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Quality Improvement Activity: Care transition from ICU to Telemetry Unit

This is the case of a 63-year-old male, who, on December 6, 2020, presented to the Emergency Department with chest tightening and diaphoresis. He was seen and admitted for stat Coronary Artery Bypass. The patient has a history of hypertension, Type II Diabetes Mellitus and cardiovascular disease. After all laboratories and diagnostic modalities done, he was cleared for surgery by his cardiologist and the cardiothoracic team performing the surgery. The surgery was successful and uneventful. The patient was transferred back to the Surgical Intensive Care Unit for monitoring for any post op complications. One day post op, the hospitalist assessed the patient and suggested to the cardiologist and thoracovascular surgeon that the patient is stable enough to be transferred to the telemetry unit. The pandemic is making it hard for SICU to keep patients longer than they should because a lot of Covid patients are needing ICU beds as well. Three days post-op at the telemetry unit, the patient's vital signs started to become unstable and he has become febrile. Upon assessment of the patient, it was observed that the surgical site was inflamed, warm to touch and showing signs of infection. Upon further investigation, it was noted that the post op antibiotic medication was not continued and administered at the Telemetry unit.

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

The telemetry unit nurse failed to give the post op antibiotic to the patient thus resulting to infection. The nurse in charge failed to deliver proper patient care by omitting to carry out the prescribed antibiotic to this patient. This is not a common occurrence. The pandemic has ben causing a chaotic environment for both staff and patients but this is not an excuse to deliver sup-par patient care compromising patient safety.

What circumstances led to the occurrence?

The busy and increased nurse to patient ratio lead to the occurrence of the scenario. The pandemic undoubtedly is creating a negative impact on delivery of patient care. The nurses are worn out and everybody are just thinking of not getting infected. The failure of the telemetry nurse to double check chart orders is also something that needs to be addressed, as well.

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

The frequency of occurrence of the premature transfer of critical patients to a step-down unit or med-surg floor could be measured in a number of ways: interviewing nurses, reviewing incident reports, and reviewing the average length of hospital stays in relation to readmissions to critical care floors or even reviewing the morbidity and mortality census.

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

It is important for nurses to always double check the chart for physician orders especially any new medications. I have seen nurses not doing a thorough chart check or documentation. Most of the time, they rely on hand-off report. For this reason, errors may also be handed off. In this particular case, if the SICU nurse failed to mention the post op antibiotic but the Telemetry nurse should have double checked the EMR for other medications.
To address these problems, they can make a checkoff list for important tasks to be done and vital information to be reported. The endorsing nurse should do a detailed bedside report to the nurse that they are transferring the care of the patient to. In cases of increasing number of patients, additional staff should be provided to ensure quality care if needed.

How will you measure the efficacy of the interventions?

The efficacy of these interventions can be done by noting the number of readmissions to ICU from Telemetry or other stepdown units after implementing proper hand off and other nursing protocols.