Critical Communication in Escalation of Care
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Problem Statement

This presentation will discuss a critical event, the barriers within escalation and what can be done within debriefing to improve outcomes. Critical events occur throughout hospital environments. Communication during critical events can be very stressful for the family, nurse, critical care team, and the patient.

Debriefing can pinpoint areas of improvement while providing emotional support for those involved in the events.

Critical events occur when patients need escalation of care such as the patient experiences a change in heart rate, blood pressure, levels of oxygen saturation, decreased level of consciousness. These events need to be examined in a safe and effective way that improves patient safety and decreases cost.

Goals

1. The learner will be able to identify a critical event on a medical surgical unit.
2. The learner will recognize the importance of information exchange in a critical event.
3. The learner will be able to express two benefits of debriefing.

Case Study

65 year old black male admitted to medical floor. Patient complains of tightness in chest and has visible trouble breathing. The vital signs are as follows: blood pressure 88/46, heart rate 118, respiratory rate 32, and oxygen saturation 89% on 100% non re-breather. Nurse initiates emergency team for assistance. Team arrives, stabilizes patient with a breathing treatment, and a bolus. Patient is left on the floor. ICUs are full. Patient remains on 70 % open face tent, heart rate 105, blood pressure 94/63. The team recommends getting the following labs : ABG, CBC, BMP, PT/PTT. A chest x-ray and EKG are done with signs of slight pulmonary edema.

No Debriefing was done—2 days later: A different nurse activates the emergency team again for assistance due to the patient in respiratory distress on 100% non re-breather, abdomen tight, rapidly decreasing consciousness. Emergency team arrives and begins to try and stabilize patient. Patient begins to vomit large amounts of coffee ground emesis. Suction is quickly set up at bedside, no heart beat, emergency team initiates chest compressions and code measures. Resuscitation measures unsuccessful.

Debriefing as an Educational Strategy

A literature search for ‘peer evaluation in teams succes’ yielded 276,143 results for peer reviewed articles. Debriefing should be the peer/self evaluation of critical events. Debriefing reduces the costs by reducing errors and helps save lives.

“An analysis of briefing content revealed that a substantial number of the briefings benefitted clinical work by revealing knowledge gaps or provoking a change in the care plan.”

(Limgard, 2014)

References


Debriefing identifies the good an bad of a situation and uses multiple viewpoints to establish a better course of action and to identify strengths and areas of improvement. The purpose is to be better next time not to punish!

Debriefing is the a discussion and analysis of a shared experience. Within debriefing is the basis for evaluation and increased awareness of processes and events (Gardner, 2013). Debriefing allows the critical care team to share their knowledge of critical situations and ways to improve how emergencies are handled.