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Quality Improvement Activity: Interdisciplinary Orders

A patient arrived at the Emergency Department presenting with kussmaul's respirations, "fruity" breath, and complaints of nausea and abdominal pain. The patient reports that they are constantly thirsty and have been losing weight despite eating. The patient was taken back to a room, where the emergency nurse connected the patient to the monitors, started an IV, and obtained labs along with a serum glucose. The patient's serum glucose was 350 mg/dL. On further investigation it was revealed that the patient is a type 1 diabetic, that had an infection the previous week and has not taken their prescribed antibiotics. The patient's urine was positive for ketones and serum labs revealed acidosis. The emergency room doctor diagnosed the patient with Diabetic Ketoacidosis and proceeded with verbal orders. The physician told the nurse to administer a normal saline bolus, and to give regular insulin intravenously. The nurse did not read back the order to the physician and believed the physician ordered the insulin to be given by intravenous push. The nurse entered in the orders into the patient's chart and went to grab the medications. Before administration, the nurse did not verify the medication with another nurse and instead just asked a colleague to sign quick while they had a moment. Instead of grabbing a pump, the nurse hung the normal saline wide open to gravity and pushed regular insulin into the proximal port. About thirty minutes later, the nurse went to check back in on the patient. The patient was diaphoretic, confused, tachycardic, and had slurred speech. The nurse checked the patient's blood glucose, and it was 45 mg/dL. The nurse recognized that the patient was experiencing hypoglycemia. The nurse then under the standing orders, administered D50W and reported the event to the physician. The nurse then recognized their mistake, that they pushed the insulin in a hurry, and it caused overtreatment of the patient's condition by giving the insulin too rapidly. The patient remained in the emergency department until their blood glucose was stabilized and they could be transferred.

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

One way in which the patient care environment lacked is the nature of the emergency department. Nurses at one time can be taking care of 1-4 critical patients and are prioritizing care to the best of their ability. Due to this fast environment, things are done to cut down the time it takes to do things. The way this was done is the use of verbal orders, not getting a nurse to properly double check the insulin and having no check and balance system to make sure the nurse entered the order correctly. Physicians are an important member of the interdisciplinary team and are too trying to save time. In the hope to be more efficient, the quality of care was compromised. When I first went to the emergency department, I was shocked that the nurses were allowed to enter in the chart the orders the physician gave to them. With that being said, verbal orders have a place in the emergency department, with critical situations with everyone is the room there may not be time for the physician to enter the orders when they need something right away. That is why there needs to be a system to verify that they are inputted correctly and eliminate human error. Even if the occurrence is minimal, it occurring at all should prevented

and safeguards should be put in place to protect the patient, nurse, and the rest of the interdisciplinary team.

What circumstances led to the occurrence?

One of the circumstances that led to this occurrence is the emergency nurse was taking care of three other critical patients at that time and did not take the necessary amount of time to verify that the verbal order from the physician was correct. The emergency room nurse also did not get the insulin double checked by another nurse in which the mistake would have been caught. The other nurse that "verified" the medication should have asked the nurse to show them the medication before signing. Another circumstance that may have contributed is the physicians use of a verbal order, rather than entering it into the electronic medication administration record. This would have prevented the nurse from inputting the misheard verbal order.

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

The frequency of this occurrence could be measured by examining incidence reports and examining patient charts. Verbal orders from physicians are a very common in the emergency department and the nurse is then responsible for entering them into the electronic medication administration record. The incidence reports would provide insight not only into nurses accidently entering insulin orders wrong but other medications being entered incorrectly as well that result in patient harm. The patient's chart would reveal these incorrect orders and the frequency that they are occurring.

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

The first and easiest intervention that would address this problem is, having the nurse repeat the verbal order back to the physician. Similar to what the standing procedure is from telephone orders.

-The physician would give the nurse a verbal order(s)

-The nurse would then, read back the order to the physician, before entering the order into the patient's chart.

This could be further improved by also requiring another nurse to be present for this interaction. That way the other nurse could witness and verify the correct order from the physician too. Another intervention that could be put into place is once the nurse enters the verbal order into the chart, it must be verified by the physician before the nurse is able to access the medication from the pyxis.

-The physician would give the nurse a verbal order(s)

-The nurse would then alongside the presence of another nurse, read back the order to the physician, before entering the order into the patient's chart.

-Once the nurse has entered it, the physician would be required to verify the order before it can be pulled and administered.

How will you measure the efficacy of the interventions?

The efficacy of the interventions could be measured by examining the number or verbal orders given, and the subsequent results of them. If no incident reports follow a case in which a verbal order was given, then the interventions would be therefore, successful.