Brenda Romero

Quality Improvement Activity: Stroke Protocol

On October 31, 2021, the Emergency Department gets a call from EMS on route with a patient showing signs of a stroke with the last known normal approximately 2 hours ago. As soon as the patient arrived on the unit multiple nursing staff surrounded the patient in an effort to expedite care. A Stroke assessment was performed rapidly. The patient was exhibiting confusion, unilateral facial droop, loss of balance, right sided weakness. After assessment of the physician, orders were verbally made to obtain blood samples, IV access, and a CT scan. Without communication multiple nurses worked on the tasks, one nurse placed an 18-gauge IV catheter on the patients left forearm, another placed EKG leads on the patient's chest and immediately connected her to a portable monitor, another nurse called ahead to alert CT of the incoming patient. The primary nurse assumed everything was performed so she rushed the patient to CT with 2 other nurses that helped transfer the patient off the stretcher and onto the CT bed. The technician quickly positioned the patient as required for the scan and connected the contrast to the IV line that was placed in the left arm. Once all was prepped the technician joined the nurses behind the window to begin the scan. The patient was told to hold still, and all went smoothly for the scan. The nurses transferred the patient back to the stretcher and rolled her back to the unit where her room was assigned and prepped for her by another nurse while they were in CT. After getting the patient settled in the room, the primary nurse retuned to her desk where she awaited further orders from the physician. The scan was being read and the nurse was chatting with others at her computer. After reading the scan the physician confirms an ischemic stroke and would like to begin the treatment with Tissue Plasminogen Activator (tPA). The nurse is made aware this medication must be given within 3 hours of the last known normal, and at this point the patient is at 2 and a half hours, so well within the window. Before the medication is given the physician must check the current lab work for clotting factors, but there are no updated lab values in the computer. The nurse asked everyone who was helping on intake of the patient, but nobody collected the lab work that was ordered by the physician. The nurse had to quickly draw labs and treatment was delayed until results were obtained.

1. Describe the scenario. In what way did the patient care or environment lack? Is this a common occurrence?
    a. In the scenario, the patient was taken to the emergency room for what appeared to be a stroke. When the patient arrived, there was chaos and little organization and communication with the nursing staff. The physician made verbal requests and since there were so many nurses, they assumed someone else would be checking off that everything was completed. The emergency room is chaotic already but without communication and leadership, mistakes tend to happen. I feel like things like this are common because of how busy the unit gets.
2. What circumstances led to the occurrence?
    a. What led to the occurrence was the staff not communicating what duties they were performing and the primary nurse not double checking what had been done. She just assumed someone else had drew blood because there were so many people. The fact that the patient was emergent, and the nurse was so concerned with getting her to CT also contributed to the mistakes.
3. In what way could you measure the frequency of the occurrence? (Interviewing nurses, examining charts, patient surveys, observation, etc.)

    a. To measure the frequency of this occurrence the nurse educators could keep record of when tasks are missed due to miscommunication. Interviewing the nurses on the unit could also be used.
4. What Evidence based ideas do you have for implementing interventions to address the problem?
    a. I think to prevent mistakes like this, the unit could have a checklist for emergencies like this. For example, an emergency comes in and the physician checks what labs or tasks they would like performed and hands it to the primary nurse. The primary nurse then completes each task or delegates the task to another nurse and checks them off as well as they are completed. This way protocol is done in an organized manner with written proof of each assignment done.
5. How will you measure the efficacy of the interventions?
    a. At the end of each week a meeting can be held with the nurses to track the efficacy of the checklist. The nurses can give their input on whether mistakes are being minimized when it comes to emergencies like strokes.