Transitions in professional nursing

It can be difficult for nurses to accept that they must change their current practice in the delivery of patient careas described in *American Nurse Today* (Sherman & Cohn, 2019, para. 1), but reimbursement models in healthcare can drive evidenced-based practice changes(Sherman & Cohn, 2019, para. 2)and nurses are individually accountable for keeping their education in compliance with state, local and employer policies. Nurses are continually accountable for implementing new policies and procedures, and sometimes new statutory requirements which are up to date for the nursing profession. It is incumbent upon individual nurses to take ownership of their day to day practice responsibilities instead of passing off duties to the next shift or another specialty. Incorporating new workflows to improve safe patient care is part of an individual nurse's responsibility to practice under a nursing license.(Sherman & Cohn, 2019, para. 4)Individual nurses must recognize and be responsible for their contribution to quality outcomes in a multidisciplinary care delivery model. Nurse leaders should reinforce the culture of professional accountability(Sherman & Cohn, 2019, para. 11)when nurses who are not following new evidence-based practice policies seem to have difficulty aligning their core nursing values with their workplace's values. This will assist in preventing the undermining of a culture of accountability for professional nursing practice with a focus on quality care delivery.

Impact of Assigned Article Content on Future Practice

In reading the article I understand what the authors are saying about my responsibility to be a team player in the implementation of new changes that affect the quality of care delivery; however, it is written, I feel from a

leadership perspective. This article is brought to us by 2 nurses with many credentials in advanced nursing and education and I am surmising many years removed from direct bedside care. Fine, you want the bedside nurse to learn and then do this new protocol for HAPU prevention. Let's not hurt patients. That's wrong. They come to hospitals & other care settings to heal not to acquire new injuries. So, if the management or leadership team want to add some new responsibility or workflow, what responsibility are they taking away from the daily list of bedside nursing responsibilities that allows the bedside nurse to accomplish all patient care in a timely manner? Has a time analysis been completed so that all parties understand what impact the new workflow will have on the time a bedside nurse has available to give patient care? Has anyone in leadership stopped to assess why Steve is reluctant to get on board with the changes? Is it truly because she feels her patients aren't affected or because she feels overworked, overwhelmed and " Here comes another mandatory workflow?"

Is accountability a codeword for " you will be written up" in the leadership style at her facility? Has anyone addressed the issue that the perfect way all the various tasks a nurse must perform in many cases take more than the actual shift time allotted? Is nursing leadership offering additional staffing to assist with the teaching/ training of the new Unit Based Practice Council workflow until all the nurses have been trained? I feel for Steve. I think there is more to the story than just a nurse unwilling to adjust to best practices for patient safety. Perhaps she is correct in saying that her patients don't suffer from HAPU because she renders great care. Did anyone look at her patient outcomes versus all the other patients? Perhaps Steve is right to say that the

way she cares for her patients is not wrong. What is her reason why she will not comply? A good leader would find out, address it, and manage to integrate her into the new patient care workflow.

In my personal nursing practice as a case manager/ discharge planner, there are a couple of areas where I can adjust my practice for professional accountability. The first area was the passage of SB 1152 in California, for homeless patient discharges.(Senate Bill 1152 Hospital patient discharge process: homeless patients, 2018)I will align my nursing assessments to better assist the Medical Social Workers in coordinating with me to place a homeless patient within the parameters of the newly enacted law, effective July 1, 2019. It is vitally important that we work closely together with all of the interdisciplinary care team in order to be in compliance with this new legislation while appropriately meeting the medical needs of the patient. Sometimes even an Environmental Services staff person sharing that a friend is visiting the patient at the bedside right now and then being able to interview that person at the bedside (with the patient’s permission for HIPAA compliance) can mean the difference between a homeless shelter discharge with continuing care services or a safe community discharge plan with continuing care services.

The second area I feel I can improve my accountability and professionalism is for my stroke patients after discharge. I need to follow up after discharge for some of these patients who are not followed within our health system to make sure they have the information or tools to access care after discharge. Attending the Stroke Center Rounds Monthly Meeting and keeping up to date on the latest best practices can enhance my contribution to our continued

success as a Comprehensive Stroke Center. I look forward to touring our affiliated Acute Rehabilitation Hospital to better describe to the stroke patients and their families the environment and services offered. It would be great to be able to give a first-person account of the main facility I frequently refer patients to for the acute inpatient rehab level of care as part of the accountability I have to my patients and our Stroke Center excellence scores. (“ Stroke Post-Acute Continuum,” n. d.)

References

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