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 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. And, I have a hard time believing that health care providers and nurses cannot be acquired for such health care assignments—so I don't want to hear it!!

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. CAH hospitals in the less populated "frontier" communities might not be as affected by such CAH minimization—they probably have no choice. These smaller hospitals that have no choice and can barely meet the minimal criteria probably just to survive and do not have the staff—to boot! So, 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?

Hello-has anyone considered the need for separate categories within the "frontier" CAH status (especially in the ER) that require larger corporate hospitals in larger populated areas to provide more

adequate and safe health care? Or, maybe, the larger hospital systems (the systems with large hospitals elsewhere) that are located in "frontier areas" *take advantage* of the CAH minimal criteria to save money for their larger corporation? I hope that is not the case!! No one can blame the large corporate hospitals for not complying to the given law to their advantage—but, consumers feel and experience the difference! Maybe it is time for re-identifying/recategorizing/differentiating the minimum CAH criteria for community "frontier" hospitals that are an extension of larger health care organizations and the smaller non-corporate hospitals, as well as considering the population number being served. And—how about the hospital that has a school of nursing in their backyard/same town. Maybe my perception is distorted!? Email me your perception. I am willing to read it and maybe change my mind.

I think my thoughts are indicative of what is called, "Poking the Bear!"

My question is: 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 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. 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

met the Critical Access Hospital criteria (a minimum requirement); however, no quality of care or concern was evident! After a lengthy time of waiting, 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 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" for my hubby for my efforts. I found out that there are 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 7a.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! 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 as to the reason for my visit was given by me. 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. 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.

Now—I am not a "spring chicken." 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 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.

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 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 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.

Communication: What needs to happen in a leader's professional life to have them recognize that verbal or written communication is extremely important? We have telephones and computers—if no actual person is at our side or within hollering distance. Communication and sharing of ideas are two of the most important aspects of professionalism. A leader can push a communication off to another person who might have such a job assignment, but, if one person is willing to take the time and effort to communicate to one person in a health care employment situation, that person receiving the communication should find the time to say at least, "Thank you for keeping me informed," or something of that nature—or maybe answer a question that was posed. Leaders that learn soon in their career that sharing and confirming receipt of information will immediately have an extreme edge on leadership success! Don't effectively communicate---watch out for negativity in all areas of work and lack of support to get "the job done." Many times, I have written an email to share information to hospital personnel (leaders) with no response. No response of some kind is irresponsible!

OK—so I have experienced a negative outcome of this! Have the courtesy to respond in <u>some appropriate way</u> to any/every person who uses health care services, provides information, or asks a question. Maybe it is a verbal "Thank You." Maybe it is a call, "How are you doing?" I have, also, experienced something very positive. The positive communications were signed cards from the local hospital staff thanking me and my spouse for using the hospital for surgical events—good job!

What should **we, as nurses,** do about the problems? 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 on her face! I have to wonder why?!

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." 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. I was one (nursing educator) for many years 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). It takes all of us, educators, health care consumers, and hospital administrators/leaders, 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 teaching 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. The consumer's role on a board is mainly to share concerns of quality care and, perhaps, share possible needed changes that could decrease concerns and improve the quality and safety of care. Both types of board members 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 of the household.

Nursing leaders need to understand that all practicing nurses in an organization must have standards of performance (job descriptions) that must 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 leaders and hospital 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.

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)

Job Descriptions: The Theoretical Yin/Yang Process

Verbal Communication: A “No-Return” Policy (to be published in Feb. 2019 in MNA PULSE)

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Impoverished Leadership:

Recognition and Restitution