

Meagan Britt
QI Assignment
March 10, 2023

Quality Improvement Activity: Pre-op Checklist

A 64-year-old female is admitted to the hospital with a subarachnoid hemorrhage due to a hemorrhagic stroke and requires immediate surgery. The patient's daughter was with her when the stroke occurred and told the EMTs that her mother complained of a sudden severe headache and trouble seeing before she became unconscious. Since the patient arrived at the hospital unconscious and the daughter is her decision maker the nurse went through the pre-op checklist with her. During gathering information about the patient, the daughter tells the nurse they that were in such a hurry she didn't grab the list of medications her mother was on from their home. Going through the patient's history the nurse notes that the patient had a recent knee surgery and ask the daughter if she can remember if her mom was put on any kind of blood thinner after the surgery to prevent blood clots. The daughter explains that she wasn't here for the surgery and didn't keep list of her mother's medications and that she only knew of the medications listed on the fridge at home. Again, the nurse reassures the daughter that she will check the medical records. Driving to work this morning the nurse was told of a personal situation that was happening and the surgeon told her she could leave after the checklist was completed and they'd have someone step in for her. As the nurse is rushes going through the patients MAR she overlooks that the patient is currently taking Warfarin for blood clot prevention and submits the pre-op checklist. During the surgery the surgeon discovers an aneurysm and cannot control the bleeding, leading the patient to bleed out and pass away.

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

In the scenario above there is so much going on that is emergent and causes very important information to be overlooked. Along with everything going on with the patient the nurse also has stuff going on in her life that she let affect her at work and ultimately caused a life to be lost. As sad as this scenario is, it is also a very real occurrence. Medication errors happen daily and sometimes we as nurses do not leave our personal lives at the door before we come in and it ends up creating an unsafe environment for not only our patients but also everyone else on the unit.

What circumstances led to the occurrence?

Due to the nurse allowing her personal life to cloud her judgment, a medication listed on the patients MAR was missed. This specific medication was prescribed to the patient after her knee surgery to prevent the formation of blood clots. Ultimately this patient had a hemorrhagic stroke caused by an aneurysm, leading to a subarachnoid hemorrhage, making Warfarin (a blood clot preventative) a very important medication for the surgeon to know that the patient was taking before starting the procedure.

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

I feel that there are many ways to measure the frequency of this kind of occurrence, one being to interview nurses that feel comfortable sharing medication errors that they have made and times that they have overlooked something that was very important to the type of care the patient was needing. Another way we could look at the occurrence would be to review the hospitals sentinel events that have occurred over the years.

Meagan Britt
QI Assignment
March 10, 2023

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

In this situation I also feel that a survey asking nurses how many times that they check medication orders could help with implementing interventions. Also, reminding the staff of the many therapeutic outlets within the hospital that are available to them during times of stress, including therapy and emotional support groups. It becomes easy to overlook important aspects of patient care, so possibly even doing regular in-services in person to go through the process of a pre-op checklist and how to effectively find important information that the patient/family couldn't provide.

How will you measure the efficacy of the interventions?

We can measure the efficacy of the interventions by reevaluating sentinel event logs at the hospital, but also looking into individual units medication error logs and evaluating how some floors keep their occurrences lower than others.