Podcast 2: Assessment Story SK Transcript

Real-life situations help illustrate the ramifications of our actions. These assessment stories will help you gain a better understanding of the importance of collecting patient data, utilizing critical thinking, and evaluating abnormal findings in the practice setting.

My patient assessment story does not have a happy ending, but it does serve as an illustration of what can go wrong when a nurse does not take the time to perform the necessary assessments based on the patient's diagnosis.

Mabel was a heavy-set lady in her mid-50s. She had visited the emergency room of her local hospital with left flank pain. She was quickly diagnosed with a large kidney stone, and she was given several liters of intra-venous fluids in order to flush the stone out through the ureters and urethra. This procedure proved to be unsuccessful as the stone was snugly lodged in her left ureter and would not budge, nor would it allow any fluid to escape around it. This situation was further complicated by the fact that Mabel's right kidney had been removed several years prior to this incident. The stone was firmly lodged in the ureter of the one kidney that she had remaining.

Since the stone would not flush out, the decision was made that Mabel would need to have the stone removed through a routine procedure by her urologist called a *lithotripsy* – where the stone is pulverized and broken into small, passable pieces through the use of an ultrasound. The urologist was completely booked up for the day, so Mabel's lithotripsy would be scheduled for early evening. In the meantime, she would be transferred to a medical-surgical floor where she could wait and be observed.

Mabel's stay in the medical-surgical unit was relatively uneventful. Since she had been given so much fluid earlier in the day in the ER and had not passed a single drop of urine – her Foley bag was bone dry – she was still suffering with considerable left flank pain. However, despite her discomfort, Mabel was up walking around, visiting with family, and frequently venturing out to the smoking lounge (which existed at the time). Her pain was being managed conservatively to keep her as comfortable as possible.

When the night shift nurses arrived at 7 p.m., Mabel was still waiting for the urologist. However, just before the night shift nurse began her assessment of Mabel, word came through that the urologist was ready, and that the OR team would be coming up to get her. As quickly as she could, the nurse performed a quick assessment of her lung sounds (present, but diminished) and vital signs (BP elevated as would be expected with so much fluid on board). She looked at the notes from the previous shift and saw that Mabel's oxygen saturation was 90% on room air, and that her 18-gauge saline lock in her right A/C was patent and flushed a few hours ago. Since time was so short, she trusted those notes and did not perform the assessments herself.

While her family waited in her room, the OR team placed Mabel on the gurney in Fowler's position (since she was quite short of breath when she laid down flat) and wheeled her downstairs for her lithotripsy. Having that patient taken care of, the nurse was now able to finish her assessments on her other six patients before Mabel returned from the OR.

Forty-five minutes later, the nurse received a call from the physician saying that Mabel was dead. After a shocking and devastating silence, the physician explained that the OR team had transported her to the operating room, and shortly thereafter, moved her onto the table. When Mabel was placed supine on the OR table, she rapidly went into cardiac arrest. He was not sure, of course, but the physician explained that this was probably due to flash pulmonary edema and sudden heart failure. In other words, all of that fluid that had been given to her earlier now had now accumulated in her heart and lungs. The physicians in the OR swiftly began resuscitation efforts, but to no avail. One reason? They were unable to administer the needed IV drugs because her IV line was no longer patent, and they could not get another line started, not even in her jugular. They worked for 30 minutes straight but were not able to get even a flicker of life. A woman who was up walking around less than an hour before was now dead.

The responsibility for Mabel's death lay with many among the medical team and raised many questions. For example, why would so much fluid be given to a patient with one kidney? Why was her surgery delayed for such a long time? Why would they lay a patient down flat on an operating table under these circumstances? Despite these questionable actions, we know, as nurses, that much of the responsibility for a patient's well-being and safety abides with us. Did the nurse do everything she could to ensure a good outcome for Mabel? For example, what if the nurse had checked the IV line herself rather than relying on previous notes? What if the nurse had checked her oxygen saturation herself, rather than relying on another nurse's previous assessment hours before? Would that have been enough to save Mabel's life? Maybe or maybe not. This experience should teach all nurses that the few minutes you save by taking a shortcut or skipping a small assessment could truly mean the difference between life and death. Your patients have been placed in your care, they trust you, and their families trust you. Please take your assessment seriously, no matter how routine it may seem.