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Chapter 1 : Nursing and Medicine During World War II | blog.quintoapp.com Blog

Nurse anesthetists, nurse midwives, and nurse practitioners, also referred to as advanced practice registered nurses (APRNs), coordinate patient care and may provide primary and specialty healthcare. The scope of practice varies from state to state.

You woke up with a burning sore throat, and your mom says you need to go have it checked. Nurses are important people. Not only are they often the first health care professional that a sick or injured person sees, but they do their job in all kinds of settings â€" from local hospitals to faraway military bases. Some even work in the sky or at sea, helping to transport sick people on planes or caring for passengers on ships. In fact, anywhere in the world you can find someone who needs health care, you can probably find a nurse. Where Do Nurses Work? Where are you most likely to meet a nurse? Nurses in medical offices typically assist the doctor by asking you about your symptoms, taking your temperature and blood pressure, checking your weight, giving shots, and collecting blood or urine samples for lab tests. School nurses certainly see their share of kids with stomachaches, chickenpox, nosebleeds, and bumps and bruises. But they also have the important job of promoting good health. How do they do it? School nurses do vision, hearing, and scoliosis screenings and teach kids how to take care of themselves through good nutrition, exercise, and hygiene. They also help kids with special conditions, like diabetes, by teaching them about their condition and monitoring them. Hospital nurses provide round-the-clock patient care. Some nurses even work in the operating rooms alongside the doctors. Some nurses work directly in the community. These nurses teach people with special health problems like diabetes or asthma how to manage their conditions. Whatever type of work they do, the best nurses have one thing in common: They also give patients and their families compassionate support at a time when they need it most. Nurses are educated to care for the whole person, not just treat whatever health issue somebody has. How Does Someone Become a Nurse? There are actually dozens of different types of nurses, each with its own level of training. Basically, the more formal education a nurse has, the more responsibilities he or she can take on. People who want to become nurses have to decide which path is right for them. Some people know early on that they want to be a nurse. They might volunteer in hospitals when they are in high school and then go on to college to get a nursing degree. Whichever way people come to nursing, here are some of the paths they can take: A licensed practical nurse provides basic care to patients under the supervision of a registered nurse. Things an LPN might do include helping a patient bathe and dress, administering certain types of medications, changing wound dressings, and taking vital signs. An LPN has at least 1 year of training in providing this kind of care. All RNs have a degree from a 2- to 4-year nursing program. They study subjects like chemistry, biology, anatomy, and psychology, and they also get lots of hands-on practice called "clinical training. Registered nurses need a nursing license. To get a license, a nurse must successfully complete a nursing program and pass a test called a licensing examination. To keep that license, a registered nurse must continue to take classes every few years to make sure his or her skills are up to date. RNs also need additional training if they want to "specialize" â€" that is, focus their care on one type of patient, such as newborn babies or the elderly. Registered nurses also can become certified in a certain area of expertise, such as emergency or intensive care. There are many types of APNs, including a certified nurse midwife who is trained to deliver babies , certified registered nurse anesthetist CRNA, who specializes in giving and monitoring anesthesia , and a nurse practitioner NP. A nurse practitioner is a type of advanced practice nurse with training in a specific area, such as pediatrics. An NP often is the one who takes a medical history, does an initial physical exam, writes prescriptions, and treats illnesses and injuries. In fact, you may see an NP instead of a doctor at some of your office visits. They wore white dresses, white shoes, and a crisp white hat. And they were all women. A lot has certainly changed in the last 40 years. In fact, the number of men in the profession has been steadily rising. Still, with people living longer and needing more health care, there are simply not enough nurses to go around. Some experts estimate that by the year , there will be a shortage of 1 million nurses â€" and that translates to a lot of sick people who may not get the care they need.

Chapter 2 : Nursing - Wikipedia

The International Council of Nurses chose the theme of 'A force for change: Care effective, cost effective'. In the UK, The Royal College of Nursing have chosen the theme '#WhyInurse' for Twitter. This is to show the public the reasons why they chose that path.

They treat patients who are chronically ill or at risk for deadly illnesses. Once the exam is passed, then someone can start working as a regular registered nurse RN. After getting hired into a critical care area, additional specialized training is usually given to the nurse. After hours of providing direct bedside care in a critical care area, a nurse can then sit for the CCRN exam. The American Association of Critical Care Nurses advisory board sets and maintains standards for critical care nurses. The certification offered by this board is known as CCRN. Depending on the hospital and State, the RN will be required to take a certain amount of continuing education hours to stay up to date with the current technologies and changing techniques. All nurses in the US are registered as nurses without a specialty. The CCRN is an example of a post registration specialty certification in critical care. These certifications are not required to work in an intensive care unit, but are encouraged by employers, as the tests for these certifications tend to be difficult to pass and require an extensive knowledge of both pathophysiology and critical care medical and nursing practices. Intensive care nurses are also required to be comfortable with a wide variety of technology and its uses in the critical care setting. The training for the use of this equipment is provided through a network of in-hospital inservices, manufacturer training, and many hours of education time with experienced operators. Annual continuing education is required by most states in the U. Many intensive care unit management teams will send their nurses to conferences to ensure that the staff is kept up to the current state of this rapidly changing technology. In Australia there is no compulsory prerequisite for critical care nurses to have postgraduate qualifications. However, the Australian minimum standard recommends that critical care nurses should obtain postgraduate qualifications. There are many critical care nurses working in hospitals in intensive care units, post-operative care and high dependency units. They also work on medical evacuation and transport teams. The Globe staffers spent eight months shadowing an experienced nurse and a trainee nurse to learn about nursing practice first hand. The result was a four-part, front-page series that ran from October 23 to 26, , entitled Critical Care: The making of an ICU nurse. When the nurses develop strong relationships between their patients they are able to obtain important information about them that may be helpful to diagnosing them. Also, family members that become involved in this relationship make it easier for the nurses to build these trusting relationships with the patients because the family members could ease any stress that could lead the patient to be timid. Geriatric patients are considered to be people over the age of 65 and nurses that specialize in geriatrics work in an adult intensive care unit ICU. Pediatric patients are children under the age of 18, a nurse that works with very sick children would work in a pediatric intensive care unit PICU. Finally, a child is considered a neonatal patient from the time they are born to when they leave the hospital. If a child is born with a life-threatening illness the child would be transferred to a neonatal intensive care unit NICU. Some places that they can work most commonly include hospitals: For example, a unit that is an adult intensive care unit, specialized in the care of trauma patients would be an adult trauma intensive care unit. Another example could include an intensive care unit solely to care for patients directly before and after a major or minor surgery. In South Australia critical are nurses are recorded to work approximately While in the Northern Territory critical care nurses have been documented to work It all depends on the job and where they are working [12] Critical care nurses in Australia do not need to have extra training than regular RNs do unless they have completed a postgraduate qualification. Therefore, their salaries are usually similar. Commonwealth and all State and Territory Health Ministers. University Alliance, Bisk Education Inc.

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Chapter 3 : Nurses Take on New and Expanded Roles in Health Care - RWJF

RN tells my mom that I don't need to take pre-requisites to become a nurse. Today my mom met with an Nurse on her job (my mom is a CNA) she asked, about what I wanted to do and my mom told her I want to become an RN.

Print Nursing is one of the most exciting and in-demand jobs in the world today. The profession is known globally for having excellent wages and greater benefits. However, the idea that nurses are nothing more than a supplementary asset for doctors is just one of the many preconceived notions that nurses have been facing for years. People often think that nursing is just an easier alternative to becoming a doctor. When can we escape from this? But this irrational assumption has proved nothing through the years. It only motivated nurses from showing the world their worth and how much of a difference nursing makes. So what can we do about this? If you are a nurse, then you should wear the title with pride. Not many people are capable of doing what you do, and even fewer are capable of doing it with the charisma and passion you do it with. Just always remember that we, nurses, are unique. We have the power to promote comfort and relieve strife. Many times we are gifted with the privilege of seeing rapid results of our caring actions. The true benefits of nursing are felt in our minds and hearts. No matter how hard we try, only a nurse can truly understand and appreciate the magnitude of our job. Below are some of the greatest nursing quotes written by famous historical figures. Take time to read and experience the potential and influence of nursing through these inspirational quotes! Great Blessings of Humanity The trained nurse has become one of the great blessings of humanity, taking a place beside the physician and the priestâ€¦. Nurses dispense comfort, compassion, and caring without even a prescription. Nurses are patient people. Biggest Strength and Fatal Flaw Nurses are a unique kind. They have this insatiable need to care for others, which is both their biggest strength and fatal flaw. In most every culture, such moments are regarded as sacred and private, made special by a divine presence. What an honor that is. They may forget your name, but they will never forget how you made them feel. It takes a very strong, intelligent, and compassionate person to take on the ills of the world with passion and purpose and work to maintain the health and well-being of the planet. Our job is to stand together, to carry the burdens of one another and to meet each other in our questions. All in Caring for Patients is part of Nursing Soul!

Chapter 4 : 45 Nursing Quotes to Inspire You to Greatness â€¢ Nurseslabs

Nurses Take on New and Expanded Roles in Health Care January 20, Massachusetts General Hospital is known for medical innovations such as the first public demonstration of surgical anesthesia and the first replantation of a severed arm.

One of these way involved the medical field, or specifically, nursing. Nursing is a key element of healthcare and during times of war it can be the difference between life and death for a wounded soldier. During World War II, this important fact became more obvious than at any other time in the history of war. Not only did the number of female nurses increase significantly during the war, but the roles that nurses played became more critical. In , the Army Nursing Corps had a severe shortage of nurses with fewer than seven thousand nurses, leading to the need for nurses to volunteer to serve. In order to join the Nursing Corps, a woman had to meet certain criteria. Naturally, she had to be a citizen of the United States and she had to be a registered nurse. Women interesting in serving had to be between the ages of 21 and 40, meet the military health requirements, and have no children who were younger than 14 years old. Prior to , nurses were not required to have any special military training, but this changed in July of From that point forward, WWII commissioned Army nurses were required to undergo additional training such as field sanitation, and depending on their area of nursing, psychiatry and anesthetics, and physical training to help build up their endurance. Training also taught the nurses new skills that were necessary for serving as a field nurse such as learning to set up field medical facilities. This allowed them to provide faster care to the wounded. The nurses often worked and served under harsh conditions. Their reality forced them to not only adjust to these conditions, but to also improvise and make emergency decisions on the spot. In some instances their proximity to war saw Army nurses using firearms for protection. In addition to working in field hospitals, some nurses underwent additional training to become flight nurses or evacuation nurses. The positive advancements of nurses were not shared by all women, however. African-American nurses battled for admittance to serve during the war. Ultimately, only five hundred African-American nurses were allowed to serve, and those who did were allowed to only care for African-American soldiers and German prisoners of war. World War II brought nurses closer to battle than ever before. They were allowed to demonstrate their skills and competence during extreme, dangerous conditions. In addition, they were also able to serve in all of the arenas of war. Although being so close to battle also put nurses at risk of becoming prisoners of war, the risk was outweighed by the service that was provided and the lives saved. Read the following links for more information about nurses during WWII. A Story of Caring and Sacrifices: This article reviews the history of female nurses in WWII. Although it begins discussing Britain, the primary focus is on American war nurses. Short History of American Nursing Overseas: The page discusses flight nurses and nurse POWs. On this page readers can review the information from a brochure from the U. The information provides a thorough review of nurses during WWII. Nurses in All Branches: This is a brief article that discusses women becoming nurses during WWII and the change from normal roles expected of the women at the time. On this page readers will find a brief history of modern nursing. An Introduction to the Past: Click this link to read about the overall history of nursing. Click on this link to learn about the struggles of black nurses during WWII. The article discusses the effort to serve as nurses and the restrictions that were met. Further down visitors to the page are given further information about the nurses who served during the Second World War. Click this link to learn how Pearl Harbor affected nurses entering the war. A brief review of what flight nurses did.

Chapter 5 : Letters: Doctors and nurses -- who will take care of us? - latimes

To combat the impending physician shortage all across California, and the crisis already facing rural areas, state law absolutely must change to allow greater independence for non-physician medical professionals such as nurse practitioners. Merely increasing the number of medical students will not.

They attend deliveries, weigh and measure infants, bathe them and monitor their health. They also teach new parents about newborn care and breastfeeding. Neonatal nurses certainly have their work cut out for them. Newborns today face some challenges -- addiction, HIV infection, premature birth. They need care and comfort to survive and thrive. Neonatal nurses give them the care and compassion they deserve. We work as a team with the doctors to help the babies," says neonatal nurse Susan Early. Hospital work requires nurses to be composed, caring and in control every second of their shift. Although neonatal nurses witness the miracle of birth every day, they also view untimely infant deaths. I would say my career is more rewarding than fun. Intensive-care nursing demands sharp monitoring skills and special care immediately after birth. Typical duties include starting and maintaining IV lines, managing ventilators, assessing vital signs and drawing blood. New parents also require special care during this time, so neonatal nurses are in frequent contact with worried families. Neonatal nurses work with needles, feeding pumps, incubators and ventilators. This means neonatal nurses must keep current with the latest instruments, procedures and research through continuing education and medical journals. As nurses take on increasing responsibilities previously restricted to physicians, a strong educational background is a must. Johnson is the operations manager for the National Association of Neonatal Nurses. Working hours depend on the facility. Some hospitals schedule a three-day week with hour days. Other hospitals schedule eight-hour shifts. Expect to work some weekends, evenings and holidays. Neonatal nurses must be physically fit with adequate vision, hearing, dexterity and mobility. At a Glance Take care of newborn children You must be comfortable with modern medical technology Tools of the trade: This movie requires QuickTime.

Chapter 6 : 15 Super Great Non-Hospital Nursing Jobs for Nurses - blog.quintoapp.com blog.quintoapp.co

Home About us Newsroom Healthy Headlines. Healthy Headlines Health heroes She does it all. She does it all 'Doctors and nurses take care of patients. I take care of.

You have a very salient point Nonetheless, a sizable number of Boomers in my personal life are now deceased, including my mother age 58, died of ESRD , a female stepcousin age 62, died Dec. To be fair, my numbers might be skewed because I come from an environment where preventive care and healthy living were basically blown off. He is also a pack-a-day smoker. If he continues his unhealthy lifestyle, I do not foresee him living into old age. Again, this is just a glimpse into my world and the unhealthy Boomers I know or knew. A lot of this also has to do with education levels and SES. Most of my friends and acquaintances exercise frequently and try to eat healthily. But the key is we are all college educated, gainfully employed and relatively affluent, so access to good, preventive health care is not a barrier. You also have a really salient point. Thank you for commenting. Your post was eye-opening and helped me see the situation of sick Boomers from another valid angle. Honestly, it is not the fault of the patient. It is when hospital administration brings in Disney Corporation to ensure that they receive an amazing experience. I was a traveler for years and it was just getting worse and worse. I went to see my primary care doc yesterday who is now owned by a large hospital corporation here in Georgia. He told me it is "misery". I already knew this. They have to see a patient every 5 to 10 minutes. The demands are getting greater and people think that since medical care is so expensive they are entitled to an almost vacation experience. When I get older I am already old! I will have to leave the USA or check out permanently. I have also left the hospital for the same reasons you did. I disagree with you though that is not the patients fault. While I see your point for some patients, there are also those who go way above and beyond what they should expect and the hospital environment is way out of control. As an older nurse I have seen the horrible changes. I think that newer nurses will not stay because of these changes. This will affect the quality of care for everyone. Bad environment and more inexperienced nurses equals accidents waiting to happen. Wow, that is interesting TheCommuter. Simple life changes can save lives and you must take control of your health such as eating smart, dental checkups and controlling your stress. And do not forget sleep. Sleep gets overlooked but it just as important as an adult as well. I also know many that do not practice disease prevention. Why the lack of motivation? If many only knew that they must take control of their health. We have many home tests. Do doctors provide that information in patient teaching? Another is routine blood tests. Blood tests have benefits that go far beyond disease prevention and you can catch changes in your body before they flare up to heart disease, cancer, diabetes, or worse. I suppose this is the lane for health and wellness coaches. Who in the right mind would even think about fully staffed dialysis, tele-equipped and memory care "cabins" on a cruise ship 30 years ago?? Semi Private , Private Costs vary greatly by state: Reading on, I now post as double "Dang". I will admit to NOT being as healthy-lifestyle proactive as I would have liked. I cringe when I think there are those consumers out there with even more limited resources, if any. As I see it, the future poses a two-sided dilemma. Sicker pts needing healthcare services that are unreasonably costly. Or none at all. Yes, many boomers fall into this cauldron. I see future problems with the actual future healthcare providers, be they nursing or medical providers. The professions are changing as the healthcare industry grows bigger and more profit driven. I also think Big Pharm is bedfellow to Healthcare. I also cringe to consumers with limited health care resources. I suppose working in a nursing home for a while has opened my eyes in many ways than you can imagine. I also remember one of my clinical instructors in nursing school who was 72 years old at the time gave us the ins-out of nursing homes and refused to stay in one when she gets older. She would tell us all the time to get long term care insurance to have care at home and pass away instead. I honestly never knew why should would say that then once i started working at home i realized what she was talking about. It is not the fault of the nurses but the health care system. And like you said amoLucia, i also agree its black or white when it comes to resources. Either you are financial stable and will get top notch care or vice versa. However, the cause and solutions do not lie in our corporate or govt healthcare systems. The healthiest states for older adults are concentrated in the Northeast

and West, whereas the least healthy states are located in the South. As most people know, much of the South has been plagued with higher poverty rates and lower incomes than the rest of the country.

Chapter 7 : Critical care nursing - Wikipedia

Obstetrical nurses help provide prenatal care and testing, care of patients experiencing pregnancy complications, care during labor and delivery, and care of patients following delivery. Obstetrical nurses work closely with obstetricians, midwives, and nurse practitioners.

Nurses Take on New and Expanded Roles in Health Care January 20, Massachusetts General Hospital is known for medical innovations such as the first public demonstration of surgical anesthesia and the first replantation of a severed arm. When a patient arrives at Massachusetts General Hospital MGH now, he or she is assigned an attending registered nurse ARN for the duration of the hospital stay and after discharge. Unlike other RNs, ARNs are designed to promote continuity of care, ideally with a five-day, eight-hour work schedule. We evaluate this work closely and we know ARNs have significantly contributed to improved quality and patient satisfaction. The ARN is just one of the many new roles for nurses in a changing health care system. These new roles are empowering nurses to play a greater role in improving patient experiences and population health and lowering costs. Nurses in new roles are doing that by reducing unnecessary and costly hospital readmissions and preventable medical errors, providing more affordable, more convenient, and more patient-centered primary care in community-based settings, and more. Nurses today are playing new roles in coordinating care from multiple providers, managing caseloads of patients with intense care needs, and helping patients transition out of hospitals and into the home or other settings. And they are charting new paths in emerging fields like telehealth, informatics, and genetics and genomics, and as scientists and leaders in society. Traditional RNs and advanced practice registered nurses APRNs , meanwhile, are playing expanded roles as the health care system evolves to meet new needs. Once viewed as subservient and subordinate, nurses are now serving as full and essential partners on interdisciplinary health care teams. During and , he and his colleagues visited 30 high-functioning primary care practices to learn about innovative staffing arrangements that maximize the contributions of nurses and other staff. During the visits, the LEAP team noticed that nurses are increasingly providing more direct, face-to-face care in independent nurse visits or shared visits with providers. The benefits, he said, are clear. They also can take on reconceptualized roles as health care coaches and system innovators. In all of these ways, nurses can contribute to a reformed health care system that provides safe, patient-centered, accessible, affordable care. Payment changes, based in part on improved patient outcomesâ€”such as with shared savings in accountable care organizations and bundled paymentsâ€”will allow nursing contributions to be maximized, she noted. Medicare coverage for wellness and behavioral telehealth visits and care coordination for patients with multiple chronic conditions are services often led by nurses. Evidence reveals that such role changes will better align with the care experience and needs of patients and their families, and result in improved outcomes. As health care incrementally transforms to embody a Culture of Health, there will certainly be increased opportunities to

Chapter 8 : blog.quintoapp.com - Career Profile

In this issue of American Nurse Today, we take a close look at nurse suicide, including the lack of research and information, the steps nursing can take to support colleagues suffering from depression or burn out, and how healthcare organizations can develop and implement suicide prevention resources and services.

Major Methodological Considerations in This Literature Staffing Staffing levels can be reported or calculated for an entire health care organization or for an operational level within an organization a specific unit, department, or division. Specific time frames at the shift level and as a daily, weekly, or yearly average must be identified to ensure common meaning among collectors of the data, those analyzing it, and individuals attempting to interpret results of analyses. In many cases, staffing measures are calculated for entire hospitals over a 1-year period. It is fairly common to average or aggregate staffing across all shifts, for instance, or across all day shifts in a month, quarter, or year and sometimes also across all the units of hospitals. However, staffing levels on different units reflect differences in patient populations and illness severity the most striking of which are seen between general care and critical care units. Furthermore, in practice, staffing is managed on a unit-by-unit, day-by-day, and shift-by-shift basis, with budgeting obviously done on a longer time horizon. For these reasons, some researchers argue that at least some research should be conducted where staffing is measured on a shift-specific and unit-specific basis instead of on a yearly, hospitalwide basis. A distinct, but growing, group of studies examined staffing conditions in subunits or microsystems of organizations such as nursing units within hospitals over shorter periods of time for example, monthly or quarterly. The first type divides a volume of nurses or nursing services by a quantity of patient care services. Common examples include patient-to-nurse ratios, hours of nursing care delivered by various subtypes of personnel per patient day HPPD , and full-time equivalent FTE positions worked in relation to average patient census ADC over a particular time period. Commonly, the composition of the nursing staff employed on a unit or in a hospital in terms of unlicensed personnel, practical or vocational nurses, and registered nurses RNs is calculated. The specific types of educational preparation held by RNs baccalaureate degrees versus associate degrees and diplomas have also begun to be studied. Additional staffing-related characteristics studied include years of experience and professional certification. The incidence of voluntary turnover and the extent to which contract or agency staff provide care have also been studied. As will be discussed, the majority of the evidence related to hospital nurse staffing focuses on RNs rather than other types of personnel. For the most common measures, ratios and skill-mix, determining which staff members should be included in the calculations is important, given the diversity of staffing models in hospitals. Most researchers feel these statistics should reflect personnel who deliver direct care relevant to the patient outcomes studied. Whether or not to count charge nurses, nurse educators involved in bedside care, and nurses not assigned a patient load but who nevertheless deliver important clinical services can present problems, if not in principle, then in the reality of data that institutions actually collect. Outcomes research examining the use of advanced practice nurses in acute careâ€”for instance, nurse practitioners and nurse anesthetistsâ€”to provide types of care traditionally delivered by medical staff and medical trainees has been done in a different tradition analyzing the experiences of individual patients cared for by specific providers and does not tend to focus on outcomes relevant to staff nurse practice; therefore these studies are not reviewed here. No studies were found that examined advanced practice nurse-to-patient ratios or skill mix in predicting acute care patient outcomes. There have been calls to examine advanced practice nurses supporting frontline nurses in resource roles for instance, clinical nurse specialists who consult and assist in daily nursing care, staff development, and quality assurance and their potential impact on patient outcomes. No empirical evidence of this type was found. Outcomes Clearly, capturing data about patient outcomes prospectively i. This approach is the most challenging because of practical, ethical, and financial considerations. However, researchers can sometimes capitalize on prospective data collections already in progress. For instance, hospital-associated pressure ulcer prevalence surveys and patient falls incidence are commonly collected as part of standard patient care quality and safety activities at the level of individual nursing units in many institutions. Patients are not all at equal

risk of experiencing negative outcomes. Elderly, chronically ill, and physiologically unstable patients, as well as those undergoing lengthy or complex treatment, are at much greater risk of experiencing various types of adverse events in care. For instance, data on falls may be consistently collected for all hospitalized patients but may not be particularly meaningful for obstetrical patients. Accurately interpreting differences in rates across health care settings or over time requires understanding the baseline risks patients have for various negative outcomes that are beyond the control of the health care providers. Ultimately this understanding is incorporated into research and evaluation efforts through risk adjustment methods, usually in two phases: Without sound risk adjustment, any associations between staffing and outcomes may be spurious; what may appear to be favorable or unfavorable rates of outcomes in different institutions may no longer seem so once the complexity or frailty of the patients being treated is considered. However, as was noted earlier, quality of care and clinical outcomes and by extension, the larger domain of nursing-sensitive outcomes include not only processes and outcomes related to avoiding negative health states, but also a broad category of positive impacts of sound nursing care. Knowledge about positive outcomes of care that are less likely to occur under low staffing conditions or are more likely under higher levels is extremely limited. The findings linking functional status, psychosocial adaptation to illness, and self-care capacities in acute care patients are at a very early stage 37 but eventually will become an important part of this literature and the business case for investments in nurse staffing and care environments. Linkage In staffing-outcomes studies, researchers must match information from data sources about the conditions under which patients were cared for with clinical outcomes data on a patient-by-patient basis or in the form of an event rate for an organization or organizational subunit during a specific period of time. Ideally, errors or omissions in care would be observed and accurately tracked to a particular unit on a particular shift for which staffing data were also available. Most, but not all, large-scale studies have been hospital-level analyses of staffing and outcomes on an annual basis and have used large public data sources. Linkages of staffing with outcomes data involve both a temporal time component and a departmental or unit component. These include some types of complications as well as patient deaths. Attribution of outcomes is complicated by the reality that patients are often exposed to more than one area of a hospital. For instance, they are sometimes initially treated in the emergency department, undergo surgery, and either experience postanesthesia care on a specialized unit or stay in an intensive care unit before receiving care on a general unit. Unfortunately, in hospital-level datasets, it is impossible to pinpoint the times and locations of the errors or omissions most responsible for a clinical endpoint. In the end, if outcomes information is available only for the hospital as a whole which is the case in discharge abstracts, for instance , data linkage can happen only at the hospital level, even if staffing data were available for each unit in a facility. Similarly, if staffing data are available only as yearly averages, linkage can be done only on an annual basis, even if outcomes data are available daily or weekly. Linkages can be done only at the broadest levels on the least-detailed basis or at the highest level of the organization available in a dataset. Many patient outcomes measures such as potentially preventable mortality may actually be more meaningful if studied at the hospital level, while others such as falls may be appropriately examined at the unit level. One should recognize that common mismatches between the precision of staffing measures and the precision of outcome measures i. This finding is particularly relevant when staffing statistics span a long time frame and therefore contain a great deal of noiseâ€”information about times other than the ones during which particular patients were being treated. High-quality staffing data, as well as patient assessment and intervention dataâ€”all of which are accurately date-stamped and available for many patients, units, and hospitalsâ€”will be necessary to overcome these linkage problems. Such advances may come in the next decades with increased automation of staffing functions and the evolution of the electronic medical record. Recent prospective unit-level analyses, now possible with datasets developed and maintained by the NDNQI, CalNOC, and the military hospital systems, make it possible to overcome some of these issues. These databases, although not risk adjusted, stratify data by unit type and hospital size and have adopted standardized measures of nurse staffing and quality of care. The resulting datasets provide opportunities to study how variations in unit-level staffing characteristics over time can influence patient outcomes for instance, pressure ulcers and falls, as discussed later. As data sources do not exist for all types of staffing and

outcomes measures at all levels of hospital organization nor will they ever , research at both the unit level and the hospital level will continue, and both types of studies have the potential to inform understanding of the staffing-outcomes relationship. Research Evidence Perhaps staffing and outcomes research has such importance and relevance for clinicians and educators as well as for managers and policymakers, staffing-outcomes research is a frequently reviewed area of literature. As was just detailed, a diversity of study designs, data sources, and operational definitions of the key variables is characteristic of this literature, which makes synthesis of results challenging. Many judgments must be made about which studies are comparable, which findings if any contribute significantly to a conclusion about what this literature says, and perhaps regarding how to transform similar measures collected differently so they can be read side by side. The review of evidence here builds on a series of recent systematic reviews with well-defined search criteria. These findings have appeared in studies conducted using a variety of designs and examining hospital care in different geographical areas and over different time periods. In these papers, reviewers identify specific measurement types and established criteria for study inclusion in terms of design and reporting and examined a relatively complete group of the studies one by one to provide an overview of the state of findings as an integrated whole. Major Integrative Reviews of the Staffing-Outcomes Literature The contrasts in the conclusions are interesting but are probably less important than the overall trend: An additional important point is that nearly all studies connecting staffing parameters with outcomes have been conducted at the hospital rather than the unit level. In a 2-year AHRQ Working Conditions and Patient Safety study built on the work of CalNOC, Donaldson and colleagues 17 engaged acute care hospitals using ANA nursing indicators for reporting staffing, patient safety, and quality indicators in a research, repository development, and benchmarking project. Data were drawn from 25 acute care, not-for-profit California hospital participants in the regional CalNOC. The sample included urban and rural hospitals with an average daily census from to more than patients. The aims of the study were to test associations between daily nurse staffing on adult medical-surgical units and hospital-acquired pressure ulcers, patient falls, and other significant adverse events, if they were of sufficient volume to analyze. A prospective, descriptive, correlational design tested associations between patient outcome measures and daily unit-level nurse staffing, skill mix, hours of care along with hours covered by supplemental agency staff , and workload. Unit activity index and hospital complexity measured by bed size were also significant predictors of falls. In another analysis, Donaldson and colleagues 39 traced daily, unit-level direct care nurse staffing in 77 units across 25 hospitals over a 2-month period using data on staffing effectiveness the match between hours of care and hours provided. By law in California, each hospital unit uses an institutionally selected, acuity-based workload measurement system to determine required hours of care for each patient. For each patient-care unit, the ratio of actual to required hours of care, was expressed as both a mean ratio and as a percentage of days on which required hours exceeded actual hours over the 7 days prior to a pressure ulcer prevalence study. These analyses linked unit-level staffing and safety-related outcomes data, and measured for time periods at the unit level closely and logically connected staffing measures relevant to conditions before the outcome occurred. Both researchers and research consumers need to reflect on the time frames involved in the evolution of various outcomes when assessing the validity of data linkages across time and units. For instance, in contrast to the lags between quality problems in care and evidence of their impact on outcomes such as infections and pressure ulcers, practice conditions will tend to have more immediately observable impacts on outcomes like falls with injury and most adverse drug reactions. Recent legislation in California that introduced mandated nurse-to-patient ratios at the unit level provides an interesting context for studying the association of staffing and outcomes. CalNOC has reported early comparisons of staffing and outcomes in medical-surgical and step-down units in 68 California hospitals during two 6-month intervals Q1 and Q2 of and Q1 and Q2 of before and after introduction of the ratios. Data were stratified by hospital size and unit type. On medical-surgical units, mean total RN hours per patient day increased by However, there were no statistically significant changes in the rate of patient falls or pressure ulcers on these units. Summary and Comment Researchers have generally found that lower staffing levels are associated with heightened risks of poor patient outcomes. Staffing levels, particularly those related to nurse workload, also appear related to occupational health issues like back injuries and needlestick injuries and

psychological states and experiences like burnout that may represent precursors for nurse turnover from specific jobs as well as the profession. Associations are not identified every time they are expected in this area of research. Other aspects of hospital working conditions beyond staffing, as well individual nurse and patient characteristics, affect outcomes since negative outcomes are relatively uncommon even at the extremes of staffing and do not occur in every circumstance where staffing is low. A critical mass of studies established that nurse staffing is one of a number of variables worthy of attention in safety practice and research. There is little question that staffing influences at least some patient outcomes under at least some circumstances. Future research will clarify more subtle issues, such as the preferred methods for measuring staffing and the precise mechanisms through which the staffing-outcomes relationship operates in practice. Areas Where the Evidence Base Is Currently Limited Nurse executives and frontline managers make decisions about numbers of staff to assign to the various areas of their facilities. They also establish models of care to be used in caring for patients in terms of the constellation of nursing staff and distribution of responsibilities among professional nurses and other types of nursing staff. Policymakers want assurances that the nursing workforce in their jurisdictions is adequate; they also want to know whether or not regulatory intervention is necessary to ensure acceptable staffing levels and desirable patient outcomes. Staffing researchers are ultimately constrained by the limitations of their data in answering many questions of relevance to the real worlds of health care delivery and public policy. Investigators most commonly examined the correlations of complex patient outcomes with staffing measures derived at some distance from the delivery of care perhaps aggregated over time. Researchers then asked whether measures of staffing and outcomes were statistically associated with each other. A clear distinction between direct conclusions from research findings and the opinions of particular authors or interest groups must be made. It is impossible to specify parameters for staffing that will ensure safety based on current evidence without many qualifiers. The adequacy of staffing the degree to which staffing covers patient needs even for the same patients and nurses may change from hour to hour, particularly in acute care settings. Nurse-to-patient ratios and skill mixes in specific settings that are too low for safety still cannot be identified on the basis of the research literature, but decisions must be made on the basis of the judgments by frontline staff and their managers. On a related note, the specific nursing care processes that are more likely to be omitted or rendered less safe under different staffing conditions are not well understood, empirically speaking, and deserve further attention. A number of other areas identified in the staffing literature are relatively underdeveloped.

Chapter 9 : Emergency Nurse | Specialty

Take time to read and experience the potential and influence of nursing through these inspirational quotes! Here are some of the greatest nursing quotes written by famous historical figures and various writers.

Nursing includes the promotion of health, prevention of illness and the care of ill, disabled and dying people. Nursing is an peer-reviewed journal for the rapid publication of innovative research covering all aspects of Nursing and Healthcare. Nursing Journal with highest impact factor offers Open Access option to meet the needs of authors and maximize article visibility. The scope of topics covered in the journal includes: It is an organized framework of concept and purpose designed to guide the practice of nursing. Nursing theories are used to describe, develop, disseminate, and use present knowledge in nursing. Nursin g theories include Grand nursing theories - Grand nursing theories have the broadest scope and present general concepts and propositions. Theories at this level may both reflect and provide insights useful for practice but are not designed for empirical testing. Mid-range nursing theories - Middle-range nursing theories are narrower in scope than grand nursing theories and offer an effective bridge between grand nursing theories and nursing practice. They present concepts and propositions at a lower level of abstraction and hold great promise for increasing theory-based research and nursing practice strategies. Nursing practice theories - Nursing practice theories have the most limited scope and level of abstraction and are developed for use within a specific range of nursing situations. Nursing practice theories provide frameworks for nursing interventions, and predict outcomes and the impact of nursing practice. They reflect a desired and achievable level of performance against which actual performance can be compared. Their main purpose is to promote, guide and direct professional nursing practice. These nurses quickly recognize life-threatening problems and are trained to help solve them on the spot. They can work in hospital emergency rooms, ambulances, helicopters, urgent care centers, sports arenas, and more. To provide quality patient care for people of all ages, emergency nurses must possess both general and specific knowledge about health care to provide quality patient care for people of all ages. Emergency nurses must be ready to treat a wide variety of illnesses or injury situations, ranging from a sore throat to a heart attack. Many emergency nurses acquire additional certifications in the areas of trauma nursing, pediatric nursing, nurse practitioner, and various areas of injury prevention. Nurse practitioners manage acute and chronic medical conditions, both physical and mental, through history and physical exam and the ordering of diagnostic tests and medical treatments. NPs are qualified to diagnose medical problems, order treatments, perform advanced procedures, prescribe medications, and make referrals for a wide range of acute and chronic medical conditions within their scope of practice. A veterinary nurse works as a member of the veterinary team, providing expert nursing care for sick animals. Veterinary nurses also play a significant role in educating owners on maintaining the health of their pets. They carry out technical work and are skilled in undertaking a range of diagnostic tests, medical treatments and minor surgical procedures, under veterinary direction. Veterinary nurses help veterinary surgeons vets by providing nursing care for sick, injured and hospitalised animals. They also play an important role in educating owners on good standards of animal care and welfare. A veterinary nurse needs to be calm and confident when handling animals. Nurse education consists in the theoretical and practical training provided to nurses with the purpose to prepare them for their duties as nursing care professionals. This education is provided to nursing students by experienced nurses and other medical professionals who have qualified or experienced for educational tasks. During past decades, the changes in education have replaced the more practically focused, but often ritualistic, training structure of conventional preparation. Nurse education integrates today a broader awareness of other disciplines allied to medicine , often involving inter-professional education, and the utilization of research when making clinical and managerial decisions. Orthodox training can be argued to have offered a more intense practical skills base, but emphasized the handmaiden relationship with the physician. This is now outmoded, and the impact of nurse education is to develop a confident, inquiring graduate who contributes to the care team as an equal. In some countries, not all qualification courses have graduate status. It is a specialized field of nursing that focuses on the health needs of communities, aggregates, and in particular vulnerable populations. It is a

practice that is continuous and comprehensive directed towards all groups of community members. It combines all the basic elements of professional, clinical nursing with public health and community practice. It synthesizes the body of knowledge from public health science and professional nursing theories to improve the health of communities. The community health nurse conducts a continuing and comprehensive practice that is preventive, curative, and rehabilitative. The philosophy of care is based on the belief that care directed to the individual, the family, and the group contributes to the health care of the population as a whole. This branch of medical science deals with the care of children from conception to adolescence in health care. A pediatric nurse is a nursing professional that primarily works in the field of pediatrics. Pediatric nurses often work in a team of pediatric healthcare professionals. This includes pediatricians, pediatric specialists, and other pediatric nurses. They may assist pediatricians or work alongside them, providing their own care. In addition, they acknowledge the expertise of the family and collaborate with them to provide care for the child. Nurses in this area receive more training in psychological therapies, building a therapeutic alliance, dealing with challenging behavior, and the administration of psychiatric medication. The most important duty of a psychiatric nurse is to maintain a positive therapeutic relationship with patients in a clinical setting. The fundamental elements of mental health care revolve around the interpersonal relations and interactions established between professionals and clients. Caring for people with mental illnesses demands an intensified presence and strong a desire to be supportive. Understanding and empathy from psychiatric nurses reinforces a positive psychological balance for patients. Conveying an understanding is important because it provides patients with a sense of importance. Family nursing is directed to improving the potential health of a family or any of its members by assessing individual and family health needsand strengths, by identifying problems influencing the health care of the family as a whole and those influencing the individual members,by using family resources, by teaching and counseling, and by evaluating progress toward stated goals. Science has bestowed health care delivery system with excellent technological innovations. One such innovation is use of computers in nursing. Obstetrical nurses help provide prenatal care and testing, care of patients experiencing pregnancy complications, care during labor and delivery, and care of patients following delivery. Obstetrical nurses work closely with obstetricians, midwives, and nurse practitioners. They also provide supervision of patient care technicians and surgical technologists. Obstetric nurses are also present in hospital maternity wards and birthing centers. They will typically provide the majority of the care during the initial stages of labor. During this particularly stressful â€” not to mention uncomfortable â€” time for the mothers, obstetric nurses will help keep mothers as comfortable as possible and find ways to manage their pain. They will also continually monitor expecting mothers and fetuses for signs of impending delivery.