

Shamari Mims
IM8-Griffin
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Reflection

During my clinical this past Sunday, I shadowed my preceptor who was in the charge nurse role for the day when the secretary reported an upset family member during morning report. He was upset that the patient was vomiting a lot according to him and he felt that nobody was acting on it. The night-charge nurse was already aware of her condition as far as the nausea and her cancer. The night nurse that was taking care of the patient basically handed off report as if nothing was wrong with the patient. The staffing nurse came to us after her assessment and stated that her patients' pupils were fixed and she was unresponsive. We immediately called rapid response. On their arrival, they found that the patient was withdrawing to painful stimuli only in her lower extremities and that her pupils were fixed. The neurosurgeon and nurse practitioner came to the unit explained that the patient had been taken off Decadron too quickly, when she should have been weaned. She has also been given Phenergan for nausea and vomiting by the hospitalist, which was not the appropriate choice for her condition per the neurosurgeon. The neurosurgeon ordered a stat ABG and IV Decadron before the patient was transferred to CT. I felt a mix of emotions, but as the situation progressed, I felt worried about the outcome and how quickly decisions needed to be made for the patient. The actions of all the team made me realize how critical it is to recognize subtly changes in a patient's neurological status and to act quickly. The most important feeling I had was concern for the patient and seeing how there was a communication gap between the providers that contributed to her decline from my understanding. The thing that went well rapid recognition of the emergency and the teamwork to keep the patients condition stable for the transfer. The difficult part of it was that the family was not from Lubbock and needed to make quick decisions. I contributed by observing the sequence of events and learning how information is communicated between the charge nurse, rapid response, and the providers. I analyzed knowing that with steroids you are supposed to be tapered slowly. This type of situation shows how broader issues, like communication and medication management, can impact patient safety. She had cancer all over her body so according to the neurosurgeon there was nothing they would have been able to provide for the patient. The neurosurgeon told the son that it would be humane to let her pass without intubating and making her a DNR as his recommendation. In conclusion, the situation could have been improved if there had been clearer communication about the patient's medication plan and closer monitoring. The family members might have been better prepared for decision making if they had received more education ahead of time. This experience taught me to always question orders and the importance of recognizing status changes and act on them. I will use what I learned to strengthen my professional practice and become a more proactive advocate for patients' safety in the future.