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Quality Improvement Activity: Interdisciplinary Orders

On November 26th, 2020 a 32-year-old female was admitted to the emergency department after accidently spilling scolding hot coffee on her neck and chest while driving to work. She received second-degree burns over 9 percent of her body and her neck is blistered. At the admission assessment, the patient was alert and oriented to person, place, and time. The patient's weight was 89 kilograms, heart rate 110, blood pressure 109/92, oral temperature 99 degrees Fahrenheit, oxygen saturation 95% on non-breathing mask 10L/min, and 30 respirations per minute. The patient's blood glucose level was within normal limits. The patient has no known allergies and no medical history. After checking the vitals, the total patient care nurse admits two new patients that were involved in a motor vehicle accident. The nurse forgets to look for any signs of airway obstruction or listen for breath sounds. The patient hits the call light button and ask for pain medication. The nurse places an order for pain medication. While talking to the doctor she fails to mention the status of the patient because she is overwhelmed with her new patients. The doctor is also distracted and didn't ask about the patient's status. Once the nurse finished the call with the doctor, she was met by the wound care nurse who had assessed the patients burns and noted that she was in pain from the inflammation and swelling. After getting the report, the total patient care nurse was called to the MVA patients' rooms and forgot to chart the change in status of the burn patient. As time went on fluids continued to shift around the patients burns and the swelling around their throat increased. This swelling increased to the point that it shut off the patient's airway and led to a code. Unfortunately, because of the swelling the rapid response team was unable to start an artificial airway, CPR efforts were not effective, and the patient passed away.

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

- From the very beginning the nurse did not prioritize her time to fully assess her patient from top to bottom which led to the patient dying. She failed at properly assessing her patient who was at risk for obstruction due to swelling. Airway and pain should always be the number one top priority when assessing a patient. She also failed at checking the updated status of the patient from the wound care nurse and the order for pain medication. Regardless of how busy or overwhelmed the nurse was she failed at communication and taking the time to read an order.
- Unfortunately, many nurses in critical care settings tend to get overwhelmed and make simple mistakes which lead to death.

What circumstances led to the occurrence?

The circumstance that directly led to this occurrence was poor communication and the nurse thought she was too busy to properly assess the patient from top to bottom and failed to read a simple order which lead to the patient dying.

In what way could you measure the frequency of the occurrence? (interviewing nurses, examining charts, patient surveys, observation, etc)

The frequency of not assessing and communicating a patient's status can be measured in many ways: interviewing the interdisciplinary team involved, checking documentation from all parties involved, reviewing incident reports, and reviewing previous route cause analysis from similar incidents. Evidence shows that critical patients should be monitored at frequent regular intervals to asses for changes in their status.

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

Implementing protocols that require and incentivize nurses to increase promptness and accuracy of nursing assessments. This will persuade nurses to be more proactive in their patients care.

- There should be an admitting nurse that can place the patient in the room and do an initial assessment to report to the main nurse if they are busy with another patient.
- Initiate multiple q30 minute reports between the doctor and nurse to verify the patient's status.
- Initiate an incentive protocol that pays nurses based on promptness of reporting, patient outcomes, and advocacy for their patients

How will you measure the efficacy of the interventions?

Measuring the efficacy of interventions can be done by reviewing patient outcome reports, incident reports, and causes for patient demise.