Long-Term Care (LTC) Facility Planning and Effectiveness

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Abstract

In long-term care (LTC) facilities, both legal and ethical considerations are important. Ethical considerations concern issues such as beneficence, the futility of treatment, confidentiality, and, autonomy and informed consent. Other ethical considerations required among care providers include therapeutic alliances regarding physician-patient relationships, truth telling, justice (regarding fairness and lawfulness), and non-abandonment. Therefore, ethical and legal requirements exhibit a complementary relationship in such a way that the latter requires LTC facility operators to comply with laws governing the health care industry at the state, federal, and local levels while the former advocates for human rights. In summary, ethical considerations are internal to the LTCs while legal requirements are external, developed by authorities governing the general state of quality service provision while curbing cases of neglect and patient abuse.

Introduction

The determination to enhance efficiency and quality among health care contributors has continually attracted quality improvement initiatives and performance management techniques. As such, health care providers seeking to learn and utilize databased operations ought to acknowledge the criticality of employee accountability. The implication to long-term care (LTC) managers is that there is a need to hold individuals and groups liable and accountable for their actions, guaranteeing performance stability (Berg-Weger, Rubio & Tebb, 2001). Indeed, liability in the health care sector prompts individuals to be liable for the respective actions in which they are engaged, abiding by the law. This paper examines the legal and regulatory requirements shaping LTC service provision at the local, state, and federal levels.

In the medical field, LTCs refer to continuums of social and medical services designed for support provision in relation to the needs of individuals experiencing chronic health problems (Kaye, Turner, Butler, Downey & Cotton, 2003). The role of these support services is to address adversities arising from the inability to engage in daily activities. Specific services include housing, social services, and medical services. Indeed, numerous state, local and federal laws have been established to protect patients undergoing assisted living and located in medical homes, the primary goal being the elimination of both neglect and abuse. Additionally, the legal and regulatory procedures at these levels seek to entitle patients to security and privacy, besides other rights. Reports of widespread abuse and neglect in medical homes attracted the involvement of representatives at the federal, local and state levels to enact legislation in 1987. Specifically, the legislation required medical homes associated with Medicaid and Medicare to comply with rules guiding care quality. Specifically, the Medical Home Reform Act prompts the highest practicable psychological, mental, and physical well-being in accordance with respective plans of care (Bogardus, Bradley, Williams, Maciejewski, Gallo & Inouye, 2004).

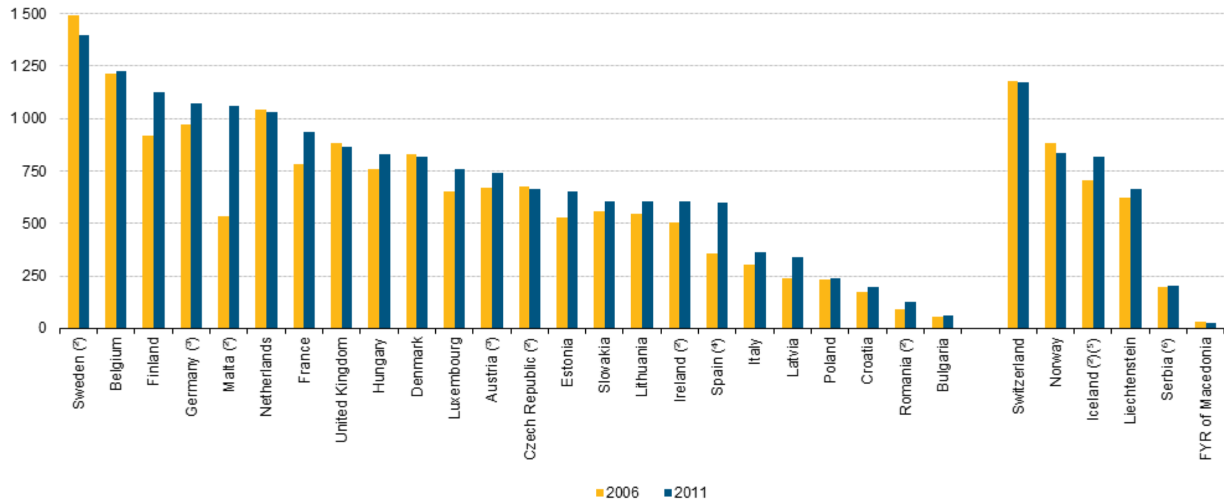
Additional regulations have been designed based on the policies of respective states and local authorities. Despite the variation in regional requirements, one of the basic regulations is that all medical homes are expected to have adequate medical staff, conduct accurate and comprehensive assessments of the functional capacity of each resident, and establish care plans that are expensive and specific to the residents (Berg-Weger, Rubio & Tebb, 2001). Furthermore, medical homes are expected to prevent deteriorations of patient ability to communicate, eat, toilet, transfer and ambulate, groom, dress, and bathe. It is also worth noting that LTCs are expected to provide necessary services for maintaining personal oral hygiene, grooming and good nutrition to promote the use of assistive devices while gearing towards proper treatment (Kaye, Turner, Butler, Downey & Cotton, 2003).

Other regulatory requirements include preventions of pressure sores, provision of assistive devices and adequate supervision with the aim of preventing accidents, maintaining desirable levels of nutritional statuses, and curbing possible causes of significant medication errors. Ethically, there is a need for LTC providers to promote quality of life among residents while maintaining respect and dignity of the respective residents (Bogardus, Bradley, Williams, Maciejewski, Gallo & Inouye, 2004). By advocating for the maintenance of easily accessible, complete, and accurate clinical records, these requirements play a significant role of preventing abuse and neglect among patients in LTC facilities.

Methods

The role played by legal and regulatory requirements in shaping the development of health care policies at the organizational level cannot be overemphasized. For example, the requirements provide standardization in operational activities conducted on a daily basis. Through standardization, uniformity in the provision of care services among LTCs is likely to be realized. Additionally, legal and regulatory requirements are critical because they provide clarity when faced with activities and issues critical to legal liabilities and, health and safety (Berg-Weger, Rubio & Tebb, 2001). Therefore, legal and regulatory requirements promote the development of LTC policies by allowing the practitioners to understand basic services that require patient-centeredness and dynamism in a quest to meet the needs of patient groups in varying demographic contexts. Additionally, the requirements are critical because their form a foundation responsible for the identification of the changing needs of patient groups in different geographic zones, supporting the design of new policies and practice strategies geared towards the realization of satisfactory services. Lastly, legal and regulatory requirements are crucial because they allow providers in LTCs to assess the state of accountability and liability of their employees – by examining the state of alignment between organizational or institutional policies and the requirements in the larger federal, state, and local authorities' legislations (Kaye, Turner, Butler, Downey & Cotton, 2003).

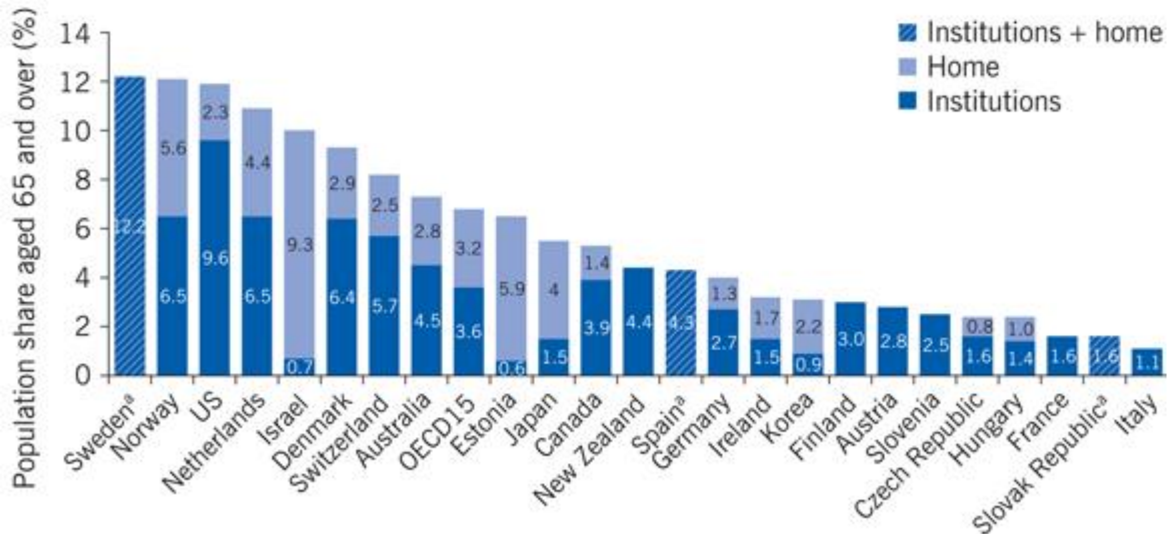
Results



(1) Greece, Cyprus, Portugal and Slovenia: not available.
(2) Break in series.
(3) Data for 2007 instead of 2006.
(4) Definition differs.
(5) Data for 2010 (estimate) instead of 2011.
(6) Includes only beds in public facilities.
Source: Eurostat (online data code: hlth_rs_bdsns)

In deciding the equipment for addition to an LTC floor plan, one of the critical factors of consideration concerns the nature of patients. Given the primary role of offering assistive devices to groups that are unable to attend to their daily activities independently, the need for diversification to give room for both easy movement and access to the assistive devices remains imperative (Baer & Hanson, 2000). Similarly, equipment supporting safety and a floor free from slipping remain ideal while reinforcing these with proper lighting to assure patient satisfaction and quality service provision. Regarding the regulatory addition, it is affirmed that LTCs ought to promote safety by designing facilities from sliding while assuring privacy (Buchanan, Choi, Wang & Huang, 2002). As such, sections for groups such as children, men, and women would be separated to avoid ethical contravention while promoting social values.

It is also worth noting that an interactive floor plan would be established to foster the planning and response to major facility incidents. By eliminating the problem of responder blind entry into LTCs without the idea of the buildings' layout, an interactive plan would allow visual abilities towards safety and capability enhancement. To support this program, a device that would be incorporated is the left ventricular assist device that supports individuals diagnosed with heart failure and operating at the end-stage. The choice of this device is informed by the need to support blood pumping in situations where weakened hearts are reported. Overall, the perceived LTC floor is that which would promote patient safety while minimizing adversities such as slipping and ethical contraventions.



Notes: a. Data for Sweden, Spain, and the Slovak Republic do not distinguish long-term care workers in institutions and at home.

Source: OECD Health Statistics Data, 2013. Online at: http://dx.doi.org/10.1787/health-data-en

In federal laws, the quality of care requires each resident necessary services and care from the LTC facilities to maintain or attain the highest practicable psychological, mental, and physical well-being. The provision of these services is also expected to comply with comprehensive plans of care (Bogardus, Bradley, Williams, Maciejewski, Gallo & Inouye, 2004). Therefore, LTC facilities participating in Medicare are likely to be liable for engaging in operations that contravene provider requirements in the Social Security Act. Some of the common liability risks include fall or slip exposures, wandering or elopement, skin integrity, neglect, abuse or resident rights issues, and, treatment and medication omissions or errors (Berg-Weger, Rubio & Tebb, 2001). In circumstances where these risks are apparent, the health care providers are sued and the eventual or respective actions taken – based on the magnitude of the failure and legal specifications underlying the specific area of concern.

Conclusion

In LTCs, both legal and ethical considerations are important. Ethical considerations concern issues such as beneficence, the futility of treatment, confidentiality, and, autonomy and informed consent. Other ethical considerations required among care providers include therapeutic alliances regarding physician-patient relationships, truth telling, justice (regarding fairness and lawfulness), and non-abandonment. Therefore, ethical and legal requirements exhibit a complementary relationship in such a way that the latter requires LTC facility operators to comply with laws governing the health care industry at the state, federal, and local levels while the former advocates for human rights. In summary, ethical considerations are internal to the LTCs while legal requirements are external, developed by authorities governing the general state of quality service provision while curbing cases of neglect and patient abuse.

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Primary Care Provider Shortage

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Abstract

Currently, the shortage of primary care providers in sections of emergency departments (EDs) has had far-reaching implications on the quality and quantity of service provided. Whereas the need to foster patient satisfaction has been a key objective at the local, state, and national levels, the challenge of physician shortage has proved to be detrimental. Some of the impacts of the shortage have been documented to include overcrowding in hallways, burnout, and dissatisfaction among sections of patient groups. As such, it is recommended that the US government's healthcare authorities engage in the establishment of a balanced ratio between physicians and the number of patients admitted in the ED departments. Apart from the revision of the existing physician-to-patient ratios in its states, there is a need for the US government to promote an equitable distribution of human resources in different healthcare organizations' ED sections at the national, local and state levels. It is also recommended that the US government creates a multi-disciplinary, multi-professional, state-wide and workforce commission responsible for formulating workforce distribution, retention and development strategies. This step could be complimented by the design of stable and adequate funding residency programs that include medical training with the objective of producing proportionate supplies of rural and urban primary care providers. Lastly, it is recommended that nurse practitioners and physician assistants be used as physician extenders to maximize the effectiveness and efficiency of a limited ED workforce in the US. Overall, the goal of subsidizing community-based and rural training sites towards the invigoration of primary care residency programs is projected to form a lasting solution to the shortage of primary care providers in the context of the United States' sections of healthcare emergency departments.

Introduction

In the healthcare sector, shortage in the number of care providers has been attributed to individual, group, organizational, and community factors. Issues such as trends, causes, effects and potential solutions to these shortages have received an in-depth analysis (Staiger, Auerbach & Buerhaus, 2009). However, organizations and different regions have continually grappled with the challenge because of the ever changing needs of health care users, as well as the dynamic nature of stakeholder group preferences (Petterson, Liaw, Tran & Bazemore, 2015). The implication of these mixed outcomes is that an examination of potential solutions to the shortages faced regarding the number of primary care providers is important in informing lasting stability at the institutional and community levels. This paper proposes some of the solutions that could be adopted and implemented in a quest to address the shortage of primary care providers. In so doing, it is projected that the healthcare industry will be characterized by high quality service provision and the attribute of improved patient satisfaction.

Methods

In this case, the proposal is from the context of a nurse practitioner seeking to inform a hospital emergency department (ED) towards the adoption and implementation of a fast track program. According to Johnson, Ghildayal and Ward et al. (2012), emergency departments (EDs) refer to medical treatment facilities responsible for acute care and emergency medicine specialization. The departments target patients presented without prior treatment, arriving

either by an ambulance or by their own means. Given the state of unplanned patient attendance in EDs, the departments provide initial treatments for broad spectra of injuries and illnesses, with some requiring immediate attention due to their life-threatening state. In most cases, EDs operate on a 24-hour basis. The notable aspect is that staffing levels vary based on the nature of the patients' volume (Dill & Salsberg, 2008).

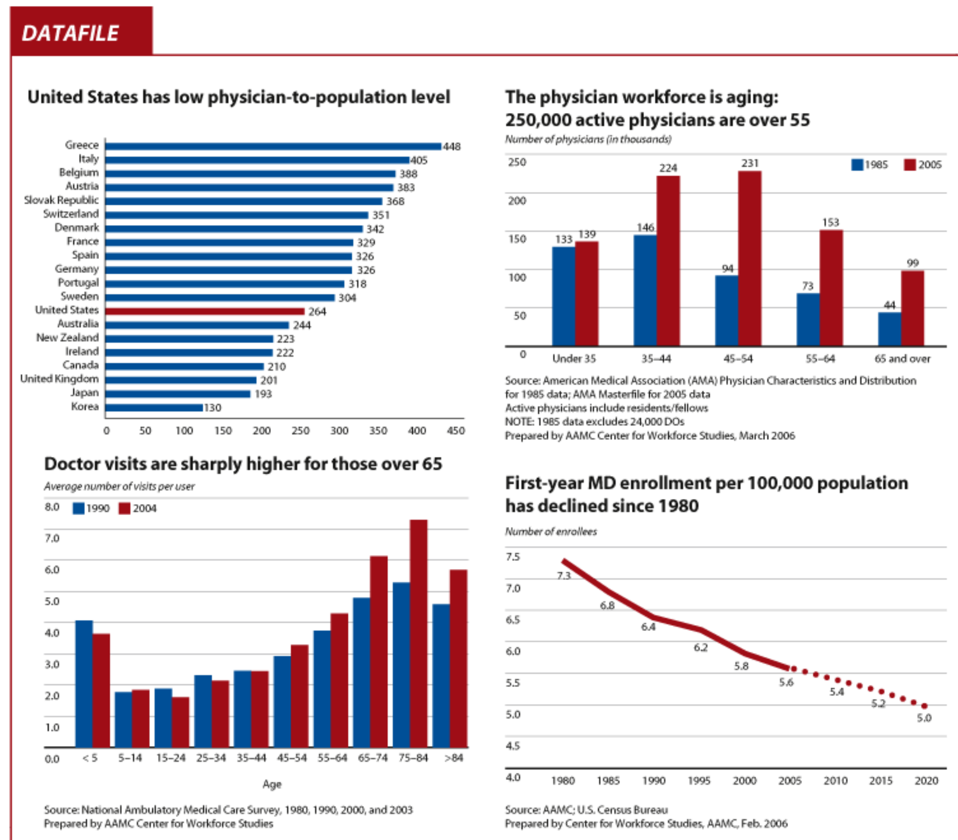
Some of the conditions that primary care providers in EDs handle include cardiac arrests, heart attack, trauma, mental illnesses, asthma, and the chronic obstructive pulmonary disease (COPD). Notably, special equipment, training and facilities are required towards the realization of efficient ED services. Specifically, the ED staff is trained to work effectively and quickly even with minimal data because most of the patients arrive have been reported to frequently arrive with unstable conditions. Specifically, most of the ED patients are unconscious and data regarding their blood type, allergies and medical history is unlikely to be available. As such, ED operators use equipment unfamiliar to average physicians, with special procedures involving traction splints and military anti-shock trousers reported to be common (Petterson, Liaw & Phillips, 2012).

Results

The shortage of primary care providers in EDs cannot be overemphasized. For example, it is projected that the demand for primary care providers will grow due to population growth and aging. Specifically, the aging population has been predicted to account for an 81-percent change in demand, projected to occur between the years 2010 and 2020 (Altschuler, Margolius, Bodenheimer & Grumbach, 2012). The remaining percentage change in demand has been linked to the estimated health insurance coverage expansion, with most of the states and regions expected to expand provisions such as Medicaid. Furthermore, the current patterns of utilization suggest that the demand for primary care physicians might grow on a more rapid basis, compared to the rate of their supply (Staiger, Auerbach & Buerhaus, 2009). Particularly, the number of full-time employees has been projected to exhibit an eight-percent increase between the years 2010 and 2020 while the demand has been predicted to increase by 14 percent. As such, unless addressed, a looming crisis regarding an imbalance between the supply and demand for primary care physicians is likely (Petterson, Liaw, Tran & Bazemore, 2015).

Another notable aspect is that an absence of changes in the delivery of primary care indicates that the growth of physicians might fall below the demand in 2020, with the estimated shortage recorded at 20,400 (Johnson, Ghildayal and Ward et al., 2012). Whereas this deficit may not be larger than that which has been recorded in prior studies, the predicted shortage remains significant. It is further noteworthy that physician assistant and nurse practitioner workforces might grow on a far more rapid rate than the supply of physicians. Whereas nurse practitioners might increase by 30 percent between the years 2010 and 2020, the same period has been estimated to experience a 58 percent increase in the number of physician assistants (Dill & Salsberg, 2008). Lastly, an increase in the use of physician assistants and nurse practitioners is likely to alleviate the projected shortage of primary care physicians but the extent to which these groups might be effectively integrated into health care delivery systems poses a dilemma. The documentation suggests that physicians will continue to be dominant providers in primary care provision but the dire state of quality, which could be compromised by their shortage, requires immediate attention towards problem solution.

Figure 1: Illustration of primary care provider distribution in selected regions



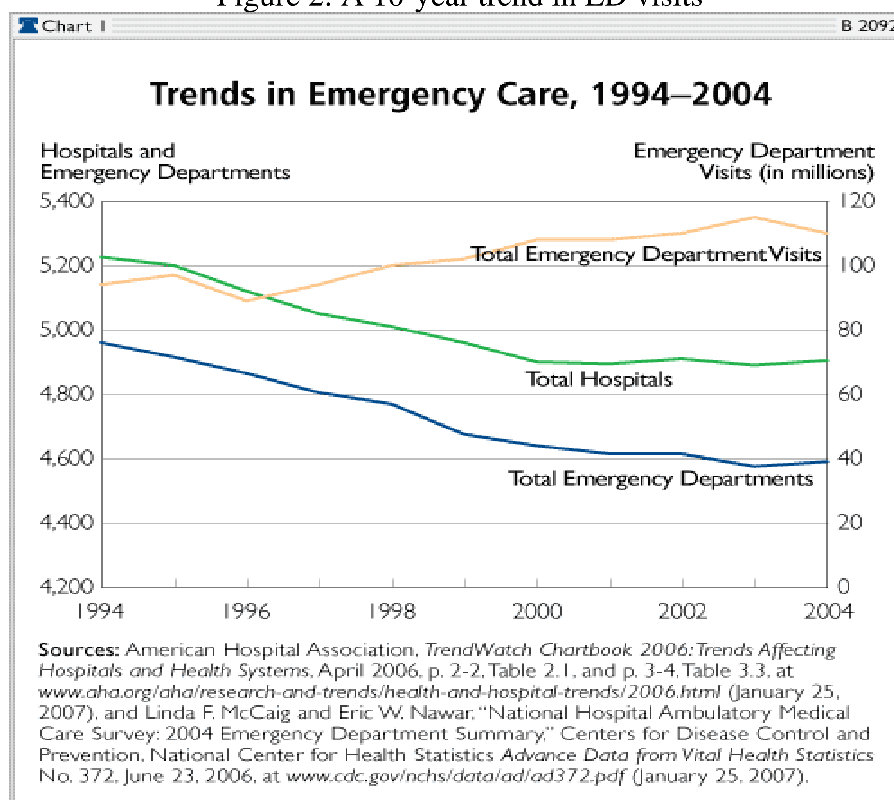
From the figure above, physician shortage and high turnover rates in the emergency departments forms a great concern. The concern arises from the effects posed by this deficit on the efficiency and effectiveness of systems in the health care delivery process. As the recruitment and retention of physician declines, adversities such as reduced job satisfaction levels are reported (Petterson, Liaw & Phillips, 2012). The implication is that two critical issues attract the attention of scholarly contributors. The first issue concerns investigations seeking to understand the correlation between job satisfaction and the intention of physicians to leave. By understanding this correlation, it becomes possible to understand the potential causes and effects of physician turnover and shortage in the emergency departments. The second issue concerns the understanding of the role played by government authorities in ameliorating patient adversities arising from physician shortages in the emergency departments. Indeed, the figure illustrates a worrying trend because ED visits are sharply increasing, leading to a higher demand compared to the rate of the supply of primary care providers.

In this case, the crisis in America's emergency rooms attracts a region-based attention in a quest to gain critical insights into the extent of the problem. In the US, emergency medical systems have been stretched beyond capacity. For example, the period 1994 to 2004 saw the visits to hospital EDs increase by 18 percent. Specifically, the number of visits was reported to stretch from 93.4 million to 110.2 million (Altschuler, Margolius, Bodenheimer & Grumbach, 2012). Despite this trend, a significant decline in the number of EDs, hospital beds, hospitals and physicians was reported. It is also worth noting that a majority of the states in the US have seen systems absorb surges in demands accompanying terrorist attacks, natural disasters, or pandemics. As such, warnings from the global projection indicate the physicians available are unlikely to promote effective public health, should a moderately severe pandemic occur. This category accounts for 25 states (Staiger, Auerbach & Buerhaus, 2009). On the other hand, physicians in 47 states have been documented to lack the capacity to handle severe outbreaks because of their limited number.

It is further notable that the United States' recent increase in the demand for ED services has been attributed to patients admitted for non-urgent problems. For example, the State Children's Health Insurance Program (SCHIP) and Medicaid enrollees have used EDs at a rate that is about two times that of Medicare beneficiaries or uninsured patients and roughly four times that of privately insured patients (Petterson, Liaw, Tran & Bazemore, 2015). Degradations in patient care quality have also been associated with the nature of the current conditions. In sections of EDs, patients have been "boarded" for a long period until hospital beds become available. In others circumstances, precious time has been lost after diverting ambulances from overcrowded emergency departments. In relation to this trend, about one in every six urban hospitals has reported ambulance diversions in over 20 percent of the time. This challenge has been exacerbated by shortages of ED physicians offering on-call emergency services. This outcome has seen over 65 percent of ED directors report problems arising from physician coverage (Johnson, Ghildayal and Ward et al., 2012).

Uncompensated care burdens faced by ED physicians have also been attributed to the contributory role of the current conditions. Notably, over 30 percent of ED physicians offer emergency medical services while 42 percent of those who are self-employed have indicated that a significant amount of their bad debt has arisen from the federal laws required delivery of medical services. Overall, an annual estimate of $4.2 billion has been reported to account for bad debts, posing a critical burden on the part of ED primary care providers (Dill & Salsberg, 2008). The following figure illustrates trends in the past ED visits, compared to other sections of the hospitals in the US.

Figure 2: A 10-year trend in ED visits



Despite the mixed outcomes, several actions have been adopted in different regions of the US. For example, California's legislative mandate designed an ED patient-to-physician ratio of 4:1 (Petterson, Liaw & Phillips, 2012). Whereas the enforcement of this ratio sought to curb pressure on the part of physicians, moments of extreme crowding have led to a near double number of patients in sections of the treatment areas. With the rigid ratio of 4:1, patients have ended up in hallways without direct physician observation during crowding periods. To

foster flexibility in Ed's moments of overcrowding, there is a need to relax this rule. Another step in the EDs has been to board the admitted patients (Altschuler, Margolius, Bodenheimer & Grumbach, 2012). This action has been informed by the challenge of limited hospital bed capacities. Whereas the intention has been to accommodate more ED visitors, some of the patients placed in hallways have been reported to be sicker than those occupying the inpatient beds. The eventuality is that significant ED congestion, which is associated with poor patient outcomes, could be addressed from the perspective of both ED physician shortages and facility expansion.

Conclusion

In summary, an evaluation of the formulated project will involve examinations of the stakeholder groups and other practitioners involved in patient care during ED visits. Trends in patient visits and the duration taken to address their needs will be examined in conjunction with the burnout level of physicians and the funding of residency programs to understand the effectiveness of the formulated strategies. Furthermore, the number of new employees in the ED sections, the state of funding in community-based and rural training sites, and the creation of a multi-disciplinary, multi-professional, state-wide and workforce commission responsible for formulating workforce distribution, retention and development strategies will be used as predictor of project success.

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Case Scenarios in Medical Leadership

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Abstract

In the current state of health care provision, concerns about safety and practitioner laxity have arisen from the growing demand to improve the state of patient satisfaction. This case scenario paper has focused on the concept of medical leadership, gaining critical insights from the cases of Drew and Lindsey. Whereas the case of Drew reveals a concerned RN working under an experienced RN but the latter poses laxity that raises safety concerns, Lindsey's case reveals a team member whose patients continue to complain of pain. Additionally, Lindsey depicts a team member whose quality of service provision has deteriorated significantly, besides exhibiting critical changes in character (including mood changes, diminishing returns on performance, altered appearance, and problems with relationships). To address Drew's dilemma, it has been recommended that the RN establishes a safety accountability system, promotes safety awareness campaigns through warning signs and safety posters, and emphasizes on the importance of acquiring safety directors at the departmental levels. On the other hand, a team member to Lindsey's section could address her problem by acting as a concerned colleague, rather than an enforcer. This process could be achieved by collaborating with the manager to examine and document her signs before designing a plan and implementation procedure that seeks to correct her character. However, it is worth noting that care should be taken to avoid possible ripple effects of resistance to change – by approaching her as a concerned colleague. If left unaddressed, Lindsey's lapse in the workplace could cause patient dissatisfaction and high burnout levels among her colleagues.

Introduction

In the medical field, an emergence of gaps between theoretical teachings in medical textbooks and other correlated aspects such as the published literature, the hospital's policy and procedures, and actual practice has been attributed to the changing nature of health care needs. Specifically, differences in the demand of user groups in different geographic locations have been documented to account for these gaps, complementing the role of individual practitioner differences and preferences as a contributor to the gaps (Fick, Mion, Beers & Waller, 2008). Whereas the gaps may prove to be detrimental to care provision by forming predictors of compromised quality and failed adherence to the policies and procedures of healthcare organizations, they play a significant role in medical leadership. For example, the gap sensitizes scholars regarding the need to acknowledge differences in the RNs geographic backgrounds, upon which population-specific and relevant information can be incorporated into the existing literature to reduce the knowledge gap among care providers and other practitioners. Additionally, the gap aids in aligning the course objectives and goals to the vision and mission of the healthcare industry. This process is achieved when the gaps are used to identify the strengths of a training program in comparison with opportunities for improvement (Tam, Kwok & Fan et al., 2008).

Therefore, it can be inferred that the gap aids in understanding some of the ways in which healthcare organization policies and procedures could be revised to make them more

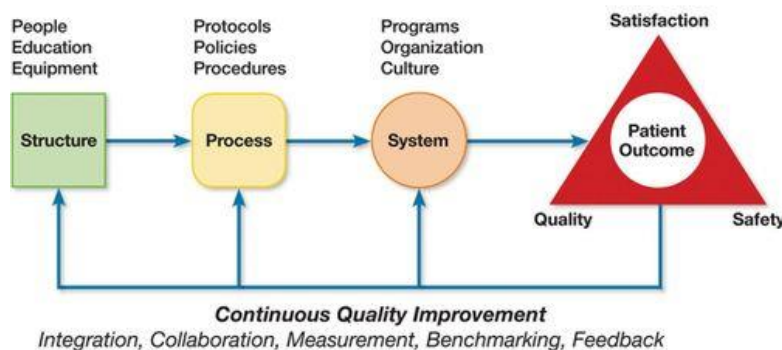
relevant to the needs of populations. In addition, the gap is used as a background for informing practice in such a way that it sensitizes the instructor groups in training institutions to engage in in-depth research practices towards the provision of insightful curricula that seeks to foster a smooth transition as the RNs transit from theory-based scenarios to practice-based situations (Biron, Loiselle & Lavoie-Tremblay, 2009).

Methods

In medical, a culture of safety refers to shared attitudes, practices and beliefs that exist in establishments. The implication is that these attitudes, beliefs and practices shape behavior at the organizational, departmental, and organizational level (Fick, Mion, Beers & Waller, 2008). Regarding the case of Drew, a culture of safety would aid in striving beyond encouragements of work towards change to engage in action taking when the need arises. Indeed, a culture of safety suggests that inaction in the face of crises or safety-related problems could be deemed as a taboo. Rather than point fingers at others (or distance himself from safety-related responsibilities), Drew could adopt the culture by openly sharing information about health care safety. In turn, the active role assumed could form a basis for encouraging other members of staff to report unsafe conditions and adverse events without fearing reprisal or, a belief that reporting might not yield significant changes.

Therefore, Drew could focus on a culture of safety towards change implementation by demonstrating a personal commitment top safety while mobilization other members of the team towards the achievement of results. Similarly, Drew could deliver messages about safety in a sustained and consistent manner because culture change may take long. In summary, Drew could use a culture of safety to take up an active role of sensitizing other members about the need to report adverse events (by taking up responsibility). In so doing, Drew is likely to influence other members to acknowledge error inevitability and proactively engage in latent threat identification. With the culture of safety spearheaded, Drew's potential program outcome might yield a health care setting in which members are confident of error reporting without fears of retribution, besides collaborating across ranks to address system vulnerabilities.

Results

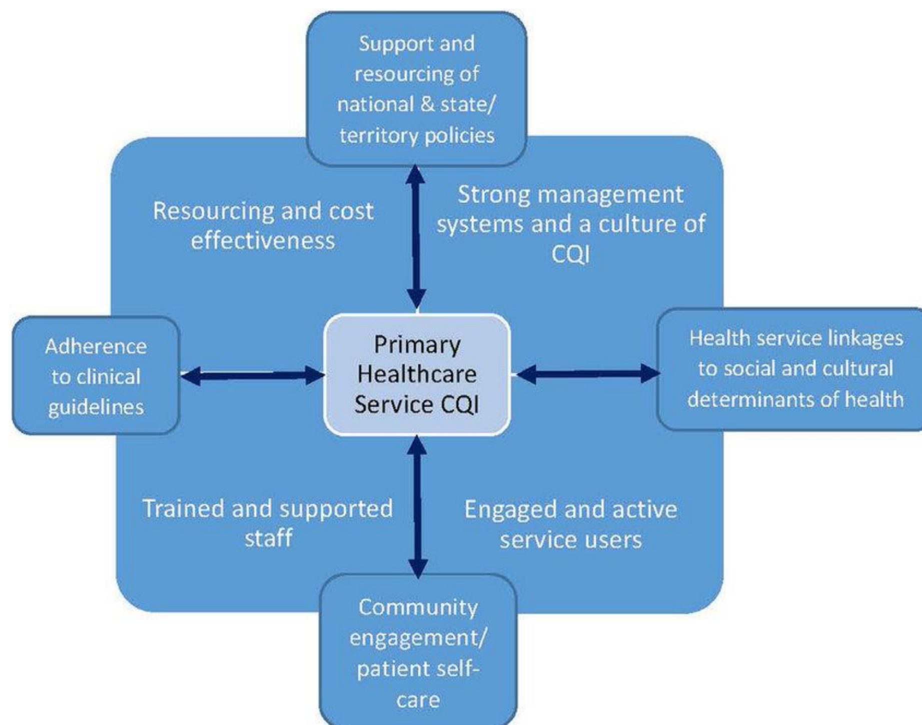


In strong safety cultures, all individuals feel responsible and pursue safety on a daily basis. Specifically, employees in strong safety cultures operate beyond the call of duty to engage in the identification of unsafe behaviors and conditions, intervening to correct the same (Tam, Kwok & Fan et al., 2008). In this case, one of Drew's options is to encourage the experienced RN to exercise safety on a consistent basis. However, this approach could be perceived to be over-zealous or forward but may be rewarded and valued by the organization.

Similarly, Drew could point out unsafe behaviors exhibited by the experienced RN. However, this approach, unless taken with care, could lead to adverse effects regarding workplace relations between Drew and the experienced RN.

Another option is for Drew to seek permission from the organization's senior leaders and begin a campaign regarding safety awareness. This program could be implemented through warning signs and the use of safety posters. With more devotions of commitment and time, Drew may develop safety recognition programs by addressing physical hazards, besides developing incentive programs and creating safety committees in a quest to address the observed lapse in the experienced RN on a long-term basis.

Furthermore, Drew may seek support from the top management (regarding a safety culture) by sensitization the leaders about the need for safety training, resource provision towards incident investigation, and the importance of acquiring safety directors. It is also worth highlighting that Drew could advocate for accountability systems through the establishment of safety goals, design of charge costs to units that demonstrate unsafe approaches to care provision, and the measurement of safety activities. Ultimately, Drew might achieve the goal of making safety everyone's responsibility, rather than leave it to the safety director. In summary, Drew's approach to the experienced RN, effort to establish a safety accountability system, safety awareness campaigns through warning signs and safety posters, and emphasis on the importance of acquiring safety directors at the departmental levels might yield fruitful outcomes in the selected health acre context.



In the medical field, continuous quality improvement involves quality assurance that constitutes service provision to meet appropriate standards, and problem resolution that involves all departments in addressing the issue at hand (Biron, Loiselle & Lavoie-Tremblay, 2009). Therefore, continuous quality improvement involves a collaborative approach to the production of better health care services, involving all departments. As such, Drew's role is to engage in a total system reform by engaging in radical changes, rather than stop at the stage of current system alteration. However, this approach is informed by an assumption that service provider staffs are acting in good faith, rather than willfully fail to engage in the correct safety procedures.

The first step for Drew is to identify the need for change by assessing the health care service status. This step should be followed by process improvement. To achieve the latter, Drew could structure the workplace environment in a manner that facilitates the other team members' ability to foster constructive action for care improvement. In addition, Drew could use quality improvement forums, quality councils, and quality circles to coordinate and facilitate efforts geared towards quality improvement across the organization's departments. To assure the realization of the desired outcomes, Drew could aggregate data in relation to professional standards and the requirements of insurers, as well as other external regulatory agencies. The health care environment could also be reshaped by empowering and inspiring the staff towards process improvement. However, it is worth noting that Drew's efforts towards quality improvement could be successful through the involvement of other ancillary personnel and professionals while promoting positive inter-departmental interactions.

In this case, proof is yet to be established but signs are evident. The important consideration is to deal with the situation without making false accusations or violating private policy rights of the Lindsey. The first step that could be taken is to collaborate with managers to stretch beyond performance issues to look for signs such as Lindsey's mood changes, diminishing returns on performance, altered appearance, and problems with relationships. These changes could include being talkative or energetic after lunch or breaks, in appropriate dressing, equipment misuse, and being accusative, uncooperative and argumentative. Upon documenting these signs based on specific incidents, the team member may collaborate with senior members to approach Lindsey as a problem solver, rather than an enforcer. By approaching Lindsey as a concerned colleague, potential ripple effects such as resistance to change and compromised workplace relationships might be avoided. The approach could involve explaining that a problem has been noticed and have consulted the senior leader to confirm the suspicions, attacking the problem from angles suggesting that the intention is to help Lindsey to regain her performance trend, rather than accuse her. The process could culminate into a presentation of a plan and implementation procedure in the form of an employee assistance program.

If Lindsey's situation is not addressed in time, several adverse outcomes might be witnessed. One of the issues concerns patient dissatisfaction because of the perceived failure to administer the right drugs in the right manner and at the right time. Specifically, dissatisfaction might arise from the continuous complaints of pain. Another consequence concerns a deterred state of nurse-to-patient relationship. With Lindsey's signs of compromised quality and keenness during care provision, a significant deterioration in her relationship with patients might be witnessed. Another consequent involves burnout on the part of Lindsey's colleagues, as they will be forced to dedicate additional time to attend to the patients in her section, leading to a workplace conflict that could arise from either a confusion of roles or overload. Overall, Lindsey's behavior, if unaddressed, could cause adversities such as patient dissatisfaction and burnout among the other members of the team.

Conclusion

In conclusion, this case scenario medical leadership paper has focused on the experiences of Drew and Lindsey in the context of care provision. The case of Drew suggests an RN whose dilemma arises when the experienced RN under which he works depicts laxity issues that pose safety risks to the patient groups. To address this dilemma, some of the options at Drew's disposal include establishing a safety accountability system, safety awareness campaigns through warning signs and safety posters, and an emphasis on the importance of acquiring safety directors at the departmental levels. On the other hand, Lindsey's problem could be addressed by collaborating with the manager to examine and document the aforementioned signs before designing into a plan and implementation procedure that seeks to

correct her character. However, care should be taken to curb potential rippled effects by approaching her as a concerned colleague, rather than an enforcer. If left unaddressed, Lindsey's issue could lead to patient dissatisfaction and burnout among the remaining members of the team.

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