

Missed Opportunities

Key information can go missing during the multitude of handoffs that occur in a hospital on any given day. Communication among providers continues to be one of the most frequently cited patient safety and risk management issues found in our closed claims analyses. As the following case illustrates, miscommunication and missed opportunities resulting from hurried handoffs can produce fatal results.

A 37-year-old female presented at 9:11 PM to the community hospital emergency medicine department (EMD) complaining of nausea, vomiting, and numbness of the left side of her face and left arm. She had anxiety, difficulty swallowing, fever, chills, severe intermittent abdominal cramps, and abrupt onset of chest pain for a few hours prior to admission. The patient, who was five feet four inches tall and weighed 192 pounds, had a blood pressure of 190/120.

The patient reported a history of hypertension, but she had stopped taking her blood pressure medication approximately six months before due to financial problems. The emergency medicine (EM) physician ordered a complete blood count, chemistry profile, cardiac enzymes, and an electrocardiogram (ECG).

After receiving Vistaril and Phenergan, the patient's nausea improved. Cardiac enzymes were within normal limits, however, her white blood count was 12,700 per mcL (normal 4,500–11,000 per mcL), blood urea nitrogen was 27 mg/dL (normal 7–20 mg/dL), and creatinine was 2.6 mg/dL (normal 0.5–1.5 mg/dL). The ECG (read by the computer) showed sinus bradycardia, left ventricular hypertrophy, and nonspecific ST and T wave abnormality.

The EM physician diagnosed dehydration and renal failure and contacted the on-site hospitalist for admission. The hospitalist admitted the patient for observation. She ordered intravenous fluids and a 24-hour urine test for creatinine and protein. The hospitalist later noted that because the EM physician had not communicated a sense of urgency, she planned to see the patient in the morning. Neither physician ordered any medications to treat the patient's hypertension.

At 12:30 AM, the patient arrived on the nursing unit, and the emergency nurse gave a report to the floor nurse. According to the floor nurse, the emergency nurse mentioned that the hospitalist was aware of the elevated blood pressure and was going to "deal with it in the morning."

The registered nurse assigned to the patient was fairly new and inexperienced. The patient's blood pressure was 180/100 upon admission to the floor. At 1:00 AM, the patient's skin was pale, and she complained of back pain.

The nurse called the hospitalist, obtained an order for Tylenol for the back pain, and administered it 30 minutes later. At that time, the patient's blood pressure was recorded as 190/100. An hour and a half later, the nurse called the hospitalist again to report that the patient continued to complain of nausea and of back pain. There was no note to indicate that the nurse reported the elevated blood pressure.

The nurse later stated that because the blood pressure was unchanged from when the patient was admitted in the EMD, she did not consider reporting it. She understood that the hospitalist was already aware it was elevated. The hospitalist stated that she was not aware of the elevated blood pressure and, if she had been notified, would have seen the patient and ordered

additional testing. The doctor ordered Percocet and Compazine; the Percocet was given to the patient.

Forty-five minutes later, the licensed practical nurse working under the registered nurse was unable to obtain a blood pressure reading using a conventional cuff. She switched to a blood pressure machine, which recorded the pressure as 212/162. She reported this reading to the RN.

The RN, according to hospital policy, reported the elevated blood pressure to the nursing supervisor. The supervisor later stated that she thought the nurse reported the pressure as 212/106; when asked if the patient was symptomatic, the nurse said no. The supervisor testified that she decided not to call the doctor and did not direct the RN to call the doctor because the patient's blood pressure was not significantly different from the reading taken in the EMD.

The patient continued to complain of chest tightness and back pain with no radiation. Her skin was warm and dry, and she was up to the bathroom. At 6:30 AM, the nurse noted that the patient was sitting quietly in the bedside chair with unlabored respirations and normal skin color.

While taking another patient to surgery at 6:55 AM, the nurse passed the patient's door and noted the patient lying on the floor. Her color was dusky, and she was unresponsive. A code was called and resuscitation attempted, but it was unsuccessful. The patient was pronounced dead at 7:21 AM.

The autopsy listed the cause of death as cardiac tamponade caused by acute aortic dissection that had developed over hours. The autopsy also noted that aortic dissection was caused by "years of hypertensive cardiovascular disease" and that the heart was enlarged; it weighed 550 gm (normal 250–280 gm). The dissection extended from the root of the aorta to the iliac arteries—the full length of the aorta. Also noted were left ventricular concentric hypertrophy and arterioneurosclerosis.

What Went Wrong

Critical lapses in communication and in understanding what was being communicated were major factors in this case.

The EM physician and the hospitalist gave widely divergent accounts of what was communicated during their handoff. Handoffs between providers—whether via an electronic template or a written or verbal exchange—need to be structured and consistent in order to standardize the information exchanged.

Patient Safety Recommendations

- Watch for human errors. Opportunity for errors is multiplied when workload, hour restrictions, or other factors increase or complicate handoffs.
- Implement a structured handoff protocol. Communicating required information in a consistent way will help decrease human error. Handle sign offs with care—actively listen and take notes.
- Ask about any anticipated patient care problems, including considered diagnoses, pending significant laboratory results, procedures, or consultations.
- Think about what else the problem could be—have a backup plan in place.
- Encourage staff to go up the chain of command until all concerns are addressed.
- Ask for critical information to be repeated back.

Additional Resource

Patient Safety Primer, Handoffs and Signouts, Agency for Healthcare Research and Quality website. <https://psnet.ahrq.gov/primers/primer/9/handoffs-and-signouts>. Updated July 2016.

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The guidelines suggested here are not rules, do not constitute legal advice, and do not ensure a successful outcome. The ultimate decision regarding the appropriateness of any treatment must be made by each health care provider in light of all circumstances prevailing in the individual situation and in accordance with the laws of the jurisdiction in which the care is rendered.