

Quality Improvement Activity

A patient was being admitted to the hospital on a medical-surgical floor due to complications from an NSTEMI. Once on the floor, this patient had expressed that they were upset and confused. We then asked the patient why he was upset and he told us that down in the Emergency Department that he was going to be admitted to the ICU for close observation and that he was indeed not in the ICU. Later into his stay with us, he was NPO after midnight for a procedure but the patient had not been told about the procedure or anything. Come the morning of procedure, none of the doctors were agreeing with what to do. In establishing trust, the patient told us that one doctor told him there was nothing that they could do for him, another doctor told him he was going to Cath Lab for exploration of the arteries of the heart, and another doctor was discharging him home that day. When the nurses were talking to the doctors, they all still couldn't agree with what to do. By them not agreeing on what to do, they were stressing the patient out and not making nursing staff nervous because no one seem to know how to treat the patient. As the patient was getting more frustrated he was becoming violent towards the nursing staff. Once the patient was labeled verbally violent, the nursing staff was scared to go into the room alone because no one knew how he would react or what would be said. The patient then started to threaten to fire the nursing staff because he believed it was our fault and that the nurses are the ones who make decisions on patient care. When the issue was brought up from the charge nurse, primary RN, and the director of the unit, the doctors then decided it was time to sit down and consult with one another of what to do. This took the doctors a few day as they still had other patients to see and the charts to go through for this patient. Unfortunately, by the time that the doctors came up with a plan of care together, the patient left against medical advice and there was no changing his mind.

Describe the scenario. In what way did the patient care or the environment lack? Is this a common occurrence?

In the scenario, none of the doctors caring for this patient could agree on how to treat him and what care they were going to provide to him. The doctors failed to recognize that none of them knew what to do and they also failed to realize that they had told the nursing staff different things of what were going on. Once the RN addressed the diet with the doctor who ordered it, he then realized that he had not told anyone way he was doing it and what it was being done for. During this, patient cared lacked because no one knew what was going on or what was going to happen. The patient had been told many things that were going to happen but when brought up to the nursing staff, they did not know how to respond because they were not sure as well. I believe that this is a common occurrence as many doctors do not know how to agree on what to do. They each think that they have the better decision than the other.

What circumstances led to the occurrence?

It was a late night admission and there were multiple doctors handling the care of this patient and none of them had sat down together to decided what was best for the patient.

These doctors also had not attended any of the huddle meetings with the nursing staff to determine a plan of care or had the time to talk amongst one another. These doctors also did not take the time to look at the other notes that the other doctors had made or what they thought what the plan of care should be. This ultimately led the patient to wanting to leave AMA.

In what way could you measure the frequency of the occurrence?

We can track the documentation of the doctors and the progress notes that had been made and to see if any of them agreed with a course of treatment or if they were all independent plans of care. We can also track the HCAHPS scores for communication with doctors and look at the results month to month and determine what needs to be done to fix it and raise the scores.

What ideas do you have for implementing interventions to address the problem?

I believe that when administration goes around to round on the patients on the floor instead of asking about the nursing care they are receiving, they can also include how the communication is with the doctor and determine where it is lacking and how they can also help solve the problem. The issue also shouldn't go for a long period of time and needs to be addressed immediately to improve care for all patients. There should also be a daily huddle with everyone that is caring for this patient so that everyone will be on the same page for the patients well being.

How will you measure the efficacy of the interventions?

Patients that are being cared for by multiple doctors will be able to put that communication was good with the doctors on the HCAHPS questions and there will be an increase of score of the scores. Each patient will also be able to tell nursing staff what the doctor as decided to do for patient care. The nurse will also make it their responsibility that there is a common ground between all doctors and that there is a huddle to discuss plan of care.