

Activity 2-3.

Case Studies in Critical and Reflective Thinking

Small Group Exercise

Take turns role-playing as mentor and mentee and work through the steps of critical and reflective thinking to help the mentee analyze how the situations could be improved.

Case Study #1

The mentee had a very difficult assignment on the medical/surgical unit. A patient was admitted for liver problems. She was stable and had no ascites. Her daughter asked to stay the night, but was refused. The policy on the unit was for family to stay only if the patient was critical or terminal. During the course of the night, the patient was found with blood all over her, in respiratory and cardiac distress. Esophageal varices had burst. The patient was coded and died. Your mentee feels badly that she did not do a better job in anticipating problems with this patient, and that she had not allowed the daughter to stay overnight.

Case Study #2

A Young man was admitted with a stab wound. His intestines had been damaged and he needed TPN while the anastomosed ends of the intestine healed. The doctors were in the room to insert the central line. He needed to be in trendelenberg position, but the bed would not rise to the MDs' level and tilt at the same time. The MDs positioned the patient in such a way as to cause him extreme pain. The mentee pointed this out to them, but the MDs would not stop the procedure because it would disrupt the sterile field they had set up and they did not want to start over. The mentee wondered how she could have done better in advocating for her patient.

Case Study #3

A 35-year-old female patient was admitted to the ER for observation. She was unsteady on her feet, crying, and told a family member that she had been raped. The LVN who had been working with the mentee stated that an order had been written for a catheter to obtain a urine specimen. The mentee questioned the LVN, because she recognized that this might be traumatic to a rape patient, but the LVN insisted. The patient was upset, fought the procedure, and had to be restrained while it was taking place. The mentee was upset that she was not successful in halting the procedure, and that she also had too much work to be able to successfully handle the emotional consequences, both to herself and her patient.

Critical Thinking I—In the Moment

1. What is the exact nature of the incident? (Examples: background information—age of patient, diagnosis, medications, pain, etc.)
2. What factors are influencing this situation?
3. What was happening just before the situation occurred?
4. What changes have been noted?
5. What are the emotional reactions to the situation?
6. What is familiar about the situation, and what is not?
7. What should be happening?
8. What is the optimal outcome of the situation, the ultimate goal?
9. What aspects of the situation require the most careful attention?
10. What further information is needed?
11. Why is it important to intervene?
12. Is there more than one approach to the problem?

Determine Accountability

1. Who needs to do what?
2. What needs to be delegated?
3. In what order should personnel be contacted?
4. What is the next step?
5. What actions need to be taken immediately?
6. What resources need to be mobilized?
7. What is good about the situation?
8. How can the new information be used to improve the care plan?
9. How will the patient's care be improved as a result of the situation?
10. What has been learned from the situation?
11. What learning deficits have been identified that can be corrected?

Critical Thinking II—Reflecting with a Mentee

1. What factors influenced the mentee's behavior in the situation?
2. What was familiar about the situation? What was new?
3. What information was needed? How was it obtained?
4. What information was missing, and how could it have been obtained?
5. Who was available to help in the situation?
6. What were some alternate ways the situation could have been handled?
7. Did the mentee feel there was adequate time to handle the situation?
8. What would the mentee have done differently?
9. How can the mentee effectively anticipate and plan for similar events in the future?
10. What is a possible explanation for what happened?

