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Privileged Communication

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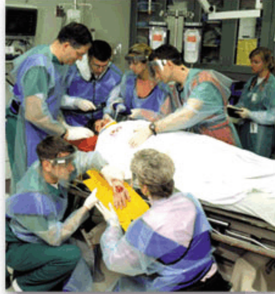
Medical Malpractice in Trauma Care

Most missed injuries and misdiagnoses that occur with trauma patients are avoidable. The two most common reasons for a missed diagnosis or injury are an inadequate clinical assessment and misinterpretation of radiology films.

Whenever a trauma patient enters the health care system, all providers need to have an index of suspicion for injuries bases on the mechanism for injury. For example, in high impact traumas, the clinician should look for open fractures, pelvic fractures, posterior hip dislocations [in a driver], bilateral leg injuries [in a pedestrian], calcaneal [heel] fractures in a jumper or escapee and entrance and exit wounds in a gun shot wound.



The most frequently missed clinically significant injuries are: pneumothorax [collapsed lung], liver or bladder rupture, pelvic fracture and other orthopedic injuries.

Emergency personnel should have a high index of suspicion for **blunt carotid injuries** in anyone who complains of neck pain from a motor vehicle accident or has a seat belt mark or abrasion over their neck. This diagnosis is often delayed until the onset of neurological symptoms and has a high rate of significant residual neurological problems because of the delay. Common signs and symptoms they may experience are: headache, syncope, and signs of cerebral or retinal ischemia. The gold standard for testing to determine if there is a carotid injury is an angiogram.

Spinal cord injuries [SCI] are also missed or the diagnosis delayed due to: failure to appreciate findings on x-ray, poor film quality [needs to be repeated], entire spine is not visualized, x-rays of uninjured areas are requested or no x-rays are taken or an obvious fracture is missed. SCI may also be caused by taking the patient out of the cervical collar before the x-rays are cleared or allowing them out of bed or sitting upright before they are cleared. Another thing to look for if you suspect a spinal cord injury was missed or the diagnosis delayed, is whether your client had hypotension [low blood pressure] and bradycardia [slow heart rate] as opposed to hypotension and tachycardia [fast heart rate]. The former is indicative of spinal shock and the latter, all other forms of shock.

Thoracic injuries that most frequently involve a delay in diagnosis are: pneumothorax, pericardial tamponade, bilateral lung contusions, rib fractures and aortic ruptures.

Abdominal injuries that are commonly missed involve the spleen, liver, bowel and peritonitis. Duodenal injuries need to be diagnosed early. If diagnosed after 24 hrs, they carry a 40% mortality rate.

One-third of delays in diagnosis of **orthopedic injuries** occur because of the failure to follow trauma protocols. Other causes for delays in diagnosis occur because of misinterpretation of x-rays, miscommunication and the lack of a formal orthopedic consult. Commonly missed orthopedic injuries include: hip fractures [avascular necrosis can occur within 4 hrs], open fractures [require repair within 6 hrs], posterior shoulder dislocation [frequently missed with clavicle or collarbone fractures], pubic rami fracture [in pelvis], patellar tendon injuries and compartment syndrome.

As you can see from the above, what may seem like only a personal injury case may also become a medical malpractice case, so wouldn't it make sense to have your legal nurse consultant review all your personal injury cases. *Source: AALNC 2007 Conference session.*

5 Million Lives Campaign

In response to all the publicity about medical errors, the Institute for Healthcare Improvement began a campaign in 2004 called the "100,000 Lives Campaign" that aimed at reducing the death rate from preventable errors by 100,000 in 18 months. The campaign was an overwhelming success. It was credited with saving 122,000 lives at 3100 participating hospitals across the country and set new standards of care.

The six interventions employed during the "100,000 Lives Campaign" were:

- "Deploying rapid response teams... at the first sign of a patient's decline.
- Preventing adverse drug events...by implementing medication reconciliation
- Delivering reliable, evidenced-based care for acute myocardial infarction... to prevent deaths from heart attacks
- Preventing central line infections...by implementing a series of interdependent, scientifically grounded steps
- Preventing surgical site infections ... by reliably delivering the correct perioperative antibiotic at the proper time
- Preventing ventilator-associated pneumonia...by implementing a series of interdisciplinary, scientifically grounded steps"

After the success of this program a new initiative was begun to "dramatically accelerate efforts to reduce non-fatal harm, while continuing to fight needless deaths."

So began the **"5 Million Lives Campaign**". The goal is to protect patients from five million incidents of medical harm over a two year period [Dec. 2006 - Dec. 2008]. Over 4000 US hospitals have been enlisted.

Below are the new interventions targeted at harm, that were added to the interventions previously mentioned:

- "Preventing harm from high-alert medications...starting with anticoagulants, sedatives, narcotics and insulin
  - Reducing surgical complications...by reliably implementing all of the changes recommended by SCIP, the Surgical Care Improvement Project
  - Reducing methicillin-resistant Staphylococcus aurea [MRSA] infection...by implementing scientifically proven infection control practices
- Delivering reliable, evidenced-based care for congestive heart failure...to avoid readmissions
- Get Boards on Board...by defining and spreading the best known leveraged processes for hospitals Board of Directors, so that they can become far more effective in accelerating organizational progress toward safe care."

Source: www.ihi.org

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