Misadventures

By Ed Rudin, MD

A case study reveals system lapses but no mishaps.

A 75-YEAR-OLD WOMAN ARRIVED at the Emergency Department by ambulance at 2000 hours. She had fallen in her home and, even with help, could not sit up without intense pain in her pelvis and lower back.

EMTs responded to a 911 call from her husband and found her lying on the floor, conscious and alert, but in severe pain. Heart and lung sounds were normal; blood pressure and pulse were normal; pupils were normal and reactive. Upper extremity strength was normal and bilaterally equal. Speech was coherent and relevant. Her pain was extreme on any active or passive leg movement.

Within half an hour of the 911 call, the patient arrived at the closest Emergency Department accepting ambulances with non-life-threatening cases. The ER could not reach her primary care physician, who was not on the staff.

X-rays revealed two simple fractures of the right pubic ramus, abrasions on the right elbow and knee, and a bandage on her left index finger. The patient shamefacedly reported falling down four steps of a longer flight three days earlier, abrading her right elbow and knee. That same night she had cut her left index finger while preparing dinner. Her daughter had taken her to another emergency room, where six sutures were placed, and she was told to see her attending physician (who was on that staff) in 10 days for suture removal.

The patient received IM Dilaudid in the ER nearly an hour after arrival. During three hours there, the patient rated her pain at 9 on motion and 3 at rest. The ER physician recommended admission and patient and husband agreed. An orthopedist seeing another patient in the ER agreed to admit the patient sight unseen.

Husband and ER physician left the hospital at 2300 hours, but the patient remained on a gurney in a hallway outside the ER, until 0200 hours.

During that time, the admitting orthopedist met the sleepy patient and ordered 1-4 mg of morphine prn IV, a urinary tract catheter if unable to void, a physical therapy consultation, and a regular diet.

The patient assumed that the frequent questions about her pain level would activate her prn morphine, but despite reporting pain at 9 on motion and 2-3 at rest throughout that first hospital day, she received only 1 mg of morphine in the morning and none the rest of the day.

An indwelling urinary catheter and a pulsating cuff on both legs kept the patient sufficiently immobile to make the pain bearable.

Her husband returned in the morning to find the patient had not had breakfast or seen a physical therapist. He asked at the nurses' station and learned that those orders had not

been electronically transmitted. The patient got her breakfast at 1030 hours and her physical therapy evaluation at mid-afternoon.

Nursing staff tried unsuccessfully to coordinate physical therapy and the morphine. On the second hospital day, a nurse asked the patient whether the physical therapist had been there that afternoon. The patient said yes, but that she had not received her pre-therapy morphine so the therapist had left to arrange for the morphine and to return in half an hour.

The nurse, for whom English was a second language, frantically started for the patient's morphine until the patient quickly explained the past pluperfect — she had by then received both the morphine and the PT visit.

Throughout Day 2 the patient rated her pain at 8 on motion and 1-2 at rest. She also told staff, to no avail, that she was returning more than half her food, considering it redundant and excessive for an almost immobile patient.

At the start of Day 3, pain was unchanged until the morphine was changed to Darvocet. After that the patient reported pain at 6-7 on motion and 0 at rest. A "case manager" arrived to tell the patient and her husband that the patient would soon be leaving the hospital but would likely need continued nursing care and physical therapy, for which the hospital offered a Medicare reimbursable non-hospital nursing facility.

The husband asked whether those services were also available at home paid by Medicare. He was told yes, but when the patient expressed fear of the pain of transit home, the case manager promptly returned to the residential option without offering a transportation alternative or better pain control.

On the fourth hospital day, the patient was discharged to home and referred for visiting nurse and physical therapist homecare services. She was then told that a van equipped for a wheelchair could be available if the patient would accept responsibility for all of the cost. The patient did and the charge was a small fraction of the cost of one day in a skilled nursing facility.

In the 86 hours the patient occupied a hospital bed, only one person who entered her room, visitor or staff, used the alcohol foam dispenser or the disposable gloves conveniently affixed to the wall just inside the door to the room. That person took a glove for removing the urinary catheter.

No one offered the patient help with her personal hygiene. Even when urinary and IV attachments were out, and the patient asked for such help, she did not get it. On the fourth day, the patient insisted and got help with her perineal hygiene.

In the afternoon of the first non-weekend day at home, the husband called the visiting nurse service to ask why no one had called to make arrangements. The charge nurse apologized and a PT arrived later that day. Darvocet was keeping the patient's pain at 6 on motion and 0 at rest.

Thirteen days after the first ER visit, ten days after the second ER visit, and four days post- hospital, the patient phoned her primary care physician, from whom she had not heard. She learned that he did not know of any of the three events.

He requested the visting nurse to remove the sutures and replaced Darvocet with Aleve. After her first dose, the patient reported pain at 5 on motion and 0 at rest and it continued down after that.

How many system lapses raise a misadventure to a mishap, and what is the most parsimonious diagnosis that might lead to correction?

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