

1. Identify the team members involved in this scenario.

The team members involved in this scenario were Thomas, RN, who was the primary nurse caring for Sophia, and Anna, RN, who took over care during Thomas's lunch break. Dr. Payne was the physician who assessed the patient and placed new orders. The unit coordinator was responsible for handling the chart and communicating new orders. Other team members that were included were the transport orderly who took Sophia to X-ray, the X-ray technician who identified the missing patient arm band, and the Spanish speaking interpreter who assisted with communication. Sophia, the patient, was also a participant in the care process.

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

There were multiple communication and safety errors that occurred in this scenario. The biggest error was not communicating Sophia's critically low blood glucose level of 42 and the new D50 order during handoff. The patient was transported for a chest X-ray before her hypoglycemia was treated, which put her at risk for further problems. Another serious error was allowing the patient to leave the unit without a proper identification armband. Also, the language barrier was not addressed early, which delayed accurate assessment and contributed to the confusion.

3. Identify what was done correctly in this scenario.

There were also many things that were done correctly in this scenario. The X-ray technician correctly refused to perform the X-ray without proper patient identification, which helped with patient safety. Anna requested a Spanish interpreter to assist with communication. Anna also reviewed the patient's chart, identified the missed D50 order, and administered the medication promptly. After treatment, Sophia became alert and oriented, which showed effective interventions were done.

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

If I were Thomas, I would have reviewed all the new physician orders before giving report. I would have communicated the patient's critical

glucose level and the D50 order to Anna using the SBAR method. I also would have made sure Sophia was wearing an identification armband and confirmed that her hypoglycemia was treated before transporting her to X-ray. Making sure to have a complete and accurate handoff would have reduced the risk of miscommunication and patient harm.

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

If I were Anna, I would have immediately reviewed the patient's chart after receiving report to verify recent lab results and new orders. I would have clarified information that was incomplete or unclear with Thomas before taking full responsibility for care. I would have also verified patient identification and assessed for language barriers earlier. By doing this it could have helped identify the missed medication order sooner and prevented delays in treatment.

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?

There are a lot of healthcare professionals that need to communicate effectively to provide safe patient care. Some of these include nursing assistants, pharmacists, respiratory therapists, physical and occupational therapists, case managers, social workers, dietary, laboratory, and administrative staff. Collaboration between all members of the health care team is important for positive patient outcomes.

7. What should you consider when communicating with others?

When communicating with others it is important to be clear, accurate, and professional. Information should be communicated clearly and completely, especially during patient handoffs. Nurses should be mindful of cultural and language differences and use an interpreter when needed. Communication should also be respectful and focused on patient safety. It is important to verify understanding and document information appropriately.