

# [3 assignment](https://assignbuster.com/3-assignment/)

ASSIGNMENTS Assignment Issue and players The issue with this practice can be seen from two perspectives, that of the nurses who want to keep 8 hourschedules, and that of the nurses who want to work 12 hour flex time. From the hospital’s perspective, the practice of flex time is not valued highly in most cases, because it affects staffing time and budget allocations, and there is also the worry that nurses who have worked consecutive twelve hour shifts may become exhausted and compromise patient safety. From the perspective of many nurses, however, flex time has many benefits, since it frees up substantial time for other responsibilities such as school and family. The background of this problem is extensive and involves process and change in the healthcare environment in general, and the nursing workplace in particular, for many years. The changes that occurred to make hospitals and other healthcare facilities such as clinics more competitive with each other has resulted in a situation where, in some places, the patient is getting served better and the client treated better, and in some other situations, where the nursing professional and the healthcare facility or hospital is served better from a cost perspective, perhaps at the expense of the patient.   
Goals and values   
There are many reasons to support either 8 or 12 hour shifts. First of all, many nurses want 12 hour shifts because they have young children to take care of, and this allows them more time to do so. Also, nurses can pursue a higher education. After all, knowing the basics forms a basis on which all other educational measures can build, and education is and remains one of the key facets of nursing. Also, flex time allows nurses to take a second job. In a similar vein, 8 hour shifts also give nurses time off so that they can relax and unwind before going through another rigorous session of caring for patients and clients at the healthcare facility. In many cases, these facilities such as hospitals don’t want flex time because it costs more money, compromises sick leave, and requires more nurses.   
Conflict resolution   
There are categorizations to be made between situational conflicts, which may differ under varying decisions and stressors that are unique to each situation, and relational conflicts. Relational conflicts might be more static in terms of how they can be   
applied to a real-world type of pattern and be seen to be reasonable in the mediation   
process. Relational conflict styles are more about what might be differences between   
individuals, and may be a more subjective type of conflict, whereas in a case of content conflict styles, it is more about the message than the messenger.   
Two alternatives   
#1A mediator can come in and help the nurses reach a consensus. Mediators can plan in many different ways and can provide the disputants with many different opportunities for rapport, but overall the credibility of the mediator should be based on creating a warm and supportive atmosphere in which disputants can feel that their opinion is valued.   
#2The healthcare facility can make a decision not based on the needs of the nurses, but on the safety of the patient, regarding 8 vs. 12 hour shifts.   
Assignment 2   
I think that in an advanced, industrialized, and very rich nation like the USA, healthcare coverage is not a privilege; it is a right. It is something that the advanced industrialized nation owes its citizens. It is surprising to me that so many other advanced nations realize this, and yet the USA does not seem to. I think it is important for nurses to advocate their beliefs in healthcare programs through advocacy, and in doing so they would be confronting the reality of the situation or core problem behind which other associated problems are located. From this perspective, the main point of advocacy would be to bring universal healthcare from the theoretical to the practical, or to make true the promise of universality suggested by the goal of providing quality care to all individuals, rather than just those who can work the system or who live in certain areas of socio-economic privilege. Communities that are able to stand up and lead in the face of problems like poverty with an eye on reducing the devastation of the cycle can also expect to improve the average life-expectancy in their demographic. This solution would work on a long-term basis as both a preventative and a reactionary response to the needs of all individuals in terms of quality care. The general socio-economic environment of the community would also benefit.   
Too many poor people in the USA suffer because they do not have health coverage. Representation in areas that are socio-economically challenged helps to see what underlying issues reflect this under-representation. That is, it must be determined that various factors, including incognizance, social stigma, and confusion, may work together to create an effective block towards healthcare service utilization, even in communities that do provide such services adequately. That is, adequacy must be measured against clarity and community involvement, and some equation must emerge that represents an attention not only to supplying for a need, but also to making sure that the people in the community know that the supply is present. This may be a more difficult method of solving the current problems of universal health coverage, since individuals tend to differ greatly in the reasons for which they may not be asking advantage of healthcare opportunities.   
Healthcare coverage is an issue that often has weighted resonance in political circles because it is very important to large segments of the population. In 1996, it was estimated that 100 million Americans “ were in managed health plans (National Committee for Quality Assurance, 1996). As approximately 20% of the population in the United States has some type of disability (Kraus, 1996), the number of people with disabilities in managed care health plans is estimated to approach 20 million” (Grabois and Young, 2001). This current system of healthcare basically seeks community and society influences to make healthcare better for the average consumer, even though some critics say that the system managed care is run not by concern for the customer, but by the bottom line of profits. It is therefore not a community healthcare organization necessarily, but a consumer one. Community health care has many advantages in that it seeks to support the whole of a society, whereas consumer health care is often about the bottom line and is dictated by supply and demand. “ It makes price, availability, accessibility and the quality of medical care a function of free-market determination or negotiation” (Pellegrino, 1998). In occupying a sort of middle ground, the individual can see both sides of the equation more objectively. But as for my personal opinion, I believe that health coverage is a right, not a privilege.   
Assignment 3   
To Whom It May Concern:   
I am very concerned about the issue of managed care health reform in the USA.   
I write to you in supplication, because I know that you see how legislators see managed care as an issue, and how the legislation process can cause change in the managed care system. The basic assumption here is that legislation reflects the political side of managed care and the capacity for change.   
As a nurse and advocate, I see the need to highlight the issue of regulatory bodies possibly playing a part in the ways in which managed care is operated into the future, which affects hospitals, physicians, and nurses profoundly. Of course, basic regulatory bodies already in place do have their current duties, but many physicians and hospital administrators also think about the way that HMOs and the managed care system often plays out in emergency situations, and these individuals want to make change on a regulatory level.   
I think we all need to focus on how legislators see managed care in a post-9/11   
environment and the ways in which this change is still being felt years later in terms of   
highlighted emergency preparedness. This includes looking at high deductible plans,   
organized systems of healthcare intervening to promote quality care being more   
important than targeting healthcare at the right demographics, and ideas of value and   
cost-effectiveness. This also involves looking at how legislators and managed care   
organizations see consumers in terms of risk and price negotiation. This perspective   
shows a more positive reflection upon the relationships between legislators, hospitals,   
physicians, and managed care insurance companies.   
REFERENCE   
Grabois, E., and M. E. Young (2001). Managed Care Experiences of Persons with   
Disabilities. Journal of Rehabilitation.   
http://www. findarticles. com/p/articles/mi\_m0825/is\_3\_67/ai\_79741186   
Pellegrino, E. D. (1998) Managed care: an ethical reflection. Century.   
http://www. findarticles. com/p/articles/mi\_m1058/is\_n22\_v115/ai\_21066277