Madison Rios
Jamie Stone

QI: Collaboration with Healthcare Team Members

Scenario: On June 29, 2020 a 91-year-old male was moved from an acute care hospital to a skilled nursing unit at a local hospital to receive wound care from a specialist and to be given IV antibiotics for MRSA osteomyelitis of the heel. The patient was getting IV vancomycin and started passing frequent, large stools that occurred with urgency.

At the local hospital, the doctor ordered a lab test for C. Diff on Thursday and took the rest of the week off. Later that night at 2100, the lab results came back positive for C. Diff. Infection control was called by the laboratory, who relayed the message to a nurse floating the unit. Upon seeing the patient, the nurse saw that the patient was already getting vancomycin and assumed that someone on the regular nursing staff had called the lab results in to the doctor, who then placed the medication order to treat the C. Diff.

The dutiful float nurse placed isolation signs on the patient's door, wrote the note of the result in the chart, and finished her float shift. None of the nurses assigned to this patient over the weekend questioned the patient's care until Monday morning when the next nurse who was assigned this patient received report and began to review his assignments and build his task list for the day. When he saw that the patient was receiving IV vancomycin instead of oral vancomycin, which he knew is used to treat C. Diff., he began to look further into the chart and discovered that the IV vancomycin was being given to treat MRSA osteomyelitis, not C. Diff. He then realized that there was no charting done on the doctor being notified of the initial lab results.

This nurse called the doctor and asked him to come round on the patient as soon as possible. When assessing the patient, the doctor noticed the isolation signs immediately and questioned the nurse on the lab results. It was determined that the float nurse wrongfully assumed that the doctor had been notified of the test results and gave the wrong information in report.

Due to the lack of communication between healthcare team members, this patient went the whole weekend without the proper treatment for C. Diff. that he deserved. Because the patient is elderly, this incident, the loss of fluid and electrolytes, and this amount of GI disturbance ultimately played a key role in the decline of his health, lengthened his hospital stay, and cost him more money.

Questions:

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

   In this scenario, the patient, a 91year old male, was transferred to the unit for wound care and IV vancomycin for MRSA. When the patient began to have frequent large stools, the attending physician ordered a test for C.diff on Thursday before he left for an extended weekend. The positive C.diff results were reported to infection control who then reported the results to the float nurse. The float nurse saw that the patient was already receiving vancomycin and assumed the physician had been notified of the results. It wasn't until the nurse that had experience on this unit noticed that the patient was receiving IV vancomycin instead of PO vancomycin (required for C.diff), that the physician was notified. The patient's C.diff went untreated for four days which not only lengthened his hospital stay and increased cost, but also was life threatening.
   After talking with several nurses, I learned that communication failures are common,

especially when nurses are unfamiliar with a unit's protocol or when the healthcare members are overwhelmed with their workload and understaffed and fatigued.

2. **What circumstances led to the occurrence?**
    a. *a floating nurse* - Being a float nurse can be difficult as this nurse is tasked with being on a floor he or she are not used to and perhaps taking care of patients that they are not equipped to handle.
    b. *wrong information being given* - When she gave report, she stated that the doctor was notified, as that is what she assumed, and that he had ordered vancomycin to treat the infection, both of which were false.
    c. *lack of follow up* - If the doctor had, even on his days off, realized that he had not been notified of any results, he could have followed up and the patient could have been treated that much faster.
    d. *lack of communication* - The lack of communication played a major part in the neglect of this patient. If the first nurse had asked why the patient was receiving IV vancomycin to begin with, she would have noted that it was being used to treat MRSA. If the first nurse had spoken up and verified that someone on the regular nursing staff had called the doctor, this could have been avoided.
3. **In what way could you measure the frequency of the occurrence?**
    To measure the frequency of this type of miscommunication, all aspects of the healthcare team would need to evaluate and observe patient care and patient charts to identify circumstances where adequate care was delayed or neglected. Patient surveys would also be helpful to identify the areas in which quality care was lacking.
4. **What evidence-based ideas do you have for implementing interventions to address the problem?**
    a. *The physician* is responsible for following up on any lab results that he ordered, but he failed to do so. It could have been due to fatigue or distraction, but this mistake could have been avoided if he had a "to-do" list or follow up list as a reminder before signing out.
    b. *Float nurses* often have an added challenge with not being fully oriented or educated on protocols for different units and the disease processes that are common to those units. It would be helpful to have a quick reference sheet to help identify critical lab values and protocols specific to each unit.
    c. *A standard protocol* for communicating critical lab values should be explained as well as proper documentation of the physician notification. Every caregiver should be able to look at the patient records and know, not assume, that the physician has been notified.
    d. *The hospital* should strive and cultivate a culture that encourages effective communication. Team members should be free to question each other and hold one another accountable for errors in a supportive and non-threatening way.

5. **How will you measure the efficacy of the interventions?**
    a. *patient surveys* – this will allow the patient to provide feedback and report whether or not they witnessed active communication happening between coworkers.
    b. *Reviewing patient charts* – documentation of a patient's care gives us a picture of the quality and efficacy of the treatments provided and reporting discrepancies

when they are found would help us to evaluate the benefit of the new interventions.

c. *Interviewing and observing staff* - if the facility has been effective in creating a positive communicating environment and if they have educated the staff of the new standards, then the team members would feel safe to evaluate themselves and their peers to assess the unit's progress in eliminating preventable communication errors.