

Nursing-sensitive indicators essay sample

[Sociology](#), [Ethics](#)



Nursing-sensitive indicators are utilized in healthcare to increase quality patient care, as well as patient safety. They reflect the organization, procedure, and products of patient care. In the presented scenario involving Mr. J, nursing-sensitive indicators can be used to identify the issues that interrupted the flow of quality patient care.

Understanding Nursing-Sensitive Indicators

A solid understanding of nursing-sensitive indicators can assist the nurses in the case of Mr. J in identifying issues that may interfere with patient care. Knowledge of appropriate restraint use, as well as the care involved while caring for a patient in restraints, and prevention of pressure ulcers could have prevented some of the issues in this scenario. Mr. J should have been given frequent breaks from the restraints, assisted to use the restroom more often, and turned from side to side at least every two hours. Mr. J was also given an inappropriate meal. The order for his diet was kosher; however, Mr. J was given a pork chop cutlet with his meal. The nursing supervisor then encouraged the nurse to “keep quiet” about the mix up, and did not inform the patient or his family about the mistake. This has a negative outcome on patient satisfaction, and is culturally insensitive. Mistakes and mix-ups unfortunately do happen, and when they do, it is important that the issue is addressed and the patient and family is notified of the mistake. The nurse was also rude and insensitive when she stated, “Half a pork cutlet never killed anyone.” A concrete understanding of nursing-sensitive indicators could have prevented some of the negative outcomes in this scenario.

Hospital Data and Nursing-Sensitive Indicators

Hospital data on particular nursing-sensitive indicators can advance

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quality patient care throughout the hospital. For example, the data on the prevalence of pressure ulcers could be analyzed to determine best practices to reduce their occurrence. On the unit in the hospital where I work, an evidenced-based practice committee is in place to study issues such as pressure ulcers. They study what factors lead to the development of pressure ulcers in real-life scenarios, and thus develop best practice standards to determine how to prevent them from occurring. Hospital data on the use of restraint can also be analyzed to improve patient outcomes and satisfaction. This information could be scrutinized to determine if restraints were truly warranted in that particular situation, or if another method could have or should have been utilized first. Documentation should also be examined to determine if the patient was adequately cared for during this time period. In my hospital, the patient must be released from the restraints at least every two hours, and must be toileted at that time. The nurse must also do range of motion exercises with the extremities affected by the restraints. The skin and circulation should be assessed at this time. Every hour, the nurse is required to check the pulses in the extremity affected by the restraint. The nurse's documentation should reflect that all of these assessments were performed and the appropriate precautions were taken.

Analysis of System Resources

As the nursing supervisor in this scenario involving Mr. J, I would utilize several resources to address and resolve the ethical issue. When I was first informed of the kosher meal mix-up, I would have informed the patient's daughter of the mistake, and would have notified the dietary department of

the mix-up. I also would have informed staff on the floor of the non-kosher meal served, and ask them in the future to double-check that the meal being served is the one that was ordered.

Another ethical issue that was encountered in this scenario was the development of a pressure ulcer and the use of restraints. The scenario does not indicate that the patient was combative, nor does it indicate if other methods were used prior to the initiation of restraints. As the nursing supervisor, I would ask the appropriate resources to audit the documentation, and analyze whether restraints were warranted in this situation. The ethics committee should also evaluate the situation. The patient also developed a pressure ulcer on his lower back. Pressure ulcers can and should be prevented in the hospital setting. Turning and repositioning every two hours, proper and timely cleaning up of incontinent episodes, proper cushioning of bony prominences, and appropriate bed mattresses will prevent the development of pressure ulcers. As the nursing supervisor, I again would assess whether the patient was properly cared for using the above criteria. The ethics committee would also be appropriate to refer this case to. If necessary, I would work to arrange a training session to refresh the nurses' knowledge of caring for a patient in restraints, as well as pressure ulcer prevention. A wound care nurse, if available, should be consulted to obtain her expert opinion on methods to reduce pressure ulcer formation in this particular patient.

Conclusion

In conclusion, the scenario involving Mr. J was teeming with ethical

dilemmas. An appropriate use and understanding of nursing-sensitive indicators could have prevented many of the issues presented. The hospital should utilize the data collected from this situation to prevent similar issues from occurring in the future. Finally, as the nursing supervisor, there are many tactics that I could utilize to address and resolve the ethical predicaments presented, and several resources that I could refer to for assistance with addressing the ethical issues.