Quality Improvement Activity: Documenting ICP

A 15 year old male was brought to the Pediatric Emergency Department experiencing sudden right lower extremity weakness, headache, and vomiting. He was diagnosed with a left sagittal subdural empyema and was taken to the operating room for a craniotomy and excavation where he had a left EVD placed and clamped. He was then transferred to the Pediatric Intensive Care Unit with a new diagnosis of a subdural abscess. The primary care physician placed an order in the patients chart for strict ICP monitoring and to report any ICP greater than 20 mmHg lasting longer than 5 minutes. The nurse assigned to this patient was given two other admits during the same shift and fell behind on safety checks and hourly charting. The 15 year old patients vitals were supposed to be monitored and charted hourly while the nurses other patients vitals only had to be charted every four hours. Toward the end of the nurses shift she finally had time to sit down and catch up on charting. She had to rely on the monitor that had been collecting the patients vitals throughout the shift to recall the patients ICP values. Because all of her other patients vitals were only charted every four hours she charted the 15 year old ICP patients vital the same. While the values collected from the monitor for the hours that the nurse charted were within normal limits, because she didn't collect the values for every hour and neglected to monitor it herself during her shift, she missed important trends that showed the patients ICP was increasing and had been over 20 mmHg for longer than 5 minutes at a time multiple times throughout the shift.

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

In this scenario, when the patient was admitted to the PICU he was assigned to a nurse that was receiving multiple admits at once which led her to fall behind and neglect certain aspects of care. The ICP patient was not monitored as closely as they should have been which caused critical changes in his vitals to be missed and not reported. The nurse was overloaded all at once with multiple patients causing her to fall behind and then when she went back to document at the end of her shift she neglected to collect all the data necessary and charted all the patients with the same level of acuity. This can be a common occurrence for a nurse to receive multiple new patients at once. It is the responsibility of the nurse to make sure she carefully goes through each patients chart and takes note of all orders during admission.

What circumstances led to the occurrence?

What led to this occurrence was possible poor management and nurse assignments from the charge nurse who should have probably given at least one of the other admits to a different nurse instead of overloading one nurse. The nurse who took the assignment also contributed by not being thorough enough when admitting the patient and missed important orders regarding documentation and reporting.

In what way could you measure the frequency of this occurrence?

This could be measured by tracking admission data for the unit to know how frequent admissions occur and how they are assigned to hopefully create new strategies for reducing overload and preventing mistakes. Interviews could also be conducted to learn how patient overload and time management issues effect the nurses on the unit.

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

Better strategies should be implemented for assigning patients based on acuity and workload in order to reduce patient overload and improve nursing care. Electronic medical records should also flag all orders and important information for the nurse conducting the admission process to have to acknowledge and confirm before completing the admission. This would help nurses slow down and avoid missing crucial information for each patient.

How will you measure the efficacy of the interventions?

More nursing interviews could be conducted to assess how new patient assignment strategies are being perceived and whether they believe it is helping to reduce stress and patient overload. Informatics could be used to track reduced errors in charting which could show how the changes implemented to the electronic medical records help nurses not to miss crucial information.