

## Research Article

# Prevention of Nursing Interruption Disputes in Obstetrics and Gynecology Based on Nursing Process Reengineering

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During the nursing administration process, including preparation, management, and documentation, there is a high proportion of work interruption that results in nursing administration errors that consequently affect the safety of patients, increase the occurrence of nursing risks, and cause adverse reactions. To investigate the impact of nursing on drug withdrawal disputes in obstetrics and gynecology and reduce medical disputes are of great importance. In this study, documents related to medical disputes are collected and linked to relevant professional information systems for data collection and consultation. The patients are divided into groups and treated with different nursing methods, and then the correlation between nursing methods and disputes in different groups is computed. The results show that, based on the proposed nursing process, medical disputes caused by the cessation of nursing can be effectively reduced. Compared with traditional nursing methods, when the proposed nursing procedures are followed, the dispute rate is reduced by more than 10% and the possibility of serious disputes is also reduced with a reduction rate of about 15%. This shows that, based on the proposed nursing process, reengineering can play an effective preventive role in stopping obstetrics and gynecology nursing disputes.

## 1. Introduction

Patient safety is an important aspect in the care of the patients and one of the dimensions to determine the quality of care. Medication errors have been recognized as one of the most common types of errors affecting patient safety [1]. The nursing medication administration process includes the preparation, management, and documentation in an incessant process through a sequence of actions without disruption [2]. However, the nursing administration process remains the most interrupted nursing activity worldwide. Nursing work interruptions are a break in the continuity of nursing tasks and result in the suspension of the nursing task at some step before completion due to intrusion of unplanned secondary demands or tasks [3].

Recently, nursing dispute cases have increased intensely worldwide. Nursing disputes are occurring from time to time, and the number of nursing disputes is increased.

Conflicts have occurred frequently, and the nursing-patient relationships are further deteriorated [4]. At present, nursing disputes have aroused widespread social problems and become a new social contradiction. At the same time, it has also become a common problem that plagues the medical and judicial fields. For medical institutions, nursing disputes have become a sensitive issue that affects the normal operation of medical institutions [5]. This not only causes financial burdens on medical institutions but also seriously interferes with normal medical orders. For medical staff, medical disputes have increased the psychological burden of medical staff and reduced the social evaluation of medical staff. It is not uncommon for medical staff to be violently injured due to medical disputes. Interruption of care severely reduces the efficiency of nursing staff and threatens the safety of patients. The termination of nursing tasks is an overall screening factor that will increase the incidence of nursing risk, increase the risk of procedural errors by 12.1%,

and increase the risk of clinical errors by 12.7% [6]. Interference at nursing work increases the risk of errors and may have disastrous consequences [7].

Regarding the nursing process, domestic and foreign experts also have studied nursing disputes and devised preventive measures. Ju et al. [8] collected and analyzed medical dispute cases data related to pain management from 2012 to 2016 through the Medical Dispute Mediation and Arbitration Institute. In the collected data, 210 publicly disclosed cases were identified, of which 36 cases were related to pain management. Orthopedics was the most relevant to these pain management cases, and the time to resolve disputes was 8.0 to 17.5 months. Wakasiaka et al. [9] conducted a quantitative cross-sectional study of 83 nurses and midwives selected using quotas between May and June 2012. Structured questionnaires were used to collect data. For data analysis, SPSS was employed and descriptive statistics were applied to summarize the data. To determine the correlation between different variables, the Pearson correlation coefficient was used. The author in [10] adopted two sets of pre-test-post-test of experimental designs and employed sampling techniques to select 41 nurse participants working in the inpatient management department from 2 regional hospitals. Data reliability was determined using Cronbach's alpha index in the range of 0.77–0.91. He reported that the average score of nursing process knowledge in the two groups before the intervention was lower than the average level, but the average score of nursing process knowledge in the experimental group was higher after the intervention. Trevisan et al. [11] recorded inpatients in the Intensive Care Unit (ICU) to verify the content of the tools that record the steps of the nursing process. Getnet and Biftu [12] conducted a cross-sectional study on 278 nurses. For data collection, a structure observational sheet was used and for data analysis, EPI Info version 3.5.3 and SPSS version 20 software were utilized. Binary and multivariable logistic regression was fitted to identify the associated factors using an odds ratio and 95%. The incidence of work interruption was found to be 1,152 during the medication administration process. The authors in [13] selected a total of 17 hospitals in Xiamen city of China, including 8 tertiary hospitals and 9 secondary hospitals. All nursing dispute cases, between 2012 and 2014, were collected through questionnaires. Multiple logistic regression analyses were used to identify risk factors related to medical disputes. It was reported that the main causation of medical disputes was improper communication (24.0%) in tertiary hospitals and lower therapeutic skills (43.7%) in secondary hospitals, respectively. Amirthalingan [14] investigated that most of the medical and nursing disputes are better resolved through alternative resolution mechanisms and suggested that medical disputes and patient safety have to be observed through a new lens, namely, patient autonomy. Although the existing studies have investigated the causes of nursing disputes and presented preventive measures, the results of the experiments are unconvincing due to the small sample size and short time. The present researches explore more about the status quo of medical disputes, their causes, and current solutions, while there are fewer studies on the specific medical behaviors that

cause medical disputes and the law of occurrence of medical disputes. Based on the analysis of the relevant factors of medical disputes, this study proposes preventive measures and suggestions for medical institutions and nursing staff. It provides a scientific basis for alleviating doctor-patient conflicts and establishing a medical dispute prevention mechanism. It also provides a mechanism for building a harmonious doctor-patient relationship and promoting the healthy development of medical and health services which creates a good social environment.

The rest of the manuscript is ordered as follows. Section 2 illustrates the different methods for the analysis of nursing interruption disputes. In Section 3, different results are explained. Section 4 is about discussion and the conclusion is given in Section 5.

## 2. Analysis Methods of Nursing Interruption Disputes

*2.1. Medical Disputes.* Medical disputes generally refer to disputes between patients and medical institutions or medical staff regarding the medical-legal needs, methods adopted, expected results, and understanding of the rights and obligations of both parties [15]. Compensation is the main claim. The nature of medical disputes is civil disputes. When medical institutions provide corresponding medical services to the patients, the medical-legal relationship between the two is a civil legal relationship, and there is no coercion. Medical institutions often face barriers when dealing with medical disputes, including lack of integrity between doctors, nurses, and patients, difficulty in obtaining evidence for medical disputes, the unwillingness of the government to intervene in management, lack of security systems, and medical law linkages. These problems are extremely harmful and have become a serious obstacle to the improvement of healthcare institutes [16].

The violent conflicts caused by medical disputes make medical and nursing staff feel unsafe, bring great physical and psychological pressure, affect the enthusiasm of the medical staff, and even resist clinical patients during emergencies [17]. Many clinicians consciously avoid high-risk operations and worry about using immature new technologies and new methods, and most of them tend to adopt "defensive medical" behaviors. To alleviate the contradiction between doctors, nurses, and patients to the greatest extent, to establish a harmonious relationship, it is necessary to improve the medical dispute resolution mechanism and adopt different resolution mechanisms for different types of medical disputes [18].

The main reasons for medical disputes are as follows: First, patients and their families generally lack clinical knowledge and cannot fully understand and understand the specific medical conditions and risks of disease. Second, the lack of moral education for patients and their families hinders the smooth progress of doctor-patient communication. Third, patients and their families have high expectations [19]. Fourth, some patients and their families have a mentality of compensation. For diseases, there is a gap in understanding between doctors, nursing staff, and patients,

which affects the effectiveness of doctor-patient communication. “Medical problems” have become a “perverted” culture, which has seriously disrupted the normal work of medical staff. To a certain extent, the entire society is accustomed to “medical problems” when dealing with medical disputes. The negotiation of such medical disputes occurs in an unreasonable place, and the result of the negotiation will inevitably harm the interests of one party. The essence of resolving medical disputes is to resolve and deal with disputes or disputes among doctors, nursing staff, and patients [19]. The reason for this disagreement is the conflict among these parties. These parties failed to agree on the negative consequences and causes of the diagnosis and treatment process, which led to conflict.

For medical disputes, the distribution of reported incidents in recent years is ranked according to the number of occurrences. The top 5 medical disputes in order are due to the drug incidents, fall incidents, pipeline incidents, injury behavior incidents, and inspection incidents [20]. The top 5 in the past 5 years are all these 5 types of events, and the ranking has not changed. On the whole, the types of incidents still account for a relatively high proportion of drug incidents, fall incidents, and tube incidents. The main causes of the medical disputes are shown in Table 1.

It can be seen from Table 1 that medical disputes caused by medical defects account for the majority of the medical disputes, which require adequate attention from medical institution managers.

*2.2. Interruption of Care.* Nursing interruption refers to the external behavior that occurs suddenly, interrupts or delays things, and distracts the nurse when the nurse provides standard nursing functions in the prescribed time, role, and environment [21]. With the transformation of nursing work methods and the integration of information technology, nurses are constantly changing different duty hours. Interruption of care leads to interruption of work, and the result is unpredictable, and its risk factors need to be analyzed. The interruption process of obstetrics and gynecology care is shown in Figure 1.

Nursing staff factors and organizational management factors are the main source of nursing interruption events, followed by patient and family factors [22]. Therefore, in terms of organization and management, it is necessary to promote the scientific and standardized work process and improve the nursing work system and the construction of the information system. Likewise, it is essential to strengthen the training and assessment of nurses’ nursing knowledge and set up full-time positions to handle obstetric nursing interruption events [23].

Low-age nurses have insufficient risk assessment and response-ability to care interruption events. There is a certain gap between low-professional nurses and high-professional nurses in various aspects, such as knowledge reserve, professional quality and level, and clinical work experience. In addition, the way of responding to care interruption events and the ability to grasp them depend on their own clinical and emergency handling experience.

Nurses with high professional titles can optimize care interruption events that may have adverse outcomes [24]. With the improvement of nurses’ educational qualifications, the risk assessment scores of nursing interruption events have an upward trend, and there is no statistical difference. Studies have shown that the level of nurses’ educational background will have an impact on nursing interruption events [25]. Nurses with lower educational backgrounds make more mistakes in dealing with interrupting events. The prerequisite for improving the ability to manage interruption events is to improve the professionalism of nurses. However, the development of postgraduate education in China is slow. Most of the master’s degrees in nursing are mainly based on nursing education and scientific research, with weak clinical workability and insufficient ability to control risks [26]. This study found that there was no statistically significant difference in the interruption risk assessment scores among nurses with different educational backgrounds. The possible reason is that, generally, undergraduate nurses accounted for 91.4%, which is a relatively large proportion. It may be related to the small proportion of the number of college and master degrees. It may also be related to oral administration as the basic nursing operation, requiring nurses to observe the verification process and maintain a high degree of work responsibility [27].

In the nursing process, limited manpower and material resources can be effectively used to encourage patients and their families to participate in the care of patients with the greatest potential, giving full play to the self-care ability of patients and the effectiveness of family participation in healthcare. Healthcare services must be provided to patients with depression through a systemic management program to alleviate symptoms of depression and anxiety [28]. This mode of care is often implemented through family follow-up or telephonic follow-up. In obstetrics and gynecology nursing, objective support refers to objective, visible, and practical support, subjective support refers to the emotional support that can be experienced, respected, and understood, and the utilization of social support reflects the individual’s social support active use of talking, asking for help, and participating in activities.

*2.3. Data Visualization.* Data visualization is a process that is based on qualitative or quantitative data results in an image that is representative of the raw data, which helps in exploration, examination, and communication of the data. When the dimensionality of the data is large, direct visual analysis can create a very messy representation of data, and it is difficult to find the relationship between the data, resulting in extremely low efficiency in obtaining information and increasing the difficulty of visual analysis [28]. Therefore, when disputes occur in hospitals, data visualization can effectively highlight medical disputes and help to reduce the intensity of disputes [29]. To visualize the data, we perform the following correlation analysis process.

To determine a point  $x$ , we assume  $S_x(R)$  is a sphere with  $x$  as the center and  $R$  as the radius, and the density  $S_x(R)$  inside  $f(x)$  is constant. Then,

TABLE 1: Causes of medical disputes.

	Cause	Number of cases	Percentage
Courtyard	Negligence caused medical malpractice	1	0.36
	Medical error caused by negligence	3	1.09
	Inadequate medical skills	10	3.64
	Failure to inform	55	20
	Violation of medical regulations	50	18.18
	Overmedical	21	7.64
	Defects in medicines and equipment	1	0.36
	Have a bad attitude	57	20.73
Patient	Expectations are too high	17	6.18
	Cost issue	8	2.9
	Driven by profit	8	2.9
	Dissatisfied with the service quality	29	10.55
Other	Accident	3	1.09
	Bad media reports	7	2.55
	Other bad conditions	5	1.82

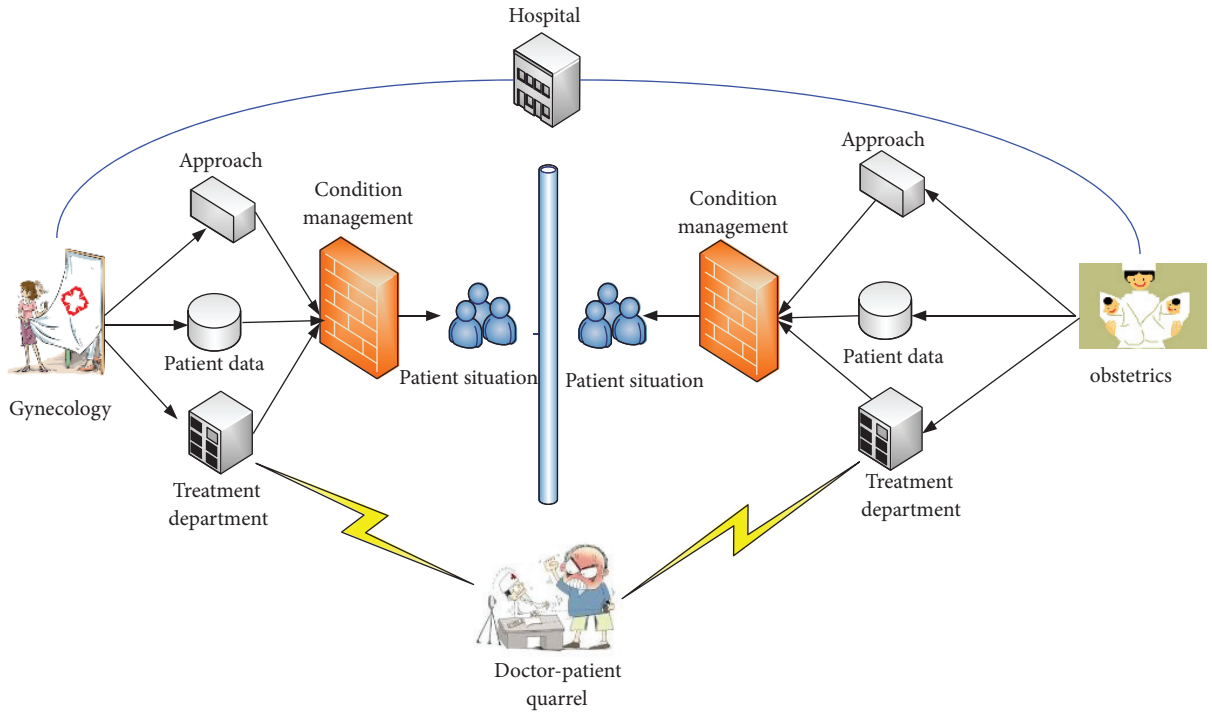


FIGURE 1: Medical care interruption process.

$$N(t, x) = \sum_{i=1}^n 1\{(X_i \in S_x(t))\}. \quad (1)$$

Since the process can approximate the binomial process without considering the influence, the likelihood function expression form of the Poisson process can be established as

$$\lambda(t) \approx f(x)V(m)mt^{m-1}. \quad (2)$$

We take the logarithm and get the logarithmic form of the likelihood function sorting as

$$L(m, \theta) = \int_0^R \lg \lambda(t) dN(t) - \int_0^R \lambda(t) dt. \quad (3)$$

Let  $(\partial L / \partial \theta) = 0$ ,  $(\partial L / \partial m) = 0$ ; we can get the likelihood equations as

$$\frac{\partial L}{\partial \theta} = \int_0^R dN(t) \int_0^R \lambda(t) dt = N(R) - e^\theta V(m)R = 0, \quad (4)$$

$$\frac{\partial L}{\partial m} = \left( \frac{1}{m} + \frac{V'(m)}{V(m)} \right) N(R) + \int_0^R \lg t dN(t) - e^\theta V(m), \quad (5)$$

$$\hat{m}_r(x) = \left[ \frac{1}{N(R, x)} \sum_{j=1}^{N(R, x)} \lg \frac{R}{T_j(x)} \right]^{-1}, \quad (6)$$

where  $T_j(x)$  represents the neighbors; the distance to the  $j$  nearest neighbor  $x$  is arranged from near to far. In actual calculations, since  $k$  is easier to calculate the number of neighbors than  $R$  with a fixed sphere radius, the formula can be rewritten as

$$\hat{m}_r(x) = \left[ \frac{1}{k-1} \sum_{j=1}^{k-1} k \lg \frac{T_x(x)}{T_j(x)} \right]^{-1}. \quad (7)$$

Radial coordinates are one of the common multidimensional data visualization techniques [30]. It expresses the relationship between characteristic space attributes and target space mapping points based on the principle of spring force balance. The core idea is to map multidimensional data to a point in the unit circle of two-dimensional space. The coordinate position of "anchor point" is computed as

$$\text{position}(V_i) = \left( \cos \frac{2\pi i}{M}, \sin \frac{2\pi i}{M} \right). \quad (8)$$

To ensure that the mapped point is in the unit circle, the data item must be normalized. Then, the coordinate position of the mapping point can be computed as

$$S_{ij} = \frac{x_{ij} - \min(x_{kj})}{\max(x_{kj}) - \min(x_{kj})}. \quad (9)$$

$$\text{positon}(xi) = \left( \sum_{k=1}^M \frac{S_{ik} \cos(2k\pi/M)}{\sum_{k=1}^M S_{ik}} \right). \quad (10)$$

The mapping performance is defined according to the intraclass aggregation degree of data points in radial coordinates and the interclass separation degree between different classes. The intraclass aggregation degree  $S_G$  is defined as

$$S_G = \frac{1}{n} \sum_{i=1}^c n_i (\mu_i - \mu) (\mu_i - \mu)^T. \quad (11)$$

The  $S_S$  degree of separation between classes is defined as

$$S_S = \frac{1}{n} \sum_{i=1}^c \sum_{j=1}^{n_j} (x_{ij} - \mu_i) (x_{ij} - \mu_i), \quad (12)$$

where  $n$  is the total number of data points in the dataset,  $c$  is the number of categories in the dataset,  $n_i$  is the number of samples contained in the label class, and the mapping value of the sample on the radial coordinate is

$$\mu = \frac{1}{n} \sum_{i=1}^c \sum_{j=1}^{n_j} x_{ij}. \quad (13)$$

Radial coordinates can be a good visualization of multidimensional static data. Aiming at the dynamic change of streaming data, we designed a visualization scheme, making

the visualization method of radial coordinates suitable for streaming data.

### 3. Nursing Interruption Experiment and Results

**3.1. Obstetrics and Gynecology.** Obstetrics and gynecology are medical subjects that emphasize two different aspects of the female reproductive system. Obstetrics deals with the care of the pregnant women, the unborn baby, labor and delivery, and the immediate period following childbirth. Gynecology is associated with any disease concerning the reproductive organs: uterus, fallopian tubes, cervix, ovaries, and vagina.

After obtaining consent, we conducted a questionnaire survey on the nursing staff of the obstetrics and gynecology department of the first hospital in the city and then collected the survey results and handed them over to expert analysts for analysis. All experts were experienced and had rich and solid experience in obstetric nursing. They also possessed specific scientific research abilities and were familiar with the research content. We evaluated all the results in terms of the degree of authority for each expert. The degree of authority for an expert is the average value of the three values, that is, the sum of professional level, familiarity, and judgment basis divided by 3. The overall authority of experts is the sum of the authority of each expert divided by the number of experts. The specific results in terms of the degree of authority are shown in Table 2.

We completed two rounds of an expert consultation. It can be seen from Table 2 that, after two rounds of expert consultation, the overall authority coefficient of experts was obtained. We obtained the overall authority coefficient of 0.83 in the first round and 0.89 in the second round, and both rounds of expert authority coefficients were  $>0.80$ , which shows that the experts participating in this study are highly authoritative.

After two rounds of expert consultation, the mean value of the content importance score of each item of maternal postpartum care needs was 4.00~4.92, the agreement rate was 93.2%~100%, and the coefficient of variation was 5.63%~18.63%. In the two rounds of expert consultation in this study, the coordination coefficients of experts were 0.197 and 0.215, respectively. The significance test of the coordination coefficient is  $P < 0.05$ , which shows that the difference is statistically significant. It confirms that the expert opinions are well coordinated and the criteria for judging the item system are more consistent. The results of the two rounds are shown in Table 3.

For data collection, a total of 260 questionnaires were distributed among individuals, and 252 valid questionnaires were returned. The general demographic data and survey objects are shown in Table 4.

We computed the correlation coefficient between the items in the questionnaire and the total score of the scale. Correlation analysis between the items in the questionnaire and the total score shows that the correlation coefficients between the items in the questionnaire and the total score of the scale are all

TABLE 2: Expert judgment basis and influence.

Judgments base	Influence level		
	Big	Medium	Small
Work experience judgment	0.5	0.4	0.3
Theoretical knowledge analysis	0.3	0.2	0.1
Related domestic and foreign literature	0.1	0.1	0.05
Personal intuition	0.1	0.1	0.05

TABLE 3: Expert coordination coefficient.

Rounds	Coordination coefficient	Degree of freedom	Chi-square value	<i>P</i>
First round	0.196	45	121.64	<0.001
Second round	0.204	41	114.54	<0.001

TABLE 4: Composition of obstetrics and gynecology patients.

Project	Group	Number of cases	Composition ratio
Age	20–25	67	26.6
	26–30	104	41.3
	31–35	47	18.7
	≥36	34	13.5
Education	Junior high school and below	25	9.9
	High school	69	27.4
	Junior college	99	39.3
	Bachelor degree and above	59	23.4
Profession	Worker	49	40.8
	Farmer	13	9.5
	Private enterprise	53	5.2
	Public officials	62	24.6
	Personal account	34	13.5

greater than the significant level ( $P > 0.4$ ), reaching a significant level ( $P < 0.001$ ), so these items can be retained. Figure 2 shows the different results in terms of nursing needs, psychological care, ward conditions, and hospital services.

We also analyzed the influencing factors of the postpartum care needs of the parturient. The analysis of variance is used between multiple samples. The *t*-test was used when the variances of the two groups of samples are uniform. *t*-tests are commonly used in statistics and econometrics to establish that the values of two outcomes or variables are different from one another. In this study, we analyzed the age, education level, occupation, family monthly income of patients in obstetrics and gynecology, whether the mother is an only child, and whether the spouse is an only child, etc. An only child is an individual with no siblings, either adopted or biological. The correlation between them is shown in Figure 3.

It can be seen from Figure 3 that, among the listed parameters, the correlation between the patient's age, education level, occupation, and family per capita monthly income is extremely close. The final *t* value is about 0.8, which shows that there is a significant relationship among education level, age, and monthly income of patients.

**3.2. Impact of Nursing Process on Medical Disputes.** To examine the recovery status of patients, we divided the surveyed patients into 3 groups, namely, the nursing process

group, the traditional nursing group, and the nonnursing group. We collected statistics on their physical changes within seven days after treatment and compared the nursing effects of different groups. The comparative results of the three nursing methods are shown in Figure 4.

We also computed statistics on the adaptation status of patients in nursing, as shown in Figure 5. It can be observed that different care groups have a different sense of identity after treatment. Comparing the three different groups for 11 days, it can be seen that the patients after the treatment according to the proposed nursing process obtained the highest degree of sense of identity. After 5 days of nursing, the sense of identity reaches the highest, and then the sense of identity stabilizes.

The patient's sense of identity caused by different nursing methods may lead to the degree of a dispute after the interruption of nursing. Therefore, we have made statistics on disputes in different nursing methods. The results are shown in Figure 6.

It can be seen that the nonnursing group had the largest number of medical disputes, with an average of about 3 disputes per month, while the medical disputes based on the proposed nursing process are significantly reduced; the number of disputes was controlled at about 1, which shows that the emergence of medical disputes can be effectively reduced based on the proposed nursing process. The different medical disputes can also be divided into degrees.

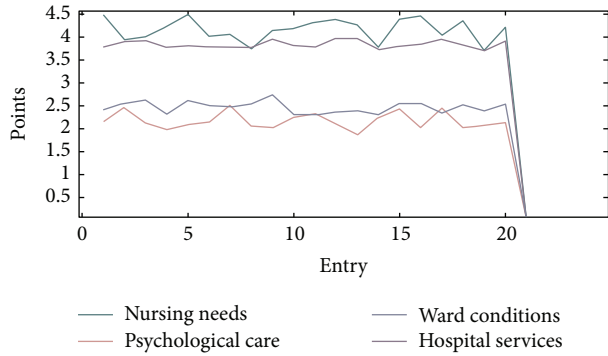


FIGURE 2: Question relevance.

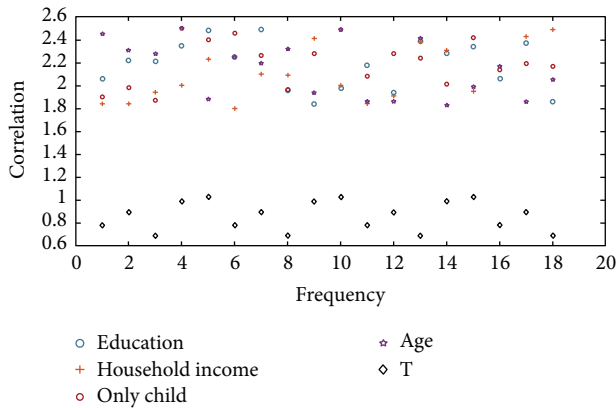


FIGURE 3: Correlation of patient parameters.

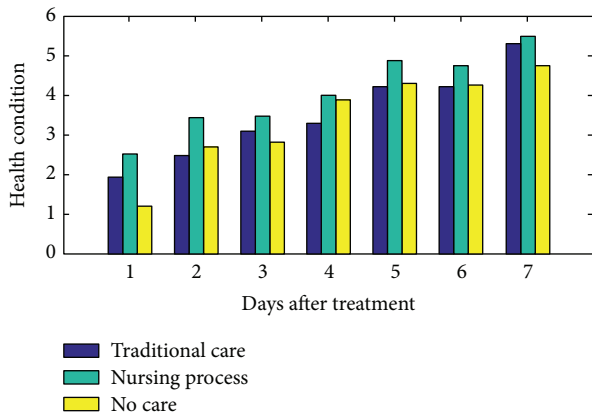


FIGURE 4: Recovery status of different groups.

Therefore, we have computed statistics on different medical disputes, as shown in Figure 7.

It can be observed that, in different groups of nursing care, the severity of nursing disputes varies. Most disputes are mild disputes, accounting for more than 60% of the total disputes, while severe disputes only account for about 10% of the total disputes, but from the perspective of different groups, the number of serious disputes without nursing is higher than the number of disputes based on the proposed nursing process. This has once again verified the significance of this study, which confirms that the present nursing process can effectively reduce and alleviate nursing disputes.

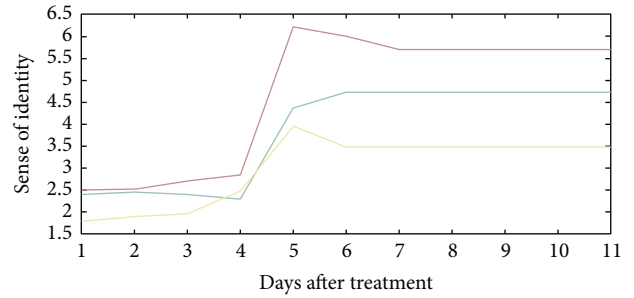


FIGURE 5: Patient's adaptation in nursing.

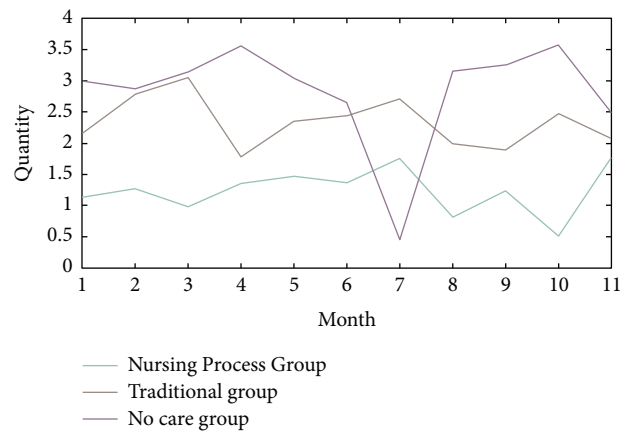


FIGURE 6: The number of medical disputes in different groups.

### 4. Discussion

Work interruptions are a common and frequently occurring public problem during the nursing medication administration process in hospitals, usually harming patients' safety and outcome, employees' well-being and performance, and hospital resources. In a hospital, nursing staff and organization managers are the main contributors to care interruption events, followed by patient and family factors. Therefore, from the perspective of organization and management, it is necessary to promote scientific and standardized work procedures, improve work and information system construction, and at the same time strengthen the training and assessment of nursing staff. It is essential to create a full-time job, provide nurses flexibility, and check the nursing process. Interruption of care events provides a better understanding of interruption of care events. For the nursing staff, the ability and overall quality of nurses to cope with the interruption of nursing care are improved, the attention of nurses is improved, and interference is reduced. In a healthcare institute, it is vital to provide health knowledge and education to patients and nursing staff, and at the same time let patients and their families understand and cooperate to stop nursing. Nurses have often rest breaks in a few hours, which increases the risk of error. The survey

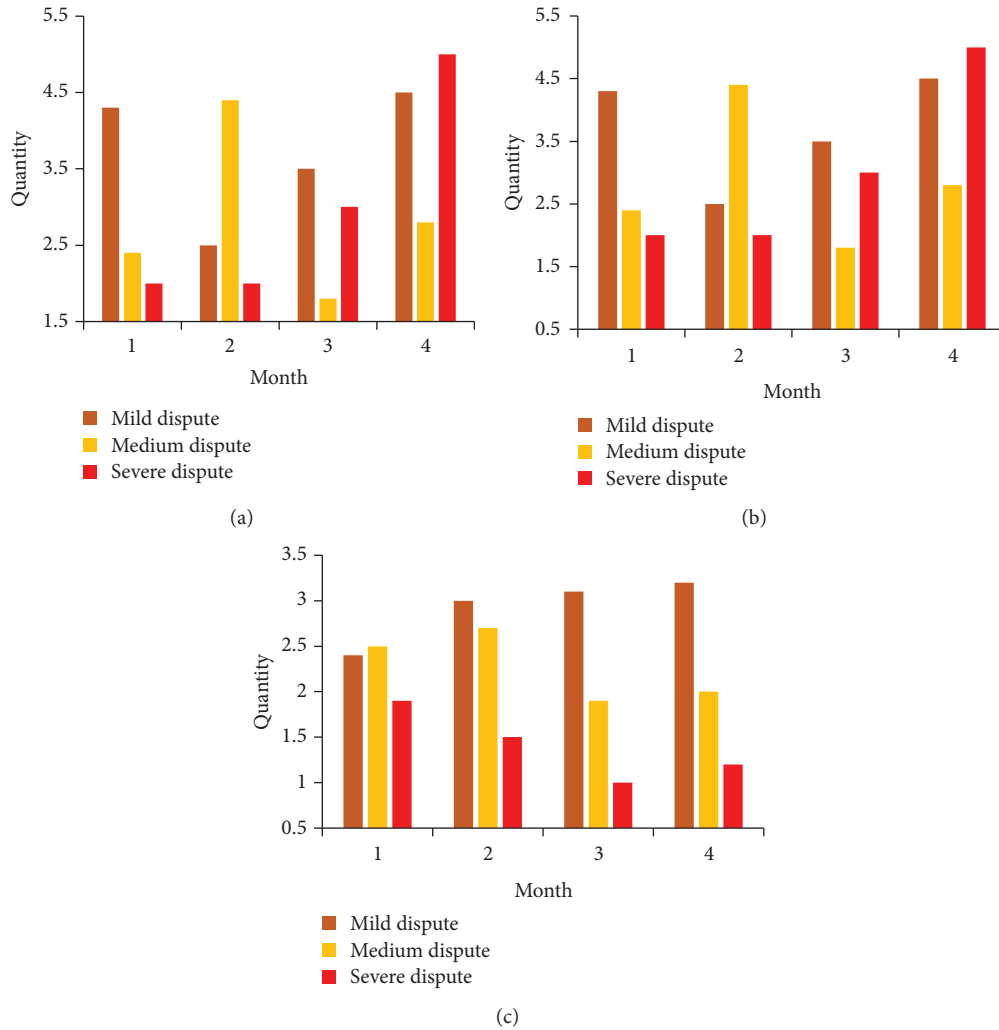


FIGURE 7: Degree of nursing disputes in different groups. (a) Nonnursing group. (b) Traditional care group. (c) Nursing process group.

results found that day-night shifts often occur in hospitals. The night shift is the peak time for breastfeeding interruptions and is related to a small number of nurses. The research in this study shows that there is little difference in the proportion of nurses who control the peak time of interruption of care, and attention should be paid to each peak period. During peak periods, it is necessary to improve link and process management, reduce interference and interruptions in critical periods, and increase the time for feedback and information exchange.

As working hours and professional qualifications increase, the risk assessment of care interruption decreases. Nurses get the highest scores in five years of work. Young nurses do not respond well to risk assessment and interruption of care. There is a certain gap between low-skilled nurses and high-quality nurses in terms of knowledge base, professional quality and level, and clinical experience. In addition, their response to interruption of care and their ability to understand it depends on their own clinical and emergency experience. Highly qualified nurses can optimize nursing breaks that may adversely affect them.

With the improvement of nurses' educational background, the scores of nursing interruption risk assessment showed an upward trend, and there was no statistical difference. The education level of nurses affects nursing leave. Nurses with low levels of education make more mistakes when taking vacations. The premise of improving vacation management skills is to improve the professional level of nurses. However, the development of postgraduate education in China has been slow. Most nursing graduate programs are mainly based on nursing education and scientific research. The clinical workability is weak, and the risk management ability is insufficient. In this study, there was no statistically significant difference in the scores of discontinuation risk assessment among nurses of different educational backgrounds. The possible reason is that, overall, undergraduate nurses account for 91.4%, which is relatively high. This may be related to a lack of university or graduate education. It may also be related to primary medical institutions. Nurses need to adhere to the review process and maintain a high sense of responsibility in the workplace.



When an individual's consciousness or attitude changes, it can control the behavior. We also compared the training team scores, management organizational factors, and nursing staff factors with non-participating teams, showing that the differences are statistically significant. Current nurses, whether in school or pre-employment training, may not have received training on the safety risks of nursing leave or may not be particularly involved in managing the quality of care. Due to the lack of training, the risk of interrupting care has not been proven, it is impossible to distinguish errors from mistakes, and therefore it cannot be applied to early work. It is necessary to strengthen education on the adverse effects of nursing interruption events, attract attention, and improve nurses' awareness and ability to respond to nursing interruption events.

## 5. Conclusion

Medical disputes are a serious social contradiction at this stage all over the world, and the social problems it brings are worth pondering. This study investigated the important role of nurses as educators, promoters, and psychological supporters, clarified the importance of nurses' work, and effectively promoted the improvement of nursing service quality. The patients were divided into different groups and treated with different nursing methods. The correlation between nursing methods and disputes in different groups was computed. The results showed that the medical disputes caused by the interruption of nursing can be effectively reduced. Compared with traditional nursing methods, when the proposed nursing procedures are followed, the dispute rate is reduced by more than 10%, and its possibility of occurrence by 15%. The outcomes of this study can play an effective role in preventing obstetrics and gynecology nursing disputes. The proposed analysis cannot fully explain the reasons that affect the differences in the risk assessment of nursing interruption events by nursing staff. In future work, the scale will be adjusted and revised. The next step will continue to focus on nursing interruption research and continue to collect and improve data.

## Data Availability

The data used to support the findings of this study are included in the article.

## Conflicts of Interest

The authors declare that there are no conflicts of interest.

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