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## Z-Chapter 12: Case Study

Thomas, an RN on a busy medical-surgical unit, is caring for 32 year-old Sofia who is a Hispanic female admitted with hypoglycemia. During patient rounding, Dr. Payne notes that Sofia has a glucose level of 42. He writes an order for an amp of D50 and a CXR. Upon completion of the orders, he hands the patient's chart to the unit coordinator.

Just as the patient is leaving for her x-ray, Anna, RN comes in to relieve Thomas for lunch. Thomas reports the following to Anna: patient is alert and oriented to self only. She has not spoken since admission and only nods when her name is called. Dr. Payne made rounds but did not report any changes in treatment for Sofia at this time. The unit coordinator did state that there was a new order for an x-ray and the patient has just been transported to the x-ray department by the orderly.

Ten minutes after receiving report, Anna receives a call from the x-ray tech who states they cannot perform the x-ray because the patient does not have an armband on and she is speaking in Spanish. Anna goes to the x-ray department and is unable to identify the patient, so she asks for a Spanish-speaking interpreter. The interpreter states that the patient is confused.

Anna returns Sofia to her room and checks the chart. She finds the new order for D50 and administers the medication immediately. The patient wakes up and is alert and oriented.

### **Questions:**

- 1. Identify the team members involved in this scenario.

The team members involved in this scenario are Thomas an RN, Dr. Payne, the unit coordinator, Anna an RN, the orderly, the x-ray tech, and the interpreter.

- 2. Identify the errors which took place in this scenario.

There were a couple errors I noted when reading through this case study. The first error that comes up is Dr. Payne handing the written orders for the CXR and an amp of D50 to the unit coordinator. The Dr. should have given this to the assigned RN as well, in this case Thomas, to get the orders completed in a timely manner. The unit coordinator also should have made sure this information was shared with the assigned RN. The next issue is Thomas's handoff report to Anna. Thomas should have included a baseline for the patient. Thomas should have also questioned why the patient only nodded and did not speak this ultimately should have led to getting her a translator earlier in her treatment. Lastly, Thomas should have rounded on his patient before giving report and report should have been completed at the bedside.

The next error that was made was that Anna did not check for the new orders right away. With the patient being hypoglycemic administering the amp of D50 was an urgent matter. It is always important to keep up to schedule with all orders and this should have been a priority nursing intervention. The next mistake that was made was the patient not having an armband. This is crucial in the clinical setting in order to pass medications and/or perform any procedures. Another mistake was delegating the orderly to transfer the patient to x-ray. The patient was not stable enough to delegate this task. It is also to be noted that the interpreter should have been brought onto the case from the beginning which could have aided in avoiding many of these errors. The biggest thing is the patients' health and well-being. The interpreter states the patient is confused which correlates with her blood sugar being at 42 and at that time possibly much lower. This is a critical lab value that should have been addressed right away. If this was done correctly the patient would have been alert and oriented way sooner.

- 3. Identify what was done correctly in this scenario.

There were a couple things done correctly in this scenario. The Dr. sharing his orders with the unit coordinator is not technically wrong, it was just the aspect that this information was not shared directly to the RN right away. Also, Thomas giving Anna a hand off report was good. Although he could have included more, he still shared valuable information that Anna needed to take over care. A huge thing that was done correctly in this case study was the x-ray tech not performing the x-rays without the patients consent and ID band. Although Anna should have seen this order earlier, she did administer the amp of D50 immediately after reading the patient's chart. Lastly, although the orderly shouldn't have been delegated the task, he/she completed it in a timely manner and correctly.

- 4. If you were Thomas, what would you have done differently?

If I was Thomas, I would have done a lot of things differently. First, I would have made sure my patient had an ID band and I also would have investigated her being nonverbal and realized a need for an interpreter sooner. Next, I would have taken it upon myself to check the new orders for this patient especially because her current state was unstable. I would have done a better assessment on my patient before giving hand off report in order to give Anna a baseline. Lastly, I wouldn't have delegated taking the patient down to x-ray to the orderly because of the patient's current status.

- 5. If you were Anna, what would you have done differently?

If I were Anna I would have asked Thomas more in depth questions about the patient during hand off report. I would have liked to know if he investigated why she is nonverbal. I also would have requested doing a bedside report to meet the patient and clarify what I was told during report. Also, if I were Anna in this case study, I would have prioritized checking the new orders as soon as possible instead of waiting to hear from x-ray.

- 6. In addition to the team members identified in the scenario, who are some individuals in the healthcare setting who must communicate with one another?

In addition to the team members identified in the scenario some other individuals in the healthcare setting who must communicate with one another are physical therapy and occupational therapy with the RN, the case manager with the RN, dietary with the RN, procedural groups such as the cath lab and the RN/Dr., the nurse manager with the RN/Dr., the social worker with the RN, and pharmacy with the RN/Dr. Then of course the ones exemplified in the case study such as the off-duty nurse to the oncoming RN, the Dr. to the RN, the Dr. to the nurse manager, x-ray to the RN, the RN to the orderly, and the RN to the interpreter.

- 7. What should you consider when communicating with others?

When communicating with others, especially in the healthcare setting, you should make sure your statements are clear, concise, and complete. Communication in the healthcare setting is extremely important and is directly linked to patient outcomes and safety. It is important to exhibit good body language and tone when communicating with the interprofessional team in order to create a healthy work environment and culture. Proper body language includes eye contact, facing the person, uncrossing your arms, standing up straight, and leaning into the conversation. It is also important when communicating via writing or meditech to not use any incorrect abbreviations and state orders in a what, when, and how often format. It is important to remain concise in the information and use proper netiquette.

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