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MEDICLINIC

MEDICLINIC MIDDLE EAST NURSING JOURNAL

2ND EDITION

WORD FROM THE EDITORIAL BODY

In the dynamic landscape of healthcare, nurses stand at the forefront of patient care, continuously striving for excellence in their practice. Central to this pursuit are the pillars of nurse research, quality in nursing, and knowledge in nursing – essential elements that not only drive innovation but also enhance the delivery of safe, effective, and patient-centred care.

Nurse research serves as the catalyst for advancing nursing practice, enabling professionals to explore new frontiers, discover evidence-based solutions, and ultimately improve patient outcomes. Through rigorous inquiry and analysis, nurse researchers contribute valuable insights that shape clinical guidelines, inform best practices, and pave the way for evidence-based interventions that drive continuous improvement in healthcare.

Quality in nursing is a fundamental principle that underpins every aspect of patient care. By upholding high standards of quality, nurses ensure the safety, efficacy, and responsiveness of healthcare services, leading to improved patient satisfaction, better health outcomes, and enhanced overall healthcare delivery. Embracing a culture of quality not only reflects excellence in nursing practice but also demonstrates a commitment to the well-being and dignity of every individual under our care.

Knowledge is the lifeblood of nursing practice, empowering nurses to make informed decisions, provide holistic care, and adapt to the evolving needs of patients and healthcare systems. Through lifelong learning, professional development, and the continuous pursuit of knowledge, nurses enhance their clinical competencies, cultivate critical thinking skills, and stay abreast of the latest advancements in healthcare – ultimately equipping themselves to deliver high-quality, evidence-based care to those they serve.

As we embark on this journey of exploration and discovery, let us celebrate the transformative power of nurse research, the unwavering commitment to quality in nursing, and the boundless potential of knowledge in nursing practice. Together, let us embrace these core principles as we strive to elevate nursing practice, advance the art and science of healthcare, and champion the well-being of our patients and communities.

Welcome to this edition of our Nursing Journal, where we illuminate the vital intersections of research, quality, and knowledge in nursing – shaping a future where excellence in nursing care knows no bounds.

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INTRODUCTION

As we continue to navigate the ever-evolving landscape of healthcare, it is essential for us to prioritise research, quality, and knowledge in the field of nursing. Research plays a pivotal role in advancing our understanding of various health conditions, treatments, and care practices. By engaging in and supporting research initiatives, we can contribute to evidence-based practices that improve patient outcomes and enhance the overall quality of care.

Quality in nursing is not just a goal; it is a commitment to excellence in every aspect of our practice. Upholding high standards of quality care leads to increased patient satisfaction, better health outcomes, and a positive impact on the healthcare system as a whole.
Knowledge is the cornerstone of nursing practice. As healthcare professionals, we must remain dedicated to lifelong learning, staying abreast of the latest developments in our field, and continuously expanding our skills and expertise. By investing in our knowledge base, we empower ourselves to provide the highest level of care and adapt to the dynamic nature of healthcare.

Trust also nurtures teamwork and collaboration within nursing teams. When team members trust each other's expertise, judgment, and intentions, they are more willing to collaborate, delegate tasks effectively, and work cohesively towards common goals. A strong sense of trust fosters a supportive environment where individuals feel empowered to contribute their unique skills and perspectives, leading to improved problem-solving and innovative solutions. Ultimately, the impact of trust within nursing teams extends beyond individual interactions to directly benefit patient care. Patients benefit from the increased collaboration, communication, and shared decision-making that trust enables among nursing professionals. When nurses trust each other, they can provide coordinated, holistic care that meets the diverse needs of patients, enhances their experience, and improves health outcomes.

Together, let us champion research, uphold quality, embrace knowledge, and nurture trust in our teams as we journey forward in our noble profession of nursing. Your dedication, expertise, and compassion are invaluable assets that shape the future of healthcare.

Thank you for your unwavering commitment to excellence.

Dirkie Theunissen
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NURSING AND QUALITY

1. INTRODUCTION TO THE CONCEPT OF PEER GROUP FORUMS

Nursing peer group forums were introduced to ensure standardising nursing practice and ensuring quality care in all Mediclinic Middle East facilities. These forums provide a platform for nurses to come together, share knowledge, and collaborate to improve patient outcomes. By connecting with peers in similar roles, nurses can exchange best practices, discuss challenging cases, stay updated on the latest advancements in the field, and find creative solutions which will benefit the organization across the region.

Peer group forums help in standardising nursing practice by promoting consistency in care delivery. Nurses can use these platforms to align their practices with evidence-based guidelines and protocols. By learning from one another and comparing approaches, nurses can identify areas for improvement and develop standardized processes that enhance the quality of care across different healthcare settings.

Furthermore, peer group forums facilitate continuous professional development for nurses. Engaging in discussions with a peer group challenges nurses to think critically, reflect on their practice, and strive for excellence. By participating in these forums, nurses can expand their knowledge base, strengthen their clinical skills, and stay current with industry trends, ultimately enhancing the overall quality of care they provide to patients.

In addition to professional growth, peer group forums also foster a sense of camaraderie and support among nurses. The collaborative nature of these forums creates a supportive environment where nurses can seek advice, share concerns, and celebrate successes with their peers. This sense of community not only boosts morale and job satisfaction but also encourages teamwork and collaboration within healthcare teams, leading to improved patient outcomes.

Overall, peer group forums play a crucial role in standardizing nursing practice and ensuring quality care in healthcare settings. By promoting consistency, fostering professional growth, and building a supportive community, these forums empower nurses to deliver high-quality, evidence-based care that meets the needs of patients and upholds the standards of the nursing profession.

2. CONCISE OUTLINES AND SNAPSHOTS OF A SELECTION OF PEER GROUP ACTIVITIES AND THEIR CENTRAL THEMES FOR 2024

1. Maternity Peer Forum

Expertise which comprises of Midwifes, LDR Nurses, Maternity Nurses, Lactation Consultants, Maternity Coordinators, and Assistant Midwifes

Objectives

- To have high standards of quality care for antenatal, intrapartum, postnatal and new-born care, high risk pregnancies through various guidelines and frameworks, by utilising best evidenced based practice, respectful maternity care to our patients
- These standards encompass essential competencies, education, regulations DOH/DHA, and practices for midwives, nurses to ensure safe and effective maternal and new-born care throughout MCME
- Cost efficiency and effectiveness standardization of consumables, equipment and standardisation of care
- MCME facilities to become Baby Friendly Accredited Hospitals, according to WHO/MOH Standards
- To be the number one Birthing Centre in MCME and the provider of choice

Achievements

Standardisation of care

- Mandatory training framework and tracker for Midwifes, LDR Nurses, Maternity nurses and New Born to ensure competencies are done yearly, 2 yearly as per the High Risk/Low Risk Volume
- Standardisation umbilical cord blood gases for every delivery, standardised across MCME preventing legal cases
- MEWS esclation across MCME
- Maternity fundamentals training
- Major revision of Code Purple-obstetric emergencies
- Physical exam - maternity assessment
- International peer group meeting with SA, learnings & sharing of information and best practices
- Obstetric fall risks, interventions added reducing/precautionary measures falls in OBG Patients
- Bayanaty Workflows developed to guide nurses on proper documentation by attaching the policies to the workflows on flow charts in Labour Room
- Cross CSA Audits done between hospitals for learnings, documentation audit and facility visit in the units LDR/Maternity
- Standardisation of policies with Nice Guidelines/RCOG Guidelines, involving the teams and getting standardisation practices across MCME
- FHR Policy's updated according to the latest Nice Guidelines and 2nd reviewer on Bayanaty
- Swab count and Epidural competencies to be align with high standards of care and best evidenced based practice
- PPH/PET Trolleys with Checklist and standardization across MCME with policy's
- 2023 & 2024 YEARLY PLANNER: MCME OBSTETRIC EMERGENCY DRILLS
- DHA/DOH/MCG AUDITS –WITH NO MAJOR FINDINGS
- Trolleys for weigh scales to reduce fall rates in the hospitals
- Drug library, B B-Braun trainings
- Yearly equipment trainings on life saving equipment
- MCME Orientation Program for Midwifes/LDR Nurses
- Job Descriptions/standardization
- Prompt training yearly with Proformas which match policies, standardisation
- Key Performance Indicators 2023 & 2024 on JAWDA/EJADH (REGULATORY BODIES DOH/DHA)
- Standardisation of swab count boards in delivery room
- Maternity education library standardisation of education materials
- Baby infant massage training
- Water Birth training 2021-MCIT
- BFHI –Working towards documentation on Bayanaty, training on21 hour E-learning for staff
- Standardization of education leaflets example, SIDS, Vaccination etc.
- •Antenatal calendar developed for Baby friendly initiative
- IUFD Policy and Purple butterfly outside patients room for respect, privacy and offer emotional support
- Standardisation of care and policies based on high quality care and evidence-based guidelines, labour management policies, foetal heart rate, and epidural policies.

Obstetric plan 2024

Review and audit plans in place to monitor the compliance rate, and GAPS and to address non-compliance, action plans to improve Obstetric care towards Excellence by utilising guidelines and best evidenced based practice.

1. Education and Training

Yearly CTG Training /Prompt training for all staff

2. High Risk Policies and Guidelines

- Induction of Labour-policy and consent to meet the standards plus documentation on Indications
- Oxytocic Drugs
- Instrument Deliveries

3. Accreditation and Standards

- BFHI Accreditation

2. NEONATAL INTENSIVE CARE PEER REVIEW GROUP

Goals and Objectives

- To link Neonatal Services throughout Mediclinic Middle East
- To standardise best practice and standards of care provided to NICU patients and their families
- To link neonatal services to local communities through Corporate Social Responsibilities
- Enhance educational standards of practice and management of neonatal care.
- Continuous development of family education.

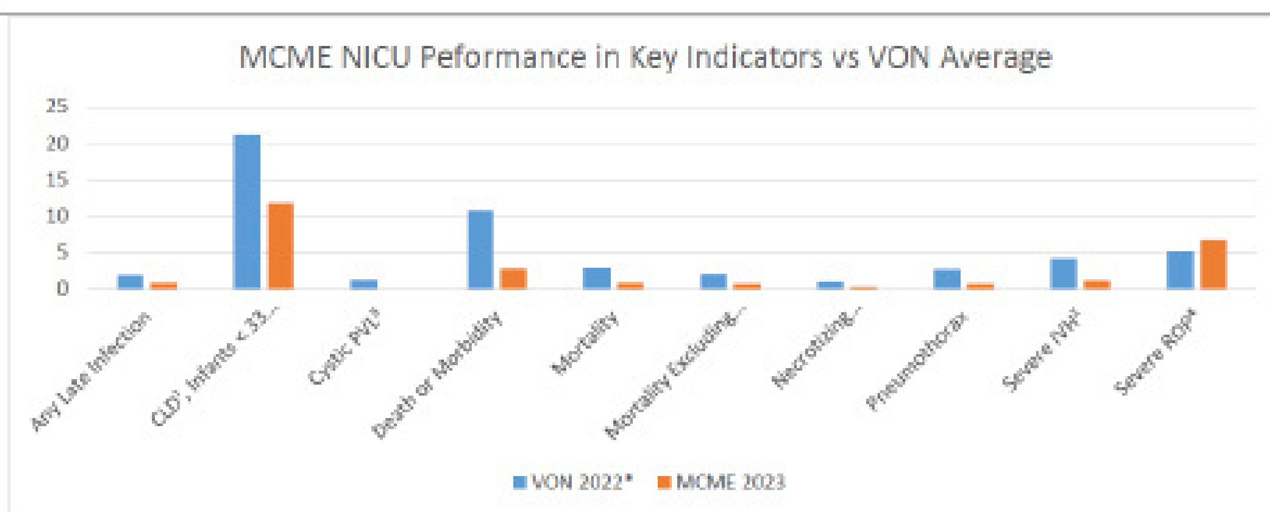
Our Previous Achievements

In 2023 MCME saw a total of 1498 newborn infants admitted in our NICU units.

Babies admitted in MCME NICUs are:

- **3 times less likely to develop an infection**
- **Have rates of Chronic Lung Disease less than half the Vermont Oxford Network (VON) benchmark**
- **5 times less likely to develop any associated morbidities**

When compared with direct comparison NICU's across the VON Network:



- The NICU Peer Review has standardised a number of significant neonatal policies, in accordance with International guidelines. These policies include (but are not limited to):

o The 'Golden Hour' – optimal care of babies born below 32 weeks of gestational age to help minimise the risk of long term complications of prematurity

o Retinopathy of Prematurity Pathway and Screening – we have set a benchmark to ensure that all babies who require screening for ROP have this screening prior to discharge from hospital.

o Non-pharmacological pain management with breast milk.

- All NICU's in MCME now have the ability to provide Therapeutic Hypothermia for the management of Hypoxic Ischemic Encephalopathy with dedicated neonatal Whole Body Cooling Systems
- Our families are integral to the care of the babies in NICU, to ensure that families supported the NICU Forum introduced:

o Graduation and milestone cards to celebrate our babies' journey through NICU.

o Infant BLS and Safe Sleep family education prior to discharge

o Standardized Feeding Rooms and Milk Kitchens to ensure that expressed milk is safely stored for use.

Our Focal Points for 2024

- Introduction of a Safe Enteral Feeding system for neonates and standardized enteral nutrition pathway.
- Continuous collaboration to help update our Electronic Health Record with neonatal specific care bundles.
- Adopting neonatal Baby Friendly Hospital Initiative standards to ensure that we continue to support the use of breast milk in NICU.

3. Paediatric Peer Review Group

At the heart of our commitment to pediatric care excellence lies the Paediatric Peer Review Group. This dedicated team plays a pivotal role in upholding the highest standards of quality and safety in our practices for the pediatric population. Over the years, the group has demonstrated remarkable efficacy, spearheading vital initiatives to review processes and standardize policies and procedures across MCME.

As we embark on the journey of 2024, our focus remains unwaveringly clear: "Keep It Daily Safe." Under this banner, we have initiated a Quality Improvement project aimed at tackling a critical concern – "Preventing IV Infiltration in Children." This endeavour underscores our steadfast dedication to enhancing patient outcomes and ensuring the well-being of our youngest patients.
With the collective expertise and unwavering dedication of our Paediatric Peer Review Group, we are poised to make significant strides in advancing pediatric care and safeguarding the health of our paediatric population. Together, we stand committed to excellence, innovation, and continuous improvement in paediatric healthcare delivery.

Goals and Objectives of this group includes:

- To link Paediatric nurses throughout the MCME facilities
- Review and approve all relevant activities ensuring that they are in compliance to the standards of regulatory bodies and hospital requirements.
- To advise and implement standardised Nursing practice, roles and responsibilities utilising evidence based practice across MCME facilities.
- To take a leading role in formulating, reviewing and updating policies, standards and guidelines.
- To create a supportive environment of collaboration and sharing of innovative ideas across the group.
- To establish a group for review, input and open discussion into Paediatric related matters.
- To ensure corrective action is initiated and managed where gaps are identified.
- To promote Nursing research and ongoing education in the field of Paediatric Nursing.
- To have an avenue to escalate concerns and recommendations to the NLF.

2022/2023 Achievements

1. Standardised Policies

- Toys and Patient Safety
- Play room Safety
- Intake and Output in Children
- Paediatric Early Warning Score
- Guidelines of Administration of IVIG
- Potassium Infusion in Children
- Pain Assessment in Paediatric Patient
- Paediatric Standard of Care
- Paediatric Admission and Discharge Criteria
- Standardised Fall Prevention Leaflet

2. Paediatric Specific Nursing care Plans Developed:

- Hyperthermia
- Risk for fall related to age dependency
- Ineffective breathing pattern related to respiratory infection
- Risk for infection due to compromised immune system
- Deficient fluid volume related to vomiting, diarrhoea and decreased fluid intake.

QUALITY IMPROVEMENT PROJECT 2024

IV Safety in Children

Our Focus for 2024 is:

KIDS – “Keep It Daily Safe”

4. Operation Theatre Peer Group

The objectives of the MCME Operation Theatre Peer group, are to ensure that we are all following evidence based practices in all our units and that we keep our patients safe while ensuring a safe working environment for our staff. Our aim for 2023/24, is to standardize and implement the same practices across the group, which will ensure compliance in all our theaters. The peer group serves as a network for the unit managers to help and support one another.

Achievements over the last two years:

- CSA (critical self-assessment) Implemented this tool for use in all our theatres across the group to ensure compliance to all Quality, JCI and regulatory standards
- Policy acknowledgment action plan
- Orientation program for OT, endoscopy, Cath lab and CSSD
- Addendums for job profiles – Scrub nurse, circulating nurse, PACU nurse, anaesthesia nurse
- Job Profile for anaesthesia technicians
- OT/Endoscopy/PACU documentation guidelines for Bayanaty
- Customisation of consumable packs
- Standardized scrub suits in light blue for OT only

Focal points for 2024:

- OT Nurses educational day
- Training objectives though the fundamental course
- Policy review
- Job profiles for other Allied Health positions in OT e g perfusionist, cathlab technician.
- JCI Accreditation in 2025

5. ICU Peer Review Group

Mediclinic International Nursing Conference 2024 | Empowering Nurses for a Brighter Tomorrow: Our Nurses, Our Future. The Economic Power of Care

Our Purpose
To enhance the quality of life for our patients across the continuum of care

Our Values
1. Patient safety
2. Mutual trust and respect
3. Client-centered
4. Performance driven
5. Team orientation

Our Strategic Pillars
1. Strengthening core capabilities
2. Customer focused
3. Digital Transformation

NURSING SERVICES OVERARCHING OPERATIONAL OBJECTIVES FOR ICU PEER FORUM

STRENGTHENING CORE CAPABILITIES
1. **Standardize ICU Clinical Policies:** Ensure uniform clinical protocols across the MCME ICU to improve patient care quality.
2. **Uniformity in ICU Consumables:** Achieve consistency in the use and availability of ICU supplies to streamline operations.
3. **Staff Development for High Acuity Care:** Enhance ICU staff expertise through targeted training and exchange programs within MCME hospitals.
4. **Promote Clinical Excellence and Innovation:** Foster a culture of research and innovation to advance ICU care practices.
5. **Launch CNE-Accredited Virtual Learning:** Develop and introduce online educational activities accredited by the CNE to enhance nursing skills.
6. **Implement Clinical Mentoring Program:** Establish a clinical accompaniment program to support ongoing professional development.

CUSTOMER FOCUSED
7. **Standardization Of nursing uniform within ICU:** Achieve a professional image in dress code within ICU that is practical and appropriate for woriking in a specilaity departement
8. **Increase ICU Staff Registration towards completon of ICU fundamentals:** Ensure all ICU staff meet minimal standards of ecrtification for working within ICU.
9. **Pressure Injury Prevention Initiative:** Implement proactive measures to reduce the incidence of pressure injuries in ICU patients.

DIGITAL TRANSFORMATION
10. **Improve Data Management:** Enhance the collection and analysis of ICU data to inform practice and policy improvements.
11. **Nursing Informatics Training Program:** Develop and provide training to improve ICU nurses' competencies in informatics and technology use.

STRENGTHENING CORE CAPABILITIES

STRENGTH	WEAKNESS	OPPORTUNITY	THREAT
• Specialized Expertise: ICU staff are highly trained and experienced in critical care, handling severe medical conditions precisely. • Fundamental courses: 13 staff completed ICU fundamentals cohort 1.	• High Cost: Critical care is expensive. • Stock not standardized. • Policies not standardized. • Billing and documentation. • The clinical and education alignment.	• Training and Education: Continuous training programs for ICU staff to enhance skills and adaptability to new medical practices. • Peer audits and visits. • MDT collaboration /celebration.	• Staff Burnout: The demanding nature of ICU work can lead to high levels of stress and burnout among healthcare professionals. • Staffing shortages compromise the quality of care and lead to staff burnout. • High workload within the ICU leads to stress and burnout.

Objectives and Key Results (OKR)

What – Objective	Key Result	Timelines
1. Standardize ICU Clinical Policies: Ensure uniform clinical protocols across the MCME ICU to improve patient care quality.	1. All ICU POLICIES are standardised 2. All local unit specific policies are made obsolete 3. 100% Compliance with Alarm management, chest auscultation, Pressure Injury Prevention.	June 2024
2. Uniformity in ICU Consumables: Achieve consistency in the use and availability of ICU supplies to streamline operations.	Procurement Alignment: Align procurement processes with the standardized list, ensuring that 100% of consumables purchased are from the approved list.	December 2024
3. Staff Development for High Acuity Care: Enhance ICU staff expertise through targeted training and exchange programs within MCME hospitals.	JOB profile addendum published April 2024.	April 2024
4. Promote Clinical Excellence and Innovation: Foster a culture of research and innovation to advance ICU care practices..	Identify and assign two research projects per region that address pressing clinical questions or operational challenges.	September 2024
5. Launch CNE-Accredited Virtual Learning: Develop and introduce online educational activities accredited by the CNE to enhance nursing skills.	Successfully design and **execute 4 to 6** CNE-accredited virtual training sessions by the end of the year, with at least **40%** of the nursing staff in attendance, and an average participant satisfaction rate of **85%** or **higher**.	April 2024 to March 2025
6. Implement Clinical Mentoring Program: Establish a clinical accompaniment program to support ongoing standardisation and professional development of preceptors	By the end of the year, achieve a **100%** completion rate of clinical accompaniment sessions for all ICU nursing staff,	December 2024
7. Increase ICU Staff Registration towards completon of ICU fundamentals : Ensure all ICU staff meet minimal standards of ecrtification for working within ICU (x13 ICU Staff completed cohort 1).	Successfully complete the training for all 22 registered staff in Cohort 2, ensuring they meet the established competency standards and objectives of the program,	December 2024

CUSTOMER FOCUSED

STRENGTH	WEAKNESS	OPPORTUNITY	THREAT
• Rapid Response: All ICU's within Mediclinic Group are designed for quick response to emergencies. • A strong focus on patient-centered care ensures that treatments are tailored to the individual needs of patients, improving outcomes.	• No formal survey available for patients to rate service /care within ICU. • Nursing care plan – customisation gaps still exist	• Collaborative Care Models: Develop partnerships with other healthcare units. • Implementing tools that enhance communication and involvement of patients in their care process, improving satisfaction and outcomes.	• Poorly Managed Transitions of Care: Inadequate coordination during patient transfers within or between healthcare facilities. • Competitive healthcare environment – Risk of losing patients if unable to provide optimal high-quality care. • Not all facilities equipped to admit pediatric patients with resources and skills.

Objectives and Key Results (OKR)

What - Objective	Key Result	Timelines
Standardization Of nursing uniform within ICU: Achieve a professional image in dress code within ICU that is practical and appropriate for working in a speciality department.	Achieve 100% compliance with the standardized ICU scrub/uniform policy, enhancing professional appearance and team identity, with positive feedback from staff and patients.	June 2024
Pressure Injury Prevention Initiative: Implement proactive measures to reduce the incidence of pressure injuries in ICU patients.	Reduction of HA pressure injuries from 12 to zero of zero stage 2 pressure injuries. Zero sentinel pressure injuries.	December 2024 July 2024

DIGITAL TRANSFORMATION

STRENGTH	WEAKNESS	OPPORTUNITY	THREAT
Technology: All ICU are well equipped with electronic health records.	• EMS system is time consuming and takes away the nurse from the bedside. • Poor data collection systems and processes. • No Informatics competencies for managers. • Training Gaps in Digital Tools. • ICU benchmarking. • Constraints in technology resources. • Cybersecurity Risks.	• Integrate emerging technologies to improve patient monitoring, diagnosis, and treatment. • Improving Digitalization and streamlining processes, data collection & analysis. • Invest in training and education for nurses to keep up with advancements in digital health care.	• Technological Dependencies: Relying heavily on technology exposes the ICU to potential disruptions due to technical failures or cyber threats. • Data privacy

Objectives and Key Results (OKR)

What - Objective	Key Result	Timelines
• Improve Data Management: Enhance the collection and analysis of ICU data to inform practice and policy improvements.	Unified ICU dashboard	September 2024
• Nursing Informatics Training Program: Develop and provide training to improve ICU nurses' competencies in informatics and technology use.	Program to be established	January 2025

6. Oncology Peer Review Group

Goals and Objectives

- To link all oncology services throughout Mediclinic Middle East.
- To standardise best practice and standards of care to be provided to all oncology patients either in our Oncology units or across our two Comprehensive Cancer Centres.
- Enhance educational standards of practice and management of oncology care.
- To continue to promote specialised nursing training, through Oncology fundamentals courses as well as through ONS (Oncology Nursing Society).

Achievements over the last 12 months:

- The Oncology Peer Review has gone through and standardised a number of significant oncology policies in accordance with international guidelines (which at present are going through approval).
- The oncology fundamentals course was commenced across Mediclinic Middle East in April 2024.
- The review and standardisation of the Orientation Manual Framework.
- Standardisation of the Critical Self-Assessment tool for Oncology
- A collective review and update of all job profiles for Oncology RNs, as well as for the specialised roles of RNs within our comprehensive cancer services, including Radiotherapy and Nuclear Medicine Nurses.

Focal Points for 2024:

- To prepare for JCI reaccreditation in 2025.
- To continue to roll out the newly appointed fundamentals course across all of our oncology RNs across all MCME facilities.
- Continuous collaboration to help update or revisit all policies as required.

7. Ambulatory Peer Group

The Purpose of the MCME Ambulatory Peer Review Forum is to establish, maintain and review current processes, policies and proposed recommendations for the improvement of Out Patient Department and Ambulatory Care within MCME.
The Ambulatory Peer Review forum has nursing representation from All MCME OPD facilities within Dubai & Abu Dhabi Region

Forum Goals and Objectives

- To link all oncology services throughout Mediclinic Middle East.
- To standardise best practice and standards of care to be provided to all oncology patients either in our Oncology units or across our two Comprehensive Cancer Centres.
- Enhance educational standards of practice and management of oncology care.
- To continue to promote specialised nursing training, through Oncology fundamentals courses as well as through ONS (Oncology Nursing Society).

Achievements over the last 12 months:

- To link / promote collaboration between OPD nurses across all the MCME platforms.
- Review and approve all relevant activities ensuring that they are in compliance to the standards of regulatory bodies and hospital requirements.
- To unify and standardize Nursing practice, roles and responsibilities across MCME facilities.
- To take a leading role in formulating, reviewing and updating policies, standards and guidelines.
- To ensure corrective action is initiated and managed where gaps are identified.
- To escalate concerns and recommendations to the Clinical Nursing Leadership Forum

Achievements 2022/2023

During the past two years OPD forum has achieved following:

- Standardised Nursing Departmental Orientation Process across the OPD clinics (Developed & Implemented OPD Nursing Orientation Manual)
- Standardized Nursing & Allied Health Mandatory & Unit Specific Competencies across the OPD Clinics (Development & Implementation of OPD Competency Matrix)
- Documentations Guidelines/ Standardized Patient Priority guideline
- EWS Policy Implementation across the OPD
- Nursing Assessment standardization across the OPD (Implementation of OPD Nursing Assessment)
- Active Role in JCIA re-accreditation and Preparation through development/ implementation of OPD CSA Audit tools and cross audits between OPD facilities
- OPD Peer Group Workshop

Focus/Goals 2024

- Continue to promote collaboration between OPD nurses across all the MCME platforms
- Take leading role in reviewing/ updating Nursing/ allied Health Job Profiles
- Take leading role in reviewing/ updating/ standardisation of the relevant Clinical Pathways
- Implementation of New Clinical Pathways
- Implementation of New IPSG Audit tools across the Clinics
- Implementation of OPD Nursing Orientation Program/ Manual for Newly Graduates
- Active role in preparation/ audits towards JCIA re -accreditation 2025

Medical/Surgical Peer Group

Leading with ownership. It requires efforts, dedication, insight, but most of all TEAMWORK.
AND this is how it started. Putting patient first and this all can be in place when the quality of care is of a high standard.

Having different practices in different clusters/hospitals under the same institution has been a challenge since ever. Therefore; the idea of having peer review forums came and the aim of this was to standardise the practices; share the challenges, come up with solutions, share knowledge among teams and leaders, highlight the risks, focus on the trends, etc. Most importantly is to inspire a culture of accountability within the organisation and the teams.

Medical and surgical peer review started two years back, it included all the medical and surgical departments' leads across Mediclinic facilities in United Arab of Emirates.
In the first meetings, a lot was discussed on the way moving forward. Then a chairman was chosen to be the lead of the team who was the one taking all discussions to other forums where bigger discussions happened then changes published in all clusters.

Peer review group meetings took place every month virtually initially then started to happen in person where the team meet in different locations and this is where the bond started.

Many topics were discussed and decisions taken. Among these are the below:

- Creation of the Intravenous Insertion Care and Documentation guideline
- Formulated a new policy about “Immediate Post-Operative Nursing patient care and management in the ward”
- Successfully completed Bayanaty Documentation Guide for Medical- Surgical and Daycare
- Onboarding Orientation Manual (Mandatory trainings and Competency Framework)
- Review of 10 relevant policies with all nurses from all facilities working in Medical Surgical teams
- Formulation and revision of Job Profiles for registered nurses and assistant nurses
- Interdepartmental audits and formulation of a standardized tool called Critical Self assessment.
- Creation and implementation of Clinical Alarms
- Successfully done Cross Audits
- Standardization of the Documentation audits

And it continues. The enthusiasm of the leads looking back at the difference it had on practices and how we all now speak the same language, is pushing us to continue this journey and look or more opportunities and contributions.

The plan going forward for 2024-2025 is to tackle more topics and discuss practices to ensure that it is same across all facilities. It will include a lot of topics; among these are the below:

- Standardisation of Policies and processes across all facilities
- Standardisation of Journey Boards
- Video creation for the room orientation upon patient admission to wards
- Nursing care plan to be available on the Trakcare for easy access and creation
- Revision of the job Profile of ward clerks and senior registered nurse

NURSING AND KNOWLEDGE

1. ELEVATING HEALTHCARE: THE CRUCIAL ROLE OF SPECIALTY NURSING IN THE UAE

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Specialty nursing plays a pivotal role in elevating healthcare standards globally, and its significance is particularly pronounced in the United Arab Emirates (UAE). This abstract presents an overview of the conference topic "Elevating Healthcare: The Crucial Role of Specialty Nursing in the UAE."

The presentation aims to underscore the indispensable contribution of specialty nursing in enhancing healthcare outcomes and evaluate the current state of specialty nursing training within the UAE healthcare system.
The UAE's healthcare landscape is characterised by rapid growth, increasing demand for quality healthcare services, and a diverse patient population with evolving healthcare needs. Specialty nursing emerges as a vital component in addressing these challenges effectively. Defined as nursing practice that focuses on specific areas of expertise, specialty nursing involves providing tailored care and expertise to patients with complex health conditions. Studies demonstrate that specialty nursing leads to improved patient outcomes, reduced hospital stays, and enhanced patient satisfaction.

Despite its importance, the state of specialty nursing in the UAE faces various challenges. These include limited resources such as faculty, educational materials, and clinical training opportunities, as well as regulatory barriers related to accreditation and licensing. However, the UAE has made significant strides in developing training programs for specialty nursing, including diploma, bachelor, and postgraduate programs. Collaborations with international institutions for curriculum development and faculty training further enrich the landscape of specialty nursing education in the UAE.

The presentation also highlights innovative approaches to specialty nursing education, such as technology integration and interprofessional education, aimed at enhancing the quality of training and preparing specialty nurses to meet the evolving healthcare needs of the UAE population. Additionally, the presentation offers strategies for enhancing specialty nursing training, including investment in education and collaboration with international partners.

In conclusion, the conference on "Elevating Healthcare: The Crucial Role of Specialty Nursing in the UAE" serves as a platform to recognize the importance of specialty nursing in the UAE healthcare system and to advocate for continued investment and collaboration to further advance specialty nursing education and elevate healthcare standards in the region.

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2. BRIDGING THE GAP: A REFLECTION ON THE ROLE OF THE CLINICAL FACILITATOR IN NURSING EDUCATION BETWEEN SOUTH AFRICA AND THE UNITED ARAB EMIRATES

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In nursing education, clinical facilitators play a crucial role in linking theoretical knowledge with practical application. Their guidance is instrumental in helping students translate classroom learning into real-world patient care scenarios (Harris & Smith, 2009). This presentation delves into the responsibilities, challenges, and strategies for enhancing the effectiveness of clinical facilitation, focusing on the contexts of both South Africa and the United Arab Emirates (UAE).

Clinical facilitators in both South Africa and the UAE serve as mentors, providing support and guidance to nursing students during their clinical placements (Van Graan & Williams, 2018; Alsairafi & Al-Moteri, 2017). They engage in clinical teaching, demonstrating procedures and best practices, while also assessing students' performance and providing constructive feedback (Coetzee et al., 2015; Mabuda et al., 2015).

Despite similarities, differences exist due to cultural influences, healthcare system structures, and regulatory frameworks (Henderson et al., 2014; George et al., 2017; South African Nursing Council, 2020). Common challenges faced by clinical facilitators include workload, resource constraints, and communication barriers (Kelly et al., 2019; Al-Maskari et al., 2015).

To address these challenges, strategies such as mentorship, collaboration, professional development, effective communication, technology utilization, and reflective practice are essential (Alhajjy et al., 2020; McGarry, 2018; Coetzee et al., 2015; Van Graan & Williams, 2018).
Collaboration and knowledge exchange between clinical facilitators from both countries are crucial for professional growth and sharing best practices (Al-Maskari et al., 2015). Research collaborations can lead to the development of new knowledge and innovative approaches to clinical education (Alhajjy et al., 2020).

Establishing professional networks, standardizing guidelines, investing in professional development, promoting interprofessional collaboration, supporting research, and advocating for supportive policies are key to enhancing clinical facilitation. Continuous learning is vital for clinical facilitators to adapt to changing practices, enhance teaching effectiveness, promote critical thinking, develop cultural competence, and foster professional growth and satisfaction.

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NURSING AND RESEARCH

1. AI IN HEALTHCARE: IMPLICATIONS FOR THE FUTURE

A literature review

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Introduction

Healthcare today has many emerging issues that are challenging the provision of quality healthcare. Some of these challenges include rising costs of healthcare, financial challenges for providers, shortage of healthcare professionals, increased demand for personalised care management of large volumes of data and data analysis, deterioration in the quality of care provided, and regulatory changes impacting healthcare.

Advanced technology, digitalisation and artificial intelligence appear to provide solutions to many of the emerging challenges in the current paradigm as evidenced by research conducted to date. As per (Lai et al., 2021) and (Davenport and Kalakota, 2019) advances in Artificial Intelligence (AI) have led to the rise of human-AI collaboration. In healthcare, such collaboration could mitigate the shortage of qualified healthcare workers, assist overworked medical professionals, and improve the quality of healthcare.

However, amidst the benefits provided by AI lurks that challenge that requires insight and concerted efforts for the successful merging of AI in healthcare. (Hee Lee & Yoon, 2021) have envisioned how rapid advances in AI and related technologies will help care providers create new value for their patients and improve the efficiency of their operational processes. However, they have also taken full cognisance that effective applications of AI will require effective planning and strategies to transform the entire care service and operations to reap the benefits of what technologies offer (Cossy-Gantner et al., 2018) and (Schwalbe & Wahl, 2020) harbour similar thoughts highlighting the impact of AI in a global health context. AI in healthcare is intended to enhance the efficiency and effectiveness of care delivery and has the potential to help address challenges unique to the field of global health, especially in low- and middle-income countries.

Research indicates that AI's insights can improve clinical outcomes, facilitating a high standard of care irrespective of geographical boundaries (Bajwa et al., 2021) AI has the potential to revolutionize the healthcare industry by improving the efficiency and quality of patient care across borders.

However, the application of AI within the context must be carefully managed to ensure ethical use, and protection of patient privacy, and avoid exacerbating existing disparities within healthcare globally.

What is AI or Artificial intelligence?

As (Kok et al., 2009) suggest AI definitions could be classified into four main categories: (1) systems that think like humans, (2) systems that act like humans, (3) systems that think rationally and (4) systems that act rationally. In synthesis, Artificial intelligence is “the ability of a digital computer or computer-controlled robot to perform tasks commonly associated with intelligent beings” (Copeland, 2020). Therefore, we speak of Artificial Intelligence when it comes to programs and machines that can make decisions and draw conclusions independently without having clear “rules of the game”, analyzing gigantic data sets, comparing, drawing conclusions, and making decisions (Raisch & Krakowski, 2021), 2021; Plastino and Purdy, 2018; (Sourdin Cornes, 2018).

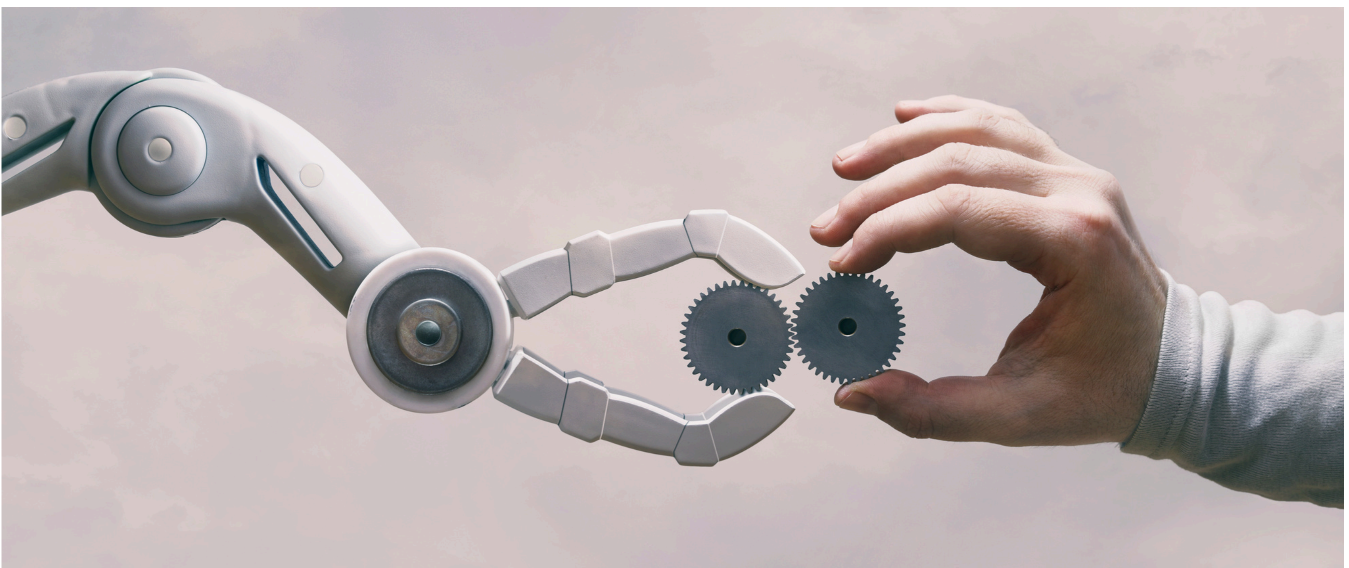
Artificial intelligence in healthcare refers to the use of complex algorithms and software, often encompassing machine learning techniques, to emulate human cognition in the analysis, interpretation, and comprehension of complicated medical and healthcare data. Specifically, AI within healthcare can be deployed:

1. Augment the ability to process large datasets beyond the scope of human capability, quickly identifying patterns and insights that can aid clinical decision-making
2. Increase the personalization of treatment by analyzing an individual patient's genetic makeup, lifestyle, and other factors to suggest targeted therapy options.
3. Assist in diagnostics by interpreting images and recognizing conditions from visual data where human diagnosis may be limited.
4. Automate tasks such as administrative work, patient scheduling, and workflow optimization, freeing valuable time for healthcare providers to spend on patient care.
5. Improve healthcare accessibility through telemedicine and remote monitoring technologies, potentially reaching underserved populations.
6. Contribute to drug discovery and development by accelerating the identification of potential therapies and reducing the time and cost associated with research.

AI applications

A comprehensive review of current literature indicates where we stand with AI in healthcare. AI in healthcare has made significant strides, particularly in high-income countries, with advancements in personalized medicine, precise diagnostics, patient risk assessment, and telemedicine. AI algorithms have been developed for interpreting medical images, predicting patient outcomes, and identifying potential treatment plans. These innovations are beginning to be adopted in clinical settings, supporting clinicians in decision-making, and enhancing patient care.

“Advances in computational and data sciences for data management, integration, mining, classification, filtering, and visualisation along with engineering innovations in medical devices have prompted demands for more comprehensive and coherent strategies to address the most fundamental questions in health care and medicine”. (Shaban -Nejad et al., 2018)



Artificial intelligence (AI) and related technologies are increasingly prevalent in business and society and are beginning to be applied to healthcare. (Davenport & Kalakota, 2019Healthcare in clinical and community settings is being revolutionised by artificial intelligence (AI) theory, methodologies, and models.

Numerous healthcare applications, including patient education, geocoding health data, social media analytics, mobile health, syndromic and epidemic surveillance, predictive modelling and decision support, integrated health information systems, and medical imaging, have already shown them to produce promising results (e.g. radiology and retinal image analyses). Health intelligence uses artificial intelligence and data science methods and technologies to enhance understanding, reduce waste, and expedite processes and in so doing improve productivity, accuracy, and efficiency. (Shaban -Nejad et al., 2018)

Precision medicine is one of the recent and powerful developments in medical care, which has the potential to improve the traditional symptom-driven practice of medicine, allowing earlier interventions using advanced diagnostics and tailoring better and economically personalised treatments. (Ahmed et al., 2020) Enhancing the conventional symptom-driven practice of medicine by enabling early treatments through sophisticated diagnostics and customising more effective solutions and treatments that are individualised is not achievable by an Individual on his own.

Studies have revealed that AI can surpass human performance in several domains, which in healthcare can lead to better disease prevention, detection, diagnosis, and treatment (Fogel & Kvedar, 2018). AI-enabled systems can analyse large amounts of medical data and identify patterns that may not be easily detectable by human physicians (Lee & Yoon, 2021). This can lead to early detection of diseases, more effective treatment options, and ultimately, better patient outcomes.

Finding the most effective route to customised population medicine requires the capacity to monitor and differentiate between individuals who are ill and those who are generally well. This process will improve our knowledge of the biological markers that can indicate changes in health. While it has been challenging to use healthcare information in clinical decisions due to the complexity of disease at the individual level, technological improvements have significantly reduced some of the current limits. (Ahmed et al., 2020).

To successfully apply precision medicine, the capability of electronic health records must be utilised in its execution with increased capacity to impact patient outcomes and provide real-time decision support positively. This can be achieved by combining different data sources and discovering pathways of illness progression unique to each patient. In addition to improving the networking and interoperability of clinical, laboratory, and public health systems, useful analytical tools, technologies, databases, and techniques are needed to effectively balance ethical and societal concerns regarding the privacy and preservation of healthcare data. (Ahmed et al., 2020).

There's also growing interest in AI's potential to improve global health, especially in low-resource settings. Research indicates that AI can contribute to health in these areas by addressing system gaps and supporting diagnoses where healthcare professionals are scarce. (Bajwa et al., 2021; Cossy-Gantner et al., 2018; Schwalbe & Wahl, 2020) AI’s impact is also significantly felt in the operational aspects of healthcare. It improves the efficiency of nursing, administrative, and managerial activities within hospital settings (Bajwa et al., 2021; Bohr & Memarzadeh, 2020; Hee Lee & Yoon, 2021) monopolise the viewpoint that AI can automate administrative tasks, freeing healthcare professionals to spend more time on direct patient care.

The implementation of AI streamlines administrative tasks and optimizes healthcare workflows. AI applications in hospital management systems (HIMSS, 2021) contribute to cost reduction, improved resource allocation, and enhanced overall efficiency. AI is becoming increasingly crucial in managing health data, providing insights derived from electronic health records, and supporting large-scale disease surveillance and tracking efforts, an aspect that has been particularly emphasized during the COVID-19 pandemic.

AI-powered applications improve patient engagement and monitoring. Intelligent chatbots (Laranjo et al., 2018) offer personalized health advice, while wearable devices equipped with AI algorithms (Baca-Motes et al., 2019) enable continuous health tracking and allow for remote clinical monitoring and intervention.
AI has an innate power to revolutionize healthcare in the present and the future however in the interim period the challenges faced by the merging of AI into the healthcare industry cannot be avoided or ignored.

Challenges faced

Concurrently AI also poses many challenges that include ethical considerations, algorithmic biases, interpretability, regulatory constraints, and integration complexities and data challenges, technical infrastructures that impede the seamless adoption of AI in healthcare.
An exploration of available literature indicates quality and accessibility of data as some of the primary obstacles to AI adoption. AI systems require vast amounts of reliable data to function effectively. In healthcare, this translates to the need for robust electronic health records and the ability to exchange and share data across platforms, which is still not well-incentivized in many healthcare environments (Jiang et al., 2017).

Moreover, there can be issues with data privacy, patient consent, and the responsible handling of health data, especially in low- and middle-income countries where regulations might be less established (Cossy-Gantner et al., 2018).

The need for technical infrastructure is another significant hurdle. Many healthcare settings, especially in resource-poor environments, lack the foundational IT infrastructure to support AI applications (Cossy-Gantner et al., 2018). This deficiency includes both hardware, like computers and servers capable of handling AI processes (Haefner et al., 2021), and software challenges, including the integration of AI systems with existing health technologies (Chen et al., 2023).

Organisational capacity is likewise a challenge as healthcare providers must cultivate the necessary skills among staff to leverage AI effectively. This encompasses everything from the design and implementation of AI tools to proper training and communication within healthcare teams (Chen et al., 2023). Ensuring that personnel are engaged and adequately instructed is critical for consistent user implementation.

There are abundant ethical and safety considerations, including biases in AI algorithms and concerns about AI decisions' opacity. As AI usage in healthcare expands, ethical concerns and patient privacy become paramount. Studies (Char et al., 2020; Raghu et al., 2019) discuss the challenges associated with maintaining confidentiality and minimizing the risk of bias in AI algorithms. Regulatory challenges also present, with a need for frameworks that address the responsible development and deployment of AI in healthcare (Chen et al., 2023). Misaligned incentives and the lack of a streamlined regulatory approach can slow down the adoption of AI(Jiang et al., 2017).

The environmental impact of AI is an emerging concern, as some advanced AI applications have been shown to require significant energy consumption (Haefner et al., 2021). Socially, the adoption of AI must take local contexts into account, especially in areas with distinct cultural or infrastructural attributes that might affect how AI is perceived and used (Cossy-Gantner et al., 2018)

The Future

Transparency is key to building this much-needed trust among users and stakeholders of AI and healthcare. (Fogel & Kvedar, 2018) highlight the need for building trust of the public through transparency about how AI systems work, their benefits, and their limitations to optimize widespread adoption.

The exploration of attitudes of clinicians and consumers across 27 studies by (Scott et al., 2021) indicated positivity towards AI if safeguards were met. Both stakeholders wanted trustworthy advice from AI applications. “AI applications must be developed and assessed to maximize explainability and transparency regarding their inner workings while acknowledging limits to the extent this can be achieved. As much as possible, important features underpinning AI predictions should be identified, and outputs should be presented in ways easily interpretable to clinicians and patients.” (Scott et al., 2021).

re should be full transparency on the composition, semantics, provenance, and quality of data used to develop AI tools.

There also needs to be full transparency and adequate assessment of relevant performance components of AI. The prevention of bias in AI systems is crucial, and mechanisms should be established to monitor and correct such bias (Davenport & Kalakota, 2019). AI development should focus on including diverse data sets to ensure that AI tools are effective across all populations, preventing healthcare disparities (Fogel & Kvedar, 2018). Studies emphasize the need for evidence-based approaches to validate AI tools through rigorous testing and clinical trials before full implementation (Wang & Preininger, 2019).

(Davenport & Kalakota, 2019) emphasize the need for strong data governance protocols to ensure privacy, security, and proper use of data, facilitating trust in AI systems. “AI developers must ensure they adhere to legal and community expectations regarding privacy, confidentiality and security of health and medical data.” (Scott et al., 2021a) Authors suggest that strong data governance protocols need to be established to ensure privacy, security, and proper use of data, facilitating trust in AI systems (Davenport & Kalakota, 2019).

For AI to be effectively integrated, collaboration between clinicians, computer scientists, ethicists, and policymakers is essential. Such partnerships can help align the development of AI with clinical needs and ethical considerations.

AI offers several benefits, such as helping clinicians to complete tasks that are currently reserved for specialists, eliminating routine or low-acuity clinical cases so specialists can focus on their areas of expertise, assisting people with inattention, microaggressions, and exhaustion, and automating business processes. Because the public has an understandably low tolerance for machine error and because AI tools are being implemented in an environment with insufficient regulation and legislation, it is imperative to ensure that human intervention is maintained in AI systems.

Researchers recommend that AI development should prioritize enhancing the patient experience and preserving the human touch in healthcare (Fogel & Kvedar, 2018). The conversation about artificial intelligence (AI) in healthcare should be on creating, testing, and assessing tools that assist humans rather than completely automating tasks. Engaging clinicians in the design, implementation, and evaluation of AI tools is vital. This helps to ensure that AI supports clinical workflows and addresses real-world challenges (Fogel & Kvedar, 2018).

As AI becomes more prevalent in healthcare, educational initiatives should be put in place for healthcare professionals to understand and work with AI technologies effectively (Amisha et al., 2019). To reap the benefits of AI tools in healthcare, we require a deliberate, all-encompassing, and thorough extension of pertinent training and educational initiatives. The educational expansion must be multidisciplinary and involve AI developers, implementers, frontline clinical teams, healthcare system leadership, ethicists, humanists, patients, and patient caregivers, as each brings a core set of much-needed requirements and expertise.

This is because healthcare AI systems have the potential to alter the medical domain drastically.

The core curriculum for healthcare professional training programs should include instruction on how to use data science and artificial intelligence (AI) goods and services effectively. By requiring them to continue their education, practising healthcare professionals can meet their demands and become better-informed consumers. Furthermore, retraining initiatives to address a shift in desired skill sets due to increasing levels of AI deployment and the resulting skill and knowledge mismatches will be needed. Last, but not least, consumer health educational programs, at a range of educational levels, to help inform consumers on health care applications selection and use are vital.

Implications of Ai on the healthcare workforce

Health systems have to radically rethink strategies to safeguard quality and safety, maximize efficiencies and ensure that staff are satisfied and actively supported in their jobs. Rapid, disruptive technological change has the potential to drive healthcare reforms to improve efficiency and augment provider satisfaction, thus improving patient experiences and outcomes.

This prospect has focused global attention on the integration of technologies such as artificial intelligence (AI) to address current and emerging health system challenges, including the workforce.

The integration of AI in healthcare has become a focal point of research, promising transformative impacts on diagnostics, treatment, and administrative processes. The impact and implications of the integration on the healthcare workforce, evolving job roles, skill requirements, ethical considerations, workforce dynamics, and the influence on patient-provider interactions cannot be ignored. As highlighted by (Smith et al., 2021), the advent of AI is reshaping traditional healthcare job roles.

Automation of routine tasks allows healthcare professionals to allocate more time to complex aspects of patient care, improving overall efficiency. The study emphasizes the evolving nature of roles, with a shift towards collaboration between AI systems and healthcare workers, particularly in medical imaging analysis and diagnostic support. In addition, the use of AI enables healthcare providers to manage care for a larger number of patients. In nursing, for instance, it has been reported that the use of AI-enabled tools increases productivity by 30–50%.

The combination of AI and human intelligence, or 'augmented intelligence', has been touted as a powerful approach to deliver on the fundamental mission of healthcare. In addressing the changing landscape, (Hazarika, 2020) stress the importance of adapting skill requirements for healthcare professionals. Competencies related to data interpretation, algorithm understanding, and seamless collaboration with AI systems emerge as crucial.

The literature advocates for ongoing training programs to equip healthcare workers with the necessary skills, ensuring they remain proficient in their roles amid technological advancements.

The work of Miller and Schwartz (2019) delves into the ethical considerations surrounding AI in healthcare. Privacy concerns, issues of informed consent, and the potential for algorithmic bias are explored. The study underscores the necessity of establishing ethical frameworks to guide AI deployment, aligning with established medical ethics principles and maintaining the trust of both healthcare professionals and patients.

Research by (Siala and Wang, 2022) delves into the broader workforce dynamics influenced by AI adoption in healthcare. This includes potential job displacement and the creation of new roles. The literature suggests that strategic planning and proactive measures, such as reskilling programs, are imperative to mitigate negative impacts on the healthcare workforce and foster a smooth transition.

Examining the impact on patient-provider interaction, the study conducted by Anderson and Clark (2020) reveals a dual perspective. While AI has the potential to enhance communication by providing data-driven insights to healthcare professionals, maintaining a balance to ensure the preservation of the human touch and empathy in patient care remains a challenge. A well-functioning provider-patient relationship is still the essence of healthcare.

The success of providing care depends on collaboration, empathy and shared decision-making. Empathy skills of healthcare providers have been shown to positively influence patient outcomes and can assist in improving efficiency and quality but are limited by their inability to possess some human characteristics, such as compassion, empathy and the human touch.

Future developments in AI technology may redefine the relationship between providers, patients and their caregivers. For now, the role of healthcare providers is unchanged, but AI can be a very useful cognitive assistant.

Integration of AI within healthcare – Cost implications

The cost of implementing AI in healthcare can vary widely based on several factors, and it's essential to consider both direct and indirect expenses. Creating and refining AI algorithms specific to healthcare applications involves costs related to hiring skilled data scientists, engineers, and domain experts. Purchasing or developing the necessary software and hardware infrastructure to support AI applications contributes significantly to costs. Ensuring access to high-quality and diverse healthcare data requires investments in data collection, curation, and integration. Implementing robust security measures and ensuring compliance with data protection regulations add to the overall cost.

Healthcare professionals need training to effectively use and collaborate with AI systems. Training programs incur costs related to materials, instructors, and potential staff downtime. Adhering to regulatory requirements and obtaining necessary certifications involves additional expenses to meet standards and ensure patient safety and privacy.

Ongoing costs for maintaining and upgrading IT infrastructure to support AI applications and ensure scalability. Regular updates, troubleshooting, and support services contribute to the overall cost of AI implementation. Ensuring seamless integration with existing healthcare systems, Electronic Health Records (EHRs), and other technologies may require customized solutions, contributing to implementation costs. Rigorous testing, validation studies, and clinical trials to assess the efficacy and safety of AI applications contribute to the overall cost. Investments in robust cybersecurity measures to mitigate potential risks associated with AI implementation. Some organizations may opt for additional insurance coverage related to AI applications and potential liabilities. Considering future scalability requirements and planning for potential expansions. Anticipating ongoing costs for updates, improvements, and iterative development to keep AI systems current Conducting a thorough analysis of the expected benefits and outcomes to justify the initial and ongoing costs of AI implementation.

Healthcare organisations must conduct a comprehensive cost-benefit analysis, considering the specific context, goals, and challenges of their implementation. While the upfront costs can be substantial, the potential benefits, such as improved diagnostics, operational efficiency, and patient outcomes, may outweigh these expenses over time.

Conclusion

AI's impact on healthcare is profound and transformative, spanning diagnostics, predictive analytics, drug discovery, patient engagement, administrative efficiency, and data management. The value it adds to the healthcare industry cannot be denied however continued research and advancements in AI technologies are essential for maximising benefits while addressing potential challenges in this evolving healthcare landscape. Future research should focus on addressing these challenges and refining AI applications for broader healthcare integration.

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2. ELEMENTS AFFECTING EMERGENCY DEPARTMENT RATE OF RETURN WITHIN 72 HOURS: A RETROSPECTIVE CROSS-SECTIONAL STUDY

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Introduction

Dubai has a well-developed healthcare system that provides high-quality medical care for both residents and visitors. The healthcare system in Dubai is regulated by the Dubai Health Authority (DHA), which oversees the planning, development, and regulation of healthcare services in the emirate. The healthcare system in Dubai consists of both public and private healthcare facilities. The healthcare system in Dubai has been continuously improving in recent years, and emergency services are one of the main areas that they always focus to improve. The rate of return to the emergency department (ED) within 72 hours of discharge with the same complaint is an important measure of the quality of care provided in the ED. A high rate of return can indicate that the initial treatment and discharge plan was inadequate or that there were issues with follow-up care.

The ED is a critical component of the healthcare system, providing immediate medical attention to patients with acute illnesses or injuries. The emergency department is defined as a hospital facility that operates 24 hours a day, seven days a week and provides unscheduled outpatient services to patients whose condition requires immediate care, according to (NHAMCS).(1) However, managing patient flow and ensuring efficient use of resources in the ED can be challenging. One important aspect of ED management is the rate of return or the number of patients who return to the ED within a specific time after the initial visit.

An unplanned return visit is defined as a patient presenting to the ED with the same problem within 72 hours of their initial visit. (2)

The purpose of this study is to identify the elements that are associated with the rate of return to the emergency department within 72 hours among patients who have been discharged from the emergency department. Also, to identify the rate of a return visit to ED within 72 hours from the initial visit to determine the underlying factors associated with unplanned ED return visits.

A high rate of return to the ED can indicate that the initial treatment and discharge plan was inadequate or that there were issues with follow-up care. This can lead to increased healthcare costs; long wait times for other patients, and a potential decrease in the quality of care, which is directly affecting patient safety. Identifying the factors that are associated with the rate of return to the ED can help healthcare providers improve the discharge process and reduce the number of avoidable hospital admissions.

Objectives

The objective is to investigate the factors that affect the rate of return to the emergency department within 72 hours with the same complaint.

Methods

A retrospective cross-sectional study was used to determine the underlying factors associated with unplanned ED return visits. Medical records of patients who visited the Mediclinic Welcare Hospital emergency department between 01 January 2019 and 31 December 2019 were reviewed. The data collected included patient demographics, patient age, gender, nationality, acuity of triage level, diagnosis, and time of initial visit. As well as information about the initial visit to the ED, such as the diagnosis during the first visit and the return visit. The collected data was analysed using statistical package for the social sciences (SPSS) to determine the rate of return visits to the ED within 72 hours, as well as identify associations between patient characteristics with the rate of return visits.

Inclusion criteria

All return to the emergency department within 72 hours with the same complaint.

Exclusion criteria

Return due to other conditions, dressing, injection (with injection card), and return after discharge against medical advice.

Ethical approval from the corporate and local government to carry out the study was obtained, as well as the approval from the dataset owner to use the data in databases for the research.
Patient name, URN, and date of birth are all kept completely anonymous.

Measures

A retrospective cross-sectional study using return visit data in Mediclinic Welcare Hospital emergency department in 2019. All data generated from the data warehouse as per the set criteria and variables. Data extracted by the IT department is based on the set criteria.

Data analysis

The data were analysed using IBM SPSS version 22.0. Descriptive statistics, including the mean (M), standard deviation (SD), and percentage were used. Data were expressed as mean (M), and standard deviation (SD) for continuous variables and as numbers and percentages for categorical variables. The p value ≤0.05 was considered significant for all statistical analyses.

Frequencies and percentages were calculated for all nominal variables.

Results

Demographic characteristics

The data provided in pertains to the characteristics of patients who made an unplanned return to the emergency department within 72 hours (Table 1). The Data provides demographic information on unplanned returns to the emergency department within 72 hours for 1,535 patients. The table shows the distribution of patients by age, gender, and ethnicity.

Table 1: Demographic characteristics.

Characteristic	Value (%)
Age (years), N (%)	
<14	234 (15)
≥14	1301 (85)
Gender, N (%)	
Female	720 (53)
Male	815 (47)
Ethnicity, N (%)	
Arabs	1285 (84)
Asians	157 (10)
Western	21 (1)
Others	72 (5)

Unplanned return to ED demographic (1535)

The table presents the data in terms of age, gender, and ethnicity. In terms of age, the sample is divided into two groups: those under 14 years of age and those 14 years or older. The majority of the sample (84.8%) is aged 14 or older. In terms of gender, there are more male patients (53.1%) than female patients (46.9%). In terms of ethnicity, the majority of patients are Arab (83.7%), followed by Asians (10.2%), and then by patients from other ethnic backgrounds, including Westerners (1.4%) and others (4.7%).

These demographic characteristics can provide useful information for healthcare professionals and policymakers when designing interventions to reduce unplanned returns to the emergency department. For instance, the data suggest that more attention may need to be paid to the care and management of male patients and patients from specific ethnic backgrounds who are at a higher risk for unplanned returns. Additionally, interventions may need to be tailored to different age groups, given the higher proportion of patients aged 14 or older who made unplanned returns.

Main category

The data presents the results of a study on the return visit to the emergency department within 72 hours, categorised by gender, age, ethnicity, triage level, and primary diagnosis. The analysis shows the number of cases, proportion, percentage, 95% confidence interval, and p-value for each category (Table 2).

Gender

There were 815 male patients (53.09%) and 720 female patients (46.91%) who returned to the emergency department within 72 hours. The difference between the two genders was statistically significant ($p=0.0153$).

Age

Of the patients who returned, 234 were under the age of 14 (15.24%), and 1,301 were 14 years or older (84.76%). The difference between the two age groups was highly significant ($p<0.00001$).

Ethnicity

The majority of patients who returned were Arabs, with 1,285 cases (83.71%). Other ethnic groups, including Asians, Western, and Others, had a much smaller proportion of cases. The difference between Arabs and other ethnic groups was highly significant ($p<0.00001$).

Triage level

Of the patients who returned, 7 cases were categorised as level 2 (0.51%), 385 cases were level 3 (28.12%), 714 cases were level 4 (52.15%), and 263 cases were level 5 (19.21%). No patients were categorized as level 1. The difference between the different triage levels was highly significant ($p<0.00001$).

Primary diagnosis

The study found that certain types of presenting complaints, such as fever, cough, and throat pain related to respiratory tract infection, were associated with a higher rate of unplanned return to the emergency department within 72 hours at a rate of 33% (513).

The most common primary identified diagnosis for patients who returned was respiratory tract infection-associated symptoms and fever which included 513 patients representing 33% of the total diagnosis. Back pain total cases of 94 patients representing 6.12% and infectious gastroenteritis total patients 38 cases representing about 2.47%, while other unidentified diagnosis and presenting symptoms were 850 cases representing 55.37% of total cases. The difference between the different primary diagnoses was highly significant ($p<0.00001$).
In conclusion, the study found that there were significant differences in the proportion of patients who returned to the emergency department within 72 hours based on gender, age, ethnicity, triage level, and primary diagnosis. These findings may have important implications for emergency department management and patient care.

Table 2: Main category for patients return to ED with 72 hours.

Category	Numbers	Proportion	%	95% CI	P value
Gender					
Male	815	0.530944625	53.09446	0.5059 to 0.5558	0.0153
Female	720	0.469055375	46.90554	0.4442 to 0.4941	
Age					
<14	234	0.152442997	15.2443	0.1353 to 0.1713	<0.00001
≥14	1301	0.847557003	84.7557	0.8287 to 0.8647	
Ethnicity					
Arabs	1285	0.83713355	83.71336	0.8178 to 0.8548	<0.00001
Asians	157	0.10228013	10.22801	0.0881 to 0.1185	
Western	21	0.013680782	1.368078	0.0088 to 0.0209	
Others	72	0.046905537	4.690554	0.0374 to 0.0587	
Triage level					
Level 1	0	0	0	0	
Level 2	7	0.005113221	0.511322	0.0022 to 0.0107	<0.00001
Level 3	385	0.281227173	28.12272	0.2580 to 0.3056	
Level 4	714	0.521548576	52.15486	0.4951 to 0.5479	
Level 5	263	0.19211103	19.2111	0.1721 to 0.2138	
Primary diagnosis					
Infectious gastroenteritis and colitis, unspecified	38	0.0247557	2.47557	0.0180 to 0.0339	<0.00001
Acute upper respiratory infection, unspecified	202	0.131596091	13.15961	0.1156 to 0.1495	
Back pain	94	0.061237785	6.123779	0.0503 to 0.0744	
cough	46	0.029967427	2.996743	0.0225 to 0.0398	
throat pain	110	0.071661238	7.166124	0.0598 to 0.0857	
Fever	155	0.100977199	10.09772	0.0869 to 0.1171	
Headache	40	0.026058632	2.605863	0.0191 to 0.0354	
Others	850	0.553745928	55.37459	0.5288 to 0.5784	

Discussion

Several theories have been proposed to explain the factors that contribute to return visits to the ED within 72 hours of discharge, and many studies have been conducted to investigate these theories and their relationship to ED return visits. The individual and family self-management theory (IFSMT) proposes that patients who can effectively manage their illnesses are less likely to return to the ED within 72 hours. (3) While self-regulation theory proposes that patients can regulate their health behaviours and that providing them with the necessary information, skills, and resources can reduce the rate of return visits to the ED.(4)

Numerous retrospective studies have examined the rate and factors influencing the rate of return to the ED within 72 hours. One study conducted at a tertiary care paediatric ED over two years examined all revisits within 96 hours of an initial visit and found that 1.3% of patients returned within 72 hours, with males accounting for 51.3% of these returns.(5) While another study found that the ED revisit rate was 0.8%.(6) Though another study found that unscheduled 72-hour ED returns account for 4% of all ED visits.(7) An additional study investigating patient returns to the ED demonstrated that the highest point on the time-to-return curve was observed between 24 and 48 hours after the initial visit, followed by a steady decline until 96 hours after the initial visit.(8) Studies have reported varying reasons for return visits to the ED within 72 hours. For instance, one study identified the recurrence of the same complaint with no symptom improvement and suboptimal management by physicians as the primary reasons for most ED revisit within 72 hours.(5)

Furthermore, another study found that several potential risk factors, such as ED length of stay, the type of quality assurance issues, and diagnostic procedures, contributed to patient safety events, suggesting that systematic interventions may have a more significant impact on mitigating the risk of such events.(9)

Unplanned return visits to the ED within 72 hours following discharge are a significant burden on patients, families, and healthcare systems.(7) A previous study examined the influence of patient age, triage severity, month, payment methods, and length of stay on the 72-hour unplanned return visits after the ED index discharge indicator.(10) Patients who return to the ED within 72 hours of discharge are often perceived to have received inadequate treatment or evaluation.(11) The reasons behind such returns can be broadly categorised into three groups: illness-related, doctor-related, and patient-related. Illness-related returns occur when disease progression prompts the patient to seek further emergency medical care despite receiving appropriate treatment during their initial visit. Doctor-related returns are associated with substandard care during the index hospitalisation and are preventable with better care. Patient-related factors, such as poor medication compliance or lack of understanding of discharge instructions, may also contribute to 72-hour ED re-attendance.(12) Return visits to the emergency department (ED) within 72 hours are often caused by illness-related factors, where the patient initially received appropriate medical care, but disease progression prompts the ED return visit.(5) Additionally, physician-related and patient-related factors may also contribute to these returns.(11) However, some studies have suggested that illness-related factors are more common than patient- or healthcare-related factors in causing return visits to the ED within 72 hours.(2,13)

Physician-related return visits, which constitute one of the three categories of ED return visits within 72 hours alongside patient-related and illness-related returns, exhibit variable percentages based on available search results.(5) A study focused on a subset of return visits resulting in admission found that illness-related admissions accounted for nearly all admissions within 72 hours, while physician-related admissions accounted for only 3.5%.(14) On the other hand, another study that identified risk factors for admission in 72-hour return visits found that physician-related factors were not significant predictors of admission.(15) One study reported that around 4.8% of ED visits occurred within 72 hours of patients being seen in the same emergency department, while another study reported this figure as 5.7%.(16,17) Additionally, 20.3% of adult ED revisits within 72 hours were high-risk visits necessitating admission or resulting in death in the ED.(17,18)

Conversely, a study reported that 4.2% of ED returns were attributable to system-related factors.5 Furthermore, several studies have indicated that the current 72-hour ED metric misses almost 70% of 30-day ED revisits and that initially categorised system-related complaints account for about 57.9% of ED revisits within 72 hours.(6,8) The percentage of system-related return visits within 72 hours to the emergency department varies by age group, with patients aged 65 and over having the highest number of ED visits in 2019.(19) Abdominal pain is the most common chief complaint in the first return visit, followed by cough and upper respiratory tract infection, with illness-related complaints being the most common reasons for revisits.(2,13)

To minimise the need for patients to revisit the emergency department, healthcare providers need to ensure that patients are adequately prepared to manage their recovery at home and adhere to discharge instructions and prescription regimens. A study on general paediatric patients found that having access to a paediatrician reduced the likelihood of a return visit to the ED by nearly 30 percent.(12) Providing clear instructions and education on the disease process upon discharge, as well as identifying warning signs for when to return to the ED, may be beneficial in reducing revisit rates.(5)

To prevent unnecessary testing, treatment, and hospitalisation, it may be necessary to provide more attention and preventive treatment measures for common complaints, particularly for children who frequently return to the ED.7 This can help avoid increased costs for patients, longer stays, and ED overcrowding. As such, 72-hour return visits are an important quality indicator and benchmark for ED care.(7) To address issues at both the system and clinician levels that contribute to early returns, it is common practice to review patients who revisit the ED within 72 hours, which is also known as "bounce-backs".(20) This quality assurance approach helps to ensure patient safety and prevent such early returns.

Ultimately, there is a need for more research to fully understand the factors that affect the rate of return to the ED, and the problem is that a high rate of return to the ED can indicate issues with the quality of care provided in the ED. Also, the lack of studies examining the relationship between primary care access, follow-up care, and rate of return to the ED within 72 hours.

The provided analysis and discussion provide valuable insights into the characteristics of patients who make unplanned returns to the emergency department within 72 hours. The demographic characteristics of the patients, such as gender, age, and ethnicity, can help healthcare professionals and policymakers design interventions to reduce the number of unplanned returns.

The analysis of the data by gender reveals that male patients had a higher proportion of unplanned returns than female patients. This finding can be used to develop targeted interventions to improve the care and management of male patients, which may help reduce the number of unplanned returns. The study also found that patients aged 14 or older had a higher proportion of unplanned returns than those under the age of 14, suggesting that interventions may need to be tailored to different age groups.

The analysis of the data by ethnicity indicates that patients from specific ethnic backgrounds, such as Arabs, were at a higher risk of unplanned returns. This finding suggests that interventions may need to be tailored to specific ethnic groups, considering their unique cultural, linguistic, and social needs.

The analysis of the data by triage level and primary diagnosis provides valuable information on the severity and nature of the conditions that result in unplanned returns. The finding that patients with a triage level of 4 had the highest proportion of unplanned returns suggests that more attention needs to be paid to the care and management of patients with less severe conditions. The finding that the most commonly identified primary diagnosis for patients who returned was respiratory tract infection-associated symptoms and fever highlights the need for more study to understand the nature of these conditions and develop targeted interventions to reduce their incidence may include improving communication and education about the natural course of illness, provide a point of contact if the patients have any queries and consider early follow up in primary health care clinics.

Several measures can be taken to address the issue of unplanned returns to the emergency department within 72 hours, based on the findings of this retrospective cross-sectional study:

- **Improve triage processes**

Since patients with higher triage levels are more likely to return to the emergency department within 72 hours, improving triage processes to more accurately identify and prioritize patients in need of urgent care could help reduce the rate of return visits.

- **Tailor interventions based on age**

Given that a higher proportion of patients aged 14 or older made unplanned returns, interventions may need to be tailored to different age groups to address the underlying factors contributing to their return.

- **Develop culturally-sensitive interventions**

The study found that patients from specific ethnic backgrounds, particularly Arab patients, were at a higher risk for unplanned returns. Therefore, developing culturally-sensitive interventions that consider the unique needs and preferences of patients from different ethnic backgrounds could help reduce the rate of return visits.

- **Improve discharge planning**

Since the most common primary diagnosis for patients who returned was respiratory tract infection, improving discharge planning processes to ensure that patients receive appropriate follow-up care and support after leaving the emergency department could help reduce the need for unplanned returns.

- **Conduct further research**

While this study provides valuable insights into the factors affecting the rate of return to the emergency department within 72 hours, further research may be needed to better understand the underlying causes of unplanned returns and to develop more effective interventions to reduce them.

In conclusion, the findings of this study can inform emergency department management and patient care by providing valuable insights into the characteristics of patients who make unplanned returns to the emergency department within 72 hours.

Causing factors

The collected data was analysed in depth, many factors were found that affected the rate of return to the emergency department within 72 hours and it provided insights into the underlying causes of unplanned returns. One of the most common causes of unplanned returns to the emergency department is communication. Poor communication between healthcare providers and patients can lead to misunderstandings about the patient's condition, treatment plan, and follow-up care. For example, patients may not understand the instructions given to them or may not have received clear information about their diagnosis or treatment plan, which can lead to confusion and anxiety. In some cases, patients may also have difficulty communicating their symptoms or concerns to healthcare providers, which can lead to misdiagnosis or inadequate treatment.

Another possible cause of unplanned returns is mismanagement, which can include issues such as inadequate monitoring or failure to follow up on test results or treatment plans. For example, if a patient is discharged from the emergency department with a prescription for medication but does not receive clear instructions about how to take it or when to follow up with their primary care provider, they may not take the medication as directed or fail to follow up, which can lead to a worsening of their condition and a need for a return visit.

Missed diagnosis is another potential cause of unplanned returns to the emergency department which is one of the most serious factors and has a potential effect on patient safety. When a patient's condition is not correctly diagnosed or treated, they may experience worsening symptoms or complications, which can lead to a return visit. This can be especially problematic if the underlying condition is serious or life-threatening.
Patient-related factors can also contribute to unplanned returns to the emergency department. For example, patients with a low threshold for pain or fever may be more likely to seek care in the emergency department, even if their symptoms are not severe. Additionally, patients who do not have a good understanding of their health or who have difficulty managing chronic conditions may be more likely to experience complications or need additional care.

Illness-related factors can also contribute to unplanned returns to the emergency department. For example, complications of an illness or disease, such as ARDS secondary to influenza, can require additional treatment and care, which may necessitate a return visit to the emergency department.

Finally, system-related factors can also contribute to unplanned returns to the emergency department. For example, if a patient is unable to secure a follow-up appointment with a specialist at a specific time, they may need to return to the emergency department for further evaluation and treatment. Additionally, if there are not enough resources or staff available to manage patient needs, this can lead to longer waiting times and delays in care, which can increase the likelihood of unplanned returns.

Limitations

There are some limitations of this study. Aside from being a cross-sectional study in which it is difficult to establish a causal relationship between variables.

Conclusion

The research topic of investigating the factors affecting the rate of return to the emergency department within 72 hours is important, as unplanned returns can contribute to emergency department overcrowding, and critical bed status, and negatively impact patient outcomes and safety. The study's sample size and demographics suggest that male patients and patients from specific ethnic backgrounds may require more attention in terms of care and management to reduce unplanned returns.

The analysis of the data showed significant differences in the proportion of patients who returned to the emergency department within 72 hours based on gender, age, ethnicity, triage level, and primary diagnosis. The findings highlight the importance of considering these factors when developing interventions to reduce unplanned returns and improve emergency department management and patient care. Future research may focus on examining additional factors that contribute to unplanned returns, such as patient socioeconomic status, comorbidities, follow-up, and the quality of initial care provided.

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3. DIVERSITY AND INCLUSION IN NURSING: EMBRACING DIFFERENCES, FOSTERING EQUITY

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Diversity and inclusion are fundamental pillars in the nursing profession, essential for delivering equitable and culturally competent care. In the Middle East, where cultural diversity is rich and varied, embracing differences and fostering equity in nursing practice are crucial for addressing the complex healthcare needs of diverse populations. This article explores the significance of diversity and inclusion in nursing within the Middle Eastern context, highlighting key strategies and initiatives to promote an inclusive healthcare environment.

Introduction

The nursing profession in the Middle East is characterized by its diverse workforce, comprising individuals from various cultural, ethnic, and religious backgrounds. As the region continues to evolve and diversify, it is imperative for nursing professionals to recognize the importance of embracing diversity and fostering inclusion in their practice. This article examines the role of diversity and inclusion in nursing, emphasizing their impact on patient care, workforce dynamics, and overall healthcare outcomes.

Defining Diversity and Inclusion in Nursing: Diversity in nursing encompasses differences in race, ethnicity, gender, religion, sexual orientation, socio-economic status, and more. Inclusion, on the other hand, refers to creating an environment where every individual feels valued, respected, and empowered to contribute their unique perspectives and talents. Together, diversity and inclusion foster a culture of equity and belonging within the nursing profession.

The Importance of Diversity and Inclusion in Nursing: Embracing diversity and fostering inclusion in nursing practice is vital for several reasons. Firstly, diverse healthcare teams are better equipped to understand and address the unique needs and preferences of patients from various cultural backgrounds. Secondly, inclusive environments promote collaboration, creativity, and innovation among nursing professionals, leading to improved patient outcomes and quality of care. Lastly, diversity and inclusion contribute to a more equitable healthcare system, where access to care is not hindered by factors such as race, ethnicity, or socio-economic status.

Challenges and Barriers to Diversity and Inclusion

Despite the benefits, achieving diversity and inclusion in nursing can be challenging. Systemic biases, cultural stereotypes, and lack of cultural competence training may hinder efforts to create inclusive healthcare environments. Additionally, unconscious biases and macroaggressions can negatively impact the experiences of minority nurses, leading to feelings of isolation and disengagement.

Strategies for Promoting Diversity and Inclusion

To overcome these challenges, nursing organisations in the Middle East must implement targeted strategies and initiatives. This may include developing cultural competency training programs, establishing diversity recruitment and retention initiatives, fostering mentorship and support networks for minority nurses, and promoting leadership opportunities for underrepresented groups. By investing in these strategies, nursing organizations can create more inclusive work environments that reflect the diversity of the communities they serve.

Conclusion

In conclusion, diversity and inclusion are integral to the nursing profession in the Middle East. By embracing differences and fostering equity, nursing professionals can enhance patient care, promote workforce diversity, and contribute to a more equitable healthcare system. Moving forward, it is essential for nursing organisations in the Middle East to prioritise diversity and inclusion in their practice, ensuring that every nurse feels valued, respected, and empowered to make a meaningful contribution to healthcare delivery.

This article serves as a call to action for nursing professionals in the Middle East to champion diversity and inclusion in their practice, ultimately leading to improved health outcomes and a more equitable healthcare system for all.

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4. LIFE AND EMINENT DEATH ON THE DOORSTEP CASE REVIEW

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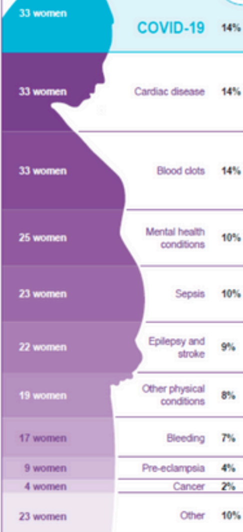
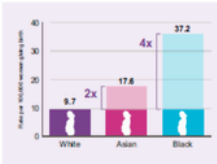
Mediclinic Parkview Hospital

A recent systematic review study done by (Dol, Hughes, Bonet, & Dorey, 2022) indicated that 48.9% of maternal deaths occurred on the first day post-delivery.

On return from the operating theatre to the maternity ward, there is no more a rewarding feeling than that of a mother who delivered a live new-born, fresh in her arms filled with joy, a sudden aura of impending doom. The mom screams aloud, terrified fear of life leaving her body. One of the most stressful and high-risk events is that of a potential maternal mortality. I had the fortunate and yet challenging experience of attending to this patient, a 40 year old, G4 P1 with history of previous caesarean section x1 and gestational diabetes at 38+2 weeks gestation, who had just had an uneventful elective caesarean section under spinal. She was received in the maternity ward at 10:30, had skin to skin by 10:35 and as the nurse attempted to take the initial set of vital signs, at 10:40 approximately the mom screams out in Spanish to her husband and nurse, the feeling that she is about to die. Fortunately the nurse and husbands responds to her cry, and immediately seek help, the baby is removed in time as she then suffers continuous tonic clonic seizures. At this point, an anaesthetist and senior registered nurse on the floor swiftly enter the room and help, 10:42 Rapid Response Team activated. As I entered the room in response to the RRT, I was met with an atmosphere of anxiety. The room filled with doctors, midwives and nurses all wanting to aid in this rescue. The seizure was managed with magnesium sulphate, labetalol and diazepam. The patient became apnoeic and hypotensive, at which point the patient was successfully intubated. Minutes later at 10:58 asystole noted and code blue activated. To the outside observer, this was a cloud of chaos that did not seem to follow any clinical guided algorithm, or at least that was my perception of what I thought, it felt like.

The impression: Maternal collapse probable causes, pulmonary embolism, amniotic embolism, eclampsia, local anaesthetic toxicity and anaphylactic shock. Amidst the observational perception I had, we had actually managed all the possible causes according to the maternal algorithm with exception of one. After 32 minutes of resuscitation, the team faced the daunting action of thrombolysis on a fresh post caesarean section. Knowing the complications to follow, the team agreed this was the last opportunity at life, and Alteplase was administered. Within 10 minutes, we achieved an organised rhythm and pre-emptively planned OT for insertion of bacri-balloon and activated the massive blood transfusion protocol as major vaginal and intra-peritoneal bleed was expected. Was this the correct decision, what options did we have, I believe we prayed silently within ourselves. The Lay Summary Report (Figure 1), one of the longest, ongoing, standing UK reports released every three years, beautifully illustrates the most common causes of maternal deaths.





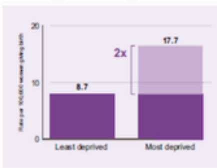


Figure1 MBRRACE UK Saving Lives, Improving Mothers' Care 2023 Lay Summary

This report in correlation with the timing and cause of maternal postpartum, illustrated in the below Figure 2 (Dol, Hughes, Bonet, & Dorey, 2022) mortality further validates our aggressive course of action going further; all must be done, especially on day 1.

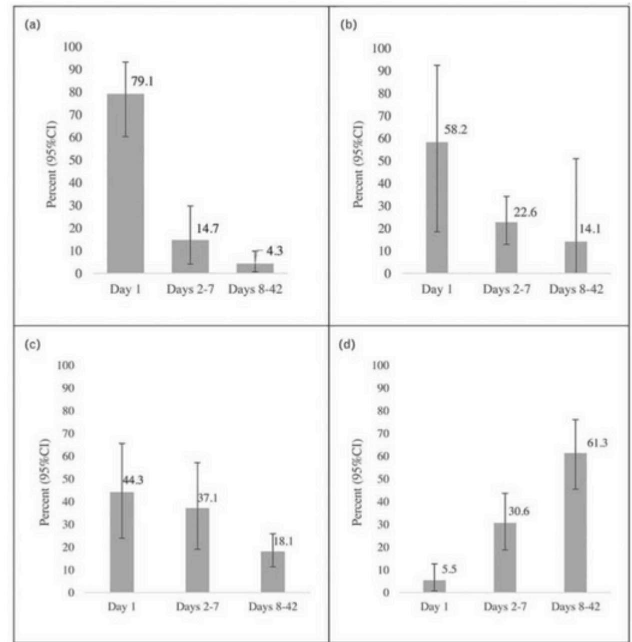


Figure 2 Proportion of postpartum maternal mortality on day 1, days 2–7, and days 8–42 due to postpartum haemorrhage (=6 studies, 1561 deaths); (b) embolism (n = 3 studies, 408 deaths); etc.

From the operating theatre to the ICU, fluid resuscitation lasted approximately 30 minutes, with increasing demands in vasopressor support and metabolic acidosis, abdominal ultrasound showed still massive intraperitoneal blood collection, far from stability we reactivated the massive blood transfusion protocol, did reversal of thrombolysis and consulted the interventional radiologist on possible uterine arterial embolization. A second visit to the OT, cathlab resulted in successful embolisation of the left uterine artery. A distressed, emotional husband who had followed behind every marathon of a decision with the team was unequivocal in his trust towards the team. I later on learned that the paediatric unit manager had supported him all the way from maternity ward, during the code blue.

Lastly, we were able to CT imaging of the patients head, chest and abdomen, the finality in identifying the cause. The fear naturally being the impact of the seizures and resuscitation time etc. on the brain function. A sigh of relief in the results being all clear. Do we know the exact cause, the diagnostic uncertainty, the challenges during the code in managing those uncertainties aroused the appearance of that anxious, chaotic atmosphere I noted. All culminating really from healthcare and medical clinicians who are really just advocating in the fight and plight for this patients life, after all, she had just delivered a live female infant, how could we lose a mother.

Our patient was successfully weaned and extubated a day later. She experienced confusion for approximately two days, appeared very emotional, erratic and of course extremely high risk after the traumatic experience. Post-partum depression a definite reality, we managed to initiate treatment in prevention, supported the mother through counselling and encouraging the bonding with her new-born. On day three in what seemed to be in the blink of an eye, our patient had a sense of calmness, finally she understood what had happened, tears followed as to what could have been the outcome.

Good or bad, you could argue, amnesia, our patient could not remember the birth event she had, a memory lost but also she could not remember the traumatic events, which could be seen as good. Mental health in maternal cases are the 4th highest percentage noted in the Lay Summary report as causes of woman's deaths in the UK, it was rather challenging to find data on woman in the UAE regarding mental health. Results from a study titled, "Beliefs and Attitudes of Health Care Professionals towards Mental Health Services Users' Rights: A Cross-Sectional Study from the United Arab Emirates" data revealed that, "their findings demonstrated that HPCs understand mental disorders and feel that individuals' rights should be equal to those who do not have mental disorders while believing in autonomy and freedom, but there is a level of discrimination and a high level of social distance. HCPs are less tolerant when interacting with those with mental disorders outside their professional lives." (Abdulla, Webb, Mahmmod, & Dalky, 2022). Hence, we as HCPs are responsible in advocating for patients who require support in mental health care, all sorts of bias needs to be identified and dissolved, how else can we sincerely render safe, quality care.

Conclusion

Are pregnant woman knowledgeable enough on reports like this, educated on prevention of certain complications, or do we manage more preferences in decisions related to method of birth delivery, this can be argued in the UAE. A study done by (Al-Rifai, et al., 2021) noted that one in 10 women would prefer caesarean section especially in the UAE and that woman should be educated on the potential risks involved, as with the Lay Summary Report data showing blood clots at 14% responsibility of maternal mortality. What about the second victims, the healthcare providers, require good mental health to manage effectively the work we do, to work through those diagnostic uncertainties, challenge each other to prevail the best outcome for our patients in our advocacy for them, our voices cannot be steadfast and compassionate simultaneously, if we do not sustain good mental health. In this case review, we successfully managed to support the husband, the patient and the healthcare providers. A debriefing session was held after, with the all the stakeholder's involved, I did not realise initially but I needed to listen to the feedback and experiences shared by all the team, all positive, all felt that we worked as a team, we reached the end goal. Yes, emotions were very real, it's not often these providers experience codes, not when their service is delivering life. I had learned in my field of critical care how to manage and cope with trauma, the harder skills, I may have deterred my perception of how this code was managed as my expectation was order, structure and follow the algorithm of ACLS. I had allowed my own bias perception during that code, now retrospectively after listening in the debriefing, I have been reminded that my beliefs and attitude of healthcare providers towards mental health was also less tolerant and that within my professional life. I have a better appreciation of strategies in which my organization approached mental health support for all clinical staff and allied services, by guidelines of a second victim policy and an external company merged to support employees through means of counselling via the Employee assistance program.

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5. NAVIGATING THE COMPLEXITIES: UNDERSTANDING AND ADDRESSING THE CHALLENGES FACED BY EMERGENCY ROOM NURSES

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Emergency room (ER) nurses serve as frontline responders in healthcare, tackling numerous obstacles while providing critical care to patients in need. This comprehensive article explores the multifaceted challenges encountered by ER nurses, ranging from high patient volumes and time constraints to workplace violence, emotional stress, and burnout. Drawing upon empirical evidence and professional insights, it underscores the urgent need for comprehensive support systems and strategic interventions to safeguard the well-being of ER nurses and optimize patient care outcomes.

Introduction

Emergency room nurses play a pivotal role in the healthcare system, serving as the first point of contact for individuals in crisis. Their job is inherently demanding, characterized by fast-paced decision-making, high-stress environments, and the constant need for adaptability. Despite their indispensable contributions, ER nurses grapple with a host of challenges that can impact their ability to provide quality care while maintaining their well-being. This article aims to delve deep into the complexities of the challenges faced by ER nurses, offering insights into their experiences and advocating for meaningful strategies to support them in their vital roles.

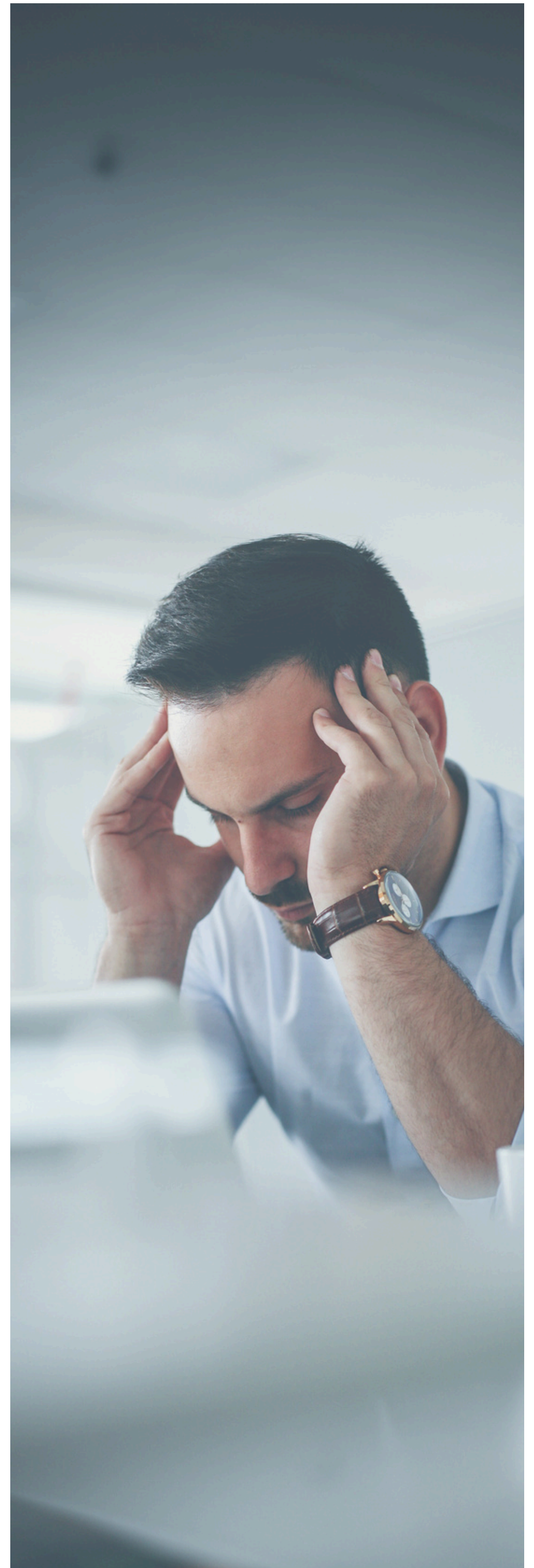
High Patient Volume

One of the most pressing challenges encountered by ER nurses is the perpetual influx of patients seeking immediate medical attention. Emergency departments (EDs) worldwide often operate at or beyond capacity, leading to overcrowding, extended wait times, and strained resources. This surge in patient volume places immense pressure on nurses, necessitating rapid assessment, triage, and prioritisation of care. Despite their best efforts, the sheer volume of cases can overwhelm ER nurses, impacting both the efficiency and effectiveness of care delivery. Research by Jones et al. (2018) underscores the pervasive nature of this challenge, highlighting the need for innovative strategies to manage patient flow and optimize resource allocation within emergency rooms.

Critical Time Constraints

Time is a precious commodity in the emergency room, where split-second decisions can mean the difference between life and death. ER nurses must navigate complex medical scenarios under intense time pressure, balancing the need for swift intervention with the imperative of thorough assessment and care. This constant juggling act can lead to heightened stress levels and feelings of anxiety among nurses, impacting their ability to perform optimally. Johnson (2019) emphasises the importance of effective time management strategies and streamlined protocols to mitigate the impact of time constraints on ER nursing practice. By implementing evidence-based approaches to workflow optimisation and task prioritisation, healthcare institutions can empower ER nurses to deliver timely, efficient care without compromising patient safety.

Workplace Violence



ER nurses are disproportionately exposed to workplace violence compared to their counterparts in other healthcare settings. Verbal abuse, physical assaults, and harassment from patients or visitors pose significant risks to the safety and well-being of nurses, creating a hostile work environment that can have profound psychological repercussions. According to the Emergency Nurses Association (ENA), nearly 70% of emergency department nurses report experiencing workplace violence (ENA, 2021). This alarming prevalence underscores the urgent need for comprehensive interventions to address this issue. ENA advocates for a multi-pronged approach, including staff training on de-escalation techniques, implementation of security protocols, and institutional support for nurses who have experienced violence. By fostering a culture of safety and respect within the workplace, healthcare organizations can mitigate the risk of workplace violence and create a supportive environment for ER nurses to thrive.

Emotional Stress and Burnout

The emotional toll of working in the emergency room is profound, with ER nurses routinely exposed to traumatic injuries, medical crises, and end-of-life situations. This persistent exposure to stressors, combined with long hours and irregular shifts, increases the risk of burnout among ER nurses. Burnout is characterized by emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment, ultimately compromising both the well-being of nurses and the quality of patient care. Lee and Scott (2017) highlight the need for targeted interventions to address burnout among ER nurses, including initiatives to promote self-care, resilience, and work-life balance. By prioritizing the mental health and well-being of ER nurses, healthcare organisations can mitigate the risk of burnout and cultivate a resilient workforce capable of providing compassionate, high-quality care to patients in need.

Support Systems and Resilience Building

In response to the myriad challenges faced by ER nurses, healthcare organizations must prioritize the implementation of comprehensive support systems. This includes access to therapy services, peer support groups, and wellness programs tailored to the unique needs of emergency room personnel. Additionally, training initiatives focusing on stress management, conflict resolution, and communication skills can empower nurses to navigate challenging situations effectively. By fostering a culture of support and resilience, healthcare institutions can mitigate the impact of workplace stressors and promote the well-being of their nursing staff.

Advocacy and Policy Reform

Beyond the institutional level, advocacy efforts and policy reforms are crucial to addressing systemic issues contributing to the challenges faced by ER nurses. This includes advocating for legislative measures to enhance workplace safety, such as stricter penalties for acts of violence against healthcare workers and improved staffing ratios to mitigate the burden of excessive workloads. Furthermore, lobbying for increased funding for mental health resources and professional development opportunities can empower ER nurses to thrive in their demanding roles and make meaningful contributions to patient care.

Conclusion

In conclusion, emergency room nurses confront a myriad of challenges in their daily practice, from high patient volumes and critical time constraints to workplace violence, emotional stress, and burnout. Addressing these challenges requires a multifaceted approach encompassing institutional support, resilience-building initiatives, advocacy efforts, and policy reforms. By recognising the unique needs of ER nurses and implementing targeted interventions, healthcare organisations can enhance patient outcomes and ensure the continued resilience and dedication of these indispensable frontline caregivers.

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NURSES REFLECT

TOWARDS EXCELLENCE: A SONNET FOR NURSES DEDICATED TO GROWTH

The little things that no one sees you do
For you know some day you may need it too
Knowing your key role in patient care
We're reshaping the perceptions to make it fair
Enabling you to have a voice to lead
Promoting a culture you wish to stay in deed
Offering prospects for professional development
Enhancing your wellbeing and betterment
Spotting the societal benefits and refine working condition
Improving patient outcome with utter dedication
Inspiring socio economic growth and fruition
Focus on fostering the spirit of innovation
Cheers to tireless work come whatever may
Wishing you all a Happy Nurses' day!

Smitha Saldanha
Diabetes Educator- Nursing Administration

EMERGENCY NURSING EQUATES TRAUMA NURSING?

A citation by Mark Lester Miranda BSN RN-PH, RN-DHA, USRN
Often people asks what is the difference between a trauma nurse and an emergency nurse. Aren't they the same in dealing with life threatening conditions, under tremendous amount of pressure and time critical actions in order to save lives? Which among the two is better professionally as a nurse? These are the just some questions anyone can have. I tell you, these questions are acceptable and actually justifiable as the differences and similarities of each are not yet know to the majority.

I remember during my nursing schools not so long ago, everything was general, from fundamentals, medical-surgical, obstetrics and gynaecology and so on and so forth, then I get the actual hospital rotations and then got exposed to an Emergency department. I got all kinds of sick people, there is blood everywhere, limbs just barely hanging. It was an eye opener for me that Emergency Nursing is for me. I wanted this type of work action it is a fulfilling one! I pursued my Emergency nursing career, went on different institutions, and end up with an emergency department which was somewhat different from where I used to be. There are more sick people, medically and surgically cases speaking there were no blood tinge patients, no limbs nearly amputated, in short no actual work action.

Initially, it was okay, but few years passed by, I felt lacking, unsatisfied professionally, I was missing terribly the "work action" that I was used too. But hey, like we always say – "what to do", the rule of the land, is that all trauma/complicated cases must go to specific specialised hospital. I tried going to those hospitals, in the end, there are more cons than the pros.

As time passed by, I've grew and was trained with all the necessary theory and experiences to be an Emergency Nurse, it lit up that I can handle any type of emergency coming my way, I was a confident lad, until I had an opportunity to level up. I have my doubts, and scratched my confidence, when I saw an opportunity to go to my first love – long awaited "work action and professionally fulfilling job. My mantra that time was – "You can do this, this was your eye opener for your nursing profession".

And then my new journey began, it was nerve-racking when I started. I challenged myself to study and learn again. I have to be on top of my game. I should be able to serve as a resource to my team. And so it began, I did courses, trainings and certifications. I've learned all possible scenarios and merge everything into daily practice. It gave the confidence I needed.

By the way, on a recent study, Emergency Nurses and Trauma Nurses has 67% satisfaction with our job, and 87% satisfaction with the work we do. Perhaps I could entice you to join our work force. Yes we may seem "busy" and probably you'll encounter disgruntled patients, these are less than 10% of what we see daily. The real cherry on the top when you see you patient discharged feeling whole again. That is the most precious feeling an Emergency or Trauma Nurse can have.

Having to experience both Emergency and Trauma Nursing, which is best to build a fulfilling and knowledgeable and experienced? Is there an actual difference from the two? Let's break it down, Emergency Nursing is a special field in nursing in which it focusses on caring of patients who are needing urgent or prompt care. It deals with wide range of medical conditions from simple to complex like ACS, strokes, respiratory illness and so and so forth, from different age groups – newborn to old age, to any gender. An Emergency Nurse will provide initial treatment, given medications, monitors and observes the patient. Trauma Nursing on the other hand, deals any patients who have experienced any traumatic injury like motor vehicle accidents, falls, stab wounds and the like. The immediate aim is to provide stabilization, assessing and treating the injury and to coordinate with other specialties for best possible outcome.

Both Emergency and Trauma Nurses must be able to work in a high pressure and stressed area, remains calms and must have exceptional critical thinking and communication skills. One thing that differentiate the trauma nurses from the emergency nurses is that, trauma nurses have more specialized training in managing traumatic injuries and has added certifications or experiences in trauma care.

Needless to say, in Mediclinic Middle East, as an established private sector group, specialisation of the emergency departments was a giant leap of investment! Each of the Emergency Departments has their own specialty, catering to the UAE's demand for different types of patient care.

Remembering the basic nursing process Assessment, Diagnosis, Planning, Implementation and Evaluation. This is still the foundation of a good emergency nursing. As an Emergency Nurse a developed cycle is constantly being practised to level the care of any emergency patient. Patients are also being triaged to determine the severity of each cases. When it come in Trauma Nursing, the patients are always unstable may it be level I or Level II, the trained trauma nurses has to do this nursing process simultaneously, time critical, and in a high stressed area and maintain a good communication with the team until dispositioned accordingly.
Trauma Nursing can be described similarly to a racing sports car in the race track. Once the car hits the pit stop. An orchestrated team approach the car, and with their individual tasks at hand like change tires, put petrol and checks the engine and the like within a minute otherwise the racer will have a significant time delay on the race track.

Trauma nursing utilises an effective and a quick and focused systematic approach of primary and secondary evaluation, in order to assess and treat and prevent further injuries. These evaluations comprises of a vivid A-B-C-D-E-F-G and S-A-M-P-L-E pneumonic which are precise and directly rule out any life threat situation to a patient. And one thing to add is the composure of the trauma nurses that can be due to the trainings and certifications and the trauma experience they gain day by day makes them confident and superb communications skills.

In summary, Emergency Nursing is a specialised wide branch of nursing and can be broken down to different subspecialty like Trauma Nursing. In emergency nursing we learn and practice the basics of any emergency care, we are fond to be called jack of all trades! But when it comes to trauma nursing it is an elevation of our emergency nursing practice. Not all Emergency Nurses can be Trauma nurses but Trauma nurses can be as efficient and effective Emergency Nurses. Utilisation of these highly skilled nurses and merging with the other EDs will in fact upskill the other respective Emergency departments. Imperatively, investing on the courses and certifications and training of the Emergency RNs on Trauma training will impact the best quality care for all patient outcomes.

MPAR has the best Trauma team and can give the best trauma nursing experience. As one of the consultants mentioned and I quote, "what we do in MPAR is almost aligned and top notch with the other Level 1 Accredited Trauma Centres in the region".

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GOOD LEARDERS DON'T JUST LEAD— THEY ALSO CONNECT AND ENGAGE OTHERS

Jesnamol Shijo MSN, RN, Emergency Department
When you think of a leader, what comes to mind? Probably an image of a strong person who's mapped out what a group needs to accomplish. A captain who commands troops, sets the course, and decides what to do and when. A company president who charts the best path for everyone.

That's a "classic" leader — and there's a drawback. A visionary leader who points the way is only half a leader. She must also look back to be sur others follow. She must communicate. She must engage others — making it a collective vision. She must lead but also be a part of the group and the vision.

I think good leaders lead by example, setting a foundation for what success looks like to them AND including followers who help create direction and purpose in work. As a leader, I'm seldom afraid to take risks, you should try to do three things: set Good goals, do what it takes to reach them, and engage others in the vision. There can be obstacles, of course, but clear direction, commitment, and engagement are keys to reading those goals.
I believe the biggest obstacles for leaders has to do with active engagement. The best leaders are those who actively engage followers and are checking in, ensuring they are in the loop, communicating, encouraging and actively seeking input they actually use to adjust trajectory. When such a leader involves his or her team for a common, agreed up on goal, everyone feels far more compelled and comfortable with risks and making changes. Why? Because they were consulted and involved, actively contributed to a vision.

That is the key to what makes the leader in successful. In their book Co – Active Leadership: Five Ways to Lead, Henry and Karen Kinsey -House write, "The 'Co' coactive is about connection, engagement, and inclusion." And Patrick Lencioni agrees in his book, ' The Advatage, he writes, " if people don't weigh in, they can't buy in." Think about it. Isn't this true in our work as ED professionals? Those actively doing the work must be part of the solution, especially when trying something new or implement new concept. It's no longer "how we've always done it."

It's up to us create conversations that produce workable situations. In a way, we all became leaders, each of us in a different way but with a common goal of taking the best care possible of patients.
As that leader, our job is to engage others who look to us in conversation, discussion, and , yes, vision that we can then incorporate into a common goal. The word TEAM describes Together Everyone Achieves More, and it's fitting in the emergency department. Leaders needs active collaboration from above, below, and around them to successfully generate the best patient outcomes.

Norman Vincent Peale, In The Power of Positive Thinking, says, "Throw your heart over the fence, and the rest will follow you." I think that means a leader needs to pour passion and perseverance into what they are doing— regardless of fear— and encourage those who follow to do the same.

Success is not just a flawless path forward. It's also about missteps along the way because those missteps make us strive harder to achieve. Being transparent with the journey truly inspires those who follow.
Imagine if we all channelled the leader concept, sharing our vision, working together to develop it, and enrolling others in the journey. How much passion, engagement, and accountability we could generate for the emergency nursing community.

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IT IS FINISHED...

by Ronelle Peters, MPAR Paediatric Unit Manager

"No matter what your struggle has been, victory is possible today."
-Lysa Terkeurst

"It is finished" is a Greek translation of the word Tetelestai, the perfect indicative passive tense of the word telos, which means to end, to bring tocompletion, to bring to a conclusion, to complete, to accomplish, to fulfil, or to finish.

Nursing and the nursing profession hold a special place in my heart. I recently announced my plans to bring my nursing career of 38 years to an end. Iam completing my professional career as a Paediatric Nurse Manager. Throughout my career, and throughout my life, I have had a profound love for children, especially the most vulnerable and those needing special care: from the micro-premature babies (<400gram) to longterm paediatric patients, thoseunable to protect themselves. My professional career may be finished for now, but the memories of the many lives I touched (and their lives who touched me in return) will continue to live in my heart for all my days.

It is finished.

I was born and raised in South Africa where I also completed my Nursing Degree. My first encounter with nursing started early in my life, while I wasstill in high school. A friend invited me to join her as a volunteer during a working holiday in a hospital in South Africa. My first allocation was inthe men's surgical ward. Every situation was a learning experience, some a bit embarrassing and unexpected for a young scholar-nurse, I remembered. Next, I was assigned to the children's ward and it was working with and seeing these helpless little ones in isolation rooms, in oxygen tents, in respiratory distress, post operative and in pain, where my mind for a career choice in paediatric nursing was made up.

No two days in the life of a nurse are ever identical. It is the unpredictability of a day that keeps nurses on their toes, and what makes this career so immense interesting! No 12-hour shift, no labour, no case observed in a theatre, no case is ever the same. Every day and every patient is unique and has a left special mark on my heart and it is all those marks, like pieces of a jigsaw puzzle, that form my memory that I will carry with me andtreasure for the rest of my life.

It is finished.

Ending a chapter in one's life can be overwhelming. But it is also the beginning of something new. I can face the future with confidence thanks to what this amazing career has taught me and how this path has enriched my life on so many levels.

Being a nurse helped me to communicate and understand people of various backgrounds, understanding cues of the little patients.

Being a nurse taught me how to think critically, quickly and strategically.

Being a nurse helped me to make good decisions based on assessment skills.

I have learned and experienced the difference a smile or a prayer orhaving compassion and showing love can make. I have always believed that love can change the world!

Being a nurse help me understand ultimately what worked well,what needed to develop and what knowledge I needed to acquire! I have learned the value of life.

However, it was undoubtedly my experience as a nurse that empowered me to become the leader I aspired to be.

Ending a chapter in one's life can be overwhelming.
But it is also the beginning of something new.

Being a nurse in Mediclinic, Middle-East, here in Dubai, I experiencedthe efficiency of our diverse teams working together, delivering patientcentred care, achieving equity, inclusion and diversity. I will beforever thankful for this opportunity.

In honour of Nurses Month, I would like to offer my most heartfeltgratitude to every nurse in whichever capacity. Your work, yourtouch, your smile and compassion have a profound impact on everypatient and is highly appreciated. I was overwhelmed during the Daisy Award Event, when me and my team, were honoured with the first ever"Best Daisy Team Award". Well done Paediatric Nurses at MediclinicParkview Hospital.

This chapter of my life is now finished, and a new season is about tostart. I am so thankful to everyone who has crossed my path throughthe course of my career. May you all find joy in knowing that you make a difference, and may your life be enriched while you write your own chapter until your own book is finished.

Thank you. Ronelle Peters

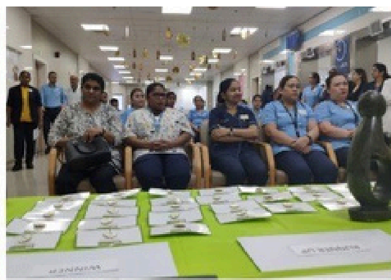
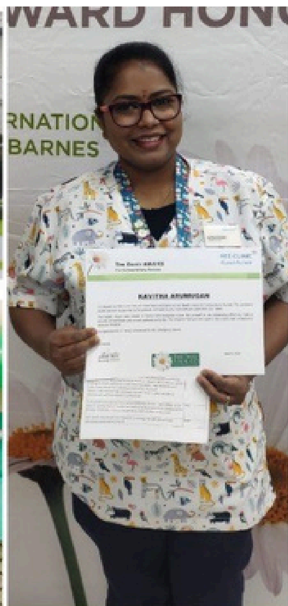
DAISY RECOGNITION

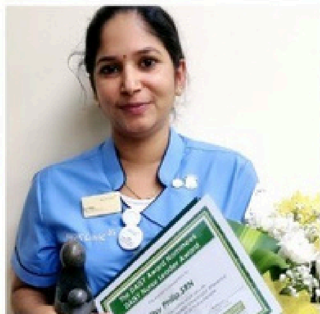
In 1999, at the age of 33, Patrick Barnes was diagnosed with the autoimmune disease ITP (Immune Thrombocytopenia). His family was fortunate to spend the eight weeks of Patrick's hospitalisation with him. During those weeks, they experienced the best of nursing. While they expected great clinical care, they did not expect the incredible kindness and compassion shown to Patrick and them every day, even when Pat was completely sedated. It eased their minds, and the nurses' sensitivity to the situation made a great difference in the hospital experience. The nurses helped the family through the darkest hours of their lives with soft voices of comfort and strong, loving hug.

After Pat died, the Barnes family knew they wanted to honour him, to somehow turn their grief into something that would help fill the giant hole in their hearts that Patrick's passing had left. The family kept coming back to conversations about his nurses, and that's when they decided to say “Thank You” for the gifts nurses give their patients and families every day, just as they had experienced.

Pat's wife, Tena, developed the acronym DAISY, which stands for Diseases Attacking the Immune System. Paperwork was filed to become a not-for-profit organisation, and The DAISY Award® for Extraordinary Nurses began at the Seattle Cancer Care Alliance at the University of Washington Medical Center, where Patrick had been a patient. It was the first programme of its kind to give patients, families, and co-workers a way to express their gratitude to nurses for what they became nurses to do - provide compassionate care to patients and their families. Since then, The DAISY Award has become a strategic tool for nurse recruitment, retention, and resilience that has been adopted by thousands of healthcare organisations and schools of nursing in the U.S. and around the world. (The Daisy Foundation, n.d.)

At Mediclinic Middle East we believe in the healing touch of our nurses and love to honour them with this prestigious reward. Our DAISY honourees and awardees wear their pins with pride and enjoys to showcase nursing excellence.

Award Honoree!





Our DAISY Award

IN MEMORY OF J. PATRICK BARNES

The DAISY Award
For Extraordinary Nurses
Floridel Nacion, RN