

QUALITY IMPROVEMENT - CARE TRANSITION FROM ICU TO TELEMETRY UNIT

DESCRIBE THE SCENARIO.

A 52-year-old man was admitted to the cardiac ICU from the emergency department following an episode of ventricular fibrillation. One of the ER nurse's jobs was to complete lab work on the patient. Lab work revealed the patient had low potassium, which was at a level of 2.3. The low potassium is what was suspected to have caused the episode of ventricular fibrillation. After several days of being in the ICU and giving potassium supplements to the patient, they become stable. The patient is now back at normal sinus rhythm and has a maintained potassium level of 3.8. Since the patient became stable, they can transfer to the telemetry unit where they will be closely monitored for any changes. When the ICU was giving report to the telemetry unit nurse, she could tell he was not really paying attention to anything she was saying. She explained the importance of monitoring the patient's heart rhythm and potassium levels. The telemetry nurse taking care of the patient is very tired from working many days in a row and decides to take a long break in the breakroom. The nurse fails to monitor the patient's vitals and keep an eye on the potassium. The patient's potassium level drops to a severely low level of 2.4 and the patient goes into another episode of ventricular fibrillation. When the nurse comes back from break and goes to check on the patient, he sees the patient has no pulse and notices ventricular fibrillation on the ECG. The nurse begins CPR and calls for help. This leads to the patient having to go back to the ICU and delaying discharge.

IN WHAT WAY DID THE PATIENT CARE OR ENVIRONMENT LACK? IS THIS A COMMON OCCURRENCE?

In the scenario above, the patient was admitted to the ICU from the emergency department due to an episode of ventricular fibrillation. After lab work was performed, the results showed that the patient had a low potassium which led to the episode of ventricular fibrillation. The telemetry nurse who was taking care of the patient decided to take a long break because he was tired and left the patient unattended, which then led to another episode of ventricular fibrillation. The patient care was lacking while under the care of the telemetry nurse who was supposed to be monitoring the patient closely. There was also a lack of care when the ICU nurse noticed the telemetry nurse was not paying attention and did not say anything to anyone else. Although the nurse was tired, he should have at least asked another nurse to help watch his patient while he took a break. He also should have not taken such a long break since monitoring the patient is very important. The ICU nurse should have also maybe told the charge nurse about the telemetry unit nurse not really paying attention during report. The failure to properly care for a patient because one is tired usually happens when the nurse works too many days in a row and has a lack of sleep. Being "burnt out," is a common occurrence in healthcare, especially in nursing.

WHAT CIRCUMSTANCE LED TO THIS OCCURRENCE?

The circumstances that led to the occurrence of another episode of ventricular fibrillation was the nurse being very tired, taking a long break, and failing to closely monitor the patient. Close monitoring is especially important since the patient was at risk of going into another episode of ventricular fibrillation if the potassium got to low again, which in this case it did.

IN WHAT WAY COULD YOU MEASURE THE FREQUENCY OF THE OCCURRENCE?

One way to measure how often the nurses are failing to provide quality care is by interviewing them. The charge nurse or manager could interview the nurses and ask them about scheduling and what they feel is safe for them and the patients. The charge nurse or manager could also review the charting that is done by the nurses to see how accurate it is. A charge nurse is responsible for ensuring patient and staff satisfaction and maintaining a safe environment. Therefore, by interviewing nurses, it would provide information about the frequency of this occurrence.

WHAT EVIDENCE-BASED IDEAS DO YOU HAVE FOR IMPLEMENTING INTERVENTIONS TO ADDRESS THE PROBLEM?

Having meetings with nurse staff at least twice a year would be great for this situation. There could be education for the nurses about the importance of sleep. There could also be education about ways to take care of themselves on their days off. The charge nurses could also get together a couple of times out of the year to discuss scheduling of nursing staff and how to ensure safety by making sure the nurses are not getting “burnt out.” It would also be important to educate the nursing staff about speaking up when they feel they are too tired to properly care for a patient and may need the day off. Afterall, patient safety is always number one in healthcare.

HOW WILL YOU MEASURE THE EFFICACY OF THE INTERVENTIONS?

Measuring the efficacy of these interventions can be accomplished by providing surveys to the nursing staff. These surveys can be done on the phone by scanning a QR code that directs the nurses to a few questions. This will let the hospital know just how well the education that is taught in the meetings is being effective.