

\*State Nurse Practice Acts define the scope of nurses’ professional functions and responsibilities.

**Pharmacological concepts**

\*Medications can have as many as 3 different names

 1. Chemical name: provides an exact description of its composition and molecular structure

 2. Generic name: official name listed in official publications such as United States Pharmacopeia (USP)

 3. Trade name: brand name. The name that a manufacturer markets their medication.

**Medication classification**

\*Indicates the effect of a medication on a body system, the symptoms a medication relieves, or its desired effect.

\*A medication can be in more than one class.

**Medication Forms**

\*The form of a medication determines its route of administration

**Pharmacokinetics as the Basis of Medication Actions**

\*Pharmacokinetics is the study of how medications enter the body, reach their site of action, metabolize, and exit the body.

**Absorption**

\*Occurs when medication molecules pass into the blood form the site of medication administration.

\*Absorption is affected by route of administration, ability of the medication to dissolve, blood flow to the site of administration, BSA, and lipid solubility of medication

**Route of administration**

\*Applying medication on the skin = slow absorption

\*Typically, oral meds are absorbed slowly because they have to pass through the GI tract.

\*Buccal and sublingual and respiratory airway meds are absorbed quickly because they have many blood vessels.

\*IV most rapid absorption followed by IM followed by subQ

**Ability of a medication to dissolve**

\*The body absorbs liquid more readily than tablets or capsules.

**Distribution**

\*Circulation: how fast medication reaches a site depends on the vascularity of the various organs and tissues.

 1. conditions that limit blood flow or poor perfusion inhibit the distribution of a medication.

\*Membrane Permeability: the ability of a medication to pass through tissues and membranes

\*Protein binding – the degree to which medications bind to serum proteins such as albumin affects their distribution.

\*Metabolism – after meds reach its site of action it is metabolism into a less active form, so it is easily excreted.

 1. biotransformation occurs under the influence of enzymes that detoxify, break down, and remove biologically active chemicals.

 2. Occurs mostly in the liver, but also in the lungs, kidneys, blood, and intestines.

 3. If the liver is not working correctly meds can accumulate causing medication toxicity.

\*Excretion: after being metabolized meds exit the body through the kidneys, liver, bowel, lungs, and exocrine glands.

 1. Gaseous and volatile compounds and alcohol exit through the lungs

 2. Lipid soluble meds exit through the exocrine glands

 3. Main organ of excretion = kidneys

**Types of medication action**

**Therapeutic effects**

\*Expected or predicted physiological response caused by a medication.

\*A medication can have more than one therapeutic affect

**Adverse Effects**

\*Undesired, unintended, and often unpredictable responses to medication

\*Range from mild to severe

\*Can happen immediately or over time

\*Most at risk are the very young, very old, pregnant women, people who take multiple meds, extremely under or overweight, renal or liver disease.

**Side Effects**

\*Predicted and unavoidable adverse effect produced at a usual therapeutic dose.

**Toxic Effects**

\*Develop after prolonged intake of a medication

**Idiosyncratic reactions**

\*Over or under reaction to a med

**Allergic Reactions**

****\*Antibiotics cause a high incidence of allergic reactions.

**Medication Interactions**

\*One medication modifies the action of another.

**Timing of medication dose responses**

**Nursing Knowledge Base**

\*250,000 Americans die each year from medical errors

**Types of Orders in Acute Care Agencies**

**Standing or Routine Medication Orders**

\*Carried out until canceled by provider or prescribed number of days elapse.

**Prn Orders**

\*To be given only when patient requires it.

\*You need subjective and objective data to validate that the medication is needed.

\*Must have indication

**Single (One Time) Orders**

\*Common for preoperative medications or for medications given before diagnostic examination.

**STAT**

\*One time to be given immediately.

**Now Orders**

\*Used when a patient needs a medication quickly but not STAT.

\*Nurse has up to 90 minutes to administer the Now medication.

\*Can only be administered one time.

**Prescriptions**

\*Provider writes prescription for patients to take medication home.

\*Must have:

 1. patient name, address, age, and the date

 2. Drug name, strength, and dose

 3. Instructions for the patient

 4. Provider signature

 5. DEA # if controlled substance

 6. Refills

**Pharmacist’s Role**

\*Prepares and distributes medications

\*Main task: dispensing correct medication, in the proper dosage and amount, with an accurate label.

**Nurse’s Role**

\*Med admin cannot be delegated

\*Patient education about proper med admin and monitoring is vital.

**Medication Errors**

\*Any preventable event that may cause inappropriate medication use or jeopardize patient safety.

 1. inaccurate prescribing

 2. Administering the wrong med

 3. wrong route or time interval

 4. giving extra doses or failing to administer proper dose

\*Med reconciliation:

1. during this process you identify and resolve orders that are duplicated or omitted.

2. evaluate risk for unintended medication interactions

**Critical Thinking**

**Attitudes**

\*Be familiar with all meds administered.

\*Ultimate responsibility lies with the nurse

**Standards – 7 rights of med administration**

1. Right Medication: compare meds 3 times

1. Before removing container from the drawer or shelf
2. As the med is removed from the container
3. At the patient’s bedside before administering the med to the patient

2. Right Dose

3. Right Patient: two patient identifiers

4. Right Route

5. Right Time

6. Right Documentation – document meds at time of administration

7. Right Indication

8. Maintaining Patients’ Rights

 a. informed of name, purpose, and action of a med and its potential for undesired effects

 b. refuse meds

 c. have qualified personnel assess med history

 d. be properly advised of the experimental nature of meds and provide consent for its use

 e. receive labeled meds safely and with discomfort in accordance with 7 rights of admin

 f. received appropriate supportive therapy in relation to medication therapy

 g. receive no unnecessary medication

 h. be informed if medications are part of a research study

**Nursing Process**

**Medication Administration**

**Flashcards**

**1. Can you identify an insulin syringe and an oral syringe?**

**2. Name 3 sites for an IM injection? PG 633** Vastus lateralis, deltoid, and ventrogluteal

**3. Where are subq injections administered? PG 630** Fatty areas. Back of the arm, back of thighs, abdomen.

**4. What the component of a complete med order? PG 613**

Drug, route, form, dose, frequency, provider signature, DEA # if controlled, name of patient, birth date, and date and time.

**5. What is the difference between telephone and verbal order? PG 602**

Telephone are over the phone and verbal is in person. Only in emergencies and must be signed by provider within 24 hours.

**6. What does PRN mean? PG 602** As needed

**7. What organs are the main ones for excretion of medication from the body? PG. 593**

Kidneys, lungs, bowels, liver, exocrine glands

**8. What is an ampule? PG 628** Glass. Single use.

**9. Name 4 parenteral routes of med admin? PG 596** IV, IM, ID, SUBQ

**10. What is meant by the term absorption? PG 592** When the med gets into the blood stream

**11. ID the 3 times a nurse must check med to administer them safely.** Before pulling, after pulling, before administering.

**12. What are the 7 rights of med admin? PG 607**

Right drug, right dose, right documentation, right patient, right form, right route, right indication

**13. Name 3 physiological changes that occur with aging that affect the pharmacokinetics of a drug. PG 614**

Liver doesn’t metabolize as well – prolongs drug half life

Circulation is slower

Excretion is slower – could cause accumulation of meds

**14. What is meant by med peak and med trough levels? PG 594**

Peak – highest serum level

Trough – lowest serum level

**15. What is the rule regarding leading and trailing zeros? PG 602**

Correct 0.5 and 2.1

Incorrect .56 and 2.10

**16. What is the difference between side effect and toxic effect? PG 594** Side effect is expected. Toxic effect is a buildup of meds.

**17. What is pharmacokinetics? PG591**

The study of how meds enter the body, reach their site of action, metabolize, and exit the body.

**18. What is the fastest route of admin? PG 596** IV

**19. Name 3 things affect the distribution of meds within the body. PG. 593**

Circulation, ability to bind to protein, and membrane permeability.

**20. What organ is primary involved in metabolism of med? PG 593** Liver, lungs, kidneys, blood, and intestines.

**Review Questions**

**1. It is important to take precautions to prevent medication errors. A nurse is administering an oral tablet to a patient. Which of the following steps is the second check for accuracy in determining the patient is receiving the right medication?**

1. Logging on to automated dispensing system (ADS) or unlocking medicine drawer or cart.

2. Before going to patient’s room, comparing patient’s name and name of medication on label of prepared drugs with MAR.

3. Selecting correct medication from ADS, unit-dose drawer, or stock supply and comparing name of medication on label with MAR or computer printout.

4. Comparing MAR or computer printout with names of medications on medication labels and patient name at patient’s bedside.

**2. The health care provider has written the following orders. Which orders does the nurse need to clarify before administering the medication? Provide rationale for your answers and rewrite the order so that it follows the ISMP current medication order safety guidelines.**

Timoptic .25% solution 1 drop OD BID

Metoprolol 12.50 mg QD

Insulin Glargine 6 u SC twice a day

Enalapril 2.5 mg. PO three times a day, hold for systolic blood pressure <100

**3. An older adult state that she cannot see her medication bottles clearly to determine when to take her prescription. What should the nurse do? (Select all that apply.)**

1. Provide a dispensing system for each day of the week.

2. Provide larger, easier-to-read labels.

3. Tell the patient what is in each container.

4. Have a family caregiver administer the medication.

5. Use teach-back to ensure that the patient knows what medication to take and when.

**4. The nurse must take a verbal order during an emergency on the unit. Which of the following guidelines can be used for taking verbal or telephone orders? (Select all that apply).**

1. Only authorized staff may receive and record verbal or telephone orders. The health care agency identifies in writing the staff who are authorized.

2. Clearly identify patient’s name, room number, and diagnosis.

3. Read back all orders to health care provider.

4. Use clarification questions to avoid misunderstandings.

5. Write “VO” (verbal order) or “TO” (telephone order), including date and time, name of patient, and complete order; sign the name of the health care provider and nurse.

**5. A nurse is administering ophthalmic ointment to a patient. Place the following steps in correct order for the administration of the ointment.**

1. Clean eye, washing from inner to outer canthus.

2. Assess patient’s level of consciousness and ability to follow instructions.

3. Apply thin ribbon of ointment evenly along inner edge of lower eyelid on conjunctiva.

4. Have patient close eye and rub lightly in a circular motion with a cotton ball.

5. Ask patient to look at ceiling and explain the steps to patient.

**6. The nurse is administering an IV push medication to a patient who has a compatible IV fluid running through intravenous tubing. Place the following steps in the appropriate order.**

1. Release tubing and inject medication within amount of time recommended by agency policy, pharmacist, or medication reference manual. Use watch to time administration.

2. Select injection port of IV tubing closest to patient. Whenever possible, injection port should accept a needleless syringe. Use IV filter if required by medication reference or agency policy.

3. After injecting medication, release tubing, withdraw syringe, and recheck fluid infusion rate.

4. Connect syringe to port of IV line. Insert needleless tip or small-gauge needle of syringe containing prepared drug through center of injection port

5. Clean injection port with antiseptic swab. Allow to dry.

6. Occlude IV line by pinching tubing just above injection port. Pull back gently on syringe plunger to aspirate blood return.

**7. A nurse is administering a metered-dose inhaler (MDI) with a spacer to a patient with chronic obstructive pulmonary disease. Place the steps of the procedure in the correct order.**

1. Insert MDI into end of spacer.

2. Perform a respiratory assessment.

3. Remove mouthpiece from MDI and spacer device.

4. Place the spacer mouthpiece into patient’s mouth and instruct patient to close lips around the mouthpiece.

5. Depress medication canister, spraying 1 puff into spacer device.

6. Shake inhaler for 2-5 seconds.

7. Instruct patient to hold breath for 10 seconds.

8. Instruct patient to breathe in slowly through mouth for 3 to 5 seconds.

**8. A patient is to receive medications through a small-bore nasogastric feeding. Which nursing actions are appropriate? (Select all that apply.)**

1. Verifying tube placement after medications are given

2. Mixing all medications together to give all at once

3. Using an enteral tube syringe to administer medications

4. Flushing tube with 30 to 60 mL of water after the last dose of medication

5. Checking for gastric residual before giving the medications

6. Keeping the head of the bed elevated 30 to 60 minutes after the medications are given

**9. Place the steps of administering an intradermal injection in the correct order.**

1. Inject medication slowly.

2. Note the presence of a bleb.

3. Advance needle through epidermis to 3 mm.

4. Using nondominant hand, stretch skin over site with forefinger.

5. Insert needle at a 5- to 15-degree angle into the skin until resistance is felt.

6. Cleanse site with antiseptic swab.

**10. After receiving an intramuscular (IM) injection in the deltoid, a patient states, “My arm really hurts. It’s burning and tingling where I got my injection.” What should the nurse do next? (Select all that apply.)**

1. Assess the injection site.

2. Administer an oral medication for pain.

3. Notify the patient’s health care provider of assessment findings.

4. Document assessment findings and related interventions in the patient’s medical record.

5. This is a normal finding, so nothing needs to be done.

6. Apply ice to the site for relief of burning pain.

Answers: 1. 2; 2. See Evolve; 3. 1, 2, 5; 4. 1, 2, 3, 4, 5; 5. 2, 1, 5, 3, 4; 6. 2, 5, 4, 6, 1, 3; 7. 2, 3, 6, 1, 4, 5, 8, 7; 8. 3, 4, 5, 6; 9. 6, 4, 5, 3, 1, 2; 10. 1, 3, 4.