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Title: NR 529LEADERSHIP AND MANAGEMENT WITHIN THE CLINICAL HEALTHCARE ENVIRONMENT

Instructions: follow guidelines in the attached rubric called module 2, no plagiarism allowed

Focus: please use the same introduction and references plus add more references in the attached document titled aug 2021unmod2.

Leading Person-Centered Care

Name

Institutional Affiliation

Course

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Date

Case scenario

Zack is a 67 year old white woman who brings tightness and chest discomfort, dyspnea, lightheadedness, and nausea to the emergency department. Symptoms started a few of days ago, and have gradually deteriorated till now. He has family records of mothers: cardiovascular and paternal cancer, diabetes, stroke and cancer of the lung. The patient has Positive social history of 15 years of smoking. One year ago the patient stopped smoking cigarettes because of breathlessness and refuses all alcohol and drug use. No food or medicines allergies known. His medical history includes hyperlipidemia, infarction with myocardial tissue, tobacco, COPD, diabetes mellitus, vascular peripheral illness and obesity. Her current drugs consist of 25 mcg fluticasone inhaled daily, 2.5 mg or 4 times daily albuterol nebulizer, 20 mg oral medicines, 75 mg or more daily clopidogrel, 100 mg of BID cilostazol, and 500 mg BID metformin.

After evaluating the patient's health situation, dubious MI vs angina, smoking history, hyperlipidemia and diabetes, certain serious problems become obvious. Mr. Zack characterized the discomfort of the thorn as an atrocious, scorching pain that radiates over her chest. During the treatment with ER, two doses of nitroglycerin pills were used, and 2 L O2 per nasal cannula was used. She was brought to medical critical care for medical treatment of her chest pain after stabilization. During his medical study he was planned for the next day to receive a heart catherization with an advisable PCI to open the cardiovascular blockage of the right coronary artery of 90%. Mr. Zack's heart rate dropped to 35 beats per minute throughout the surgery, whereby atropine IV was given and the procedure proceeded successfully. Patient S was transported to the OT/telemetry unit on the day after the PCI.

Introduction

Transitional care includes a wide range of services and environments aimed at promoting the secure and timely transmission of patients between health levels and care facilities. For older persons with various chronic diseases and complex therapy regimes, and their family cares, high-quality transitional care is especially vital. Typically, these patients are cared after by several providers and often travel through medical facilities. An increasing number of studies show that they are especially prone to care failure and therefore have the highest need for transitional care (Camicia & Lutz, 2016). Poor "care" from hospital to home for elderly persons and their families is related to negative occurrences, low care satisfaction, and high re-hospitalization levels. Many components influence to key shifts in care gaps. Ineffective leadership, insufficient information transmission, inadequate learning of older people and caregivers, lack of availability to critical services, and a single point person's absence, are all contributing to ensuring that care continues. The challenge is compounded by language and health education and cultural barriers (Naylor & Van Cleave, 2019).

Point of care transitions and implications for advanced nursing practice

Patients' and caregivers are vulnerable interchange spots for patients and caregivers that result in increased risk for adverse health outcomes (hospital, other institutions and homes). The Institute of Medicine and National Quality Forum have recognized as a national goal the improvement of transitions from acute care to house. Despite this, health care transitions continue to be inefficient for people with disables, such as stroke, resulting in unexpected demands of the patient and caregiver, higher safety hazards, high rates of unnecessary readmission rates and heightened healthcare expenditures (Camicia & Lutz, 2016). Family

caregivers play a very important role in helping older persons during and especially after their hospitalization. But little attention has been paid to the particular requirements of family caregivers during care transitions until recently. Accordingly, caregivers consistently assess their commitment to decision-making regarding discharge arrangements and the quality of preparedness for the next phase of care. The researchers analyzed Medline, CINAHL and Social Work Abstracts databases with combinations of the following terms: research, 65 years of age, continuity in patient care, transfers, medication management and post-discharge in attempt to comprehend the state of scientific knowledge relating to transitional care models for elderly adults and the functions of family caregivers in such models (DelBoccio et al., 2018).

Readmissions from hospital contexts to the community are a widely watched measurement of the efficiency of care transition. Readmissions may suggest persistent issues, inadequate care release, immediate aftercare quality, or a blend of all elements. 6 After the hospital release, thirty-day readmission rate is recorded at 14.4%, of which 11.9% are considered preventable (Camicia & Lutz, 2016). According to the severity of stroke deficiency, readmissions following rehabilitation output range from 9.0% to 16.7%. 8 The most important readmission rate is 30 days for patients released to specialized nursing facilities.

Conclusion

To conclude, literature research suggests that nurses need an extensive awareness of care changes from different levels of care to help patients achieve optimal health outcomes. Transitional care is aimed to encourage a safe and timely mobility of patients through the various healthcare areas. A complete transmission and communication from the ICU to the medical

surgeons was essential to this patient's promptness with the complex medical history of Patient S and his recent chest pain episode.

References

Camicia, M., & Lutz, B. J. (2016). Nursing's role in successful transitions across settings. *Stroke*, *47*(11), e246-e249.

DelBoccio, S., Smith, D., Hicks, M., Lowe, P., Graves-Rust, J., Volland, J., & Fryda, S. (2018). Successes and challenges in patient care transition programming: one hospital's journey. *OJIN: The Online Journal of Issues in Nursing*, *20*(3).

Naylor, M. D., & Van Cleave, J. A. N. E. T. (2019). Transitional care model. *Transitions theory: middle-range and situation-specific theories in nursing research and practice. New York: Springer Publishing*, 459-65.