

Towards a partnership in care: nurses' and doctors' interpretation of extremity trauma radiology

Overton-Brown P & Anthony D

Nurse practitioners and casualty house officers from a large inner city A & E took part in this study to compare the accuracy of their ability to interpret X-rays. The study group was composed of seven nurse practitioners, seven doctors at the end of the A&E rotation, and seven doctors in their first week of the rotation.

Fifty extremity trauma radiographs were studied by the participants who made a response from the rating scale: definitely normal, probably normal, equivocal/suspicious/unclear, probably abnormal, definitely abnormal. These responses showed not just a positive or negative finding, but also the certainty with which this finding was made. Outcomes of the interpretation were recorded as:

- True positive – patient has a fracture and this has been detected
- True negative – patient does not have a fracture and this has been recorded correctly
- False positive – patient does not have a fracture but has been diagnosed as having one
- False negative – patient does have a fracture but has been diagnosed as not having one.

Data was collected and analysed using recognized tools and the results presented through receiver operating characteristic curves. This methodology, although not often used in nursing studies, was felt to provide the most comprehensive picture of the abilities of doctors and nurses.

While findings were not of statistical significance, results showed that experienced doctors appeared to be more confident than nurse practitioners in making definitely normal diagnoses. As would be anticipated, experienced doctors and nurse practitioners performed better than their inexperienced peers, which supports Benner's 1984 work relating expertise to experience.

The small sample size makes the findings impossible to generalize but does appear to support the view that nurse practitioners are as competent as doctors in assessing X-rays following extremity trauma. Replication of the study over several areas and with larger numbers would be beneficial in supporting the role of the nurse practitioner in the A&E setting.

Journal of Advanced Nursing 1988; 27(5): 890–896.

The nutritional response to trauma in older people

Chu P S

This pilot study was undertaken to discover whether the nutritional status of older patients, measured

before and after a period of physical trauma, was significantly different to that found in younger patients.

A group of 21 patients admitted for total hip replacement, aged 60 and over, healthy and orientated with satisfactory nutritional status and no history of cardiovascular, renal or metabolic disorders formed the sample group. These were then subdivided into those aged 60–74 and those aged 75+. Subjects were interviewed on admission and prior to surgery, nutritional status was assessed using anthropometric techniques, a mini-nutritional assessment tool and biological and haematological tests. Re-assessment was carried out 7 days following surgery when the assessment also considered postoperative complications. Results were compared using Pearson's correlation coefficient test and unpaired *t*-tests and showed no significant pre-operative difference between the groups.

Postoperatively eight patients showed an average weight loss of 1 kg. Interestingly 12 had an average weight gain of 1.5 kg. There was no significance of the spread through the two groups. The only significant biochemical test indicated suppression of the immune system in response to physical trauma. Eight patients developed postoperative complications, these did not appear to be age related but biochemical results showed significant differences between those who developed complications and those who made an uneventful recovery.

The study offers simple interventions to overcome the recognized differences in the biochemical tests: the prescribing of extra vitamin B, C and iron in the week following surgery, the provision of food supplements and the introduction of a high protein diet. It is anticipated that these measures would help enhance patient's nutritional status and prevent postoperative complications. Nurses were advised to follow the RCN (1996) guidelines on the nutritional care of patients and update their knowledge and understanding of the nutritional needs of patients.

Professional Nurse 1998; 13(9): 597–600.

Patients' perceptions of bedside handovers

Cahill J

This study used a grounded theory approach to capture, describe and provide an analysis of patients' perceptions of the bedside handover. Ten patients participated in unstructured tape recorded interviews on the day before their discharge.

Following analysis three major categories emerged:

1. Maintaining professional dominance – described patients' perception of their position

during bedside handovers. Patients explored their participation in the handover process and could recognize a clear divide between themselves and the nursing staff. During acute illness little or no responsibility was assumed by the patient, but as their condition improved their desire to be involved in the handover increased. Some patients felt that they did not have sufficient understanding of their condition to initiate dialogue and were happy to accept a more passive role, as their knowledge increased so did their participation and assertiveness. Many commented upon the language used during the handover, finding it intolerable, dehumanizing, manipulative and controlling, although one found the use of professional jargon instilled confidence.

2. Establishing professional sharing – described patient's understanding of nurse to nurse interaction during bedside handovers. Perceptions varied from providing a forum for peer support and the expression of personal distress to ensuring a safe professional transfer of care. Inconsistencies and omissions in passing on important information were highlighted suggesting the need to streamline handovers to ensure information exchange was clear, concise and complete. All of the group recognized that these handovers encouraged group decision making, mutual support, open communication and team effort towards goal achievement. Interprofessional relationships and interpersonal skills were also commented upon both positively and negatively in this category.
3. Maintaining patient safety – described what patient's perceive the primary purpose of bedside handovers to be. All respondents recognized that this was a means of ensuring both physical and psychological security but opinions varied as to how this directly affected the care provided. Patient participation at this level was recognized as important in rectifying misconceptions or incorrect information giving. Lack of interest and quality of communication were also recognized components of the safety category.

This study is recognized as the beginning of a larger study and therefore has no definitive conclusion. It does, however, make pertinent points and many nurses involved in bedside handovers would benefit from reading it and questioning their own practice.

Journal of Clinical Nursing 1998; 7(4): 351–359

Reducing pressure sores after hip fractures

Arblaster G

Twenty-two patients aged between 51 and 99 years were admitted with a primary diagnosis of femoral neck fracture and formed the convenience sample for this study. The aim of the study was to review aspects of care given to this group in order to determine what further action could be taken to prevent pressure sore development. A data collection tool was developed which allowed recording of information during initial assessment and throughout the patient's length of stay or until completion of the study.

Risk status was assessed using the Waterlow risk assessment tool. All were considered to be at high risk and over half at very high risk; scores varied between 18 and 23. Despite a fast track system through A&E the average length of stay was 126 minutes with 15 of the group lying on a trolley for longer than 2 hours.

Three patients were found to have tissue damage at the time of admission to the ward, although there is no documentation to suggest if this was present on admission to A&E. A further six developed tissue damage while in hospital. The average length of hospital stay was 13 days and all tissue damage was completely healed at the time of discharge.

The use of tables and charts enhances the presentation of this report and also shows comparison rates, site of pressure sore development and a summary of the information to be collected throughout the hospital stay.

The discussion recognized the most significant care deficit as the lack of pressure relieving equipment in theatre. Other relevant findings were the nutritional status of the patients on admission and the length of preoperative fasting. The study, although small scale, highlights the need for a proactive approach to pressure sore prevention at all stages of treatment and accurate documentation of findings and interventions from the time of admission.

Professional Nurse 1998; 13(11): 749–752.

Summaries by Judy Scotter, Committee Member, Journal of Orthopaedic Nursing