

changed out at 9:00 a.m. What the Pharmacy Director did not understand (and did not bother to ask) was that medication times for routine (once) daily medications were set by the hospital for 10:00 a.m. Based on the hospital's once-daily schedule, the nursing staff scheduled twice-daily medications for 10:00 a.m. and 10:00 p.m. As a result of the change by the Pharmacy Director, medications that were supposed to be given at 10:00 a.m. were being returned to pharmacy as unused.

DISCUSSION QUESTION

1. What solution should the nurse managers and the pharmacy director implement?

Part Five

A simple change in the cart turnover time to 11:00 a.m. quickly rectified the problem, thus increasing the doses available for morning and twice-daily medications, decreasing the phone calls to pharmacy, decreasing wasted medications, and eliminating the workarounds that were potentially hazardous to patient safety.

DISCUSSION QUESTION

1. Given the solution, is there a need for any additional quality improvement in the medication administration process?

Emotional Intelligence in Labor and Delivery—Case for Chapters 2, 12, and 13

Louis Rubino and Brenda Freshman

It is Sunday night in Labor and Delivery. An obviously pregnant full-term mother, Mrs. Ford, presents herself, saying her doctor, Dr. Jones, told her to come to the hospital to deliver her baby. The mother tells Ms. Smith, the nurse manager of L&D that the doctor has informed her that the baby has anencephaly, and she understands that the baby will not be expected to live very long after delivery. Ms. Smith is very concerned, since the unit did not receive any prior word about Mrs. Ford coming to the hospital, nor did the unit receive the prenatal record, which is required to be submitted by the 36th week of pregnancy per hospital policy.

Ms. Smith proceeds to call Dr. Jones to ask for orders and to get more information regarding Mrs. Ford's condition. Dr. Jones gets very upset with the phone call, says that he just completed a delivery and was trying to get a couple hours of sleep before he came to the hospital to deliver Mrs. Ford's anencephalic baby. He yells that he will be there shortly now that she has woken him and tells her to start prepping for a C-section and hangs up. Ms. Smith realizes the survivability of the baby is not possible and that no measure will be able to save the life of the baby once delivered. Ms. Smith understands that in these cases, it is the nurses' job to use whatever measures necessary to make the baby and mother as comfortable as possible so the baby can have a dignified death.

Ms. Smith is agitated at Dr. Jones's response. First, he was obviously in the wrong in not notifying the hospital about Mrs. Ford coming in, let alone not sending in the prenatal record. When Dr. Jones enters the unit, he is obviously upset but gets even more upset when Ms. Smith questions why he intends to do a C-section. Ms. Smith could tell that Mrs. Ford was not expecting a C-section based on her comments to her. Dr. Jones dismisses Ms. Smith's comments about doing a vaginal delivery and begrudgingly he does do a vaginal birth, complaining during it about how he will now have to reschedule his whole day, since it will take much longer than a C-section.

The baby is delivered. It is clear that the baby is anencephalic and has very poor circulation. The nurses wrap the baby in blankets and hand the baby to Mrs. Ford for her to view. Dr. Jones says there is no reason to call in a neonatologist and that this baby will obviously only live a few hours at most. Mrs. Ford requests to have her baby fed. Dr. Jones says it is okay to do that and requests the baby be put on a cardio-respiratory monitor with an IV tube for feeding. Ms. Smith is concerned about this, since she knows it will prolong the life of the child, and this would be considered futile care. She wonders how to handle this concern since she realizes Dr. Jones will probably yell at her if she is to question his orders again.

DISCUSSION QUESTIONS

1. What is your opinion of Dr. Jones's emotional intelligence (EI)? Based on a scale of 1–10, with 1 being lowest, how would you rate Dr. Jones? Why?
2. Repeat this process for Ms. Smith, the nurse manager.
3. Do you think there should be any consequences for Dr. Jones as a result of his behavior? What can be done?
4. Should Ms. Smith question Dr. Jones's orders for feeding the terminal baby? How would she do this?
5. What about the patient, Mrs. Ford? What is her stake in all this? Should she get involved in the obvious conflict occurring around her?
6. What should the hospital do to try to educate the staff about emotional intelligence? Explain your answer.
7. How could teamwork training help this Neonatal ICU team? Explain your answer.

Communication of Patient Information During Transitions in Care —Case for Chapters 7 and 12

Sharon Saracino and Sharon B. Buchbinder

Margaret Burns is a 63-year-old woman who has suffered a left occipital hemorrhagic infarct, a cerebrovascular event. In addition to this recent stroke, Margaret has a history of rheumatoid arthritis, which limits her mobility; hypertension, which has been controlled with diet and medication; osteoporosis; gastroesophageal reflux; and depression. She is alert and oriented, and has been identified at risk for falls. She requires moderate assistance with transfers and minimal assistance with ambulation using a rolling walker. Her scheduled medications include: pantoprazole for gastroesophageal reflux disorder (GERD); alendronic acid for osteoporosis; prednisone, a steroid; metoprolol for hypertension and heart disease; and calcium with vitamin D.

Following her acute care hospitalization, she is transferred to a skilled nursing and rehabilitation facility to continue her recovery. Margaret lives alone and must be independent to return home. One week after her admission to the skilled nursing facility, Margaret develops pain and swelling in her right leg and a low grade temperature. Her blood work indicates an elevated white blood cell count. The attending physician orders a venous Doppler ultrasound of the right leg and the results are positive for an acute deep vein thrombosis (DVT). Plans are made to transfer Margaret back to the acute care hospital for possible placement of a filter as she is not a candidate for anticoagulation due to her hemorrhagic stroke.

Carol Stevens, the secretary on Margaret's unit, had a flat tire on the way to work. After calling the auto club and waiting for them to come and change the tire, she arrives late, already behind before her day has even started. After she punches in and hurries to the unit, she learns two patients are being discharged, two patients are scheduled to arrive for admission, and Mrs. Burns is scheduled to be transferred to the acute care setting. She immediately sets to work faxing the histories, current lab results, consults, diagnostics, physician progress notes, nurses' notes, and medication administration records to the physicians of the patients to be discharged and making copies of those items to send to the hospital with Mrs. Burns per protocol for continuity of care, keeping each set of patient records in a separate pile.

Carol's son then calls to say that he missed the school bus. Carol sets the papers aside while she calls a neighbor to arrange transportation for her son. As she hangs up the phone, the ambulance arrives to transport Margaret to the hospital. Carol gathers the copies of Margaret's records together and places them in an envelope. The hospital process is for a nurse to double check the records to ensure they are correct prior to the patient leaving the building, but another ambulance crew arrives simultaneously with a patient for admission, handing that patient's paperwork to Carol. Carol hands the envelope with Margaret's records to the first crew and directs them to Margaret's room.

A week later, the patient care coordinator at the skilled nursing and rehabilitation facility receives a call from the acute care hospital and is informed the medication administration record sent with Margaret Burns was that of another patient. The acute care hospital failed to notice this discrepancy on admission, and the wrong medications were ordered and administered to Margaret for three days. Margaret suffered an extension of her hemorrhagic stroke and was transferred to the ICU.

DISCUSSION QUESTIONS