Leadership/Supervision

Study Guide (Final Exam)

Please refer to your slide and your ATI Nursing Leadership and Management book

1. Explain the five rights of delegation.

Why?

- Teamwork
- Get things done
- More efficient

Goal

AP helps the LVN to get the goal done AP → LVN → Goal

Learn in this order - **5 Rights**
1) **Person** - Right person able to do the task. 2) **Task** - Scope of practice - Non-invasive 3) **Circumstances** - Stable 4) **Direction** - Communication 5) **Supervision** - Evaluation

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2. List the tasks that can be assigned to assistive personnel.

CNA / AP	
Can Do	Cant do

• Vital SIgns
• Turning
• Dressing / Clothing
• Specimens collection
  ○ Urine
  ○ Stool
  ○ Sputum
• Can take the collection to lab
• Foley
• JP
• Can do skin barrier creams
	• Sterile UA
	• Wound Culture
	• Dressings
	• Enteral Tube feeding
	• No assessments
	• Medications
	  ○ No prescribed medications or ointments

3. Discuss prioritization. Provide examples.

	What comes first	
Acute	←	Chronic
Urgent	←	Non-Urgent
Stable	→	Non - Stable

Acute vs. chronic, urgent vs. nonurgent, stable vs. unstable
●A client who has an acute problem takes priority over a client who has a chronic problem.
●A client who has an urgent need takes priority over a client who has a nonurgent need.
●A client who has unstable findings takes priority over a client who has stable findings.

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4. Explain incident report and list what should be included in incident report.

Reason for incident report

- Records of unexpected or unusual incidents that affected a client, employee, volunteer, or visitor in a health care facility.

What goes in an incident report

- Near misses
- Needle Sticks
- Falls
- Med errors
- Loss of property

Where does the incident report go?

- It goes to the risk management department
- They need to determine why and what happened.

Who writes the incident report?

- The person who discovers the incident

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5. Discuss the roles of the following healthcare personnel:
    a. Speech therapist
        a. Swallowing evals
            i. Dysphagia
                1. Difficulty swallowing
            ii. Aphagia
                1. Inability to swallow
            iii. Aphasia
                1. Difficulty Speaking
        b. Helps Pt with speech
        c. Assists swallow eval
            i. Pt with dysphasia
    b. Case manager

        a. Advocate for patient
        b. Referrals
        c. Finding placement for patient
        d. Involved with abuse
    c. Physical therapist
        a. Range of motion
        b. Activity
    d. Occupational therapist
        a. assist & plan in pt.'s ADL skills recovery (usually pt. that had strokes or car accident)
        b. Fine motor skills
        c. Helps patients feed selves
        d.

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6. Discuss informed consent.

Legal authorization form

RN's role

- Witness to signature
- Make sure patient signs without coercion

Patient needs to be alert and orientated

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7. Explain delegation and its steps.

DELEGATION

A licensed nurse is responsible for providing clear directions when delegating a task initially and for periodic reassessment and evaluation of the outcome of the task.

- RNs can delegate to other RNs, PNs, and AP.
  - ◯ RNs must be knowledgeable about their state's nurse practice act and the regulations that guide the use of PNs and AP.
  - ◯ RNs must delegate tasks so that they can complete higher-level tasks that only RNs can perform. This allows more efficient use of all team members.
- PNs can delegate to other PNs and to AP.

DELEGATION FACTORS

- Nurses can only delegate tasks appropriate for the skill and education level of the individual who is receiving the assignment (the delegatee).
- RNs cannot delegate the nursing process, client education, or tasks that require nursing judgment to PNs or to APs.

DELEGATION AND SUPERVISION GUIDELINES

- Use the five rights of delegation to decide.
  - ◯ Tasks to delegate (right task)
  - ◯ Under what circumstances (right circumstances [setting and resources])
  - ◯ To whom (right person)
  - ◯ What information to communicate (right direction and communication)
  - ◯ How to oversee and appraise (right supervision and evaluation)
- Use professional judgment and critical thinking skills when delegating.

8. Discuss the interventions when you suspect a co-worker is chemically impaired.

- Report it to your supervisor
- Do not go up to the nurse that is impaired

Impaired healthcare providers pose a significant risk to client safety.
● A nurse who suspects a coworker of any behavior that jeopardizes client care or could indicate a substance use disorder has a duty to report the coworker to the appropriate manager.
● Many facilities' policies provide access to assistance programs that facilitate entry into a treatment program.
● Each state has laws and regulations that govern the disposition of nurses who have substance use disorders. Criminal charges could apply.

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9. Explain confidentiality. Provide examples when confidentiality is jeopardized.

If a coworker is talking about a patient in public in the cafeteria

- Stop them
- Report it to your supervisor

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10. Discuss the following leadership styles:
    Democratic: includes the whole team in decision making.
    Laissez-Faire (the lazy one): makes very few decisions & does little planning.
    Autocratic: makes decision for the team.

    a. Democratic

- Includes the group when decisions are made.
- Motivates by supporting staff achievements.
- Communication occurs up and down the chain of command.
- Work output by staff is usually of good quality when cooperation and collaboration are necessary.

b. Laissez-Faire
   - Makes very few decisions and does little planning.
   - Motivation is largely the responsibility of individual staff members.
   - Communication occurs up and down the chain of command and between group members.
   - Work output is low unless an informal leader evolves from the group.
   - Effective with professional employees.

c. Autocratic
   - Makes decisions for the group.
   - Motivates by coercion.
   - Communication occurs down the chain of command, or from the highest management level downward through other managers to employees.
   - Work output by staff is usually high: good for crisis situations and bureaucratic settings.
   - Effective for employees with little or no formal education

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11. Discuss how to transfer a client with an indwelling catheter.

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12. Explain how to collect midstream urine collection.

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13. Explain the categories of triage during mass casualty:
    a. Class I (red)

    a. Highest priority is given to clients who have life-threatening injuries but also have a high possibility of survival once they are stabilized.
b. Class II (yellow)
    a. Second highest priority is given to clients who have major injuries that are not yet life-threatening and usually require treatment in 30 min to 2 hr.
c. Class III (green)
    a. The next highest priority is given to clients who have minor injuries that are not life-threatening and do not need immediate attention.
d. Class Iv (black)
    a. The lowest priority is given to clients who are not expected to live and will be allowed to die naturally. Comfort measures can be provided, but restorative care will not.

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14. Discuss advance directives and information that can be included.

The purpose of advance directives is to communicate a client's wishes regarding end-of-life care should the client become unable to do so.

● The PSDA requires asking all clients on admission to a health care facility whether they have advance directives.
● Staff should give clients who do not have advance directives written information that outlines their rights related to health care decisions and how to formulate advance directives.
● A healthcare representative should be available to help with this process.
Types of advance directives

Living will
● A living will is a legal document that expresses the client's wishes regarding medical treatment in the event the client becomes incapacitated and is facing end-of-life issues.
● Most state laws include provisions that protect health care providers who follow a living will from liability.

Durable power of attorney for health care
A durable power of attorney for health care is a document in which clients designate a health care proxy to make health care decisions for them if they are unable to do so. The proxy can be any competent adult the client chooses.

Provider's orders
Unless a provider writes a "do not resuscitate" (DNR) or "allow natural death" (AND) prescription in the client's
medical record, the nurse initiates cardiopulmonary resuscitation (CPR) when the client has no pulse or respirations. The provider consults the client and the family prior to administering a DNR or AND.

NURSING ROLE IN ADVANCE DIRECTIVES
Nursing responsibilities include the following.
● Provide written information about advance directives. ● Document the client's advance directives status.
● Ensure that the advance directives reflect the client's
current decisions.
● Inform all members of the health care team of the
client's advance directives.

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15. Explain the use of restraints and the nursing care associated with it.

Always monitor them
Always document

- Reasons why you needed to restraint
- Document patients status

Obtain a prescription from the provider for the restraint. If the client is at risk for harming self or others and a restraint is applied prior to consulting the provider, ensure that notification of the provider occurs in accordance with facility protocol.

- Conduct neurosensory checks every 2 hr or according to facility policy to include:
    - Circulation.
    - Sensation
    - Mobility
- Offer food and fluids.
- Provide with means for hygiene and elimination.
- Monitor vital signs.
- Provide range of motion of extremities.
- Follow agency polices regarding restraints, including the need for signed consent from the client or guardian.
- Review the manufacturer's instructions for correct application.
- Remove or replace restraints frequently.
- Pad bony prominences.
- Secure restraints to a movable part of the bed frame. If restraints with a buckle strap are not available, use a quick-release knot to tie the strap.
- Ensure that the restraint is loose enough for range of motion and has enough room to fit two fingers between the device and the client.
- Regularly assess the need for continued use of restraints.
- Never leave the client unattended without the restraint.
- Document client data before, during, and after restraint use, as well as behavioral interventions and care measures.

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16. Discuss conflict management and its types.

Conflict is the result of opposing thoughts, ideas, feelings, perceptions, behaviors, values, opinions, or actions between individuals.
●Conflict is an inevitable part of professional, social, and personal life and can have constructive or destructive results. Nurses must understand conflict and how to manage it.

●Nurses can use problem-solving and negotiation strategies to prevent a problem from evolving into a conflict.

5 stages of conflict - **SHE SAID WE DONT NEED TO KNOW THIS - GOOD FOOD FOR THOUGHT THO**
Stage 1: latent Conflict The actual conflict has not yet developed; however, factors are present that have a high likelihood of causing conflict to occur. Stage 2: Perceived Conflict A party perceives that a problem is present, though an actual conflict might not actually exist. Stage 3: Felt Conflict Those involved begin to feel an emotional response to the conflict. Stage 4: Manifest Conflict The parties involved are aware of the conflict and action is taken. Actions at this stage can be positive and strive towards conflict resolution, or they can be negative and include debating, competing, or withdrawal of one or more parties from the situation. Stage 5: Conflict aftermath is the completion of the conflict process and can be positive or negative.

Steps of the problem-solving process - Know this

Identify the problem. State it in objective terms, minimizing emotional overlay.

Discuss possible solutions. Brainstorming solutions as a group can stimulate new solutions to old problems. Encourage individuals to think creatively, beyond simple solutions.
Analyze identified solutions. The potential pros and cons of each possible solution should be discussed in an attempt to narrow down the number of viable solutions.
Select a solution. Based on this analysis, select a solution for implementation.

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17. Explain the following torts:
    a. Malpractice
    b. False imprisonment
    c. Assault
    d. Battery
    e. Invasion of privacy

Intentional torts

●**Assault**: The conduct of one person makes another person fearful and apprehensive (threatening to place a nasogastric tube in a client who is refusing to eat).

●**Battery**: Intentional and wrongful physical contact with a person that involves an injury or offensive contact (restraining a client and administering an injection against their wishes).

●**False imprisonment**: A competent person not at risk for injury to self or others is confined or restrained against their will (using restraints on a competent client to prevent their leaving the health care facility).

Unintentional torts

●**Negligence**: Practice or misconduct that does not meet expected standards of care and places the client at risk for injury (a nurse fails to implement safety measures for a client who has been identified as at risk for falls).

●**Malpractice**: Professional negligence (a nurse administers a large dose of medication due to a calculation error. The client has a cardiac arrest and dies).

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18. Discuss the following ethical principles:
    a. Beneficence
    b. Maleficence
    c. Non-maleficence
    d. Autonomy
    e. Veracity
    f. Fidelity

●**Autonomy**: The ability of the client to make personal decisions, even when those decisions might not be in the client's own best interest
●**Beneficence**: Care that is in the best interest of the client
●**Fidelity**: Keeping one's promise to the client about the care that was offered
●**Justice**: Fair treatment in matters related to physical and psychosocial care and use of resources
●**Non-maleficence**: The nurse's obligation to avoid causing harm to the client
●**Veracity**: The nurse's duty to tell the truth
●**Maleficence**: the act of committing harm or evil