Guided Reflection Questions for Surgical Case 5: Lloyd Bennett

Opening Questions

How did the scenario make you feel?

Inadequate. I felt like I covered all the bases, but one mis click made me redo all of it. I mistakenly clicked the administer button again after stopping it.

Scenario Analysis Questions*

PCC/S/EBP Prior to blood administration, what assessments of the blood product and the patient are required to promote safe delivery and lessen potential complications?

It would be great to set up a baseline vital sign. Any complaints by the patient, like back pain and dyspnea, can easily be tracked and differentiated through vital sign identification.

PCC What signs and symptoms first indicated the patient was having a transfusion reaction?

When the patient complained of back pain and uneasiness, it was a sign of a complication.

PCC/EBP Review the immediate priorities when a transfusion reaction occurs and the rationale for each.

Stop transfusion – prevent further progression of the reaction. Calling the provider – to get some orders for the transfusion reaction. Calling the blood bank – to notify them that the blood sent was incorrect. Obtaining a new set of vitals – to compare how far we've progressed on the reaction. NS – given to ensure adequate circulation and to dilute the blood causing the reaction. Urine and blood sample – another way to see how much damage the reaction did.

S What key elements would you include in the handoff report for this patient? Consider the SBAR (situation, background, assessment, recommendation) format.

This is Mr. Bennet, he's here post-op. He needs a transfusion but had a transfusion reaction. Blood bank and provider have been notified. I would monitor him continuously and recommend a transfusion ASAP with the correct blood.

Concluding Questions

What follow-up blood work may be required?

Type and crossmatch and more blood work to identify any changes.

What follow-up disclosure is required with Lloyd Bennett and his family?

Tell the family that a transfusion reaction has occurred, and steps have been taken to prevent further reactions. Blood bank has also been notified about the error. Will monitor him closely.1

What would you do differently if you were to repeat this scenario? How would your patient care change?

I would not change anything. I have done the things properly except re-clicking the administer blood after stopping it. If I needed to change something, I would've called the provider sooner.

** The Scenario Analysis Questions are correlated to the Quality and Safety Education for Nurses (QSEN) competencies: Patient-Centered Care (PCC), Teamwork and Collaboration (T&C), Evidence-Based Practice (EBP), Quality Improvement (QI), Safety (S), and Informatics (I). Find more information at: http://qsen.org/*