E.R. Trauma Care: Court Faults Nursing Assessments.

The patient was brought to the E.R. by emergency-response paramedics at 3:44 a.m. after a tractor-trailer rollover accident at 2:30 a.m.

He arrived in an ambulance on a backboard with a cervical collar in place. He had lacerations to both sides of his head, pain in his ribs and left shoulder and pain and swelling on the left side of his neck.

He was seen immediately by the E.R. triage nurse. Although he had obvious head trauma, there had been no loss of consciousness, no headache and no numbness or weakness.

A physician did not see the patient until 6:07 a.m. By that time the nurse had allowed the patient to remove the cervical collar, although the rationale was reportedly not documented in the nursing progress notes.

The physician's exam focused on severe right-side chest pain. A chest x-ray showed the patient's 7th through 10th ribs were fractured. A chest CT confirmed the x-ray findings and an abdominal CT was negative.

Signs of Head, Neck Injuries Not Reported to Physician

Around 12:00 noon a nurse noted in the chart a "new onset of weakness." That finding was never explained more fully in the chart or communicated to the charge nurse or to a physician.

The patient also started having pain in his neck and left shoulder and his arm went numb. That also was never communicated to anyone by the patient's nurse.

The patient was sent home at 2:00 p.m. without a head CT being done. The next morning he was found unresponsive by his family and taken to a different hospital were a head CT revealed multiple cerebral infarcts and a fracture at C-3. The patient died at that hospital six days later.

The US District Court for the Northern District of New York made a preliminary ruling endorsing a legal nurse consultant's opinion that substandard ongoing nursing assessment could have been a contributing factor in the physicians not seeing the need for a head CT scan that would have revealed the true extent of the patient's injuries. **Miller v. Wilson Memorial, 2010 WL 411002 (N.D.N.Y., January 27, 2010).**

Substandard ongoing nursing assessment could have been a factor in the physicians not getting a head CT scan which would have revealed the full extent of the patient's injuries.

A rollover motor vehicle accident must be seen as a high-risk situation.

A patient who comes in in an ambulance immobilized with obvious head injuries must be triaged with an acuity level requiring immediate assessment by a physician.

Nursing neurological assessment is required at least every two hours, unless ordered more frequently by a physician.

Neurological assessment has to include recording pupil size and reactivity, level of consciousness, orientation and Glascow Coma Scale scoring.

Hospital policy for the E.R. required pain assessments every two hours, that is, assessment and documentation of the duration, location and severity of the pain.

New onset of weakness is an ominous neurologic sign, but there was no documentation that it was reported to the E.R. charge nurse or to a physician.

UNITED STATES DISTRICT COURT
NEW YORK
January 27, 2010