Systems Thinking Case Study

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Mr. Nkonge is an 87 year-old male. He was admitted to the medical unit 2 days ago with congestive heart failure. He is hard of hearing, has intermittent confusion that is worse at night time, and requires an assist of 1-2 people to ambulate. At the beginning of the day shift, a nurse finds Mr. Nkonge resting comfortably in his bed and he appears to be sleeping. His bed is positioned in the middle of the ward. The morning reports states that the patient was received in fair and stable condition.

Following morning medication rounds and cares, the nurses are alerted by a visitor to the unit that there is a patient lying on the floor. A nurse goes to find Mr. Nkonge lying on the floor next to his bed. He still appears to be sleeping, but wakes easily and is able to communicate with the nurses. The nurse asks for help and returns Mr. Nkonge to his bed.

Approximately 2 hours later, a nurse discovers that Mr. Nkonge has experienced a significant loss of consciousness, is short of breath and appears to have had bloody emesis. He is transferred to the ICU. His transfer note and diagnosis simply stated “decreased level of consciousness.”

After 24 hours in the ICU, Mr. Nkonge died from a brain hemorrhage.

<u>Questions for consideration:</u>

1. Was this a preventable outcome? Why or why not?

2. What are the patient level interventions that could have or should have been implemented?

3. What are the nurse and provider level interventions that should have been implemented?

4. What are the systems level interventions that should have been implemented?

5. How can evidence-based practice help?

6. From your own experience and practice settings, does this sound familiar? How would the staff at your workplace react to this situation?

7. What are potential steps for action? How can we promote positive outcomes for our patients?