



Intellectual output No 2:

Case studies

Three original case studies were developed by the Estonian and Norwegian extended working groups. These case studies cover all topics of the course and include case description, guidelines for teachers and students, and tasks and guidelines for assessment of the participants' knowledge

CASE 1

Developed by Janne Pühvel, Kerli Koobak, Tiina Freimann, Ann-Cathrin Melby, Kristin Lichtfeldt

Timeline

1. Pre assignment (1h)
2. Lecture (course introduction + patient safety theory) (2h)
3. Seminar and groupwork (working with case) (4h)
4. Working in groups outside the classroom (15h)
5. Lecture (patient safety culture + problem solving and quality improvement techniques) (4h)
6. Seminar and groupwork (4h)
7. Working in groups outside the classroom (15h)
8. Final seminar (8h)
9. Self-reflection (essay) (1500 words) (25h)
10. Individual feedback from teacher to students
11. Voluntary anonymous feedback to course

Case description

- Surgical ward, where nurse-patient ratio is 1:10, one morning.
- Doctor told the nurse in the corridor that the yesterday's appendicitis patient should have a CITO CT.
- Nurse told caretaker to take patient 4-2 to CT (4 means room and 2 means bed – reading from the left side).
- Caretaker started reading from the right side and took patient 4-2 to CT and didn't ask for name nor check the wristband.
- Radiographer asked patient only her first name and performed the CT.
- Doctor was looking for the examination description and didn't see what he supposed to see.
- Doctor just ordered new CT, and everybody thought that situation was solved by that.
- Right patient had his CT hours later when CT was free.
- Caretaker asked her nurse manager to solve the problem.
- Staff started to blame each other.
- Patient was never told that she had an unnecessary CT.

Seminars

Seminar 1: Tasks for students

- Explain what happened
- Factors characterizing the case
- Contributing factors
- Impact of the case on the patient
- Secondary victim and influence on him

Seminar 2: Tasks for students

- Impact of the case on the authority
- Remedy, improvement of the case
- Incident prevention, risk reduction (forward-looking actions)

Learning aim

- To understand the concept of patient safety and safety culture
- To recognize and analyse patient safety incidents
- To propose improvements to patient safety practice

Learning methods

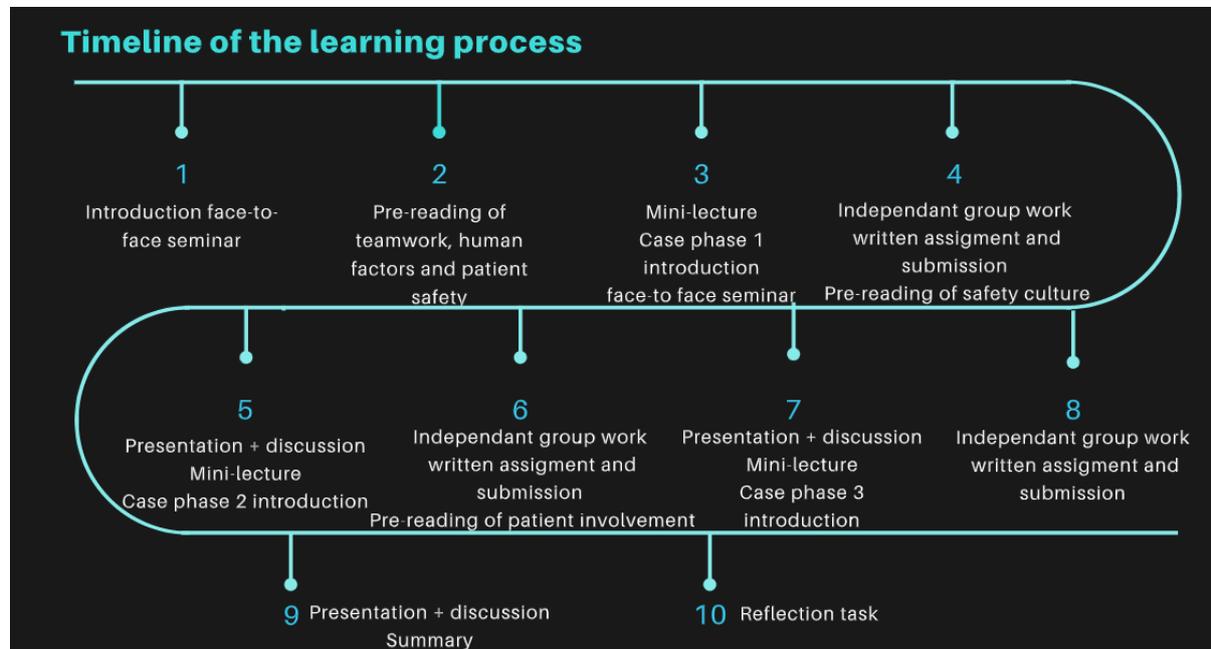
- Group work
- Independent work
- Problem solving
- Discussion
- Shared learning
- Methods we suggest for group work: brainstorming, brainwriting, fishbone method, worst possible idea...

Evaluation methods

- Presentations
- Peer-evaluation
- Essay

CASE 2

Developed by Tone Johnsgaard, Sissel Iren Eikeland Husebø, Janne Kommusaar, Airin Treiman-Kiveste, Alice Venski



Case and assignment (phase I)

(Proposed as phases)

Case background

Maria, 75- years old was admitted to hospital after she fell at home on the stairs. Examination and x-ray show *fractura colli femoris* on the left side and Maria needs surgery. She lives alone with a dog. Her son has moved to Norway/Estonia and calls sometimes. Maria has high blood pressure and diabetes II, H:162 cm; W: 87kg. Patient is admitted to the hospital for the operation. Before the operation patient blood sample: Hgb 102mmHg, EVF/Hct 40%; CRP 3 mg/L.

Case phase 1

Surgery was successful and during the operation Maria got the urinary catheter and the first dose of antibiotic. At the recovery room her condition has been stable, and she has had good effect of morphine i/v and after 6 hours she was transferred to the surgery ward. Handover is poor as the nurse was in a hurry and her report was unstructured and superficial. The nurse in the ward is new, this is her third week. It is the afternoon shift, surgical ward is full, really busy. The other nurse is occupied with two nursing students. Normally there are three nurses on the shift, but one of them is sick and there wasn't anyone available to replace him. The new nurse is concerned about bleeding from the wound, and she calls the doctor. The doctor is occupied with the trauma patient and answers angrily that he will come over later and asks her to take care of the bleeding. He also said that this patient needs antibiotic treatment. Later the doctor forgot to see the patient. The nurse was new and didn't know personnel well, so she was afraid of the doctor and didn't call again. Also, she was able to stop the bleeding herself. Nurse regularly monitored blood pressure and pulse.

Independent group task I

- What are the risk factors for this patient?
- What kind of human factors were present in this case?
- What are the responsibilities for each team member and what are the failures in teamwork?
- How this could have been prevented?

Written task 1000 words + presentation

Case and assignment (phase II)

Case phase II

Between operation and third postoperative day Maria felt good but was concerned about her dog. On third day she gets a fever 38,8 degrees. The doctor discovers that Maria haven't received antibiotics ordinated by phone after first dose given in operation theatre. There are no ordinations for antibiotics in the documentation. The doctor blames the new nurse, new nurse takes all the responsibilities to herself. Chief nurse called the new nurse to her office and started blaming and shaming the nurse. Colleagues didn't give any support to the new nurse. The other nurses started talking behind her back.

Independent group task II

- How could you create a good patient safety culture i this ward?
- If you were the chief nurse of the ward, how would you solve the situation?

Written task 1000 words + presentation

Case and assignment (phase III)

Case phase III

It is 7th postoperative day. Maria don't have a fever anymore. She is feeling well and have no complaints. Maria's condition is good enough to go home. Maria wants to go home as soon as possible because she is missing her dog. At the same time, she is very worried about coping at home alone. She told it only to the nursing student. Ward was full and the bed was needed for the new patient. Maria got prescription for the medication, but no further instructions how to manage at home. She was told that she has the right to contact with social care and family doctor/nurse for homecare. Maria was discharged from the hospital.

Independent group task III

- How do nurses have to involve the patient to the discharge process?
- What is the patient's role in one's own safety?

Written task 1000 words + presentation

Reflection task

1. What did you learn from this process?
2. How did you divide the tasks within your group?
3. What did you learn from your group members?
4. Did you achieve the learning objectives through the learning process? Why?

CASE 3

Developed by Jana Trolla, Hege Emilie Flakne, Siri Daltveit, Evelin Limberg, Maarja Âmarik

Case description

(Proposed as a video)

Patient John Smith (62) fell at home. He has history of alcohol problems, dementia. Comes to the emergency room with ambulance, GKS 13, alert to voice, confused while answering questions. CT scan confirms subdural hematoma.

Operating room:

- The name band is cut off there due to peripheral cannula insertion
- Surgical safety checklist not done because surgeon hurries home, nurse lacks the courage to speak up due to institutional hierarchy
- The operation goes as planned

Post-operative ward:

- Staff does not notice the name-band is missing - they don't check

General ward:

- Room with 4 beds
- Two patients named John Smith
- „Our“ John Smith needs a follow-up CT next morning (The nurse goes to the room and asks for a Mr. Smith. Wrong Mr. Smith answers and they take him to the CT. Patient does not ask what the indication for the CT is - assumes that it is the doctors order)
- The “wrong” John Smith gets the CT
 - “Wrong” John Smith gets unnecessary radiation
- Condition of “our” John Smith is deteriorating:
 - Missed re-bleeding (didn't get the CT)
 - Somnolent – taken as a sign of dementia
 - Asymmetric pupils - patient asleep, nurses don't check

Connection to course topics

- Human factor: two patients in the same room
- Teamwork: hierarchy, cutting of the name-band,
- Knowledge and skills: checklist not done, nurse don't speak up, behaviour, guidelines

Tasks for learning

1. Watching the video at home
2. Written task to write down their thoughts about the video (what happened?)
3. Look for local or national guidelines that are related to the error(s). Evaluate if they are followed and contain relevant and up-to-date information.
4. A moment to think, if they have had similar situations and prepare to share their experience(s) in the seminar
5. Group work in seminar (sharing experiences)
6. Presentation to co-students; discussion

7. Self-evaluation/reflection on the process of this assignment, includes feedback to the assignment

Learning methods

- Video
- Situation analysis
- Group discussion – shared learning by sharing experiences and knowledge
- Presentation
- Reflection

Timeline

At the end of previous seminar

- Small introduction to video and groupwork (5 min)

At home (60 min)

- Read written description and watch the video

Seminar (180 min +/- 30 min)

- Introduction (10 min)
- Divide students into groups, find their place (5 min)
- Groupwork/Discussion (120 min)
- Break (15 min)
- Presentation (5 min + 5 min for the questions/discussion)
- Summary, some key points from the teacher, opinions and reflections from students (30 min)
- Self-reflection at home (60 min)

Competencies to be evaluated

- Critical thinking
- Analyse the situation and finding the solution
- Knowing the local institutions' guidelines
- Plan ideas for safety improvement and patient improvement
- Teamwork skills
- Empowering patient to be an active member of the team

Evaluation methods and feedback

- Evaluation of the group presentation – oral feedback
- Feedback on the self-reflection – written
- Teacher gets feedback about the assignment from the students' self-reflections

Guidelines for students

Written description of the assignment

1. Watch the video
2. Write down your thoughts about the video (what happened?)
3. Find local or national guidelines that are related to the error(s). Evaluate if they are followed and contain relevant and up-to-date information.
4. Think, if you have had similar situations and prepare to share your experience(s) in the seminar
5. The assignment is evaluated in two ways:
 - Feedback from the teacher on the group presentation done in seminar
 - Your self-evaluation/reflection on the process of this assignment

Instructions for seminar groupwork/discussion

1. Find errors
2. Share experiences
3. Guidelines- in the hospital (or national if present)
4. Compare everyday experience and the guidelines
5. Brainstorm to find the solutions
6. Make a PowerPoint (3 slides) – points error/fails, guidelines and solution