The Management of PATIENT CARE

Putting Leadership Skills to Work

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PREFACE

Many changes have taken place in the fourteen years since this book was first published under the title *Nursing Team Leadership.* During the last five years changes have come at an ever-increasing speed. Nursing has made progress toward defining its professional role, responsibilities, and accountability in the health-care system. Members of other disciplines concerned with the delivery of health care are beginning to realize that no one group can be dominant in meeting the demands and needs for health care. All groups must work cooperatively with each other if the patient is to receive adequate health care.

Nurses are realizing that they must become the leaders in the management of patient care. This book is directed toward helping nurses, especially beginning practitioners, to understand their responsibilities in the delivery of health services and toward showing them various ways in which they may exercise leadership in providing patient care. The basic concepts presented in this book and their suggested application are only the beginning. From these the nurse should go on to determine her individual contributions in her professional practice.

Parts I and II have been updated. The problems confronting nursing today are discussed along with some of the current suggested solutions for these problems.

Part III has been completely revised to conform with the concept of the nursing process and some of the methods currently being tried in the planning and management of health care.

For those who wish to continue the practice of team nursing, Part IV discusses the application of the concepts of the nursing process, as presented in Part III, within the framework of team nursing.

The phrase "professional nurse" is employed throughout the book in the legal sense as used in licensure laws of each state. The word "patient" is used rather than the newer term, "client," just because I am old-fashioned enough to feel that the word "patient" connotes a closer interpersonal relationship between the nurse and patient. *Patient* is not to be construed to mean only an ill person, but rather any person who is in need of nursing assistance.

I am especially grateful to my husband, without whose encouragement and help this book would not have been completed. I also wish to thank the many nurses throughout the United States and Canada who offered so many helpful suggestions and criticisms. I wish to extend

special thanks to Mrs. Clarice Braschler, Mrs. Lela Reeves, and Mrs. Martha Swindle of the Current River Regional Library. They all gave unsparingly of their time and knowledge to obtain the library materials which I requested.

I would also like to acknowledge Donald J. Hancock, J.D., Missouri State Representative, for his helpful suggestions concerning the legal responsibilities in nursing practice.

THORA KRON

Beatitudes of a Leader

Blessed is the leader who has not sought the high places, but who has been drafted into service because of his ability and willingness to serve.

Blessed is the leader who knows where he is going, why he is going, and how to get there.

Blessed is the leader who knows no discouragement, who presents no alibi.

Blessed is the leader who knows how to lead without being dictatorial; true leaders are humble.

Blessed is the leader who seeks for the best for those he serves.

Blessed is the leader who leads for the good of the most concerned, and not for the personal gratification of his own ideas.

Blessed is the leader who develops leaders while leading.

Blessed is the leader who marches with the group, interprets correctly the signs on the pathway that leads to success.

Blessed is the leader who has his head in the clouds but his feet on the ground.

Blessed is the leader who considers leadership an opportunity for service.

AUTHOR UNKNOWN

Reprinted from the *Blueprint Prepared for Local Leaders* by the National Education Association, Revised April, 1958.

CONTENTS

PART 1

LEADERSHIP – THE GREATEST CHALLENGE IN NURSING TODAY

For Yesterday is but a Dream,
And To-morrow is only a Vision;
But To-day well-lived makes every
Yesterday a Dream of Happiness
And every To-morrow a Vision of Hope.
Look well therefore to this Day!

FROM THE SALUTATION OF THE DAWN,
FROM THE SANSKRIT.

CHAPTER 1

CHANGES AFFECTING NURSING TODAY

YESTERDAY AND TODAY

One of the results of rapid technological, social, and medical changes and increasing demands by society for better health care is to cause the various disciplines concerned with health care delivery to face the fact that no one group acting alone can provide all the care that the health care recipient should receive. The disciplines themselves and society at large are realizing that health is everybody's responsibility and right. Health is now defined as a state of complete well-being rather than simply an absence of disease or infirmity.* We need, therefore, to focus our attention on all the facets of health/wellness, and not on illness alone, if we are to meet the health needs of society. Nurses must realize that they work with all people, only a few of whom are ill.

For the most part, health workers deliver health care through some organization—clinic, nursing home, hospital, or community health agency. Even though people are beginning to realize that being concerned only with illness and its cure will not ensure a healthy society, the main emphasis in our delivery of health care continues to center around hospitals. However, for most people the care received in hospitals represents only a small portion of that required to meet their health needs.

Changes in Technology. In the past, technological discoveries and inventions have influenced economic and social changes as well as those

*Delbaum, Cynthia Hastings: "Hallmarks of Adult Wellness." *Am. J. Nursing, 74*:9:1623, Sept., 1974.

in scientific fields such as medicine. The invention of the microscope and other diagnostic and therapeutic machines along with the discovery of x-rays and electron and laser energy have brought about increased knowledge in medicine and improved methods of diagnosis and treatment of diseases.

The trend toward miniaturization has brought about the Age of Computers—from small hand-held models to mammouth machines occupying entire buildings. Centers are now being set up to analyze, store, and retrieve enormous amounts of information used in every walk of life. Some people prophesy that before long all our activities in the home and in business will be either taken over or regulated by computers.

Health agencies are already storing patient information in central computers that can provide data immediately on request from any hospital location.* Video or print-outs of a complete nursing care plan can be retrieved in approximately 30 seconds. Supplies, equipment, and drugs can be ordered through the computer. Physicians' orders, test results, nursing observations, etc., can all be entered to become a part of a patient's record which can be retrieved whenever needed. Computers will thus relieve the professional nurse of much of the paper work which she now does, but they will increase the need for her knowledge and judgment in the input and use of patient information and also increase her responsibilities in the direct delivery of patient care.

Changes in the Field of Medicine. Scientists continue to give the medical world additional information about the causes and treatment of certain heart, blood, and vascular diseases. The role of DNA in heredity is being studied. New and improved surgical techniques and instruments make possible, and even routine, some operations which a few years ago were unheard of. Artificial hearts and lungs serve as temporary substitutes for those vital organs, and transplantation of organs such as kidneys, lungs, livers, spleens, and hearts are becoming almost commonplace, but with this increase in transplants have come some disturbing legal and ethical questions concerning who has title to a dead body and what death is. Electronic pacemakers keep damaged hearts beating rhythmically. In several instances severed limbs have been reattached successfully. Plastic materials and certain metals are being used to replace diseased sections of the body. Many facets of psychiatry, geriatrics, public health and sanitation are receiving attention of specialists in these fields.

Although great advances have been made, much remains to be done. Neither the quality nor the quantity of medical care is consistent throughout the United States. Physicians, nurses, and health care centers are not equally distributed. In the greater metropolitan areas the patient-doctor ratio is a comfortable 500 to one, while in rural areas the

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*Cook, Margo, and McDowell, Wanda: "Changing to an Automated Information System." *Am. J. Nursing, 75*:1:46, Jan., 1975.

ratio is often 2000 or more to one. At least 132 counties out of 3,000 in the United States do not have a resident physician.*

Mortality rates continue to be lower in England and the Scandinavian countries, all of which spend lower percentages of national income on health care. In the United States the cost of health care, both in and out of the hospital, has increased more than 100 per cent since 1965.** At this writing doctors in a number of states are striking because of soaring premiums for malpractice insurance—more than 100 per cent increases in some areas.

Health authorities are becoming increasingly concerned about pollution of our environment, the effects of the increasing noise level on people and property, and the illegal use of drugs by more people than ever before. A depressingly long list of chronic, degenerative, and infectious diseases continues to exist because either no cause or no cure has yet been found. Cancer and the common cold remain unconquered. Circulatory diseases, especially those affecting the heart, are still the main cause of death. Venereal diseases, by admission of public health officials, are now out of control.

The family doctor of yesteryear is almost unknown today, although recently the medical profession initiated action to bring him back as a "specialist in family medicine." The quantity and complexity of medical knowledge favor specialization and the increased use of consultation. Technicians, under the supervision of physicians who direct their work, are using the intricate equipment found in many areas of the modern hospital, for example, in the laboratory, the x-ray and the physical therapy departments.

Changes in Hospitals. Hospitals have also changed. At the beginning of the century, a hospital was a big dismal building, thought by many people to be a place of death. Now, architecture and interior decoration are changing the physical appearance of the hospital, while progress in medical science continues to eliminate the dangers that previously lurked within its walls. Gone are the high somber tan or dingy white walls and the narrow bare windows. The effect of color on the emotional response of the individual, and hence on his recovery, is now recognized; consequently, every effort is made to make the hospital bright and attractive as well as efficient and safe. Nursing stations are being planned so that the nurse can observe quickly and communicate easily with each patient.

Automation is becoming a part of hospital life. Intricate machines monitor the vital signs of patients, keeping minute by minute records of their progress. Automation can relieve nurses of up to 80 per cent of the paper work that now takes up most of their time. Some people foresee

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*1974 Colliers Encyclopedia Yearbook: *Health Care: A Survey*. Macmillan Educational Corporation, P. F. Collier, Inc. New York, N.Y., 1973, pp. 80–82.

**Ibid. pp. 86.

hospitals in which the patients' charts in their present form will be eliminated. Instead, all information will be available through data processing by computers in the nursing stations. Data processing machines are now used in some hospitals to plan staffing, relay orders for laboratory and x-ray tests, analyze and record test results, order supplies and diets, transcribe doctors' orders, schedule patients' treatments, and record doctors' and nurses' progress notes. Nursing needs of patients can be analyzed, measures for intervention suggested, and print-outs of previously planned nursing care can be retrieved simply by pressing a few buttons in the nursing station.

As computer circuitry becomes smaller, more reliable, and speedier, our society will certainly become more machine-centered and probably less people-oriented. Perhaps symbiotic organs and robots are not so far-fetched or far removed after all. These machines, in turn, have made necessary new knowledge and skills and additional personnel, usually ward clerks, to work with the machines.

In order to make more efficient use of personnel and equipment, some hospitals are grouping patients according to the care that they need. This system of progressive patient care includes an intensive care unit for the critically ill, a recovery room for patients immediately following surgery, regular care for the average patient, and minimal care or self-care units for convalescent patients and others who are ambulatory.

The use of disposable materials, including premixed infant formulas, medications, and equipment such as needles, syringes, and linen supplies, just to name a few, decreases the time needed to prepare and maintain these supplies as well as lessens the chance of infection.

Changes in Social and Economic Conditions. With the decline in death rates has come a rise in the average age of the total population. These elderly people present special psychosocial and health care needs. In the meantime the total population continues to increase. This means that more and more people will need the services of doctors, nurses, hospitals, nursing homes and other health agencies.

In addition to the increase in the number of people, several other factors are influencing the trend toward the greater use of health facilities. The family is no longer a closely knit, stable, more or less independent entity. The shift is now away from the care of infirm, aged and ill persons by their own families. More and more the care of these individuals is assumed by service organizations such as nursing homes and hospitals. Doctors can no longer meet the demand for their services on a home-call basis, nor do they have available in their offices all the equipment and other facilities necessary for diagnostic and therapeutic care of their patients; therefore, they prescribe hospitalization.

The increased amount of information about health and disease, now being given in school and in popular literature, has made most people more health conscious. Along with this increased interest in health has come an increase in the number of subscriptions to the various hospital-

ization and health plans, thus increasing the demand for medical care and use of hospital facilities. However, the rise in the cost of living, including the cost of medical care and hospital facilities, has outrun the ability of many people to pay, especially those in the middle income range. Throughout his book, *The Plot Against the Patient,* Fred Cook, Jr., seeks to prove that the problem of health is now "Big Business" with emphasis on profit rather than on the patient.*

In spite of all the technologic and scientific advances made, people in America do not appear to be any healthier than before. Now they are beginning to ask for reforms in the existing systems of health care services, which continue to be a professionally controlled profit-making monopoly.** However, to provide adequate health services for all persons requires a reworking of the present organization.

Several plans and schemes have been submitted and discussed. The best known plan is a prepaid group practice conducted by health maintenance organizations (HMO). This plan stresses the idea of enrollment of families at a fixed monthly fee with the primary emphasis on preventive medicine, i.e., keeping people healthy. The HMO concept could easily evolve into a national health insurance, for which a number of bills have already been introduced into Congress. Some social reform legislation has already been enacted in relation to Medicare and Medicaid which affects the quality and quantity of the delivery of care by health workers.

Preparation for Nursing Today. In the past nurses did many of the housekeeping tasks around the hospital or home in addition to attending to the wants of their patients. Their duties were simple and entailed little knowledge or understanding of the patient's disease or the doctor's treatment. The nurse simply did as she was told. However, to keep pace with the changes in medicine, especially in the concept of what health is, nurses have found it necessary to assume increasingly complex responsibilities, to learn to work with new equipment safely and effectively and, consequently, to acquire more knowledge and understanding of medical diagnosis and treatment and of nursing itself. Today nurses are attempting to define what their responsibilities are in health care delivery systems. However, nursing is in a state of transition owing to the rapid changes in technology, society, and science, so that nurses continue to be uncertain of their role and the scope of their practice.

Professional nurses, like members of the other health disciplines, are unequally distributed geographically. In rural areas where there is an inadequate number of doctors, professional nurses must assume roles in which they can help to fill the need for adequate health care. In some metropolitan and educational centers the supply of professional nurses

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*Cook, Fred, Jr.: *The Plot Against the Patient.* Prentice-Hall, Inc., Englewood Cliffs, N.J., 1967.

**1974 Collier's Encyclopedia Year Book: *Health Care: A Survey.* Macmillan Educational Corporation, P. F. Collier, Inc., New York, N.Y., 1973, pp. 83, 90.

exceeds the jobs available. Doctors continue to be oriented toward the management of disease and illness while other aspects of health care are being ignored.

Gray areas of responsibility and practice continue to exist between medicine and nursing. In many instances clinical nurse specialists, such as those in coronary care units, are making diagnoses and prescribing therapy that fall within the realm of medical practice. Nurse practice laws in many states are being revised to allow nurses to assume extended responsibilities for patient care, resulting in increased effectiveness and efficiency in delivery of health services. However, when nurses fill the extended role of a primary care practitioner or the expanded role of a nurse specialist in a specific clinical area, coordination and cooperation must exist between physician, nurse, and members of other health disciplines so that total health care covering the entire health/wellness spectrum can be delivered.

Nursing education is confronted with the task of preparing the nurse to assume her role in society and in nursing. But what is that role? Several basic nursing programs are in existence—each with the expressed or implied objective of preparing nurses for first level positions, in other words, a staff nurse. But what do the phrases "first level" and "staff nurse" mean, especially since there is such a wide variation in the preparation of persons who are to fill this position? At the present time each employing agency defines what it expects of this person with the result that there is no standard job description of staff nurse responsibilities.

Members of the various health groups see the nurse in widely differing roles. Making a medical diagnosis and prescribing the treatment of the illness of a patient is the primary responsibility of the physician. Traditionally, the nurse has been considered one who "waits on" the doctor and performs the therapeutic techniques that he prescribes. On the other hand, hospital administrators think of the nurse as one who is capable of managing a section of the hospital, carrying out all administrative policies of the institution. In addition, the number of allied therapy personnel—laboratory and x-ray technicians, physical and occupational therapists, inhalation therapists, intravenous therapy teams, etc.—is increasing daily. The nurse is often responsible for coordinating the services of these people into the patient's schedule of care. As a result, she cannot find time to give nursing care to the patient. In other words, the nurse has allowed herself to become an assistant doctor, an assistant hospital administrator, a traffic manager, a service coordinator—a jack-of-all-trades but master of none. Although these duties are important to the patient's welfare, they do not constitute the giving of nursing care, which is the nurse's primary function. In her concern to perform these secondary duties, the nurse tends to neglect her main responsibility to the patient. In fact, she often delegates much of his care to ancillary workers.

Health agencies are trying different staffing categories and patterns. In place of the traditional head nurse, the ward or unit manager takes over the administrative duties usually assigned to the head nurse. This unit manager may be responsible to either the hospital administrator directly or to the director of nursing service. He may have one or more ward clerks or secretaries to do the more routine work of checking and ordering supplies, running errands, answering the telephone, and so forth. The head nurse is thus allowed to assume her professional responsibilities involving the care of her patients and supervision of her staff. Many hospitals have a general staffing secretary who plans the staffing hours for all nursing stations. In some instances the title of head nurse has been eliminated and she is given a different title to emphasize her responsibility for direct patient care rather than administration. In other situations the head nurse functions as team leader, working directly with her staff in the planning and giving of patient care.

Because of the many changes occurring in nursing today and the resulting confusion in definition of roles and responsibilities, nurses and their professional organizations are trying to define and set up standards for nursing functions.

Bedside nursing has assumed the lowest status in nursing, and is usually assigned to practical nurses or aides. Yet what is the role of the professional nurse if not to give nursing care?

Marguerite Kakosh* says:

"Bedside care seems so much less important than the work of the head nurse or supervisor. 'I'm just a staff nurse' is the common remark. 'Today I was an aide. I did all the work that an aide does—gave baths, dressed and fed patients, assisted them into wheelchairs.' Was there really any difference in the practice of the aide and the nurse? Perhaps there is little reason to value it more highly. Until we are *able* and *enabled* to practice that quality of care that has inherent in it a growing source of satisfaction, we cannot expect respect for it. . . .

"Do we know *what* we are educating nurses for? Is my care the same as that given by the auxiliary? If there is no difference, then the *profession* of nursing will die and only the *occupation* of nursing will continue to exist!"

If nursing education is to meet its responsibility for preparing nursing practitioners able to give effective patient care, the educators must remember that there must be a common understanding and acceptance of the aims of nursing and of the various functions of nursing practitioners. At present there appears to be a wide gap in the goals of nursing education and the expectations of nursing service. This gap can be demonstrated in the difference between the stated aims of the various educational programs and the job descriptions of nursing service for levels of competency, especially of the new graduate. The kind of educational background is seldom considered either in job descriptions or in requirements for state licensure.

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*Kakosh, Marguerite: Shortage: Nurses or Nursing? Reprinted by permission from the *Canad. Nurse, 60*:131, Feb., 1960.