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The Nurse and Ambulatory Care

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Abstract

When considering the concepts of nursing and the scope of work covered by the nursing profession, many mainly think of the hospital center and the health care of patients in the hospital bed. However, nurses, as the only and responsible providers of health care, can also perform their work in health centers, community health services, emergency medical services or in private practice. Nursing is an integral part of the entire healthcare business. Therefore, the organization of work in nursing must be flexible, dynamic and stimulating for the development of modern trends in health care. The common purpose of the health team is to improve, preserve and restore the health of the individual.

Keywords: Nursing; Ambulance; Patients; Ethics; Health

Introduction

An ambulatory care nurse works as part of a multidisciplinary health care team to provide primary care to a specific population [1]. Depending on the role the nurse plays within the ambulatory center, the work activities will differ. A triage nurse may work primarily in a walk-in area or over the telephone assessing the patients and determining the priority with which they must be seen or referred. Working with a multidisciplinary team entails gathering a medical history and information about the chief complaint and checking vital signs. Once the practitioner has seen the patient, the nurse will perform follow-up treatment, such as drawing labs, teaching the patient regarding the condition, and discharge instructions.

Core Skills Needed

- Knowledge of illnesses and symptoms including diagnosis and management [1].
- Experience with triage.
- Strong assessment and organizational skills.
- Communication skills.
- Ability to collaborate and function as a member of a multidisciplinary team.
- Ability to function in a fast-paced environment.
- Interest in working with a diverse population.

EMS

Ambulance services, called Emergency Medical Services (EMS) in many parts of the world, are responsible for the initial care of victims at the scene of an event and their transport to healthcare facilities [2]. There is considerable variability among these services; they may be affiliated with community fire services or government entities, or they may be operated as private businesses. The EMS staff may include various healthcare providers (physicians, nurses, paramedics, or emergency technicians) with different skill sets; and they may be paid employees or volunteer staff. These trained healthcare providers can arrive on the scene by a variety of methods, including ambulance, fast response car, bicycle, moped, helicopter, fire engine, or even on foot.

EMS prehospital personnel are known by a wide array of titles throughout the world. Basic care providers are known as Emergency Medical Technicians (EMTs) in the United States, as Emergency Medical Responders (EMRs) in Canada, as Rettungshelfers (RH) in Germany, and as Ambulance Officers in Australia. Advanced care skills generally are provided by paramedics, although some countries, such as Canada and Australia, have different levels of paramedics and in countries such as Germany and France, physicians or nurses routinely provide advanced care in the ambulance setting. Specialized care, such as administering thrombolytic drugs, is within the skill set of South Africa's Emergency Care Practitioner, and the United Kingdom's similarly titled provider can perform minor surgical procedures in the field. Typically, first responders are fire personnel with limited basic care training.

Regardless of the particular title, ambulance systems are based on the established skill levels of the accompanying staff. The differentiation of these skill sets usually is based on advanced skills, i.e., Advanced Life Support (ALS), *vs.* Basic Life Support (BLS). It is a common misconception that most prehospital EMS systems are ALS-based; in fact, the more common model is a BLS-based system augmented with varying ALS skills.

Patients

Advanced practitioners can influence groups and individuals by developing programmes to raise awareness, assisting them in acquiring new knowledge and behaviours, and focusing on what is important to them [3]. It is important the patients are involved and consulted to determine what they want. Developing programmes involves conducting an advanced health assessment that includes physical and mental health, values, attitudes, lifestyle and spiritual beliefs as well as details of social circumstances that indicate the extent to which others may influence an individual's behaviour. Existing knowledge and sources of health information will also be included to determine how much the individual knows, in this case, about skin cancer, the effects of the sun, methods of sun protection and how that person accesses information, for example through health professionals, popular magazines, friends or others.

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This assessment will help the advanced practitioner to plan, deliver and evaluate an education programme, setting aims and objectives that focus on the individual's learning needs and taking into account what can be achieved in the time available. The education plan will include strategies and resources to help the patient learn. Planning and delivering such a programme requires effective communication that facilitates the exploration of feelings and attitudes, provision of information and the practice of skills. The advanced practitioner needs to develop a repertoire of education strategies to meet the needs of different groups. For example, children learn best through play and by imitation and they tend to have a short attention span. Adults learn best in familiar, non-threatening environments and in response to a perceived need. Older people tend to require a slower pace of learning with repeat demonstrations and procedures that are explained carefully and slowly. People like different media to support learning and the younger population in particular like electronic formats. Whatever materials are chosen, they should be reviewed for their suitability for use with a specific group or individual and should be employed only if they enhance learning in some way. There are many types of written, audiovisual and interactive materials which have different uses, advantages and disadvantages. The overall effectiveness of the programme should be evaluated to determine the extent to which learning and changes of behaviour have occurred and whether the programme was cost effective.

Assessments

Detection of cognitive impairments, particularly in older adults, can be a challenge for the most skilled clinicians [4]. Clients may not report symptoms and may endure debilitating symptoms and functional decline because they fear loss of independence or are embarrassed to report symptoms. Conditions that may contribute to cognitive impairments such as depression, alcoholism, and poor nutrition are commonly not reported, and nonspecific presentations such as fatigue, apathy, and poor concentration are typical. Even when reported, a cognitive change could signal depression, AD, an underlying Urinary Tract Infection (UTI), or a myriad of other physical illnesses. As the PMH-APRN (Psychiatric-Mental Health Advanced Practice Registered Nurses) is well aware, dementia, delirium, and depression are not mutually exclusive conditions and all these three conditions can be present in the same individual at any given time. In fact, 40% of persons with AD will experience a clinically significant depression at some time in the course of the illness.

Though specific assessment parameters will be discussed with both delirium and major neurocognitive disorders, an initial comprehensive biopsychosocial assessment is critical to detect and treat the condition. Aspects of a comprehensive assessment include physical, mental, functional, and social components, along with review of medications. Such thorough initial assessment will make it possible for the PMH-APRN to gather data that can later help the clinician discern changes from baseline functioning. Likewise, each episode of care, though more focused, should include psychosocial as well as physical assessment. Follow-up after each episode of care to review the goals of treatment, evaluate progress toward remission of target symptoms, and prevent harm through careful assessment of medication use is a good practice. Assessment tools used during initial evaluation and in subsequent visits to aid in the detection of changes in cognition, mood, and functional status are particularly helpful.

Many drugs affect the Central Nervous System (CNS), and normal age-associated changes in protein and fat distribution, diminished renal function, and hepatic disease can affect pharmacokinetics, making clearance of drugs from the body unpredictable. Assessment of medication can be accomplished by using the "brown bag method." This involves asking the patient and family to bring all prescription and nonprescription medications to the appointment. The PMH-APRN can then review and eliminate unneeded medications, teach the patient about side effects and precautions, and possibly prevent an episode of delirium.

Additional considerations in assessment of the older adult are to establish communication, include the family (unless contraindicated) as an integral part of assessment, and gather information about family and social functioning. Family members are often reliable informants, contributing crucial information for assessment, bringing practical expertise and knowledge in caring for the individual, and providing critical social support. A cultural assessment to discern health beliefs and practices that may be relevant to care is another important component of a comprehensive assessment. A multidimensional assessment includes formal resources and support systems, such as Meals on Wheels, or the informal support of the neighbor who brings in the mail and talks about the news. The presence of these support systems frequently makes the difference between the patient remaining at home and being institutionalized. The empathic PMH-APRN will adapt communication strategies based on the client's presentation. Allowing more time to gather information for the initial assessment or collecting it over two sessions can preserve patient energy and facilitate communication.

Consultations

In order to work effectively with both individuals and groups, practice nurses must possess a wide range of skills and competencies [5]. These include many areas of discrete knowledge that are necessary in order to work successfully with patients to enable efficient and effective management of their conditions, including health promotion as a key skill. While there are many excellent textbooks that introduce the reader to theories and models of health promotion, it is important to consider the application of health promotion to practice. Practice nurses who come directly from an acute nursing background may have to adapt both their consultation skills and their approach to health promotion. Due to time constraints in acute settings, health promotion may only have been practised as a peripheral activity, for example providing a leaflet for the patient as he or she leaves the ward. In general practice much of the practice nurse's role will focus on asserting health promoting activities. This may entail working with the patient in primary prevention, for example administering childhood immunisations or travel vaccinations and health advice. In secondary prevention, the role may involve screening for cervical cancer or hypertension. In tertiary prevention, many practice nurses are involved with helping patients to manage their long-term conditions and activity is focused on assisting patients to attain the best quality of life within the constraints of the disease and its presentational states. In addition, practice nurses need to consistently utilise health promotion opportunities effectively, although some evidence suggests this could be improved. In order to do this they

need to have an understanding of how to influence patient attitudes and behaviour at an individual level. This requires nurses to possess an awareness of cognitive psychological theories if attitudes and changes in behaviour are to be addressed and achieved. However, such approaches need to be applied within the context of other structural factors such as poverty, socio-economic status, inequalities and opportunities which may significantly limit an individual's ability to make an informed, healthy choice. Patients may also be prompted to seek advice following 'cues to action' which may range from reading newspaper reports (e.g. prompting them to seek help following 'contraceptive pill scare stories') to direct action following personal experience of the illness of a family member or friend. Some idea of these influences elicited during the consultation will help the nurse to see how the patient may assess the positive and negative outcomes of behaviour change.

Ethics

Paternalism is an example of an unethical resolution of conflicting principles of beneficence and autonomy [6]. Paternalism exists when the nurse or physician makes a decision for the patient without consulting the patient or by disregarding the patient's preferences. Until the 1970s, health care was almost entirely paternalistic, relying on the control of providers under a "doctor knows best" approach. Corresponding with civil rights movements in the United States, legal and social norms changed over time to honor respect for the patient's decisions and reject paternalism. Yet paternalism still creeps in, albeit more covertly, in many health care situations. Fast-paced and high-pressure health care environments may lead less thoughtful providers to impose their recommendations on patients implicitly or explicitly.

Nurses must guard against their own paternalism in critical care and practice the virtues of humility through careful selfreflection. Postoperative care, which is designed to assist the patient with achieving a quick recovery, is a good example. Encouraging the patient to turn, cough, and deep breathe, and increasing the patient's activity in the form of dangling, sitting in a chair, and ambulating all promote beneficence and nonmaleficence. However, forcing this activity over the patient's objection or threatening the patient into compliance is paternalistic. Nurses are obligated to address underlying reasons for refusal such as pain and sleep deprivation and offer the patient options. Open and effective communication can usually lead to a resolution that benefits the patient and is not paternalistic.

The concept of medical futility is difficult to define, and disputes have resulted in various discussions and proposed criteria to predict outcomes of care. Futile care generally means there would be no useful results of health care interventions. Medical futility has been defined in countless ways; many prefer the terms medically ineffective or nonbeneficial care. In general, futility means that the treatments, especially aggressive critical care, do not meet the underlying goals of care (i.e., the treatment is harming the patient in some way without countervailing justification, such as benefit for the patient's overall condition). This usually occurs when there is a conflict between beneficence, nonmaleficence, and sometimes autonomy.

Faith Community Nursing

One Health Care System/Institution realigned its community-related activities through faith community nursing so that it reports to Ambulatory Services and has the status of a clinic service [7]. This formal change in structure occurred after the department to which faith community nursing were aligned, Faith & Community Health, led the institution to full recognition status with the Center for Disease Control for Diabetes Prevention Recognized Program (DPRP). The institutional model allowed the faith community Network to collaborate, integrating the highest levels of its organization, for the betterment of patients. Partnering with the American Medical Association (AMA), its Electronic Health Record (EHR) host, and its Ambulatory services quality management nurse and physician director, a patient registry was developed that gave providers Best Practice Alerts (BPAs) to stimulate a review of patients with elevated A1Cs, BMI, and risk test scores. Based on analysis of the patient, the provider then conferred with their patient and made a decision whether or not to directly refer that patient Diabetes Prevention Program (DPP) classes designed by the CDC and taught by coaches educated through the faith community nurse Network's DPRP. DPP classes have been found to be more effective than Metformin in preventing the decline of Type 2 Diabetes in 58% of those participating in yearlong lifestyle change classes. Fifty-one percent of the coaches were Network affiliated faith community nurses or health ministers. Forty percent of the classes were hosted in faith communities, 40% in ambulatory facilities of the institution, and 20% in county-owned recreational/community centers. From a 1-year dataset after implementing the registry, 77 patients were reviewed. The average weight loss was 7.05% (CDC's quality measure 5-7%). Fifty-seven of the 77 reviewed (74%) met all criteria for review by CDC; 43 (75%) of CDC eligible were 65 years or older and met full requirements for benefit reimbursement. If this ongoing care were billed, it would result in $19,135.00 ($445.00 per eligible participant) departmental revenue for the first year of DPP class participation. The CDC calculates that a $2670.00 cost avoidance is effected in the first year post DPP class per participant. The American Diabetes Association sites an average cost of $7,900.00 per year per person for diabetes care.

Nurse Informatics

Nurse informaticists play a significant role throughout the entire process, which starts with the executive leadership and board approving the capital investment in an EHR (Electronic Health Record) system [8]. Nurse informaticists also participate in the selection, design, and implementation of other software solutions and technology hardware.

The subsequent steps are typically inclusive of the Request-For-Proposal (RFP) process, vendor demonstration, end user review or vendor fair, contract agreement, build-team creation, build-team training and certification, model system validation, design team identification, design, build, testing, training curriculum development, subject-matter expert identification, end user training, cut-over activities, implementation, optimization, and upgrade installation.

The vendor evaluation stage is when many nurses first enter the realm of informatics. As they review the selected vendors, they are learning about features, modules, applications, and functionality. The input of nurses in selecting technology solutions is extremely valuable because end user buy in is essential in the success of the

subsequent steps. And nurses typically make up 80 percent of the clinical workforce in any given hospital. Once the executive team has reviewed the top vendor candidates and selected a solution for purchase, the team that will manage its implementation is identified. Bedside nurses, nurse clinical specialists, and nursing leaders are recruited for these positions because of their clinical expertise and relationships with the multi-disciplinary end users.

Considering technology impacts the practice of nursing, every effort should be made to understand, implement, and optimize the technology available. Examples include electronic health records, communication tools (smartphones, tablets), artificial intelligence and machine learning, patient engagement software, decision support tools, patient outreach software, and patient portals.

Today's healthcare consumers demand a paradigm shift for how their care is communicated and provided to them. The patient is always at the center of what nurses do every day, in every moment, and with every touch. Nurses communicate through smartphone apps, video chat, and by monitoring electronic data via wearable devices. Nurses continuously strive to improve patient care and outcomes through the continuous analysis data now provided in the EHR. Nurses explore the newest technology, push for the interoperability of that technology, and advocate that it be incorporated into their care of the patient to increase efficiencies of documenting and increase time spent directly with the patient. Nurses continually seek opportunities to learn so that they may be thought leaders.

Electronic Health Records (EHRs) are digital records that contain not only data collected in a provider's office but also a more comprehensive patient history [9]. Multiple healthcare organizations can contribute to a patient's EHR. A single EHR can contain information about a patient's medical history, diagnoses, allergies, medications, immunizations, and imaging and lab results from current and past care providers, emergency facilities, school and workplace clinics, pharmacies, laboratories, and medical imaging facilities. Providers, including hospitals, large ambulatory care systems and individual care providers are increasingly using EHRs, thanks in large part to the Center for Medicare and Medicaid Services' (CMS) Meaningful Use initiatives. EHRs may improve patient care by providing more accurate and complete information, enabling better crisis care, assisting providers to coordinate care, and giving patients and their families useful information to help them share in decisions.

Insurance claims data consists of the coded information that physicians, pharmacies, hospitals, and other healthcare providers submit to payers (e.g., insurance companies, Medicare). These data describe specific diagnoses, procedures, and drugs. Claims data provides abundant, standardized patient information because a claim results from almost every patient encounter with the medical system. The data also may include information on medication compliance and services provided (e.g., eye exam) that may not show up in EHRs. Claims data also provides a population framework needed for longitudinal outcomes studies, and captures many outcomes, regardless of where they occur.

Patient-Reported Outcomes (PROs) are those that are best reported by patients themselves. They include symptoms, such as pain, that cannot be reliably or accurately assessed by other means. They can also be used to report quality of life and activities of daily living. PROs can be collected electronically through computers and touch-screen devices and telephones with an interactive voice response system. Validated methods, including questionnaires, are available for measuring some PROs. However, researchers may need to work with patients to identify new measures that reflect what is significant to them. Caregiver reports may be appropriate if the patient cannot self-report outcomes of interest.

Quality of Life

Self-report measures of health and disease can be subclassified into two main groups: disease-specific and generic quality-of-life measures [10]. Generic measures of health aim to measure the multifaceted nature of health and well being, so they should be comprehensive and include items relating to social and psychological health as well as physical health. Also, generic measures enable comparison of the impact of an intervention across different patient groups.

Generic measures aim to evaluate a client's general quality of life, but what is quality of life? Certainly self-evaluation of how good one's life is will be influenced by many factors, including their cultural, religious and social background. In western society there is an increasing emphasis on longevity and material wealth. However, as clinicians we must be sensitive to the fact that each individual client will have their own unique perceptions of what constitutes quality of life for them. One of the major constraints of generic measures is that they lack specificity and sensitivity, and are unable to identify the condition-specific aspects of a disease that are essential for measuring outcomes.

Conclusion

Nurses are independent members of the team and have their own area of work. The tasks of the nurse include procedures for the implementation of health care, which, in addition, includes autonomous and collective care of persons at any age and in any environment. Nurses represent the first step towards the patient. A very important ability of a nurse is communication with patients, and it is especially important for the work of the medical team in which she is involved. In addition to nursing interventions, the nurse also manages administrative affairs, records, statistical processing and studies the health status of the population.

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