Attitude and formation change essay

Life, Emotions

An attitude is a personal evaluation of your surroundings.

These surroundings can be people, places, objects, or thoughts (Aronson, Wilson, Akert, pg. 211). Attitudes can be cognitively based, affectively based, or behaviorally based. Cognitively based attitudes are attitudes that are based on facts or the properties of the object (Aronson, Wilson, Akert, pg. 211). Affectively based attitudes are based more on emotions (Aronson, Wilson, Akert, pg. 211).

Behaviorally based attitudes are based on the observation of behavior towards a certain object (Aronson, Wilson, Akert, pg. 213). Personally, I hold many different attitudes. Based on my personality, many of the attitudes I hold are emotionally or affectively based. As a nurse, I encounter many things daily, which require an evaluation of my attitude. Since I seem to immediately default to my emotional side, I have trained myself to evaluate the person or situation in a more cognitive way, based purely on the facts (Aronson, Wilson, Akert, pg. 211). An example is when I assess my patient.

My assessment is based purely on the facts present. I am assessing each body system and presenting my findings to the doctor. My attitude is based on whether this patient is stable and improving, or if they are becoming unstable and requiring the doctor’s immediate attention. If I evaluate the situation based solely on the facts, I am a better nurse. If I allow my emotions to take priority, and my attitude becomes affectively based, I am more focused on my emotional perception of the patient and their situation, not the present facts.

An example of affectively based attitude I experience would be when my patient presents with an attempted suicide. Based on life situations, suicide is something that immediately involves an emotional connection for me. My mother suffers from bi-polar disorder and has attempted suicide on more than one occasion. On two occasions, I have been the one to find her after her attempt. This life altering experience has tainted my attitude towards suicide. Since I have experience with suicide and how it has affected my life, my attitude is affectively or emotionally based. When I care for a patient with a suicide attempt, my initial reaction is to focus on the strain this attempt places on the patient’s family and friends.

I wonder selfishly what could be so horrible in their life to make them want to end their life. This is where my emotional connection takes over, altering my attitude, and creating a judgment. This is how it affects my job as their nurse. As the patient’s nurse, I must remain objective, viewing only the patient and the presenting facts. I must remain cognitive in my attitude. I must stabilize the patient and adhere to the plan of care.

I have worked meticulously to remain focused on a patient’s needs in a suicide, and not my own emotions. When I then view the situation in a cognitive matter, my focus is the suicide attempt (the object) and the facts about the patient and their recovery (Aronson, Wilson, Akert, pg. 11). I can recall the first time I was faced with caring for a suicidal patient. I accepted report from the emergency room, and I was prepared to provide the patient with quality nursing care. As the patient wheeled up from the emergency

department, and I witnessed the patient’s parents weeping at the bedside, I was surprised at my reaction.

I instantly was more focused on providing comfort to the parents then my patient. I was not aware that I would behave in such a manner. This is an example of a behaviorally based attitude. The only experience I had with suicide was with my mother’s attempts; therefore I did not imagine how I would react in a situation where I was not directly involved. My assessment of my behavior during this time made me realize how I felt regarding suicide. I did not realize how I felt until I witnessed how I behaved (Aronson, Wilson, Akert, pg. 213).

A reflection of an attitude change on an important issue would have to be one I faced in the recent past. Over the last two years, there has been an initiation to implement changes on the unit I work. The hospital is currently trying to obtain Magnet Status, which is a credentialing process for a hospital to be recognized for demonstrating excellence in patient care.

There is a significant amount of data to support Magnet Status and its direct effect on improving patient outcomes as well as patient satisfaction. Who would not want to work for an organization that has achieved such a prestigious honor? This credentialing not only affects patients but also improves job security. The list of benefits is extensive. As a new graduate nurse, I was overwhelmed and doing my best to get through the day in the cardiac intensive care unit. The days are hectic and chaotic, and there are many times you struggle to keep ahead of the tasks being thrown at you.

My initial attitude towards the credentialing process was negative. My view was focused on all the steps to take to achieve this credentialing. Since I was doing all I could to complete my daily workload, it was one more thing I needed to add to my day. This attitude was cognitively based since I was looking at the facts directly involved in achieving Magnet Status, and was weighing the pluses and minuses (Aronson, Wilson, Akert, pg. 211). Based on my current personal experiences, I was directly focused on the minuses. I did acknowledge the pluses in achieving Magnet status as well, which included patient satisfaction as well as job security for nurses. The development of patient care initiatives was the way in which the data could be collected to achieve Magnet Status.

There were many staff members that were not open to the implementation of these new initiatives. Initially, many staff members were defiant towards the changes required to make the initiatives work. Hourly rounding was one of the new initiatives for the unit.

The thought process behind rounding was to decrease patient falls, improve patient satisfaction, and ensure that each patient on the unit was being seen at least hourly. Our unit’s clinical nurse manager was at the forefront of developing ways to achieve Magnet Status, and therefore was a huge supporter of the hourly rounding. As she began to realize that staff members were refusing to do it, she began expressing that hourly rounding was not optional for staff to participate in. It was becoming a part of the unit, and the lack or refusal to participate in rounding would yield disciplinary action. The

policy at the hospital states after receiving three warnings, there are grounds for termination.

All staff members are aware of this policy. My manager’s use of fear arousing communication increased the participation of hourly rounding. She persuaded staff to take part in hourly rounding with the fear of losing their job (Aronson, Wilson, Akert, pg. 222). As a relatively new staff member, I was dedicated to hourly rounding in fear of losing my job, not for the benefits to the unit. There were still many staff members that displayed a reactance theory. The staff members felt the way they performed their job on a daily basis was sufficient, and the freedom to continue doing so was being threatened.

Therefore these staff members felt that by giving into the new initiatives, and participating in hourly rounding, there was a certain confirmation that they were incorrect in their beliefs and current job performance. (Aronson, Wilson, Akert, pg. 228) As time went on, the positive changes to the unit were obvious. The unit manager stood firm with the belief that these initiatives would ultimately improve not only patient satisfaction, but staff satisfaction as well. It was obvious that many members of the staff were participating in these initiatives secondary to the benefits being experienced, and not the fear of termination. The confidence expressed by the unit manager related to the implementation of hourly rounding was always present.

The manager collected weekly data in regards to decreasing patient falls, and provided hospital surveys, which expressed patient satisfaction. This

concrete data made it difficult to disagree with the benefits of the initiatives. The data was carefully placed in areas where many of the staff members congregated, such as the break room and the staff restroom. I can't help but wonder if this placement was intentional. The staff was never aware that the data presented to them was an attempt at altering their behavior and attitudes towards the new initiatives (Aronson, Wilson, Akert, pg. 227). The staff's confidence in achieving Magnet Status also amplified.

The increase in the staff's confidence of the initiatives caused staff's acceptance of hourly rounding. It was difficult to ignore the benefits of hourly rounding (Aronson, Wilson, Akert, pg. 226). There were many things implemented that were beneficial to staff.

Even though these changes were initially put into place for achieving Magnet Status, as the unit began running with these changes in place, there was the recognition that the changes were beneficial. Two years later, hourly rounding is a crucial part of the unit and its daily success. The benefit to the staff and more importantly the patient is remarkable.

There was a period of resistance, but attitudes shifted therefore allowing the change to take place. Implementing change is never easy, and when varying attitudes are present, it makes the change more difficult.

ReferencesAronson, E., Wilson, T., & Akert, R.

(2010). Social Psychology. Upper Saddle River, NJ: Pearson.