Effective Communication Among Team Members Essential in Avoiding Patient Injury or Death

written by Nancy Brent | December 1, 2017

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Effective communication among nursing staff and other caregivers on the patient care team have been the subject of several previous Bulletins. When I read an article by Susan Shepard, MSN, MA, RN, describing a case of poor communication among team members that resulted in the death of a patient, I thought it would be a good focus of this Bulletin.[1]

A 37-year-old female, weighing 192 pounds came to the ED complaining of nausea, vomiting, and numbness of the left side of her face and her left arm. She was also anxious, had difficulty swallowing, had a fever, experienced chills and intermittent abdominal cramps. Prior to her coming to the ED, she also reported a sudden onset of chest pain.[2]

The patient's blood pressure was 190/120. She explained she had a history of hypertension but had not taken her medications for it for approximately six months due to financial reasons.

After ordered tests and blood work was completed, the ED doctor diagnosed "dehydration and renal failure".[3] A hospitalist was contacted to admit the patient and patient care orders were written.

Medications were given but no medication for hypertension was ordered by either physician. The hospitalist planned to see the patient the next day since it was late at night and she was not told of any "urgency" to see the patient right away.

Upon admission to the hospital, the ED nurse gave her report to the admitting nurse, telling her that the hospitalist was aware of the patient's high blood pressure and he would "deal with it in the morning".

The RN assigned to the patient was "new and inexperienced". She took the patient's blood pressure which was 180/100. Shortly thereafter, the patient's skin was pale, she rated her mid-back pain level as "4 out of 10", but she said she did not have any chest pain.

The RN contacted the hospitalist for her back pain and she ordered Tylenol. The patient's blood pressure at this time was 190/100. The RN called the hospitalist 2 hours later concerning the patient's continued back pain, but there was no documentation indicating that the RN reported the elevated blood pressure.

The patient's mid-back pain continued. When an LPN who was working with the RN tried to take the patient's blood pressure, she could not get a reading using a regular BP cuff, so she used a "blood pressure machine". The machine recorded her blood pressure level as 212/162. The LPN reported this reading to the RN.

The RN, pursuant to hospital policy, reported this reading to the nursing supervisor. The nursing supervisor asked if the patient was "symptomatic" and was told she was not. The doctor was not notified.

At about 6:30 am, the patient was sitting in her bedside chair despite her complaints of chest tightness and back pain earlier that morning.

However, about 20 minutes later, the RN passed the patient's room and saw her lying on the floor. The patient was unresponsive and her color was dusky. A code was called but the patient died.

The autopsy indicated that the cause of death was "cardiac tamponade caused by acute aortic dissection that had been developing over 'hours'".[4] The patient's hypertensive cardiovascular disease also contributed to the aortic dissection. Her heart was also enlarged.

Ms. Shepard's article did not indicate who filed a lawsuit due to the patient's death, but the allegations included the ED physician and the hospitalist failed to diagnose the aortic dissection. This breach of their duties resulted in delayed treatment and led to the patient's death.

The allegations against the RN and the nursing supervisor identified their "miscommunication" about the patient's highly elevated blood pressure and the RN's "repeated failure" to report the high readings and other symptoms to the hospitalist. This breach of her duties delayed a correct diagnosis by the hospitalist and led to the patient's death.

Ms. Shepard did not share the outcome of the case in her article. Even so, this brief description of what occurred is indicative of how important accurate, timely, and complete communication is among and between a health care team.

I think the case is so important that you should read the article for additional information about each side's case and Ms. Shepard's analysis of what went wrong. The link is listed below in the Footnotes.

From my perspective, the case reveals basic principles to be followed as a health team member when caring for any patient. They include:

1. When sharing health care information about a patient to another team member, be factual, accurate and complete;
2. When receiving patient care information, be an active listener;
3. If information is shared that is unclear, ask for clarification;
4. Never assume another member of a health care team will act on behalf of the patient or knows of

a patient's condition;
5. Never care for a patient if you are not capable and competent to care for that patient;
6. Nursing patient assessment is a legal and ethical obligation for which you will be held accountable;
7. When a patient's condition worsens, you must share the factual information and your concern with your supervisor in a timely manner;
8. If your immediate supervisor does not act on your concerns, you must take them up the "chain of command"; and
9. All members of a health team are legally accountable for their respective breaches of their duties of care.

FOOTNOTES

1. Susan Shepard, "A Fatal Case of Miscommunication", at: https://www.todayshospitalist.com/a-fatal-case-of-miscommunication/ . (The case name or its cite was not included in the article).
2. Id.
3. Id.
4. Id.