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Quality Improvement Activity: CVA Protocol- The Use of tPA

A 41-year-old female came into the ED with CVA like signs and symptoms, explaining in vague terms that she experienced a headache and numbness across her face and neck, neck, and arms. The woman had limited English proficiency; however, she would nod yes or to basic communication provided by the staff RN taking her health history. The RN taking her health history was on her fifth consecutive 12-hour shift as she needed the overtime to pay for a house repair expense. Giving the ED is open 24 hours a day, the RN admitting this pt was supposed to be leaving within the next 30 minutes and was indeed desperate to catch up on much needed sleep. During the pt interview, English for the pt was slim to none, and instead of calling for additional resources to translate the conversation, the RN decided to “wing it”, and gather as much health history from this pt’s CVA symptoms with simple yes or no questions. The pt simply smiled and answered yes to most questions, including the onset of symptoms which the RN noted as now, when in fact the CVA symptoms started yesterday. Already rushed to leave the ED, the RN inputs all the data within the EHR, officially admitting the pt for CVA symptoms. The pt was now under the care of the hospital, and before staff transition was approaching, the RN rushed her pt chart, and quickly consulted the assigned HCP via SBAR. Because the RN was quickly trying to finish before the oncoming staff arrived, the conversation between the RN to HCP was perceived to be urgent by the HCP. And according to the health history taken by the RN within the HER, the pt was experiencing these symptoms now and was already in the system and admitted and presumably ready for medical interventions. Given all of the data obtained by the RN, the interdisciplinary team approves STAT tPA to be administered within 4.5 Hours of onset of stroke symptoms, the standard protocol of CVA, in good faith to treat and dissolve any blood clots within the brain. Due to the urgency perceived, tPA was administer to the pt, and stat CBC and head CT was ordered as well post tPA admin. Following the CBC and CT, the results surprising showed hemorrhagic instead of ischemic stroke, and CBC revealed a PT of 16.2, PTT 90 sec, Hemoglobin 9.1, HCT 32%, all of which concluded that bleeding was indeed evident at this time.

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

In the scenario above, the patient was admitted into the ED for CVA stroke like signs and symptoms, showing up into the ED a full day post symptoms. The patient indeed lacked proficient English and only understood few words here and there. However, with no transportation or other resources, decided to wait the following day for further care and or treatment. The RN should have obtained a thorough health history given the reason for the visit, and also obtained the appropriate resources such as a certified interpreter the moment she knew that communication was going to be a barrier going forward with the plan of care. This may be a common occurrence with a population that speaks a foreign language, such as U.S. Border States like Texas, may need additional competencies around Spanish speaking peoples centered around the care provided by the hospital and its medical staff members such as Nurses, HCPs, UAPs, etc.

What circumstances led to the occurrence?

The circumstances that directly led to this occurrence was the RN not practicing the ANA Code of ethics, such as Nonmaleficence. To simply not care about the nursing obligations that come with caring for another life, and instead focus on shift change is wrong and could lead to adverse events in the future. A nurse must know their working boundaries, especially when signing up for over time, the same level of care must be expected and practice to all. Other members of the interdisciplinary team such as the HCP, should also question oncoming SBARS, and if possible, perform diagnostic tests to support the data inputted within the EHR.

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

The frequency of protocol errors can be measured by having more than one nurse evaluate and or triage incoming population from the ED department. Another option is to simply cap the amount of overtime work an RN can obtain, while also interviewing staff members on their performance to work under stress and or low energy. This could help identify potential issues that may arise from such nurses working at that time. Also, having a dedicated QI member ensure that data inputted within the EHR are matching with what is being seen on the floor/ unit as well. Lasty, having a staff obtain information from the actual patients, and asking if they need further assistance with anything that may have not been addressed during the initial build report of the visit. This would give the patient and staff members a second chance to fulfill any patient requests at that time.

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

Having a Max amount of time that a RN can sign up for overtime must be a must going forward, while ensuring that RNs feel safe and competent for that given day. Knowing that the brain starts to lose interests around the 6-hour mark, the fact that 12 hours shifts is even deemed safe to me personally is just unacceptable. If it were up to me, I'd only allow a 6 hour a day work period, while increasing pay to lessen the burden of workplace stress and or burnout. However, given the nature of a request like that to actually be implemented, even smaller changes such as posters around the desk showing the dangers of the treatment provided if it is not administered the correct way. And reinforcing strict protocols as to when tPA is administered and when it is not, to avoid death of the patient and further implication that come with that as well. Even a bar code scan warning for tPA, displaying the 4.5-hour protocol, and pre interventions needed to perform the task, just to remind everybody of what they are doing at that time.

How will you measure the efficacy of the interventions?

Measuring the efficacy of these interventions can be accomplished by having a pre tPA check list that must be filled out the RN and signed off by the HCP before tPA is fully administered. This will ensure that no cracks of care can allow any adverse event to arise within the hospital. Within the check list, will require the RN to list whether the patient requires an interpreter, a quotation section for what the patient describes word by word of the events that led them to their visit, and exact time provided by patient listed in world time and standard time. Both of which are checked off by the patient as well, this will make sure the patient is fully involved with their care, while avoiding any complication as well during the initial nurse to patient contact.