Rebecca Lamons
Jan. 24th, 2023

AMSN 2023

Z-Chapter 12: Case Study

In order to receive credit for this online content (1H), the assignment must be completed in full and submitted in the dropbox by the due date and time.

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.

    Nurse Tom, Dr. Payne, UAP, Nurse Anna, and an x-ray technician.

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

    The doctor did not communicate the new findings or need for immediate action to the UAP or the patient's nurse. The UAP failed to communicate the new orders effectively to the nurse. The patient was not wearing an identification band. The x-ray technician(s) did not check for an identification badge prior to transporting the patient. The patient's nurse was either unaware of the language barrier and need for translator or did not communicate the need in the hand-off report. The patient was delayed in receiving the amp of D50 and in receiving the x-ray.

Rebecca Lamons
Jan. 24th, 2023

3. Identify what was done correctly in this scenario.

The x-ray technicians did not proceed with the x-ray due to inability to confirm the patient's identity. The x-ray technician contacted the nurse and communicated that the identification band was missing, and about the communication issues. Anna responded to the x-ray department to assess the patient. She placed the request for a Spanish-speaking interpreter. Upon returning to the unit with the patient, she checked the patient's chart and found the new orders. She then responded immediately by administering the medication.

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

I would have assessed the patient more thoroughly. I would have called registration to get an identification band. I would have checked her blood glucose level. I would have followed up on the need for a Spanish-speaking interpreter as soon as possible. I would have tried to follow-up with the physician before they left or tried to be present during their rounds on the patient. Prior to leaving for lunch, I would have looked at the patient's chart, and taken care of any orders requiring immediate follow-up. I then would have given a more thorough hand-off report to Anna.

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

I would have asked Tom questions about the report given, such as, "what was her admitting diagnosis?", "when was the last blood glucose check and what was the result?", "do we know if she is A/O, since she has not spoken?", "Do we know why she was sent for the CXR?", "Are there any new orders that need initiating?"

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?

Other ancillary departments, such as pharmacy and radiology, team members from other units in the hospital (i.e., patient is transferred to another unit, such as ER to medical unit), patient registration, dietary, etc.

7. What should you consider when communicating with others?

When communicating with others its best to be specific, giving all pertinent information. Its also best to communicate clearly, which can involve tone of voice, word choice, and even the choice in setting (i.e., finding a quieter area for hand-off report, such as the patient's room). Ask if the recipient has any questions and if they need more information about anything. Always try to clarify points of confusion.