Professional Caring & Ethical Practice

Presenter: Carol Ann Rauen, MS, RN-BC, CCRN, PCCN, CEN
Independent Clinical Nurse Specialist & Education Consultant
rauen.carolann@gmail.com
I. INTRODUCTION

PCCN Test Plan

**Professional Caring & Ethical Practices: 20%**
A. Advocacy/moral agency  
B. Caring practices  
C. Collaboration  
D. Systems thinking  
E. Response to diversity  
F. Clinical inquiry  
G. Facilitation of learning

**Testable Nursing Actions—Systems Thinking**
A. Use word-processing applications  
B. Use Internet resources to locate patient support groups, online resources  
C. Use hospital or nursing information systems to access, enter, and retrieve data related to patient care  
D. Use database applications to enter and retrieve data and information  
E. Conduct online and database literature searches  
F. Use computer applications to document patient care  
G. Use computer applications to plan patient care, including discharge planning  
H. Use information management systems for patient education  
I. Use technology-based patient monitoring systems  
J. Operate peripheral/point-of-care devices (bedside and handheld) (eg, smart pump)

**Synergy Model for Patient Care**
Source: This text has been excerpted from *Adult CCRN/CCRN-E Certification Review Course: Handout*. Available at: [www.aacn.org/WD/Products/OnDemand/CCRN/AdultCCRNHandout.pdf](http://www.aacn.org/WD/Products/OnDemand/CCRN/AdultCCRNHandout.pdf). Accessed 3/27/14.

The core concept of the reconceptualized model of certified practice—the AACN Synergy Model for Patient Care—is that the needs or characteristics of patients and families influence and drive the characteristics or competencies of nurses. Synergy results when the needs and characteristics of a patient, clinical unit or system are matched with a nurse’s competencies.

All patients have similar needs and experience these needs across wide ranges or continuums from health to illness. Logically, the more compromised patients are, the more severe or complex are their needs. The dimensions of a nurse’s practice are driven by the needs of a patient and family. This requires nurses to be proficient in the multiple dimensions of the nursing continuums. When nurse competencies stem from patient needs and the characteristics of the nurse and patient synergize, optimal patient outcomes can result.
The AACN Synergy Model and Certification Examinations
The AACN Synergy Model for Patient Care was developed to link clinical practice with patient outcomes. The integration of the Synergy Model into the AACN Certification Corporation credentialing programs puts an emphasis on the patient, and says to the world that patients come first. Nurses make a unique contribution to outcomes, quality of care and containment of costs.

Patient Characteristics
Each patient and family, clinical unit and system is unique, with a varying capacity for health and vulnerability to illness. Each one brings a set of unique characteristics to the care situation. These characteristics span the health-illness continuum.

Resiliency
The capacity to return to a restorative level of functioning using compensatory/coping mechanisms; the ability to bounce back quickly after an insult.

- Level 1 – Minimally resilient: Unable to mount a response; failure of compensatory/coping mechanisms; minimal reserves; brittle
- Level 3 – Moderately resilient: Able to mount a moderate response; able to initiate some degree of compensation; moderate reserves
- Level 5 – Highly resilient: Able to mount and maintain a response; intact compensatory/coping mechanisms; strong reserves; endurance

Vulnerability
Susceptibility to actual or potential stressors that may adversely affect patient outcomes.

- Level 1 – Highly vulnerable: susceptible; unprotected, fragile
- Level 3 – Moderately vulnerable: somewhat susceptible; somewhat protected
- Level 5 – Minimally vulnerable: safe; out of the woods; protected, not fragile

Stability
The ability to maintain a steady-state equilibrium.

- Level 1 – Minimally stable: labile; unstable; unresponsive to therapies; high risk of death
- Level 3 – Moderately stable: able to maintain steady state for limited period of time; some responsiveness to therapies
- Level 5 – Highly stable: constant; responsive to therapies; low risk of death

Complexity
The intricate entanglement of two or more systems (eg, body, family, therapies).

- Level 1 – Highly complex: intricate; complex patient/family dynamics; ambiguous/vague; atypical presentation
- Level 3 – Moderately complex: moderately involved patient/family dynamics
- Level 5 – Minimally complex: straightforward; routine patient/family dynamics; simple/clear cut; typical presentation
Resource Availability
Extent of resources (e.g., technical, fiscal, personal, psychological, and social) the patient/family/community bring to the situation.

Level 1 – Few resources: necessary knowledge and skills not available; necessary financial support not available; minimal personal/psychological supportive resources; few social systems resources
Level 3 – Moderate resources: limited knowledge and skills available; limited financial support available; limited personal/psychological supportive resources; limited social systems resources
Level 5 – Many resources: extensive knowledge and skills available and accessible; financial resources readily available; strong personal/psychological supportive resources; strong social systems resources

Participation in Care
Extent to which patient/family engages in aspects of care.

Level 1 – No participation: patient and family unable or unwilling to participate in care
Level 3 – Moderate level of participation: patient and family need assistance in care
Level 5 – Full participation: patient and family fully able to participate in care

Participation in Decision-Making
Extent to which patient/family engages in decision-making.

Level 1 – No participation: patient and family have no capacity for decision-making; requires surrogacy
Level 3 – Moderate level of participation: patient and family have limited capacity; seeks input/advice from others in decision-making
Level 5 – Full participation: patient and family have capacity, and makes decision for self

Predictability
A characteristic that allows one to expect a certain course of events or course of illness.

Level 1 – Not predictable: uncertain; uncommon patient population/illness; unusual or unexpected course; does not follow critical pathway, or no critical pathway developed
Level 3 – Moderately predictable: wavering; occasionally noted patient population/illness
Level 5 – Highly predictable: certain; common patient population/illness; usual and expected course; follows critical pathway

For example: A healthy, uninsured, 40-year-old woman undergoing a preemployment physical is likely to be: (a) stable (b) not complex (c) very predictable (d) resilient (e) not vulnerable (f) able to participate in decision-making and care, but (g) has inadequate resource availability.
A critically ill infant with multisystem organ failure is likely to be: (a) unstable (b) highly complex (c) unpredictable (d) highly resilient (e) vulnerable (f) unable to become involved in decision-making and care, but (g) has adequate resource availability.

**Nurse Characteristics:**

**Nurse Competencies of Concern to Patients, Clinical Units and Systems**

Nursing care reflects an integration of knowledge, skills, experience, and attitudes needed to meet the needs of patients and families. Thus, continuums of nurse characteristics are derived from patient needs. The following are levels of expertise ranging from competent (1) to expert (5):

**Clinical Judgment**

Clinical reasoning, which includes clinical decision-making, critical thinking, and a global grasp of the situation, coupled with nursing skills acquired through a process of integrating education, experiential knowledge, and evidence-based guidelines.

Level 1 – Collects basic-level data; follows algorithms, decision trees, and protocols with all populations and is uncomfortable deviating from them; matches formal knowledge with clinical events to make decisions; questions the limits of one's ability to make clinical decisions and delegates the decision-making to other clinicians; includes extraneous detail

Level 3 – Collects and interprets complex patient data; makes clinical judgments based on an immediate grasp of the whole picture for common or routine patient populations; recognizes patterns and trends that may predict the direction of illness; recognizes limits and seeks appropriate help; focuses on key elements of case while shorting out extraneous details

Level 5 – Synthesizes and interprets multiple, sometimes conflicting, sources of data; makes judgment based on an immediate grasp of the whole picture, unless working with new patient populations; uses past experiences to anticipate problems; helps patient and family see the "big picture;" recognizes the limits of clinical judgment and seeks multidisciplinary collaboration and consultation with comfort; recognizes and responds to the dynamic situation

**Clinical Inquiry (Innovator/Evaluator)**

The ongoing process of questioning and evaluating practice and providing informed practice. Creating changes through evidence-based practice, research utilization, and experiential knowledge.

Level 1 – Follows standards and guidelines; implements clinical changes and research-based practices developed by others; recognizes the need for further learning to improve patient care; recognizes obvious changing patient situation (eg, deterioration, crisis); needs and seeks help to identify patient problem

Level 3 – Questions appropriateness of policies and guidelines; questions current practice; seeks advice, resources, or information to improve patient care; begins to compare and contrast possible alternatives
Level 5 – Improves, deviates from, or individualizes standards and guidelines for particular patient situations or populations; questions and/or evaluates current practice based on patients' responses, review of the literature, research, and education/learning; acquires knowledge and skills needed to address questions arising in practice and improve patient care; (the domains of clinical judgment and clinical inquiry converge at the expert level; they cannot be separated)

Facilitation of Learning
The ability to facilitate learning for patients/families, nursing staff, other members of the healthcare team, and community. Includes both formal and informal facilitation of learning.

Level 1 – Follows planned educational programs; sees patient/family education as a separate task from delivery of care; provides data without seeking to assess patient's readiness or understanding; has limited knowledge of the totality of the educational needs; focuses on a nurse's perspective; sees the patient as a passive recipient

Level 3 – Adapts planned educational programs; begins to recognize and integrate different ways of teaching into delivery of care; incorporates patient's understanding into practice; sees the overlapping of educational plans from different healthcare providers' perspectives; begins to see the patient as having input into goals; begins to see individualism

Level 5 – Creatively modifies or develops patient/family education programs; integrates patient/family education throughout delivery of care; evaluates patient's understanding by observing behavior changes related to learning; is able to collaborate and incorporate all healthcare providers' and educational plans into the patient/family educational program; sets patient-driven goals for education; sees patient/family as having choices and consequences that are negotiated in relation to education

Collaboration
Working with others (eg, patients, families, healthcare providers) in a way that promotes/encourages each person's contributions toward achieving optimal/realistic patient/family goals. Involves intra- and interdisciplinary work with colleagues and community.

Level 1 – Willing to be taught, coached, and/or mentored; participates in team meetings and discussions regarding patient care and/or practice issues; open to various team members' contributions

Level 3 – Seeks opportunities to be taught, coached, and/or mentored; elicits others' advice and perspectives; initiates and participates in team meetings and discussions regarding patient care and/or practice issues; recognizes and suggests various team members' participation

Level 5 – Seeks opportunities to teach, coach, and mentor and to be taught, coached, and mentored; facilitates active involvement and complementary contributions of others in team meetings and discussions regarding patient care and/or practice issues; involves/recruits diverse resources when appropriate to optimize patient outcomes
Systems Thinking
Body of knowledge and tools that allow the nurse to manage whatever environmental and system resources exist for the patient/family and staff, within or across healthcare and nonhealthcare systems.

Level 1 – Uses a limited array of strategies; limited outlook—sees the pieces or components; does not recognize negotiation as an alternative; sees patient and family within the isolated environment of the unit; sees self as key resource
Level 3 – Develops strategies based on needs and strengths of patient/family; able to make connections within components; sees opportunity to negotiate but may not have strategies; developing a view of the patient/family transition process; recognizes how to obtain resources beyond self
Level 5 – Develops, integrates, and applies a variety of strategies that are driven by the needs and strengths of the patient/family; global or holistic outlook—sees the whole rather than the pieces; knows when and how to negotiate and navigate through the system on behalf of patients and families; anticipates needs of patients and families as they move through the healthcare system; utilizes untapped and alternative resources as necessary

Advocacy and Moral Agency
Working on another's behalf and representing the concerns of patient/family and nursing staff; serving as a moral agent in identifying and helping to resolve ethical and clinical concerns within and outside the clinical setting.

Level 1 – Works on behalf of patient; self-assesses personal values; aware of ethical conflicts/issues that may surface in clinical setting; makes ethical/moral decisions based on rules; represents patient when patient cannot represent self; aware of patients' rights
Level 3 – Works on behalf of patient and family; considers patient values and incorporates in care, even when differing from personal values; supports colleagues in ethical and clinical issues; moral decision-making can deviate from rules; demonstrates give and take with patient's family, allowing them to speak/represent themselves when possible; aware of patient and family rights
Level 5 – Works on behalf of patient, family, and community; advocates from patient/family perspective, whether similar to or different from personal values; advocates ethical conflict and issues from patient/family perspective; suspends rules—patient and family drive moral decision-making; empowers the patient and family to speak for/represent themselves; achieves mutuality within patient/professional relationships
Caring Practices
The constellation of nursing activities that create a compassionate, supportive, and therapeutic environment for patients and staff, with the aim of promoting comfort and healing and preventing unnecessary suffering, includes (but is not limited to) vigilance, engagement, and responsiveness of caregivers, including family and healthcare personnel.

Level 1 – Focuses on the usual and customary needs of the patient; no anticipation of future needs; bases care on standards and protocols; maintains a safe physical environment; acknowledges death as a potential outcome
Level 3 – Responds to subtle patient and family changes; engages with the patient as a unique individual in a compassionate manner; recognizes and tailors caring practices to the individuality of patient and family; domesticates the patient's and family's environment; recognizes that death may be an acceptable outcome
Level 5 – Has astute awareness and anticipates patient and family changes and needs, fully engaged with and sensing how to stand alongside the patient, family, and community; caring practices follow the patient and family lead; anticipates hazards and avoids them, and promotes safety throughout patient's and family's transitions along the healthcare continuum; orchestrates the process that ensures patient's/family's comfort and concerns surrounding issues of death and dying are met

Response to Diversity
The sensitivity to recognize, appreciate, and incorporate human differences into the provision of care. Differences may include, but are not limited to, cultural norms, spiritual beliefs, gender, race, ethnicity, lifestyle, socioeconomic status, age, and values.

Level 1 – Assesses cultural diversity; provides care based on own belief system; learns the culture of the healthcare environment
Level 3 – Inquires about cultural differences and considers their impact on care; accommodates personal and professional differences in the plan of care; helps patient/family understand the culture of the healthcare system
Level 5 – Responds to, anticipates, and integrates cultural differences into patient/family care; appreciates and incorporates differences, including alternative therapies, into care; tailors healthcare culture, to the extent possible, to meet the diverse needs and strengths of the patient/family

For example: If the gestalt of a patient were stable but unpredictable, minimally resilient, and vulnerable, primary competencies of the nurse would be centered on clinical judgment and caring practices (which includes vigilance).

If the gestalt of a patient were vulnerable, unable to participate in decision-making and care, and inadequate resource availability, the primary competencies of the nurse would focus on advocacy and moral agency, collaboration, and systems thinking.
All eight competencies are essential for contemporary nursing practice, but each assumes more or less importance depending on a patient’s characteristics.

Synergy results when the needs and characteristics of a patient, clinical unit, or system are matched with a nurse’s competencies.

II. PRACTICE QUESTIONS
Source: American Association of Critical-Care Nurses
Choose the single most correct answer for each question.

1. Which of the following actions by a nurse might lower a patient’s self-esteem?
   A. Discussing the negative consequences of the patient’s condition.
   B. Requiring the patient to participate in all treatments.
   C. Providing opportunities to discuss issues important to the patient.
   D. Indicating his or her acceptance of the patient’s condition.

2. Providing culture-specific care includes understanding:
   A. That identifying the changes that need to occur, and who will be involved, is part of developing a therapeutic plan.
   B. Health beliefs among members of a cultural group are the same.
   C. Delineating standard goals of therapy will help enhance patient adherence to a therapeutic regimen.
   D. Use of nonspecific methods will enhance patient problem-solving.

3. A year ago the entire department of nursing implemented bedside report. A nurse who transferred into the PCU discovers that bedside report is not being done. The most appropriate action for this nurse would be to:
   A. Perform a literature search regarding advantages of bedside report
   B. Ask to discuss this at the next unit practice council meeting
   C. Insist on delivering bedside report to the nurse who follows
   D. Email the CNO and inquire if there has been a change in policy

4. Six members of a trauma patient’s family arrive, asking questions about their loved one’s condition. The nurse’s most appropriate initial response would be to:
   A. Ensure the chaplain is available
   B. Include the family in the patient’s care
   C. Offer the family a tour of the unit
   D. Identify a family spokesperson

5. A patient has been waiting for 2 months for a heart transplant. A family member angrily tells the nurse, "This is hopeless!" The nurse's actions should be based on the knowledge that:
   A. Expressions of frustration are normal and usually require no nursing intervention.
   B. Since expressions of hopelessness may be harmful to the patient, the family member should be encouraged to keep those statements out of the patient care area.
C. The integrity of the family system is crucial in the transplant process.
D. Encouraging discussion of negative emotions can impede their resolution.

6. A patient with type I diabetes mellitus (DM) is admitted in diabetic ketoacidosis (DKA). Since admission, the patient’s glucose levels have been in the range of 400-500 milligrams per deciliter (mg/dL), and regular insulin has been administered on a sliding dosage scale. Given these findings, the most appropriate initial nursing intervention is to:
   A. Consult with the physician about changing the regimen to regular insulin via continuous drip
   B. Arrange for nutritional consult to enhance adherence to an American Diabetes Association (ADA) diet
   C. Consult with the physician about increasing the maximum dosage of regular insulin on a sliding scale
   D. Request an evaluation by a diabetic educator

7. A Russian patient who does not speak or understand English has just had surgery. The nurse notices he is increasingly restless and splinting his incision with both hands. An effective means of communication with this patient would be by:
   A. Using a letter board.
   B. Contacting the patient’s family.
   C. Touch and gestures.
   D. Using “yes” or “no” questions.

8. The daughter of a patient with a new permanent trach is to be taught how to suction. When developing a teaching plan, the nurse must first:
   A. Obtain written information about the procedure.
   B. Determine a schedule for demonstrating the technique.
   C. Assess the knowledge and skills the daughter needs to learn.
   D. Encourage the daughter to observe the procedure on other patients.

9. When caring for a 15-year-old patient, the nurse would:
   A. Address worries about the future.
   B. Use games as a teaching strategy.
   C. Encourage the patient to talk about life experiences.
   D. Allow the patient’s peers to visit.

10. A patient with receptive aphasia and dementia is a candidate for a clinical trial. How should the nurse proceed to ensure that informed consent is ethically obtained?
   A. Involve the patient’s legal guardian in the consent process.
   B. Ensure that the investigator is aware of the patient’s condition.
   C. Inform the institutional review board (IRB) of the potential risk to the patient.
   D. Obtain a copy of the consent form to place in the patient’s chart.
11. The use of patient and medication scanning with integration into the EMR has improved patient safety by:
   A. Decreasing lawsuits against hospitals
   B. Decreasing medication errors and adverse drug reactions
   C. Increasing revenue for hospitals
   D. Increasing nurse-patient interaction time and patient satisfaction

12. An AMI patient is in critical condition. His significant other has been at the bedside providing reassurance and support since his admit 12 hours ago. His estranged wife arrives and demands that the significant other not be allowed to visit or be given condition updates. The nurse should:
   A. Ask the physician to write an order to allow the significant other to have visitation privileges.
   B. Request a multidisciplinary care conference to discuss visitation and communication of patient status.
   C. Contact the hospital's medical-legal department and request that the hospital attorney speak to the wife.
   D. Encourage the patient to express his desire to spend time with his significant other to his wife

13. The family of a patient moved to a lower acuity area verbalizes feelings of mistrust, disappointment, and rejection by the ICU staff. These are signs of:
   A. Poor self-esteem.
   B. Hopelessness.
   C. Transfer anxiety.
   D. Powerlessness.

14. When teaching a family member to perform an aspect of patient care, the nurse understands that family members:
   A. Are unaffected by the timing of teaching.
   B. Learn best if they perceive a need to learn.
   C. Learn best if shown a complex procedure all at once.
   D. Learn unrelated tasks first.

15. To assess discomfort in a patient with chronic dementia, the nurse should:
   A. Consistently use a visual or numerical pain rating scale.
   B. Analyze the amount of pain medication given to the patient.
   C. Monitor the patient’s behaviors and physiologic data.
   D. Speak slowly while looking directly at the patient.

16. A patient recalls a near-death experience (NDE) that occurred during resuscitation and wishes to tell the nurse about it. What is the optimal response by the nurse?
   A. Let the patient know that NDEs are often hallucinations.
   B. Compare the patient’s story with the actual resuscitation events.
   C. Encourage the patient to describe the NDE to his family.
   D. Make time to listen actively while the patient tells the story.
References from the content taken from AACN website

AACN Certification Corporation has been accredited by the National Commission for Certifying Agencies (NCCA), the accreditation arm of the National Organization for Competency Assurance (NOCA).

©1999
AACN Certification Corporation
101 Columbia • Aliso Viejo, CA 92656-4109
www.certcorp.org

III. CARING & ETHICAL PRACTICES

Ethical Principles

A. Patient autonomy: self-determination, freedom of choice
B. Justice: fair treatment without discrimination
C. Veracity: truth, honesty, and integrity
D. Fidelity: obligation to care to the best of one’s ability
E. Beneficence: doing good for others
F. Nonmaleficence: do no harm
G. Paternalism: deciding what is right (best) for others

Moral Concepts

A. Respect for persons
B. Justice
C. Values
D. Rights
Family Theories

Family Needs: Nancy Molter
A. Need for accurate and regular information
B. Need to see the patient
C. Need to be helpful to the patient
D. Need to understand the hospital environment
E. Need to preserve a reasonable emotional balance
F. Need to relive the incident (common for trauma families)
G. Need for realistic hope and assurance
H. Need to have personal needs met
I. Need for support
J. Need to maintain or develop confidence in care

Phases of Family Recovery: Margaret Epperson
A. High anxiety
B. Denial
C. Anger
D. Remorse
E. Grief
F. Reconciliation
Adult Learning Principles: Malcolm Knowles

A. The need to know
B. The learner’s self-concept
C. The role of experience
D. Readiness to learn
E. Orientation to learning
F. Motivation

Growth and Development

<table>
<thead>
<tr>
<th>Erik Erikson’s Stages of Life Cycle</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stage</strong></td>
</tr>
<tr>
<td>Trust vs mistrust</td>
</tr>
<tr>
<td>Autonomy vs shame</td>
</tr>
<tr>
<td>Initiative vs guilt</td>
</tr>
<tr>
<td>Industry vs inferiority</td>
</tr>
<tr>
<td>Identity vs role confusion</td>
</tr>
<tr>
<td>Intimacy vs isolation</td>
</tr>
<tr>
<td>Generativity vs stagnation</td>
</tr>
<tr>
<td>Ego integrity vs despair</td>
</tr>
</tbody>
</table>

Human Needs: Abraham Maslow

A. Physiologic
B. Safety and security
C. Love and belonging
D. Self-esteem
E. Self-actualization