

NSG330: Practice Change: Paper 3

Experienced nurses intercept poor outcomes before they create an expense. Aiken, Clarke, Sloane, Sochalski, & Silbur (2002) characterized nurses as “an around-the-clock surveillance system in hospitals for early detection and prompt intervention when patients’ conditions deteriorate,” (p. 1992). It follows that these nurses must, on some level, hold a cost-containing capacity. Hospitals are downsizing their nurses when in fact they could be costing themselves more by doing so—through monetary expenses and negative patient outcomes, both which are damaging when left unchecked.

The mind of an expert nurse is in a state of constant assessment. Every opportunity the hospital design allows for an RN and a patient to spend time together is an investment in cost-effectiveness. Increased RN-patient interaction is an opportunity for assessment. Assessment is what leads to the detection of subtle patient changes that, if unnoticed, lead to obvious and costly complications that drain the hospitals financial resources as well as the strength of a patient’s potential for wellness.

Since poor outcomes debit potential for success from both hospitals and patients, as well as the insurance companies that must pay the hospitals, it seems reasonable for all involved to support a health care system that accentuates nurses, who make deposits of success in the form of quality nursing care. If this is too unrealistic a goal, than the support of research that could demonstrated whether or not RNs are agents of cost-effectiveness might suffice. If nothing else, hospitals, insurance companies, and the patients who pay for coverage should refuse to allow the current system to continue, in which their resources are wasted on potentially preventable complications.

There are those that agree that research as well as the recent history of nursing, indicate that a practice change is necessary. A recent study (Aiken et al., 2002), which used cross-sectional analysis to examine data obtained from 10,184 staff nurses and 232,342 patients found alarming results regarding the relationship between nurse staffing and patient mortality and nurse burnout. Aiken et al.'s (2002) findings indicated that hospitals that routinely have a patient-nurse ratio of 8:1 rather than 4:1 could expect 5.0 excess deaths per 1000 patients and could expect 18.2 excess deaths per 1000 "complicated" patients. Furthermore, the nurses who worked at the hospitals with the highest patient ratio were more than twice as likely to experience burnout from work. Aiken et al. (2002) report that recent published estimations of what it costs a hospital to replace a medical-surgical nurse and a specialty nurse were \$42,000 and \$64,000 respectively. These findings spell disaster for a society in which the patient population, particularly the elderly, is growing, the number of nurses both coming into and staying in nursing is dwindling, and hospitals do not, or perhaps refuse, to recognize that the current design is only perpetuating the problem.

The truth that the current system is growing increasingly inadequate is made evident by Brannon (1996) who articulates that "critical studies of these work redesign methods indicate that in reality the methods are applied with more of a focus on improving productivity and cutting labor costs than improving the quality of products and worker or consumer satisfaction," (p. 648). In other words, under this current model, the hospital's priority seems to be cranking out the most nursing care with as few RNs as possible rather than strengthening itself with satisfied nurses and patients. This is somewhat comical considering that these two parties, who are central to the hospital

industry, whose critically intimate relationship is its framework, and who have lives and licenses hinging on its efficiency and success, ironically have the least input and influence over the manner in which it is structured. It would behoove hospitals to start paying attention to their patients and nurses, both of which, as evidenced by Aiken et al. (2002) are suffering and creating great expense in doing so.

It must be demonstrated to hospital administrators that “nurse surveillance” saves money. To this end, research must be conducted that tallies the expenses of the complications most often prevented by RNs. Special attention should be paid the costs of infection: antibiotics, length of stay, lab work, diagnostic testing. For example, how much does a course of IV Vancomycin cost, including the extended length of stay in the hospital, and corresponding lab and diagnostic testing? Does it cost more than it would to pay an RN to prevent that infection? Brannon (1996) describes team nursing as a design in which tasks are spread out among many and primary nursing as one in which tasks are combined into the nurses job description. As expressed by Brannon (1996), “if the productivity gains of recombining tasks exceeds the wage differential between RNs and nonprofessional workers, management has an incentive to reunify tasks,” (p. 645). Perhaps all of our health care resources are being consumed by complications that might have been prevented had the patients care come primarily from nurses and not unlicensed workers.

Brannon (1996) suggests that team nursing is actually an impediment to the nurse’s ability to act as a “surveillance system.” When reviewing the problems of the last trend of team nursing, and there is little, if any, reason to believe that the current trend would be different, Brannon testifies that “...a more continuous presence at the bedside

provided LPNs and NAs a countervailing presence of power in that their proximity to patients resulted in their acquiring knowledge about patients and an experience of responsibility for their care that competed with RNs' professional responsibility," (Brannon 1996, p. 646). As those with sole responsibility of patient care, nurses should be the possessors of the presence, proximity, power and knowledge that makes up the nurse-patient relationship. These are the nurse's tools by which he/she can most closely survey patients. This is a role that distinguishes an RN from other "nursing personnel" and it is in this capacity that the nurse can function as an agent of cost-effectiveness. When other members of the team interfere with the nurses relationship with the patient by taking opportunities away from the nurse to be at the bedside assessing the patient, this is cause for concern.

As concluded by Aiken et al. (2002), "the association of nurse staffing levels with the rescue of patients with life-threatening conditions suggests that nurses contribute importantly to surveillance, early detection, and timely interventions that save lives," (1993). With this in mind, a nurse's ideal work environment would be one in which allowed him/her to be at the bedside as much as possible with the most support—namely, a form of primary nursing.

During the 1970s and 1980s the interests of hospital management and nurses came together and resulted in a practice change that met both sets of needs. This change was a transition from team nursing to primary nursing. As told by Brannon (1996),

RNs were viewed as more productive than a stratified work force in that they could perform the entire range of nursing tasks with out supervision. Nursing

leaders' interest in professionalizing the hospital work force had converged with administrators' interest in containing costs and increasing productivity (p. 646).

Brannon continues to discuss how the trend switched back to team nursing in the 1990s. By its very nature primary nursing empowers RNs with autonomy and the basis on which to ask for more money. When these factors were added to reoccurring staff shortages, administrators became motivated once again to introduce nonprofessional workers into nursing.

One cannot expect the nursing profession to adopt true primary nursing at a time when the nurses are simply not there. This is why some may question if now is the appropriate time to push for primary nursing. Brannon (1996), however, offers a suggestion that could be labeled as a form of modified primary nursing, in that instead of completely eliminating all supportive nursing staff, workers could exist to "assist" the RN in what Brannon (1996) describes as "lower-level tasks" and "support services". Perhaps these workers could exist more on the periphery rather than function as nursing assistants do now, spending more time with the patient than the nurse.

This proposed practice change obviously calls for drastic structural changes that would take considerable time to implement under the best of circumstances. In order to make the change palatable for hospitals, further research similar to Aiken et al. (2002) would have to be conducted. In addition, research that determines a price list for such things as infections, pneumonia, and bed sores would provide valuable information to hospitals to weigh against a nurses salary. Finally, should the cost-effectiveness of RNs be firmly established and accepted as reality in the future, a shift back to some form of primary nursing would be worthy of consideration. The goal should be to re-empower

nurses to realize and exercise their power to drastically affect patient outcomes and to structure hospitals to support this function. In doing so, hospitals would be rewarded with a professional workforce whose purpose it is to save lives, and incidentally, money.

The profession of nursing currently finds itself at a critical time, being encompassed by the nursing shortage. Nursing is in a position where it must, as one author put it, become “distinct or extinct” (Nagle, 1999). Hospitals who concurrently face the emergent shortage must, in the interest of their budgets, problem solve. In most cases, the “solution” to the problem has been to terminate more experienced and expensive expert registered nurses (RN’s) and hire minimally trained and less expensive unlicensed assistive personnel (UAP) to support a diluted nursing staff. Many, however, question whether this restructuring of hospitals results in a lesser quality of care (Sochalski, 2001; Kovner & Gergen, 1998; Blegen, Goode, & Reed, 1998; & Blegen & Vaughn, 1998).

One must also ask how negatively this potential drop in quality affects patient outcomes. Seeing that adverse patient outcomes that result from decreased quality of care present expenses of their own, might these expenses be outweighed by the retention of expert nurses who, by serving as a “surveillance system,” have the ability to prevent them? In the event that high-quality care is proven to yield cost-effectiveness through patient outcomes, nurses would have a solid, researched based argument to present to hospitals who have adopted the opposite belief in the fight against the nursing shortage. In the event that high-quality nursing is not proven cost-effective, hospitals will have to determine how much quality they can afford.

There are those that believe that the drastic times that nursing currently finds itself in call for drastic measures. Aiken et al. (2002) affirms through their research a

connection between staffing and patient mortality and nurse burnout. These researchers therefore suggest that “by investing in registered nurse staffing, hospitals may avert both preventable mortality and low nurse retention in hospital practice,” (Aiken et al. 2002, 1993). Brannon (1996) agrees with this proposition and advocates for a form of primary nursing in which primary nurses are supported, not replaced, by assistive personnel. Brannon (1996) asserts that,

Efforts to drastically reverse staffing patterns and to displace RNs to levels characteristic of the team nursing period is obviously not in the RNs interest and may be unwise with respect to both cost containment and the quality of patient care in hospitals,” (p.653).

It is clear that nursing and patient care is in dire need of an intervention.outcomes. Coupled with the truth of Benner’s (1984) theory of nurses progressing from a novice to expert stage, and expert nurses providing the most awe-inspiring, exemplary care, it seems tragic that a popular strategy for hospitals has been to terminate large numbers of expert nurses to contain cost. In reality it could be that eliminating expert nurses only maintains the cost of poor patient outcomes. May hospital administrators, legislatures, and researchers, soon discover what perhaps nurses already know deep inside, that registered nurses, high-quality patient care, and cost-effectiveness go hand in hand when practicing in an environment that believes such.

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