RTT1 TASK1

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Abstract

The principle of nursing activities has long been based on the clear and ‘automatic’ implementation of the doctor's orders/appointments marked by the lack of attention to issues related to any emotional experience of the patient. In order to fulfill the nursing duties in full, the medical staff should possess knowledge both in patient care and fundamental issues of philosophy, psychology, and other disciplines. Given the nurse devotes much of his/her daily work to the training patients, he/she needs expertise in the field of pedagogy, sociology and psychology. Currently there are significant shortcomings in the organization of the nursing process, primarily related to the lack of understanding and lack of clarity in definitions. Nurses often speak ‘different languages’ among themselves, unlike doctors, who apply conventional definitions. Organization of the nursing process is usually based on model created by B. Henderson. The structure of the nursing process includes elements of scientific knowledge applied by the medical nurse to organize and implement the patient care. It is an ongoing ever-evolving system at a certain stage. Nursing process is aimed at preserving and successful rehabilitation of the patient's health needs after removing violations. To be successful the nurse must often address several issues to settle conflicts. This research is to regard in detail one of the hospital cases with the scenario of Mr. J., a 72-year-old retired rabbi, admitted to the hospital and undergoing medical treatment.

RRT1 TASK 1

National initiatives driven by the American Nurses Association have determined nursing-sensitive outcome indicators that are intended to focus plans and programs to increase quality and safety in patient care. The following outcomes are commonly used as nursing-sensitive indicators:

• Complications such as urinary tract infections, pressure ulcers, hospital acquired pneumonia, and DVT;

• Patient falls;

• Surgical patient complications, including infection, pulmonary failure, and metabolic derangement;

• Length of patient hospital stay;

• Restraint prevalence;

• Incidence of failure to rescue, which could potentially result in increased morbidity or mortality;

• Patient satisfaction;

• Nurse satisfaction and staffing.

The Main Criteria to Evaluate Day Patient Facilities

Under the current socio-economic conditions with the general deficit in financing the health care industry becomes very important. Greater importance gains the health care in day hospitals. However, it is rather difficult to introduce organization forms in inpatient treatment

process due to the lack of methodological support of this type of aid, the lack of economic and social motivation in moving volumes of patient care from hospitals to ambulatory outpatient level and the developed indicators to assess the performance of a day hospital.

The main criteria to evaluate day patient facilities include medical, social, and economic efficiency.

Medical effectiveness is determined to achieve the outcome of the treatment process. It is based on the following indicators:

1. Treatment outcomes in patients discharged (recovery, improvement, normalization of hemodynamic parameters, no change, deterioration, etc.).

2. Quicker treatment.

3. Reduced frequency of diseases exacerbation.

4. An increased number of the recovered (dispensary patients received anti-relapse treatment and often chronically ill persons).

5. Conducting complex laboratory diagnostic and instrumental studies without hospitalization of patients to get day hospital care.

Social efficiency is achieved through physical, psychological, emotional state of the patient during treatment, which is mainly based on his/her subjective perception of general health, social and psychological conditions of life and defined by the following criteria (Leininger & McFarland, 2006):

1. Decrease in temporary disability in the patients due to exacerbation (disease recurrence).

2. The multiplicity of temporary loss of disability is reduced.

3. Patients received day hospital treatment return to work faster compared with those going under 24/7 care.

4. The time for hospital treatment is reduced.

5. Degree of satisfaction with the organization of medical care in a day hospital (Sociological Research) is raised.

6. Psychological injury of patients and their families is reduced by means of preserving the usual daily mode of life.

7. Complaints about treatment process in a day hospital are absent.

Economic efficiency of the day hospital is determined by calculating the individual economic indicators based on:

1. The average annual cost of patients' treatment (with an estimation of labor costs and charges, medicaments and boarding, general expenses, utilities, etc.).

2. Cost per bed daily and the cost of treatment per capita.

3. Preventing economic loss due to the reduced duration of temporary disability and the cost of treatment as compared to the treatment in hospitals.

Scenario RRT TASK 1

Mr. J is a 72-year-old retired rabbi with a diagnosis of mild dementia. He was admitted for treatment of a fractured right hip after falling in his home. He has received pain medication and is drowsy, but he answers simple questions appropriately.

A week after Mr. J was admitted to the hospital, his daughter, who lives eight hours away, came to visit. She found him restrained in bed. While Mr. J was slightly sleepy, he recognized his daughter and was able to ask her to remove the restraints so he could be helped to the bathroom. His daughter went to get a certified nursing assistant (CNA) to remove the restraints and help her father to the bathroom. When the CNA was in the process of helping Mr. J sit up in bed, his daughter noticed a red, depressed area over Mr. J's lower spine, similar to severe sunburn. She reported the incident to the CNA who replied, "Oh, that is not anything to worry about. It will go away as soon as he gets up." The CNA helped Mr. J to the bathroom and then returned him to bed where she had him lie on his back so she could reapply the restraints.

The diet order for Mr. J was "regular, kosher, chopped meat." The day after his daughter arrived, Mr. J was alone in his room when his meal tray was delivered. The nurse entered the room 30 minutes later and observed that Mr. J had eaten approximately 75% of the meal. The meal served was labeled, "regular, chopped meat." The tray contained the remains of a chopped pork cutlet.

The nurse notified the supervisor, who said, "Just keep it quiet. It will be okay." The nursing supervisor then notified the kitchen supervisor of the error. The kitchen supervisor told the staff on duty what had happened.

When the patient's daughter visited later that night, she was not told of the incident.

The next night, the daughter was present at suppertime when the tray was delivered by a dietary worker. The worker said to the patient's daughter, "I'm so sorry about the pork cutlet last night." The daughter asked what had happened and was told that there had been "a

mix up in the order." The daughter then asked the nurse about the incident. The nurse, while confirming the incident, told the daughter, "Half a pork cutlet never killed anyone."

The daughter then called the physician, who called the hospital administrator. The physician, who is also Jewish, told the administrator that he has had several complaints over the past six months from his hospitalized Jewish patients who felt that their dietary requests were not taken seriously by the hospital employees. The hospital is a 65-bed rural hospital in a town of few Jewish residents. The town's few Jewish members usually receive care from a Jewish hospital 20 miles away in a larger city.

Scenario Comments

The nurses' duties include being honest and truthful to the patient as to their health condition and the methods of treatment applied, even if there is something that could hurt or offend the patient. It particularly concerns the case of medical or nursing errors. The above mentioned scenario clearly shows two nursing failures, two blunt mistakes in performing the nursing care. The first error is ignoring the physiological inconveniences of the patient; the second is inattention to his eating habits, confusion in the patient's diet, as well as inappropriate behavior in the conflict situation that has arisen as a result of the occurred mistake.

In the first case, a gross error in the treatment and care of patients is associated with ignoring the reddened skin area on the back of the patient, even after the daughter of the patient noticed and tried to draw the nurse's attention to the problem. The patient had all the hallmarks of a bedsore, manifested symptoms of stage #1. Bedsores are damages of the skin and underlying tissues arising as a result of prolonged compression of tissues. Bedsores occur more often in those parts of the skin, which are located over bony prominences: knees,

elbows, hips, buttocks, and sacrum. Symptoms of the bedsore are always visible. Development of pressure ulcers always goes in four stages. Here one may presume the Phase I, i.e. the initial stage of developing pressure sores, which has the following features: skin is not broken; redness on the skin (in patients with fair skin) is present; the spot does not change color when pressed; with darker skin its color does not change often, and the skin does not turn white when pressed; sometimes the skin spot looks irritated, crimson or cyanotic; this portion of the skin can be painful, sensitive, being softer, warmer or cooler compared with other portions of the skin. The nurse on duty is obliged to examine the patient to check for pressure ulcers occurrences, as well as to take urgent measures to address the symptoms as soon as they are discovered.

In the situation with pork cutlet, the RN was obliged to inform the patient or the patient's relatives (in this case, the daughter of Mr. J., the patient) of the confusion occurred. One is supposed to negotiate similar situations with others or just filing complaints to the senior management. This may lead to mutual insults, unwanted atmosphere in the team; however, the better developed hierarchy, as well as streamlined workflow, will soon help restoring emotional atmosphere, and most importantly, will definitely make all employees understand the degree of responsibility they bear at the workplace. The right of patients and their relatives, as well as the right of paramedics, to defend their point of view should be combined with high demands to themselves, the ability to recognize and correct their mistakes and failures found on their own or determined by the colleagues. In this case, the nurse’s expressed opinion about the insignificance of the incident, confusion and desire of the supervisor to ‘hush’ the affair, demonstrate the utter incompetence. Despite the personal beliefs and attitudes of nurses, they must respect and follow the wishes of the patient and their families to consider their cultural and social peculiarities and needs, especially in this case, when the nutritionist clearly ordered ‘regular, kosher, chopped meat’ (Leininger, 2002).

Therapeutic process largely depends on the relationship between doctors and nurses. If no understanding and harmony, the quality of care is jeopardized. Historically, the relationships between the doctors and nurses have acquired the status of a special relationship, notably in hospitals. Doctor and nurse are the dominant pair, affecting all processes in the department that have an impact on patients. Nurses interact with patients during the day and are called to create a health-protective regime, without which the recovery process is impossible. In hospitals the patient will necessarily experience physical and mental discomfort that is associated with the process of treatment and with the service and communication. Modern trends are moving towards the gradual changes in the old stereotypes. Now the nurse plays the role of a physician's assistant, the patient's assistant and a companion (Leveck & Jone, 1998).

Resources, Referrals and Colleagues to Resolve the Ethical Situation

Generally the nurses' participation in the treatment process can be considered in terms of two positions:

1. The nurse performs support functions, provides for the physicians' working activities, proactively as a team player, and is focused on the result, compassionate with the patient, wholly involved in the therapeutic process as a necessary and responsible unit.

2. The nurse supports passive aloof type of relationship with the patient, is not worried about the outcome of the treatment, does not feel responsible, requires constant monitoring by the doctor, performs the physician's orders and prescriptions just as a checkpoint, often partially.

Each health care establishment should strive to make the staff take consciously the first position and be aware of all the duties. Having a strong ethical compass is paramount to

being a good nurse, since all the medical staff should earn the trust with the patients and their families. The person in charge must be trustworthy, to prove the worth and integrity of the whole institution. These are standards of behavior that tie directly into medical professional ethics. The resources used to be guided in the professional activity are to include first of all the ACA (Code of Ethics) providing health care practitioners with a clearer professional identity and shaping how the public perceives the medical staff and offering guidelines for their professional behavior. The nurses have to use the ethical code to increase their ability to analyze issues in ways that will facilitate the ability to move on to ethical action — to make it part of who they are as professionals and prepare them to deal with ethical dilemmas before they even arise. Most of the staff is trained to 'do things right before the issues appear.

The nurses should be aware of the legislative requirements and confidentiality relating to the release of information about clients is a major requirement under the Privacy Act Amendment 2000 (and agency guidelines based on this Act). However, The Child Protection Act also has specific provisions regarding confidentiality of information about a child in care, or families who are clients of the departments of Child Safety, Communities, etc.

How Facilities Can Develop Conflict Management Processes:

1. Conduct an organizational conflict assessment.
2. Design a conflict management system that incorporates prevention and early intervention as key components.
3. Provide training in conflict prevention and management.
4. Provide ombudsperson services.
5. Provide external mediation services as necessary.

Conclusion

Conflict resolution skills are perfectly suited to the health care field and are easily understood and adopted by health care professionals once they have been explained, demonstrated and practiced. Administrators and academics often doubt that seemingly simple measures such as effective communication, positive collaboration and the involvement of the affected parties can have any measurable effect on health care culture, patient outcomes and job satisfaction. Many health care organizations resist the need to design and implement conflict management processes, and argue that there are already well-defined processes within union agreements, individual contracts or human resources policies. However, conflict management processes are not used in place of already existing contracts and policies, but as complementary additions. In many instances, conflict resolution processes allow for the early resolution of issues so that other, more adversarial options are not required.

The conflict resolution skills, processes and approaches that are discussed here may appear simple and obvious to many, and yet they are skills that require ongoing education, training and practice. Most people do not communicate effectively, especially when under stress. Collaboration is often ignored in favor of individual decisiveness, even though such decisions may not create the optimum results. Furthermore, getting all of the parties to the table is avoided for fear of emotional reactions and time-consuming discussions. Most organizations do not have well-developed conflict management systems in place, even though addressing the issue of conflict management is inherent in improving the culture of health care organizations. Moving away from hierarchical, secretive, blame-focused structures to create cultures of learning and openness requires all of the skills that we have discussed. High-reliability organizations have generally incorporated effective conflict management processes and principles into their fabric and culture. Health care cultures must adopt

strategies to manage conflict positively and place a priority on continuing education and training in conflict resolution. Conflict assessment, management and prevention are essential elements for successful culture change within health care.

References

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