Mini Review

Archives of Nursing and Care

Emergency Nursing: Nursing Care in the Pediatric Emergency Department

Abstract

The use of nurse-initiated treatments is expanding in order to enhance the efficiency and calibre of care given to kids who visit the emergency room. To illustrate how Advanced Nursing Directives effectively incorporate validated clinical scoring systems into practice, a clinical pathway for kids who arrive at our paediatric emergency department (PED) with a suspected appendicitis will be developed. The most recent studies on nurse-initiated protocols, validated clinical grading systems for emergency rooms, and Advanced Nursing Directives will all be included in this review (ANDs). Two further instances of advanced nursing directives for typical clinical PED presentations will be provided last but not least.

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Introduction

The demographic trend toward an ageing population is predicted to increase significantly in most industrialized countries. At the beginning of 2021, people aged 80 years and older constituted approximately 5% of the Danish population. This figure is predicted to increase to 10% by 2050. A projected demographic profile has revealed that by 2050, people aged 70 years and older will double their days in the hospital and account for nearly 60% of all hospital days. Despite these trends, there has been a reduction in the number of hospital beds from 2007 to 2018 in an effort to increase efficiency within healthcare sectors across Europe. Older medical patients are characterized as having several concurrent diseases [1], as well as declining physical and/or cognitive function. Due to the fact that these patients often live alone and have a decreased ability to take care of themselves, they frequently require care from primary or hospital services and heavy medical treatment.

When a patient with multiple and complex care needs is discharged from a hospital in Denmark, the municipality provides in-home or temporary care and treatment at skilled nursing facilities. Transfer across care settings and care providers require transitional care interventions and information for the patient and carers, as well as the involvement of the healthcare professionals. It is vital for the involved healthcare professionals to communicate across the sectors before the patient is discharged [2]. However, cross-sectoral electronic communication comes with challenges, such as insufficient or limited exchange of patient information, inconsistencies in communication, and the experience of not having access to all the needed information. A study by Petersen et al. disclosed that nurses tended to focus on fulfilling the standard requirements for the cross-sectoral electronic communication system rather than focusing on the patients needs and problems. The electronic communication form was also found to impede dialogue and communication.

The transitional care model (TCM) is a multicomponent, nurse-led intervention model comprising nine components that target older adults moving across healthcare settings. Components of the TCM have been used in various RCT studies, which also included older patients with multiple medical and care needs. These RCT studies showed that the TCM led to reductions in readmissions in some hospitals. The TCM approach reportedly had a positive impact on the participants' quality of life and led to reduced financial costs. From a theoretical perspective, the theory of 'relational coordination' has similar components to those of the TCM [3]. Relational coordination builds upon social networks, and in the positive cycle of relational coordination, shared knowledge, shared goals, and mutual respect are complemented by problem-solving communication that is frequent, timely, and accurate.

In Denmark, studies have been conducted on different interventions with outgoing teams

from geriatric departments following up on patients discharged from either the emergency department or the geriatric departments to various locations. These studies showed a reduction in readmission rates among nursing home residents and also a reduction in readmission rates, compared to municipality-based interventions.

In 2018, the Department of Geriatric Medicine at a university hospital initiated an intervention, the out-going geriatric team (OG-team), which was developed based on literature and clinical experiences. The OG-team consisted of a multidisciplinary team of doctors and nurses working at the Department of Geriatric Medicine. The team arranged follow-up visits with patients discharged from the Department to temporary care at a skilled nursing facility (SNF) in an urban municipality [4]. The multidisciplinary team visited the skilled nursing facility three times a week, and the face-to-face visits comprised a conference co-created by the healthcare professionals in the outgoing geriatric team (OG-Team), the healthcare professionals at the skilled nursing facility (SNF-team), and the patient. The purpose of these conferences was to make agreements on what issues should be addressed post-discharge. This study aimed to explore how the two teams experienced the cross-sectoral follow-up visit when the patient was discharged from the Department of Geriatric Medicine to a skilled nursing facility. Besides our study, the intervention was studied quantitatively with hospital readmission as an end-point.

Discussion

First of all, our study revealed that the face-to-face encounter and collaboration facilitated the teamwork and provided the healthcare professionals with a trustful opportunity to give and receive feedback when consulting. Similar results have been described in a study involving healthcare professionals, nurses from community healthcare, and general practitioners in Turkey. The study found that effective communication across healthcare settings could reduce readmission rates [5], as they found that the letter of discharge had often failed to include follow-up information on treatment started in the hospital, which resulted in an interrupted chain of care for the older patients with complex care needs.

Our study underlines the importance of constructing strong collaboration and teamwork cross-sectorally when the patient is dependent on care and assistance from many health professionals. The Transitional Care Model's nine components are: screening; staffing; maintaining relationships; engaging patients and caregivers; assessing/managing risks and symptoms; educating promoting self-management; collaborating; promoting continuity; and fostering coordination [6]. The collaboration in our study had similarities to the Fostering Coordination' in the TCM. In our study, the conference was the place where the healthcare professionals achieved shared understandings and goals for the treatment of the older patient, as they had a shared responsibility. We also found that in the face-to-face collaboration, together with patients and relatives, the patient's symptoms could be discussed and put into context to give the healthcare professionals the knowledge and competencies to act. Maintaining relationships, continuity of the healthcare professionals in the two teams, and coordination of tasks and feedback was supported by the heads of departments, as the intervention was highly prioritized by all.

The intervention in our study differed from the TCM in some ways. First of all, it was not nurse-led but involved an interdisciplinary team-led intervention. Secondly, for some patients, one visit from the OG-team was sufficient and had the impact of reducing readmission rates [7]. Thirdly, no screening was performed, as all patients discharged from the Geriatric Department had multiple risk factors. Just as our study showed interventions that had similarities to components in the TCM, the study by Burke et al., revealed that the specific components had a significant effect on reducing readmission rates.

The cross-sectoral collaboration we found in our study can also be deduced from the theory of relational coordination. This theory was developed in airline and healthcare research, where multiple individuals work together in complex systems. Relational coordination builds upon social networks and social capital. In the positive cycle of relational coordination, shared knowledge, shared goals, and mutual respect are complemented by problem-solving communication that is frequent, timely, and accurate [8]. In relational coordination, each person acts interdependently rather than independently to achieve the best outcome through the transfer of information and

resources. In our study, we found that the cross-sectoral collaboration surrounding the older patient was challenged and depended on the individual healthcare professional's competencies in observing and taking action, as well as on their ability to communicate and collaborate. In the cross-sectoral collaboration between the SNF- and OG-teams, shared knowledge was emphasized to be significant in the care and treatment of older patients. The teams created cohesion where they, along with the patient, had shared goals and mutual respect.

We identified some challenges in the study. There was no clear definition of who was responsible for the patient when the OG-team was away from the nursing facility. The participants from all teams also experienced that there was no clear agreement on what the OG-team could be contacted about on the days they were not at the skilled nursing facility or how and when the SNF-team should contact the patient's GP. Among these competencies, collaborative attitude and respect, roles and responsibilities, mutual knowledge and understanding, communication, and leadership were identified and emphasized to provide good collaboration [9]. On the other hand, unclear roles and responsibilities were described as barriers to good collaboration, which accentuates the findings in our study.

We found that the participants in our study experienced an increased level of competence in taking responsibility and caring for older patients. In a Norwegian community, a self-assessment survey examining healthcare professionals' competencies in caring for older people was conducted, and it revealed that the nurses' levels of care competencies variated across age, but also across workplaces where nursing staff scored higher at nursing homes than staff in home care. Thus, in a skilled nursing facility, it would be relevant to increase the focus on the healthcare professionals clinical caring competencies, given the complexity of older patients' treatment and care needs. Our findings emphasize that the cross-sectoral collaboration and meeting face-to-face led to increased knowledge among both teams and an experience of improved competencies, patient treatment, and care.

Strengths and limitations

To our knowledge, this is the first qualitative study in Europe to explore the perspectives of healthcare professionals in a cross-sectoral collaboration with a multidisciplinary outgoing geriatric team and healthcare professionals at a skilled nursing facility. The study was conducted as an explorative interview study, allowing the healthcare professionals to elaborate on their experiences within the intervention. We chose to conduct individual interviews, where the participants were able to elaborate on their experiences, and we in turn could explore their thoughts and spoken words. Our study could have been enriched, however, by conducting onsite field observations focusing on the healthcare professionals' relations, actions, and interactions.

A potential limitation to the study is that the healthcare professionals in the OG-team and the first author were colleagues at the time, which could have rendered them less critical during the interview. This was accommodated by ensuring the participants' anonymity before beginning the interview and exploring both the positive and negative statements. It was not examined further whether this was the reason that three participants did not reply to the invitation to participate in the interview. Another limitation is that only one doctor participated in the study, and this could have downplayed the insights of that profession [10].

Lastly, our study was performed on a small scale within only one geriatric department and one SNF in one municipality over a year. Changes such as replacement of healthcare professionals and education level might have influenced the clinical practice and evolvement of the environment of the intervention, but these factors were not taken into account in this study.

Conclusions

This study emphasized the importance of meeting face-to-face when caring for and treating patients with complex care needs. The collaboration gave the healthcare professionals an experience of having increased competencies when working interdependently. The study also contributed important insights into how roles and responsibilities in cross-sectoral collaboration need to be clearly defined and agreed upon. Collaborating across sectors is beneficial to all involved health professionals. The two teams in our study became a mutual team working with the patient and thereby creating the foundation for a coherent patient course. Future studies might explore whether these

insights could be transferable to other care settings.

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