OUR GOAL: PREVENTING LOSS OF THE THINGS THAT MATTER!

INADEQUATE & IRRESPONSIBLE NURSING PRACTICE: TODAY'S NURSING DILEMMA

It is late at night and my thoughts run to many years of teaching nursing and the values most nursing instructors try to instill in every student. My experiences the past few years have been disheartening as I have experienced what I notice as the deterioration of nursing practice. You, as nurses, might not agree with me (and that is alright); however, I would be remiss as a professional nurse if I did not bring this to our/your attention---because, I have heard many complaints and, honestly, not witnessed any other nurse *who is willing to do so.*

So, I left my little lace cap in the other room so I will say in this document what I see and the heavy heart associated with such observations. Hang onto your bonnets as this is not my usual theoretical document. This document is my "place" to say it as I see it (and as it is, really) and if you choose to read it, you will just need to take it as it comes and as I witness and experience it. I plan to add to this document as I see more concerns that need to be brought to our attention. Remember—we are professional nurses! That means we are different from physicians and other health care workers, as we are concerned with the direct and residual *health problems and outcomes of health problems and disease.* We are not subservient to any health care profession! We are unique and have a responsibility to "say it as we see it" for the betterment of the health of mankind—and be willing to represent what we know is right for the health care improvement of all mankind. Pull up you bootstraps, put on your armor as the keeper of kindness to others. Step forward, when needed, to say what needs to be said on behalf of mankind and the appropriate health care of every person in our society. Yes—you really can do this!!! And, I will be there when you do! I am the maverick you never intended to find that expects patient civility.

I wrote an document on the Critical Access Hospital (CAH) in association with the Montana Hospital Association. The officers of that association are kind, as well as the other involved group members that determined the CAH criteria. No doubt, they were very much involved in what they believed to be a legitimate and a fair compromise for services in hospitals of the "frontier" geographic locations. The concept is good—the outcome, however, now appears (to me) far too minimal to meet the health care needs in larger "frontier" communities being served by large corporate hospitals.

We have hospitals in "frontier" locations that are a part of very large national health care corporations and are located in reasonably "frontier" populated areas. The large corporate "frontier" hospitals are required to meet the same "minimum" CAH criteria as smaller "frontier" hospitals. We have extremely small "frontier" community hospitals meeting the same CAH requirements as larger national health care corporation hospitals in larger community "frontier" hospitals. If I understand this correctly, isn't there something wrong with this picture? Isn't there a wide (too wide) disparity between large corporation and small geographical community hospitals, yet they have the same CAH requirements?

Is it the corporation/institution/facility that encourages such a lack of effective nursing practice, or have we, as nurses, let the entropy process take over to the point of dismissing what was learned during our education at one time? Yes, time changes everything (so the song goes) and likewise everything in the universe. Nursing administrators are younger and less experienced, perhaps, and I wonder if there is more acceptance of not-so-good nursing—maybe due to litigious corporation/facility concerns of

employment? Or, have some nursing leaders just become lax due to longevity and lack of leadership ability regarding nursing standards?

And, the "beat goes on"----A few years ago, I became aware of a dear blind friend almost choke to death while eating alone in a hospital dining room. He had a constricted esophagus. I observed him left alone and saw the nurses during this time shopping on their computer. Today, I heard that a migrant boy was returned to the larger (much larger) group of migrants with the flu and a temperature of 103 degrees. Yesterday, I heard of an ER patient with an extremely painful headache with the recommendation to nurses just to provide him with more pain meds. It so happened he had a brain bleed and after-the-fact health professional were distraught that they did not respond earlier to his symptoms! Don't try to tell me that nurses could not have helped with these outcomes, because it is about time (if we don't), we should! Be patient advocates—speak up. As a past nursing professor, I assure you that professors attempt strongly to teach student nurses to think-think-think, perform accordingly, and you, as nurses of today and the future, are the professional light that through your thoughtful and intense (at times) insistence can save a life and the lives of many.

General management problems occur, also. Two months ago, I walked into a community hospital at 12:30 p.m. to locate a certain person (any person) to help with a personal billing problem. No one was in any office. The person I was looking for had no known office location (per the aide's knowledge)—even though she really did have an office. All offices were closed with no information on the doors in case of an emergency. The lunchroom (to my amazement) was totally full of employees eating lunch and visiting--loudly. In the corner, a committee meeting was occurring during the lunchtime with the sharing of confidential information. The Director of Nursing was not in her office, and on it goes! It is known as "location displacement." Now, this "committee meeting fiasco" occurs frequently, it appears, as I have seen it many times in the hospital lunchroom as a community visitor. To the CEO: Stop it!

A couple of weeks ago, I took my husband to the emergency room. The pain was intense, no chart was ready per a male's promise from my previous call and a female did not know of my coming—forget the male! No wheelchair was at the door, as they promised. I checked him in by sharing personal information so the whole waiting room could hear. As we waited for a wheelchair, my husband collapsed backward and fell over the back of the waiting room couch. Six patients were being seen by one provider (they said), with no one to respond to my husband or any other incoming possible emergency. Yes, they (ER) met the Critical Access Hospital criteria (a minimum requirement); however, no quality of care or concern was evident! After a lengthy time of waiting in the exam room, side rail down, excess pain experienced, and a nurse who *did not say one word* to me as I lifted his legs and held them from my one shoulder to another to relieve his abdominal pain and no question as to *my* discomfort. The nurse filled out paper work and prepared an IV site. The provider, when he arrived, was very nice and recommended surgery—which was appropriate, but did no hands-on assessment. As he left the room, he (the provider) leaned over to me and said, "Good job." The emergency room nurse did no additional nursing intervention or try to assist me with my efforts that was successfully relieving his pain and, therefore, causing me a great deal of discomfort. I resolved my discomfort after she left the room by finding a bedside table that could be used for my husband's leg elevation. I was the nurse playing the roll of the ER nurse!! By the way, I got "The Big Kiss" from my hubby for my efforts. I found out that there were two providers in the hospital at all times (so this hospitalist said). If there were ever an emergency or an over-load of ER patients (like the immediate influx of six patients we were told existed causing my husband to go without care for too long) is there ever a protocol to access the other

in-house provider for patient or emergency assistance? Who knows, but it appeared to not be happening. Would/could/should a nurse identify the need to acquire additional help?

Approximately 4 months ago, I accompanied a female friend to the emergency room with an obvious contagious viral infection accompanied by coughing, weakness, and malaise. The aide offered no wheelchair for transport, accompanied the patient to an exam room by having her walk down the hall with her (aide) arm around my friend's shoulder, and whispering in her ear, "Now, dearie—what seems to be the matter?" OK—so I bawled her out! Oh, well, she deserved it! Where was the education and expectations related to such contagious conditions? The uninvolved supposedly professional staff of approximately 4-5 stood behind the desk and heard what I said to the aide. When I went back to the patient's room, the attending nurse entered and said, "The boss was out there and he and others heard what you said—and they agreed with you!" So, who was responsible for teaching the aide, being aware of her inappropriate behavior, and redirecting her behavior? Nurses should have caught this inappropriate behavior by this aide and taught her appropriate behaviors related to disease transmission!

Last time I was a patient in the emergency room I was symptomatic of a blood clot in one leg. The stated "traveling nurse" took my vitals and did not even help me remove my leg from my pant leg or feel the pulse in my leg or foot.

I was just told of a well-known health-care corporation that sent a mother a $12,000. bill because her daughter was seen in the emergency room at night for acute abdominal pain and the insurance did not "cover" the E.R. for *such a diagnosis*. (Like a diagnosis can be determined before the assessment?) There must/should be an alternative consideration! Has anyone considered an urgent care program/service that is in-house during the night hours? It might be less expensive for the hospital and the patient/family—especially if a patient needs a pre-determined diagnosis that allows for hospital ER reimbursement before going to the E.R.---well, you know what I mean!! (As an example, my community hospital has 8a.m. to 5p.m. hours for urgent care). So, you, as a patient, better have a "payable" diagnosis by your insurance or the ability to pay thousands just in case *your* final diagnosis is not covered as an outcome of an ER visit. Now you are going to say-- maybe a patient should have better or different insurance as another option? Yes, maybe so! Oh, and another thing—the hospital in my area appears to have the ER staff (nurses?) answering the hospital incoming calls—so the operator told me. Hummmmm!

Sharing of personal/private information is interesting. The patient (or those admitting the patient to the E.R.) stands at a counter in the waiting room and shares for all to hear as they sit in the waiting room all pertinent and private patient information. Not even a rolling screen between the close areas exist. There is no attempt at patient privacy! Oh—the patient or person doing the admitting must stand and an elevated window. So—if you are the patient, you better be feeling well enough to stand and provide their required information. Yes, and I have brought this to their attention several times verbally and in writing over the past five years. One response was, "It is too expensive." Come on---

I stood at the door of a nursing administrator a few months ago. She was on the computer and grimacing as she looked at the screen. I stood there in the hallway at her open door for a few minutes in hopes that she would respond to me. Her only response was, "I cannot see you, now." "May I make an appointment," I said. Sarcastically, she suggested I come back in a day or two. No question(s) were asked by her and, consequently, no answer was given by me as to the reason for my visit. Such

disrespectful communication (verbal and nonverbal) was inappropriate! You guessed it—I never went back! I could go on and on about what I have seen, heard, and experienced.

Just today, my friend's sister tried to get up from a hospital bed where she was required to remain due to an upcoming amputation. She was also confused due to another diagnosis and sedation. She fell, hit her head, and was compromised further. Wouldn't a mattress responding to pressure be appropriate? Who "dropped the ball" on that potential problem? A law suit in progress?

I have informed the CEO in a letter of my persistent recurrent negative nursing experiences in the emergency room and elsewhere in the hospital. The Director of Nursing is not available and does not always respond to problems, even though she is a very nice young lady! However, what happens is that when a CEO is told of a problem because of no DON response, or when the DON is never available, the CEO does the usual and probably the best process—and gives the responsibility to the Director of Nursing—who usually does nothing. The Director of Nursing gives the information to the QA nurse (which she, as DON, informed me by e-mail that she (QA nurse) would be contacting me). No contact occurs. Consequently, no info is shared about the outcome of the problems. No follow-up occurs. This seems to be "passing the buck." The real question is, WHERE DOES THE BUCK STOP AND WITH WHOM? The outcome: No communication and no statement of an attempt to meet health care needs.

I promised you that I would keep adding to this document—so her goes! Recently, I visited an urgent care area. Where incoming patients use to line up and then move forward to a privately screened area to give their personal information, now this is the situation. There are three oversized booths that are suppose to accept patients to acquire their information which allows them to enter the health care system. Each booth is ringed at the top (totally) with red and green lights. So, when the green lights are on, the patient moves into that oversized booth to give his/her information to a secretary. The problem has been that the secretary inside the booth forgets frequently to change the lights to the appropriate color—green for availability to take patient information and red indicating that the booth is occupied by a patient providing personal information. The booths do provide adequate privacy; however, with three booths with numerous changing of the lights remind me (and others, they stated) of a carnival fairway or Christmas decorations. If a light system is used, would it not be just as effective (and more in keeping with appropriate decorum) to have one light at the entrance to each booth?

The booths are large enough so that in the corner there are supplies such as disposable tissue. That is good, but where do you dispose the disposable tissue once used? Hopefully, by now, someone has figured that problem out and a basket has appeared!

Not only are their lights completely around the top of the three cubicles, there are lights around a desk that sits at the end of the room that is not a part of the three oversized cubicles. Oh yes, that light has a tendency to not be the correct color (red or green) when I have visited the urgent care area—probably due to staff forgetting to change the color, as is appropriate. That desk at the end of the room was (and still is) a non-private area. When asked of the person doing the admission why she did not use the empty booth for patient privacy (which was available), her answer was, "Because I like to look out toward the door." So, the patient information I shared with her upon her request was also shared verbally with a man sitting directly to my left. Now—just the other day I went to the same desk that allows an overview of the front door and found messages to the staff posted on the wall behind the desk. The messages were what they (staff) could/need to do to improve care. My question to them was, "Why am I reading (as a patient) a message that is specifically directed toward staff? Why can't

that sign (since it is more obvious for me to see than you with your back to the sign), say something that is directed to me, as a patient, that I am of importance in this facility/organization. How about a statement indicating a goal, objective, mission statement or something reassuring to me as a health care consumer. When I talked with the receptionist who was behind the desk and explained that the message could be improved, it did not take long for a provider to come through a door to counteract my questioning of the situation. The provider said, “Yes, I see the comments on the wall as less than optimal.” So----

Being sent to the lab was an excursion down the hall to an empty lab area with locked windows, lights on, and no sign in the window. When I called per phone and asked about the situation that was causing another several mile trip to the hospital due to no lab technician available, I was, at least, talking to a young lady that understood my problem, apologetic, and upon a return visit for lab work, she appeared to be preparing a sign that would inform patients when a lab tech was out of the lab and how to contact a lab tech was in the facility.

I see that now there is a small computer imbedded in the wall near the entrance of the urgent care area. The purpose of the computer is to have a patient place their name and other information on the site. The sign as you enter the urgent care does not fully and accurately explain what a patient is to do regarding this walled computer device—or even where to accurately find the device! There is a desk near the walled computer where a person is to sit and hopefully give guidance. When I was there, this space was tentatively occupied by a man actively visiting with another large standing man who was obscuring the view of any person who might come through the door. The conversation was an obvious friendly and congenial conversation with nothing to do with the job of directing patients. I came through that door, never was greeted, asked, or directed to anything. My question is,: If I am sick, have a baby/child in my arms, elderly and have no ability in using computers, who is going to help me? Obviously, no one that day! Another question—why does a person need to personally complete information on that small walled computer when the same information will be given inside one of those lighted privacy booths?

I wanted to talk to a facility supervisor about my concerns. A lady called and I gave her suggestions to have her staff initially consider the philosophy, mission, goal, objectives of the facility. I encouraged her to allow her staff to read the document on transformational and transactional leadership. No sooner had I said that, she closed the conversation quickly and hung up. Obviously, it was just a call to fill a courtesy requirement. I know it is difficult to hear improvements and suggestions by some people. However, the fact that a person will not listen and explore possibilities of improvement is a telling of their lack of leadership.

One morning I could not get the medication cart locked with included narcotics. It was my first time to lock the med cart. It was time for shift-change report to start. When I finally got the drawers aligned so as to allow locking up the cart, I looked up at the clock and I was 5 minutes late to the change-of-report. I scurried down the hall, tried the door, and the door was locked. I knocked on the door, no one would answer the door. I went back to the nursing station. A male aide asked if I needed help. Of course, I told him no one would answer the door to the report room and I was 5 minutes late to report due to not being able to lock the med cart. He proceeded down to the door, pounded loudly and hard on the door and the door was opened. There was never an attempt to see why I was not in the report room. I could have had a resident concern, needed help, or some other legitimate problem. No attempt was made to

determine the reason I was not in the room at exactly the expected time. The resulting demeanor by the other nurse was anger with no attempt to understand the problem. Reminder: If we cannot/will not treat each other with respect and dignity, how are we suppose to be able to treat and "nurse" our patients/residents or even each other in an acceptable manner? I have often wondered why the nursing aides did not say something or do something. I later found out that the nurse who chose not to answer the door had often presented herself in the past in a negative fashion by bringing her negative behaviors to the job.

Now—I am not a "spring chicken." AND I AM A PATIENT, AT TIMES! I have been a leader and administrator in nursing institutions, worked in every department of the hospital, owned a home-care business, taught nursing at prestigious universities, taught international physicians at Stanford University about the intended role of nursing, authored a book on leadership theory, and have an active leadership website with approved ANA CNE articles. I am, also, a consistent author for Montana Nurses Association PULSE newsletter. Yes, I am a well-seasoned senior citizen—but, no dummy!! Something is happening—What I see is that nursing care is decreasing its positive involvement and increasing its participation in unacceptable nursing behavior! Administrators can always give the problem to someone else and then nothing happens. Nurses, also, seems to be doing paper information gathering as a priority. And—where are our educators in this process?

In talking with others about my hospital experiences, they confirm the same similar experiences and plan to go out-of-town for health care. We, as community consumers of health care, try to identify the reason for nursing care changes in what was considered to be very good to something less acceptable. The question is whether it is because of a nursing behavior choice, a literal entropy happening in nursing practice, hospital encouragement/allowance of inappropriate or unavailable nursing care, lack of knowledge as to what nursing is about, fear of law suits, poor nurses and nursing administrators in wrong places and jobs, nursing administrators not knowing where the buck stops? (By the way, it stops with administrators to see that quality nursing performance occurs, standards of nursing behavior--job descriptions-- exist, and holding nurses accountable to those standards!) There are probably many other covert reasons! You think about it, and you ask yourself if these behaviors are part of your nursing practice. I hope not!!

Another thing—CEO's need to learn to be appreciative and respectful of the nursing knowledge that more mature and experienced nurses offer. The young inexperienced registered nurses have some ability to offer, energy to spare, but usually very little nursing experience in leadership and dealing with human behavior! There is a place for nurses with different education, experience, and personal talents. Administrators and health care organizations should think more than twice about placing such nursing accountability, leadership, and management as a job responsibility with poorly experienced and only moderately prepared nurses when these nurses are dealing with people in crisis. More mature (yes, even older, more experienced, and educated) nurses are often the best choice for responsible leadership and management of healthcare. And—if money is the bottom line so that hiring and placing marginal nurses in responsible positions occur, you can bet that community members will get the picture of inadequate care quickly---as many already have, so they say.

What should **we, as nurses,** do about the problem? Well, we **DON'T** sit by and accept such inadequate and unnecessary sloppy nursing care. If WE don't identify the problem and hold nurses and administrators accountable, WE are part of the problem. Complacency was noted the other day when I

asked a young mother who works at the community hospital if she plans to be an administrator so she can improve the nursing care. Her response was, "No way!!" How sad to hear that comment and see the expression of non-interest (even horror) on her face! I have to wonder why?! When visiting another facility, I was told that there are several nurses who refuse to continue to work in the existing situation; therefore, they seek other employment with them.

I am sure there are many hospitals that do well and many that do poorly when it comes to providing good care. We do have nurses of all ages (including "old nurses" in many communities) who are willing to help in some way to improve a community hospital---maybe even on a hospital board or just as a free consultant. Even a local hospitalist I shared my concern with at a recent meeting agreed with me.

If a variety of talented nurses are not involved with problem-solving with hospital corporations, nurses of all ages and talents are not often hired—often times, the main emphasis is "the bottom monetary line." Oh yes, *promotion from within* and *traveling nurses* help to maintain the status quo. If sensitive caring nurses are not more out-spoken on many instances of less than acceptable nursing practice, the decline of nursing care will probably continue.

To the nursing educator invited to be on the hospital board: Thank you for listening to my concern on behalf of all patients! There is no intent by me to imply that nursing educators do not do their best to educate student nurses. But, ask yourself why you are on the hospital board. You, no doubt, have proven your support of the existing system and maybe not a person who has the personal strength to question the existing less-than-acceptable nursing behaviors. I was one (nursing educator and board member) once and like all other educators, did my best! I trust you will do your part to encourage corporate quality nursing care (QA) as well as encourage future nurses, as an educator, to perform with kindness and quality nursing that meet more than minimal standards (CAH standards). Be not afraid to carry the torch of quality nursing care, present theoretically proven concepts for possible change. It takes all of us, educators, health care consumers, and hospital administrators, to make a positive difference!

The educator's role on a board is mainly to understand the problem(s) and concerns of the organization for the purpose of <u>teaching</u> student nurses the role performance and improvement of quality nursing care. The evidence of quality expectations and performance of overall quality care is self-rewarding for students and as a practicing nurse, increasing their desire to become a part of something good that represents their vision of nursing. In contrast, the consumer's role on a board is mainly to <u>share concerns</u> of quality care and, perhaps, share possible needed changes that could decrease concerns and improve the quality and safety of care.

Oh, ya, I hear the drums saying the organization's love to hear our input as users of the existing health care system. However, the opportunity to really listen to what is being said often goes unheard and with no response. Both types of board members (educators and consumers of nursing care) provide valuable input from different perspectives! It is like looking into the "house of health care" through different windows; consequently, with different views of the internal workings. Sometimes it is so scary due to the actual listening to "the messages", the only thing a consumer can do is remove him/herself from the entire facility/organization.

Nurse administrators need to understand that all practicing nurses in an organization <u>must</u> have standards of performance (job descriptions) that <u>must</u> be readily available at all times, reviewed with

nurses frequently, evaluated as to compliance, rewarded accordingly, and inadequate nursing chastised, as needed.

We, as community potential patients, are and will go elsewhere (when possible), if nursing administrators cannot/will not use appropriate measures to control quality of nursing care. We, as community members (as well as nurses working and living in the community), deserve better. Remember that providers will also diminish in the numbers of patients as an outcome of ineffective, less than optimum, and negative facility/organizational standards. The diminishing use by health care consumers of the organization's providers might have nothing to do with the quality of provider care as much as the general carry-over of negative organizational experiences, attitudes, and feelings related to poor organizational behaviors.

I would love to hear your comments and suggestions on how all nurses can be more instrumental in nursing care improvement.

Recommended reading:

Entropy, A Factor for Change, Published by MNA in the PULSE, February 2017-Vol. 54-No. 1. Website: leadershippoweronline.com (Same author)

Job Descriptions and Application, Published by MNA in the PULSE, November 2017-Vol. 54-No. 4. Website: leadershippoweronline.com (Same author)

A Board: Power Through Selection and Process, ANA approved for CNE. Website: leadershippoweronline.com (Same author)

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Impoverished Leadership:

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