NURSING PROFESSIONAL ROLES AND RESPONSIBILITIES

The term **pathophysiology** comprises two combining forms:

- "patho" means relating to disease
- "physio" means relating to function

Thus, "pathophysio" means something is wrong (some sort of illness, disease) with the function of an organ or system of the body.

The term **etiology** means cause or origin of disease or disorder.

There are **risk factors** that contribute to the development of disease:

- Environment
- Social habits, such as smoking, alcohol abuse, illicit drugs
- Diet
- Heredity/genetics
- Personality traits
- Job, including stress as well as toxic exposure

**Clinical manifestations** are the **signs** and **symptoms** of disease displayed by the patient.

**NURSING PROFESSIONAL ROLES**

The RN after your name implies commitment to the legal, ethical, and moral responsibilities that define your **professional roles**. Be cognizant of them. These responsibilities are based on the American Nursing Association’s (ANA’s) *Nursing Scope and Standards of Professional Practice*, the ANA’s *Nursing Code of Ethics*, and the ANA’s *Nursing Social Policy Statement*.

- You are the fulcrum of patient care.
- You are the safety net for your patient.
- You are your patient’s advocate.

Remember, you have the **legal obligation** to clarify the physician’s orders!

Documentation is a legal and important role of the registered nurse.

**THE NURSING PROCESS**

What is your **assessment**? What clinical manifestations is the patient displaying?

- Subjective: What symptoms does the patient report?
- Objective: What signs do you see, hear, feel?

What does the health history indicate?

What are your **nursing diagnoses?** Physiological, Psychological–Social–Spiritual, Educational…

stated as: problem…related to (R/T) and…as evidenced by (AEB).

- Physiological
  
  Example: Pain R/T post-op abdominal surgery day 1, AEB grimacing, verbal complaint of 8/10 pain (scale 1–10)
  
  Example: Impaired skin integrity R/T physical immobility, AEB multiple skin breakdowns on coccyx and both shoulders.

- Psycho–Social
  
  Example: Behavioral disorder R/T ingestion of illicit drugs, AEB aggressiveness towards others.
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1. Airway and oxygenation
   - Is the patient's breathing unlabored or labored?
   - What is the patient's skin color?
   - Does the patient need supplemental oxygen?

2. Pain and discomfort management
   - Pain can be managed through:
     - Pharmacologic means (drugs)
     - Psychological intervention
     - Spiritual support

3. Vital signs (temperature, pulse, and respiration, including oxygen saturation)
   Although the task of assessing vital signs can be delegated, you, as the nurse, are legally responsible for patient care and assessment.

4. Patient activity
   Although the task of assessing patient activities can be delegated, you, as the nurse, are legally responsible for patient care, assessment, and outcomes.
   - If the patient is on bed rest, skin care must be considered.
   - Assess the patient's ability to have bathroom privileges (BRP), to sit up in a chair, to ambulate with help, to self-ambulate, and so forth.
   - Are physical restraints needed? (If so, you need a physician's order.) How often should you assess for complications; for psychological effects? Follow your institution's policy.

5. Nursing procedures and treatments
   (for example, blood glucose drawn through finger sticks, dressing changes, and so forth)

6. Fluid balance
   - Intake and output
     - Although you may delegate measurement of oral intake and urine and
other body fluids output, you, as the nurse, are legally responsible for results and effects on the patient. Strict and accurate recording and reporting must be maintained, and you are legally responsible for this delegation.

- Know the implications for an imbalance and know how to intervene.
- Know when to notify the physician.

**Intravenous (IV) infusions**

- Have you inspected the site?
- Is the size of the catheter appropriate?
- Are the fluid orders appropriate?
  - Osmolarity?
  - Rate of infusion?
- You must monitor and regulate the infusion rate.
  - The patient must be monitored for signs of fluid overload, such as pulmonary congestion, shortness of breath, cyanosis, and lowered oxygen saturation (i SpO₂).
- Do not catch up: If for any reason the IV infusion is delayed, do not increase the rate of the infusion to catch up. Monitor the patient.

7. **Electrocardiogram (ECG)**

- Do you know how to read the ECG?
- What do you do about the results if they are abnormal?
- If the patient is taking specific cardiac medications, when is the ECG taken and how often?

8. **Laboratory tests** (blood, serum, urine, sputum, and so forth)

You must know the normal levels.

- Compare present results to previous results, if available.
- If results are abnormal, you must notify the physician.

- If the result is out of range, retest the test.
- Anticipate intervention orders.
- What drugs affect these tests?
- Call the laboratory if results not reported in a timely manner—advocate for your patient.

9. **Medications**

Do the Seven Rights at all times before administering a medication. The Seven Rights are: right patient, right drug, right dose, right route, right time, right expiration date, and right documentation. Know what the medication is for and why the patient is taking it. Very important: Know your patient’s allergies, if any.

**Oral**

- Know adult dosage ranges.
- Know the anticipated effects (positive effects, side effects, delayed effects)
- Know the drug–drug interactions.
- Know the nursing considerations.

**Topical**

- Check the proper dosage.
- Inspect site for skin irritation.
- Wipe off residual medication from the previous site.
- Rotate sites.
- Cleanse the new site and apply medication.
- Tape the patch, as needed.

**Drops**

- Check proper dosage; know how many drops to administer.
- Wash your hands before administering.
- Position the patient accordingly.
- Glove the hand that touches the area.
- Cleanse the area, if body drainage is present.
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Inhalers
- Assess the patient's lung sounds.
- Know adult dosages.
- Know the anticipated effects (positive effects, side effects, delayed effects).
- For multiple inhaler use, know the drug–drug interactions or incompatibilities.
- Know the nursing considerations.
- Teach the patient and the patient's family or caregiver proper administration techniques.
- Teach the patient and the patient's family or caregiver the anticipated effects (positive effects, side effects, delayed effects).

Subcutaneous injection
- Which site is most appropriate? Know the anatomy of the site.
- Know the size of needle to use.
- Know how deep the injection should be; know the correct angle of administration.
- Know adult dosage ranges.
- Know the anticipated effects (positive effects, side effects, delayed effects).
- Know the drug–drug interactions or incompatibilities.
- Know the nursing considerations.

Intramuscular (IM) injection
- What site is most appropriate? Know the anatomy of the site.
- Know the consistency of the medication. Administer by "Z-tract" method for iron and thick-consistency medications.
- What French (Fr) size and length of needle is appropriate?
- Know how deep the injection should be; know the correct angle of administration.
- Understand the techniques of administration (e.g., the “Z-tract” method, dart method, and so forth).
- Know the adult dosage ranges.
- Know the anticipated effects (positive effects, side effects, delayed effects).
- Know the drug–drug interactions or incompatibilities.
- Know the nursing considerations.

IV push
- Double-check that the dose is accurate and appropriate.
- Flush the IV to check patency of the catheter; use normal saline.
- Make sure that the diluent itself and the amount of the diluent are correct.
- How fast should this medication be administered?
- Know the anticipated effects (positive effects, side effects, delayed effects).
- If multiple IV drugs are ordered, flush the line with normal saline between drug administrations.
- Know the drug–drug interactions and incompatibilities.
- Flush the IV catheter after administering the medication; what flush is appropriate—normal saline or heparin? Follow your institution's protocol.

IV infusions—peripheral
- Inspect the site: Do you note redness, inflammation, phlebitis?
- Is the size of the catheter adequate?
- Check the patency of the catheter; flush with normal saline.
- How fast should this medication be infused?
- Can you piggyback it to another infusing medication or to an existing IV infusion, or should you start another site?
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• If more than one antibiotic or another medication is prescribed, which one should you administer first?
• Know the drug–drug interactions or incompatibilities.
• Know the anticipated effects (positive effects, side effects, delayed effects).
• Flush the IV after administering the medication; know what flush is appropriate—normal saline or heparin.
• If using a peripherally inserted central catheter (PICC), know how this is different from other IV lines. Should you flush with normal saline or heparin? How much flush (amount) is needed? Follow your institution’s protocol.
• Inspect the site again for infiltration; retape the site, as needed.

10. Blood and blood products
• Has the patient been properly type and cross-matched (T & XM’d)?
• Is the size of the IV catheter adequate?
• Do you have a proper blood transfusion set up (Y-tubing with filter and normal saline for flush)? Follow your institution’s protocol.
• Know your patient’s allergies.
• Know your patient’s history of receiving blood and blood products.
• Remember that there must be two RNs to check blood and confirm patient identification at bedside before start of the transfusion.
• Follow your institution’s protocol regarding vital signs and assessments for before, during, after the start, and after completion of the blood transfusion.

11. Nutrition
Oral: regular, pureed, mechanical soft, specialty diets
• You are responsible to assess your patient’s need for a specific diet, e.g., pureed, mechanical, soft, and so forth.
• Make sure that your patient received the diet as ordered.
• How did the patient do? What was the percent of intake?
• Record and report your findings.
• You may delegate this task but you, as the nurse, are legally responsible for patient outcomes.

Tube feeding: nasogastric, orogastric, gastrostomy, jejunostomy, percutaneous endoscopic gastrostomy (PEG)
• Position the patient with head of bed at least at a 30° angle at all times.
• Know the different kinds of enteral foods, such as Ensure, Pulumocare, Renal, NutriSource, and so forth, and why a particular kind is ordered.
• Check correct tube placement before each feeding and before every medication administration.
• Flush the tube every 8 hours, or after intermittent feedings, and after medication administration.
• Measure residual gastric content before each intermittent feeding and every 4 hours during continuous feeding. Large residuals should be readministered to the patient; follow your institution’s protocol.
• Know if you can give medications through these tubes.
• Follow your institution’s protocol for care of the insertion site.

Total parenteral nutrition (TPN): delivered through central line, PICC, and so forth
• Check the composition, elements, and medication additives against the physician’s orders.
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- Know what the elements and additives are ordered for:
  - For example, % dextrose, amino acids, magnesium, potassium phosphate, and other additives
  - For example, metoclopramide (Reglan), insulin, and others
- If for any reason the TPN is delayed, do not increase the rate of the infusion to catch up. Do a blood glucose test and report to the physician if it is out of range.
- The peripheral vein can be used only:
  - For a short period of time while waiting for a central line insertion
  - For up to 10% dextrose administered through a large-bore catheter

12. Radiography, Imaging: MRI, CT scan
- What prep is required? Follow your institution’s policies and procedures.
- Make sure that the consent is signed, if needed.
- Attend to patient prep, both physical and psychological; include the family.
- Know your patient’s health history and comorbidities.
- Make sure that the vital signs are taken and recorded.
- Send the chart with the patient to the Radiology Department.

13. Radiographic diagnostic procedures: barium swallow, barium enema, endoscopy, proctoscopy, and so forth
- What prep is required? Follow your institution’s policies and procedures.
- Make sure that the consent is signed, if required.
- Attend to patient prep, both physical and psychological; include the family.
- Know your patient’s health history and comorbidities.
- Make sure that vital signs are taken and recorded.
- Make sure that lab test results are charted.
- Send the chart with the patient to the Radiology Department.

14. Invasive procedures and surgery: Billroth, cholecystectomy, thoracotomy, and so forth
- What prep is required? Follow your institution’s policies and procedures.
- Make sure that the consent is signed.
- Attend to patient prep, both physical and psychological; include the family.
- Know your patient’s health history and comorbidities.
- Make sure that ECG, lab tests, and x-ray results are charted.
- Make sure that the IV site is in place.
- Make sure that the T & XM’d blood is ready in the blood bank.
- Make sure that the pre-op checklist is completed.
- Send the chart with the patient to the Operating Room or Procedures Department.

15. Care of the post-procedure and surgical patient
- Airway management is the priority: Is the patient’s breathing labored or unlabored, skin color pink or dusky? If the patient is receiving oxygen, how much? What is the patient’s SpO2?
- Pain management is essential.
- Know how often to take vital signs.
- Make sure that you assess systems and organ functions other than the system involved. It is important that related complications are prevented.
- Inspect the site for bleeding, hematoma, and signs of infection.
• Know the institution's protocol when administering blood products.
• Know the anticipated effects of IV medications that you give (positive effects, side effects, delayed effects).
• Know how fast the medication is to be administered.
• Attend to psychological and spiritual care of the patient and the family.
• Know key information to report to staff and the physician.
• Dressing changes are part of your responsibilities.
• Know when an incentive spirometer is necessary and how it is used; teach the patient how to use it.
• Pay attention to fluid intake and output balance.
• Pay attention to electrolyte and other lab abnormalities.
• Know the patient's diet and nutritional requirements and delivery methods (oral, enteral, TPN).
• Make sure you implement the patient's activity requirements (turn, cough, and deep breathe [TCDB], early ambulation, and so forth).
• Do not forget the patient's oral care.
• You are responsible for the patient's tracheotomy care, if present.
• Be particularly attentive for care of the patient who has a chest drainage system, if present.
• You are responsible for nasogastric tube care—suction or feeding, as well as care of the site; note color, consistency, and amount; know how often should the patient be assessed.
• You are responsible for Foley catheter care, as well as care of the site.
• Weigh the patient daily, as ordered.

• You are responsible for patient care according to the post-op day pathway and the patient's condition.

16. Reassessment (after you have given nursing care and done procedures)
• When do you assess your patient again? Are there any changes?
• Do you need to call the physician for these changes?
• How often should you assess your patient thereafter?

17. Collaborative care
• You are the fulcrum of patient care.
• Assess your patient for need of collaborative care and rehabilitation during inpatient stay and upon discharge; that is, speak with the physician about the patient's need for nutrition, occupational therapy, physical therapy, speech therapy, social services, the chaplain, and so forth.

18. Gerontologic considerations
• Pain sensation is blunted.
• Hunger and thirst sensations are blunted.
• Often, there are chronic medical problems such as heart failure and diabetes, as well as renal, circulatory, and pulmonary conditions.
• Special diets are often necessary due to chronic medical problems and poor dentition.
• Skin and peripheral veins are fragile. Be careful.
• Cognition is diminishing. Be patient.

19. Evaluation of patient care
• Were your nursing interventions, including medications, feedings, and procedures, effective?
• Did you attain your goals for the patient? What about for the family?
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• Was collaborative care among caregivers successful?
• Is the patient ready for discharge? If so, to where? With whom?
• Are the appropriate referrals in place?

20. Discharge education
• You are responsible for putting together discharge instructions for the patient, family, or caregiver.

• Have you given discharge instructions to the patient, family, or caregiver?
• Make sure that collaborative partners have been informed about follow-up care, e.g., the home health nurse, physical therapist, speech therapist, occupational therapist, and others. You may delegate this task to a unit secretary, but you are legally responsible for results.