Scenario 26

Appropriate for: All Specialties
Setting: Clinic

Ann Tayner is assigned to work in a busy Internal Medicine Clinic. She recently attended an educational session on infection control techniques and the importance of hand washing. She noticed that the clinic physician; Dr. Tsu, went from patient to patient without washing his hands. Later that morning, she encounters Dr. Tsu in the corridor and addresses him saying that she attended the hand-washing seminar and noticed he did not always follow procedure. Dr. Tsu appears surprised by the comment but sheepishly agrees that hand washing is very important, and he will be more careful.

Instructor Comments
- Point out that challenging a team member’s position is an integral part of teamwork. All members of the team and support staff have a responsibility to advocate for patient safety even if it may lead to a conflict or differing positions. In this case, situation awareness was used to identify the problem and advocate for the patients.

Skills Needed

Potential Tools
- Advocacy/assertion, Feedback
Scenario 27

Appropriate for: All Specialties
Setting: Hospital

It is ordered that Mr. Johnson, a patient admitted for an upper GI bleed, is to receive a unit of blood run over 4 hours. Nurse M, who is caring for Mr. Johnson, is anxious to get started hanging the unit of blood since it was delivered to the unit 20 minutes earlier. Hospital protocol requires two nurses to verify that the correct patient is receiving the correct blood product and type before hanging the unit. At this time, however, another patient in the unit is being resuscitated, and staff availability is limited. Nurse M decides to hang the blood without the double check. Shortly after the blood is hung, the patient spikes a temperature and experiences shaking chills. Nurse M has inadvertently hung blood for another patient named Johnston.

Instructor Comments

- Point out that this is a breach of the standard for check-back with blood administration. The safety of the standard exists in the call-out of patient name and number as well as blood product information with a check-back from a second licensed professional. With other staff diverted to the resuscitation, the nurse could have chosen other options, such as asking for help from a different unit, rather than proceeding without the double check. This is a failure to advocate for the patient.

Skills Needed

- Mutual support.

Potential Tools

- Task assistance, Advocacy/assertion, Collaboration
Scenario 28

Appropriate for: All Specialties
Setting: Hospital

Joan Morris, a 67-year-old woman, is admitted to the Telemetry Unit for cerebral angiography. Another patient, a 77-year-old woman with a similar name—Jane Morrison—also is admitted to the same unit for a cardiac electrophysiology procedure.

Later that day, a call from the Electrophysiology Laboratory (EP Lab) requests that “patient Morrison” be sent to the lab. The unit secretary mistakenly informs the nurse that Joan Morris is to be sent to the EP Lab. Neither the charge nurse nor the patient’s nurse is aware of a plan for this procedure. They assume that the study has been arranged by the physician despite the absence of a written order in the chart. Ms. Morris states that she is unaware of plans for the procedure and does not want to go to the lab. The nurse informs Ms. Morris that she can refuse the procedure after she arrives in the lab. In the lab, Ms. Morris once again refuses the procedure and the attending physician is paged, the error is identified, and the patient is sent back to her room.

Instructor Comments

- This is an example of ineffective communication and failure of check-back and handoffs. When the patient first refuses, this should result in situation monitoring and awareness to double check on the accuracy of the order. Point out that effective teams communicate essential team information, and discuss ways the communication in this situation could have been improved. Remember to include the patient in the care team.

Skills Needed

- Communication.

Potential Tools

- Handoff, Check-back, Situation Monitoring
Scenario 29

Appropriate for: All Specialties
Setting: Hospital

Peter W, a 35-year-old patient with a history of multiple sclerosis and poor motor control, is admitted to 2W, a medical unit in a large urban hospital. He is complaining of severe abdominal pain and vomiting. Peter is well known to the team on the unit as having been admitted frequently for social problems. Nurse R, who is assigned to admit the patient, tells the ED nurse calling with the report that she “is well aware of the aspects” of Peter W’s case and really does not need too much detail. On admission to the unit, Peter is still complaining of pain, and vomiting a small amount of “coffee grounds” material. He also has diminished bowel sounds noted on physical exam. Two hours after admission, Peter is sent to Radiology for a repeat KUB.

Following the x ray and while awaiting transportation, Peter waits unattended in the corridor. During this time, he vomits and aspirates. A short time later, he has his x ray and is returned. Following his return, no report is given, nor is the team informed of his return. Approximately 15 minutes after Peter’s return, Nurse R finds the patient with gasping respirations, and he is markedly cyanotic. Within minutes, Peter is apneic and asystolic. Resuscitation is unsuccessful.

Instructor Comments

- Poor information transfer and lack of a handoff create consequences for this patient. In this case, a chronic patient is admitted for new complaints that are not communicated. The receiving nurse should have been challenged and told that the patient was admitted for a new illness. Also point out that handoffs are commonly used within the teams on the patient care units but emphasize the importance of handoffs between units and support services.

Skills Needed

- Communication. Mutual support.

Potential Tools

- Handoff, Two-Challenge rule, Conflict resolution
Scenario 30

Appropriate for: All Specialties
Setting: Clinic

Ed Johnson, a 41-year-old patient with a history of hypertension, is seen in the Cardiology Clinic for a followup after his recent admission to rule out a myocardial infarction. His vital signs are normal except for a BP of 170/110. An EKG shows NSR without evidence of ischemic changes. He states that he has been having episodic chest pain since his release, so the physician decides to repeat his cardiac enzymes. His CPK is 201, and a Troponin I level is pending.

Mr. Johnson's pain resolves, and he insists on going home. The Troponin I level is still pending when Mr. Johnson is discharged with instructions to call the office the next day if he is still having problems. Shortly after Mr. Johnson is discharged, the Troponin I level of 0.22 (normal <0.03), indicating myocardial ischemia, is called in to the nurse in the clinic. The nurse notifies the physician of the result. No attempt is made to contact Mr. Johnson. Later, he is found unresponsive and having difficulty breathing. His friend calls 911, and when the ambulance crew arrives, they find him apenic and they cannot detect a pulse.

Instructor Comments

- In this scenario, the nurse and the physician failed to advocate for the patient. A check-back or existing process is lacking to ensure the physician and nurse understand roles and action items, and the patient was not contacted. This failure to communicate as soon as possible may have contributed to his demise.

Skills Needed


Potential Tools

- Briefs to assign roles and develop effective communication and handoff processes. Prioritization and delegation of responsibility for followup or action items. Check-back to confirm that an abnormal laboratory value of significance will result in followup action.
Scenario 31

Appropriate for: All Specialties
Setting: Clinic

Dr. Winston has just completed her annual physical exam of Sue Garber. Ms. Rosenthal, the nurse for Hall B, asks, “Isn’t Mrs. Garber a little confused today? I think she’s depressed about her daughter moving away last month. I was wondering if she should be sent to the emergency room for evaluation.” Dr. Winston replies, “Yes, I think she may be confused, but according to her record, her confusion has existed for more than a month. I think she may have something organic going on. We need to rule out a medical cause for her confusion.” “Now that you say it,” Rosenthal observes, “her daughter mentioned that her confusion was not a new phenomenon. Maybe we just need to get an outpatient consult for a formal evaluation. Would you like me to order a consult, Dr. Winston?” “Yes, please order a consult.”

Instructor Comments

- Both providers use situation monitoring to assess the status of the patient; and by discussing their different perceptions of the patient’s status, the team is able to use information exchange to form a shared mental model that keeps them from working in two different directions. This scenario shows examples of good communication by the nurse offering information, strong leadership, and mutual support. The doctor and the nurse were able to advocate and assert for a position, and yet they communicated and outlined a plan that resulted in the development of a shared mental model without conflict.

Skills Needed


Potential Tools

- Huddle, SBAR, Check-back, Feedback, Advocacy/assertion, Collaboration
Scenario 32

Appropriate for: All Specialties
Setting: Hospital

A 60-year-old female is admitted to the ward with a 2-day history of severe left lower abdominal pain and leukocytosis. Her white count is 13,000, and she has WBCs in her urinalysis. Two hours after admission, she begins to experience an acute exacerbation of her abdominal pain and is believed to have a diverticular perforation and acute abdomen. At this point, her physician decides to send her to the OR. The unit clerk is aware of the plan, but the patient's nurse is not. The patient is transported to the OR. Moments later, the OR calls to report that the patient has no permits signed, nor have any other preop protocols been completed.

Instructor Comments

- In this scenario, a shared mental model is not developed because information regarding the patient's plan of care is not communicated to the whole team. This lack of communication and the failure to provide an accurate handoff results in a delayed start for surgery and the potential for error.

Skills Needed

- Communication. Situation monitoring.

Potential Tools

- Handoff, Brief, Cross-monitoring
Scenario 33

Appropriate for: All Specialties
Setting: Hospital

Two members of the Intermediate Surgical Unit are assessing a patient who has just been transferred from the ICU. The monitor shows an SVT rate of 180 and a BP of 76/48. The nurse calls out the vital signs while the physician continues to monitor the rhythm. A nurse passing by the room hears the call-out, steps in the room, and asks “Do you want a code cart in here?”

Instructor Comments

- Reinforce the point that monitoring both the patient and the team members supports the maintenance of situation awareness. In this case, it involves observing others and using clear communication. Monitoring is a powerful agent in responding proactively to a situation.

Skills Needed


Potential Tools

- Call-out, Task assistance, Collaboration, Cross-monitoring
Scenario 34

Appropriate for: All Specialties
Setting: Hospital

At 1000, a 45-year-old, Spanish-speaking male with hypoglycemia is admitted to the Family Practice Service. At 1200 during rounds, the patient’s doctor notes a glucose value of 38. He writes an order for an amp of D50 and a CXR. He does not verbalize this order to the nurse and hands the chart to the clerk. The lunch relief nurse comes on just as the patient leaves for X Ray. Ten minutes later, X Ray calls to say they will not x ray him because he does not have an armband on, and he does not speak English. The nurse goes to X Ray and cannot positively identify the patient, so she asks for a Spanish interpreter. The interpreter states that the patient is confused; the nurse returns the patient to his room and checks the chart. She finds the order for D50, which has not been given, and administers the medication immediately. The patient wakes up and is alert and oriented.

Instructor Comments

- In this scenario, the doctor does not tell the nursing staff about the patient’s low blood sugar level and subsequent new orders. The opportunity to communicate information and form a plan that would develop a shared mental model is missed. Therefore this information is not part of the information handoff to the relief nurse. As a result of the inadequate exchange of communication and handoff, the patient is placed at risk, and care is delayed. In X Ray, the nurse uses good situation awareness and situation monitoring to identify a problem. She then prioritizes her actions to check the chart and identify necessary actions to implement.

Skills Needed

- Shared mental model. Communication.

Potential Tools

- Handoff, Prioritization
Scenario 35

Appropriate for: All Specialties  
Setting: Clinic

A renal failure patient presents to the Family Practice Clinic for a followup exam for a UTI. The nurse places a BP cuff on the patient’s arm, and at that moment, detects the thrill from a dialysis fistula. As she removes the BP cuff, the doctor, seeing what she has done, reprimands her in front of the patient and the patient’s friends, stating abruptly, “The patient has a fistula in that arm.” The nurse is embarrassed but does not speak to the doctor about the situation.

Later that day, the same doctor asks another team member, a nurse, for a report on one of his patients. The nurse proceeds with the report but is unable to recall the patient’s BP or pulse. Another nurse who knows of this information chooses not to share it with the doctor for fear he will reprimand her for speaking up.

Instructor Comments

- Ineffective team leadership results in having team members who do not speak up or challenge when appropriate. In this case, mutual support is lacking; however, skill in conflict management could enhance team development.

- Effective teams resolve conflicts constructively rather than allow interpersonal issues to persist without resolution. Failure to share information has a detrimental effect on patient care and may result in delayed diagnosis or an inadequate plan of care.

Skills Needed

- Team structure: Identify barrier to team effectiveness. Mutual support.

Potential Tools

- Collaboration, Conflict resolution