Supplemental Digital Content Table 1. QI Nursing Scenarios

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| **Inpatient Medical-Surgical Unit:**  You are an oncoming night-shift registered nurse (RN) working on a busy medical surgical unit beginning a three, 12-hour shift stretch. On your first day, you get a very hurried report from the outgoing RN on your four patients. T.Q., one of your patients, is a 71 y/o male admitted for exacerbation of heart failure and a past medical history of Coronary Artery Disease, hypertension, rheumatoid arthritis, and Prostate Cancer treated surgically 10 years ago. The nurse reported that he is on IV Lasix and is responding well; his BNP level is down to 230 from 410. His K+ was increased from 10meq PO to 20meq PO due to his increased urine output from the Lasix. His BP was still high in the afternoon, so the intern increased his Lisinopril from 10mg PO QD to 20 mg PO BID. He has not received the evening dose yet today. The out-going RN ended the shift report with a detailed description of her date with the ‘cute intern.’  Your night shift (day 1) was busy, but relatively uneventful. T.Q.’s BP remained high, despite his second ordered dose of lisinopril. You also received word from the lab that his potassium level was 5.0 around 5AM. You gave report in the AM, remembering to mention T.Q.’s BP for further follow up by the Day RN.  You return to your shift that evening (Day 2) to hear in shift report that T.Q.’s BP remained high, so the resident increased the Lisinopril to 30mg BID. About ½ way into the shift, T.Q calls you to his room complaining of palpitations. His monitor shows frequent unifocal PVCs and short runs of V-Tach. You glance through his chart and do not notice any past PVCs. You call the senior resident (who is different than who has been taking care of him), he advises to get an ECG and mentions he is on his way to see him. You go back into T.Q.’s room to find him unresponsive, no pulse, and in V-fib. Fortunately, the code team is able to restore T.Q.’s rhythm to Sinus Rhythm and transfer him to the Intensive Care Unit. You receive a call from the senior resident who is irate. He confronts you stating, “Why you didn’t tell meT.Q.’s K+ level has been high since yesterday and that his Lisinopril was increased! When T.Q. arrived to the ICU his K+ level was 7.1! Fortunately, we were able to restore a normal K+ level and he is going to be OK.” As the resident walks away, you feel sick to your stomach because you remember the previous morning the lab told you verbally about T.Q’s K+ of 5.0 and you forgot to report this to the day shift nurse.  **Outpatient Oncology Clinic:**  You are an APRN working in a busy oncology clinic. The phone triage RN comes to you concerned about M.M. M.M. is a 58-year-old man who received his second round of chemotherapy last week for acute myelogenous leukemia. He called the clinic because he reported a temperature of 102.5 F and shaking chills that started about 45 minutes ago. You ask the RN to have M.M. come into the office immediately and you will see him as a “squeeze-in” appointment.  M.M. arrives 60 minutes later. You begin your evaluation of the patient with a strong concern for a neutropenic fever. After a history and physical exam, you order a complete blood count, blood cultures, urine analysis and culture, chemistries, and a chest radiograph to be done STAT in the clinic. You ask the patient to wait for the results to see if he needs to be admitted or can be treated on an outpatient basis. The patient receives some acetaminophen and feels a bit better after 30 minutes.  One hour (and three patients) later, you notice that his blood had been drawn by the MA but is sitting in a bag in the “transfer to lab” box. It appears that no one sent the blood to the lab. You are extremely frustrated as it is important to start antibiotics quickly in any patient with neutropenic fever *(guidelines recommend within 1 hour of arriving)*. The patient has now been here for over two hours and you’re still not sure of the diagnosis. You grab the tubes of blood and walk them to the clinic lab yourself. After 45 minutes, the blood work confirms that he is neutropenic, so you order appropriate antibiotics and start the paperwork to get him admitted to the hospital.  During a brief break, you express your concern about the lapse in diagnosis time to the office manager. He listens carefully, sighs, shrugs, and says, “Just a busy day…that’s what seems to happen.” You would agree, if it wasn’t that this has happened on several occasions in the past. You know the system can, and should, work better…but how can you start to work on this? |

Note: Quality Improvement = QI.