

# A case scenario on health care outcomes nursing essay



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**Case Scenario Part 1: Case Scenario**

A typical patient in my practice usually presents after we have already met in the hospital setting. Often times, their first 'office visit' is a post operative contact, which typically 10-14 days post-op. My ortho practice is focused on trauma, but with some degree of regularity, we also perform general orthopaedic procedures which may involve most any bone. One of the more common procedures that we perform is the fixation of hip fractures, whether they are femoral neck/sub-capital, or involving the trochanter. For my case scenario, I have chosen to focus on hip fractures, as trauma can be too complicated when trying to describe or accurately follow. These particular injuries often do not read the textbooks, and can have untoward affects.

My typical post-operative patient is within the age ranges of 50-90, with the most common procedure being the cephalo-medually nail, which might be an intertan or sliding hip screw. They often are just beginning to ambulate with the aid of a walker, and are still in a fair amount of tenderness. I am foremost concerned with their x-rays to ensure that they have not begun to cut out, and to verify that the implant has not changed in position. Secondly, during my physical exam, I will look to ensure that there are no post operative complications such as dvt's or site infection. Thirdly, I will want to know if they are getting up and walking or at least attempting to. This can be somewhat prognostic in that if they are not walking at all, then the likelihood of them making a full recovery is questionable.

Our practice uses the SF-36 for patient self assessment at each visit, from their initial post op, to their yearly anniversary. Several studies have shown

the SF-36 to especially helpful in quantifying subjective information (Kalantar-Zadeh, Kopple, Block, 2004). What makes it almost imperative in using a standardized form in relation to a patients outcomes, is that much of what is reported can be subjective. Pain is a notorious problem in quantifying as it can be different in each individual, as we all have varying degrees of pain tolerance.

## **Case Scenario Part 2: Application to Disablement Models**

When comparing my case scenario of hip fractures against the components of the disablement model, I feel that most if not all are met. There is a continuous flow of research that is related to hip fractures, in how to prevent them, what adjuncts to use in the treatment, and how best to approach them after the fact. Many of these findings have been incorporated into health policy, since we know that the effects of a hip fracture are often life altering. The authors of one article were able to quantify the loss of life as it results to those who have sustained a hip fracture. They were able to show that there is direct correlation with the loss of overall life expectancy and that at certain stages, it can result in a reduction of 81% of years remaining (Neilsen, 2008). This is important in to not only the potential dire consequences of this injury, but as it relates to the patients disabilities.

Over the past 20 years, the overall life expectancy has increased as the direct result of better orthopaedic practice and rehab. It was only two decades ago that 3 out of four hip fractures would not make it past one year (Lesinon, Schmidt, Wener, 1979). Despite our best intentions though, today, one out of every four patients who presents with a hip fractures, will perish within one year (Paulson, Yearingly, Miller, Heverty, 2009).

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I think that there is a role for disablement models in relation to this particular injury. By following the paradigm that the disablements models shows, we can continue to identify and define the problems that will continue to exist. With all of our knowledge to date, we still have a great deal to learn in not only the best approach to prevent this tragedy, but what are the best ways to handle them once they do present. 27

### **Case Scenario Part 3: Application to HRQOL Concepts**

As a clinician, unfortunately I cannot say that I actively monitor HRQOL. After thinking a great deal, about why exactly I do not, I realized that I judge success by overall outcomes. Our first goal is to get them out of the 30 mark, which has shown to be a time period where some patients might not make it. Much after that, I view a patient's HRQOL by their ability to return to their previous lifestyle. What this means, is that if they were independent and walked to the store every day, then if they are able to return to that lifestyle without impairment, then it is a success. Even if they digress in their ability to care for themselves, as long as they are happy with their relative way of life, then that too is a success albeit to a varying degree. I might be jaded in the notion that this is an immediate life threatening event, and not a benign condition that can be successfully monitored remotely.

I certainly see many of the dimension of HRQOL in the way that we treat our patient population. We too take the big picture with respect to the physical, physiological, social, and even the economic perspective. Yet I think with many of my patients, it is the psychological facet that takes the largest hit; and understandably. Almost everyone of these patients were productive, independent, citizens that had an identity. This in part is taken from them, as <https://assignbuster.com/a-case-scenario-on-health-care-outcomes-nursing-essay/>

they become increasingly reliant on those around them in ways that are unknown to them up until now. This can take its toll quicker than many of the other dimensions, aside from the physical attributes.

The roles of clinicians and patients are one that is symbiotic. One cannot survive without the other, even from a very basic business sense. In light of this relationship, I find myself more interested in the HRQOL of patients than of providers. At the very crux of why we are here, is to help people; plain and simple. Independent of what we think or feel about any given treatment, we are all taught to error on the side of the patient, and to remain objective.

## **Case Scenario Part 4: Generic and Specific Outcomes Instruments**

For my case scenario, I find that reliability, validity, precision, and feasibility, are the most important instruments in measuring outcomes. We all must follow a standard of practice, and this is dictated by literature and evidence based medicine, especially in the surgical community. Of course there are certain treatments that are provided on an off-label basis, but they are in direct line with the respective authors intentions, and do not vary to any real degree. My instruments incorporate a little of both when it comes to measurements'. The only ideal that is not in parallel with the others is feasibility, and that is due in part to the overall cost of orthopaedic care in the United States.

Very often, these instruments are implemented on the initial contact, which is either in the er/trauma bay, or on the floor as a general consult. All of the implants used are obviously FDA approved and on average have 5-10 years

of data, if not more. There are implants that we use that have 20 year follow up (Waker, Neim, Rozni, 2008). Each case is different with respect to the patient, the fracture, and the overall outcome. The surgery performed could very well be different in a hospice patient versus in an active 50 year old. One has to do with palliative care, and the other is about quality of life.

## **Case Scenario Part 5: Critiquing Your Outcomes Instrument?**

I can honestly say that I read the vast majority of the student seminars, and could not really find one that is any more appropriate than the one I have. I realize also that I am the only provider who is involved with ortho trauma, so I am sure that has a lot to do with it. I think many of the scenarios follow the same overall premise, and that they are equal to mine. It appears to be more closely related to the respective topic than to the general approach. My scenario looked into the potential benefits of low intensity pulsed ultra sound in the treatment of non-unions. The most important thought in my seminar was to critically appraise the literature to see if this particular treatment worked well enough to implement it sooner in the treatment modality; which it did not. Many of the other seminars seem to look more into critical thinking, than anything else.

## **Case Scenario Part 6: Measuring Change that is Important to Your Patient**

I have read this article repeatedly, and cannot find the MCD or the MCID values for this study. I have p values, I have average time from fracture to clinically healed, and even the cumulative percentage of healed. The most applicable measurement provided was the time interval of healing when

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compared to placebo. After 70 days of treatment, about 70% of the fractures healed compared to 19% in the placebo group (Rubin, Bolander, Rybay, Hadjiargryou, 2004). This inconjuncton with the fact that there are no known contraindications to its use, including cigarrets and alcohol, makes it an interesting choice.

The problem with not knowing the particular instrument used is that I cannot fully appreciate the exact precision of the measuring agent. I can understand the study design, and I see its relative application, but the matter in between is lost. This makes it very difficult to know what it actual change and what was not mere circumstance.

### **Case Scenario Part 7: Creating a Clinical Question**

Does the placement of demineralized bone matrix in the presence of open tibia fractures, reduce the rate of non-union

Patient- Open fracture

Intervention- placement of demineralized bone matrix

Comparison- non-placement

Outcome- decrease the rate of non-union in tibia fractures

### **Case Scenario Part 8: Important Considerations for Your Case Scenario**

One of the biggest matters to take into consideration is infection. Open fractures are notorious for two things; non-union and infection. These are often in the presence of each other, which makes the matter that much more

difficult to study. There have been countless studies over the years that have shown open tibia fractures have an overall infection rate of about 9%

(Leong, Low, Smeietz, 2005). Many in the orthopaedic community argue that placing a biological agent such as demineralized bone matrix (DBX), is not only a waste of money, but a potential nidus for infection. This is primarily due to the fact that DBX does not have the ability to fight off an infectious agent, such as staph aureus or staph epidermidus. Since DBX is essentially the foundation for bone matrix, my contention is that with the inflammatory process that is associate with healing, so too comes the interleukins which do have the ability to fight infection.

I think that my scenario can be performed in a healthcare setting, but I do not think it is likely. There is absolutely no literature that supports this theory, and on the contrary, there is one study that alludes to this idea being a potential problem (Finkmeier, 2002). Also, in this medically litigious society, if you are not following the standard of care, then you are opening yourself to a lawsuit; even in the presence of an IRB sanctioned study.

### **Case Scenario Part 9: Applying Concepts of Clinical Outcomes to Your Clinical Practice and/or Research Experience.**

Is there a component of the course that speaks to you as a member of the healthcare community? There are no wrong answers for this portion of the assignment and if you have questions about the role of outcomes in your particular healthcare setting, feel free to post a discussion board question or to contact me personally.



After this course, I have learned to not only be a better journal/study reader, but also a much more critical one. I realized that much of the material that is presented in journals is superficial and really lacks much substance. This has had a direct influence my patient population, as I really only recommend practices that have shown the data and the manner in which it was obtained. Thankfully, we use outcome assessments everyday in my practice, which makes it not only convenient but also useful. There are have been only a handful of times that I had researched a patients SF-36 from their initial encounter, prior to entering this course. Since entering, I have pulled no less than a dozen, and actively compared them with a more recent survey, to determine the overall course.

These particular studies had been implemented prior to my arrival, so I have had the luxury of entering into a practice that actively solicits this information. Despite the begrudgingly contempt from many patients about its overall vagueness, I try my best to assure them that it does affect their overall care, as its from this feedback that we can post market survey what works and what doesn't.