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Quality Improvement Activity: Transporting ventilated and with vasopressor gtts, patients to radiology

I was assisting a nurse and respiratory therapist with during the transportation of a patient to radiology. The patient was ventilated and on a norepinephrine drip. We unhooked the patient from all the equipment in the room and placed them on portable monitor. Respiratory hooked the patient up to a portable ventilator machine. The nurse had 2 other patients that also needed a lot of attention as well and did not feel like they were able to trust other nurses to care for the patients in her absence. During my time following the nurse I noticed not many other nurses were eager to help my nurse when she asked for it. While me and the respiratory therapist were getting the patient prepared to for transportation the nurse talked to the charge nurse about her concerns. When she was done, she came into the room, and it appeared we had everything prepared for the transport. We start to head to radiology and in the elevator, we realized that the elevator was not moving, and the doors would not open. Called for assistance and while we were waiting the norepinephrine drip started to beep and we realized that the medication was about to run out. Help was coming but we did not have a clear answer of when we would be able to get out of the elevator or receive a new bag of norepinephrine. Started to cycle the blood every 5 minutes in case there was any change. Luckily, we did not have to wait more than 15 minutes for the elevator to start working and we were able to get the patient to radiology and back to the unit before the norepinephrine ran dry.

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

In the scenario above there was a lot of factors that caused the patient care to lack. The nurse's focus was on the other patients and not the one that was going to radiology. That distraction caused her to not notice that the medication was running low before we left the unit. The elevator not working was out of the nurse's control but would not have been as big of issue if we had everything we needed. The elevator breaking down may not be a common occurrence but not being prepared, forgetting things, and being distracted are a very common issue in healthcare.

What circumstances led to the occurrence?

The fact the nurse did not have a person that would help keep an eye on her patients while gone. The lack of support and trust in the other nurses on the unit caused the nurse to be distracted. That distraction led to not double checking all the equipment and medications prior to leaving the unit. It is important for the unit to work as a team and support each other. In nursing you are independently in charge of your patients, but that doesn't mean you should

feel alone and lack support. Fear of what might happen with the other patients took the attention away from the patient that needed it in that moment.

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

Interviewing the nurses would be the best way to measure the frequency of the occurrence. Asking them often if they feel like the unit is working as a team, or to name a situation where they felt they did not have the support they needed to provide adequate care to their patients. I think that would also give the opportunity to make suggestions of how to improve the teamwork on the unit.

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

Team building exercises could help. Outside of work activities as well such as games, runs for cause, and dinners. This would be to help develop relationships with coworkers and help build a team like unit. The manager also needs to address the issue to each employee involved individually and correct their actions. The primary nurse would need to be corrected on concentration, and focus. The other nurses on the unit would need to correction on being a team player and someone other nurses can depend on.

How will you measure the efficacy of the interventions?

I would measure the efficacy by sending out another interview questionnaire. Ask the opinions of the employees on the floor if they feel like they can go to other nurses on the floor and if we have reached the goals of working like a team. This would not to be a way to “tattle” on another nurse but give people a chance to speak up where the unit is lacking. To avoid a situation where a patient is put at risk because a nurse is overwhelmed, feeling alone, and unable to trust other nurses on the unit.