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- Prepare medical summaries
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- Prepare demonstrative evidence
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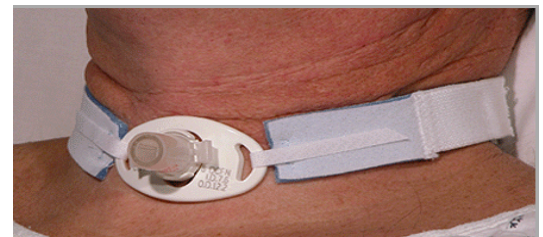
Intubation: A Lesson in Helplessness by Pat Iyer

Critically ill patients are frequently intubated and attached to ventilators. Intubation is a lesson in helplessness, and constitutes an element of damages in personal injury and medical malpractice cases. When I am asked to evaluate medical records for evidence of pain and suffering, I often see the patient's care included a stay in the critical care unit on a ventilator. First, why is it necessary to be intubated? Endotracheal tubes are inserted to gain control of a severely injured patient when the patient's behavior prevents the diagnostic testing needed to determine injuries. In addition, adult respiratory distress syndrome can result from crushing chest injuries, severe head injuries, or sepsis. Anesthesiologists typically rapidly administer medications to paralyze the diaphragm and sedate the patient in order to slide the endotracheal tube into the lungs. There are multiple opportunities for liability associated with management of the intubated patient. For example, harm to the patient occurs if improper intubation technique results in inadequate ventilation of the lungs and the resultant decrease in oxygenation.

The medical, nursing, and respiratory therapy team work together to oversee the multiple needs of the ventilated patient. The physicians look for ways to prevent ventilator-associated pneumonia, one of the quality indicators singled out by patient safety organizations. This hospital-acquired condition can kill. Physicians also look for signs the patient is ready to be weaned off the ventilator.

Critical care nurses are responsible for protecting the airway - preventing the patient from pulling on and removing the endotracheal tube. Although there is a trend away from the use of restraints in health care, preventing the patient from harming himself or others by careful use of wrist restraints, is an exception. The unplanned self-extubation can result in loss of an airway, and death, particularly if the patient has received paralyzing agents and cannot breathe on his own. Nurses are also responsible for suctioning the endotracheal tube to prevent the buildup of secretions that can block the airway. Failure to frequently suction when indicated can be a deviation from the standard of care. Mucous plugs can block airways and kill.

Respiratory therapists function within the realm of minding the machine - the ventilator - and providing patient treatments. Along with the nurses, they are responsible for checking that alarms are properly set on the machines. An alarm signals that the airway is occluded or the patient has stopped breathing. Alarms that are turned off and fail to detect an emergency, can kill.



The impact on the patient

What is it like to lose one's voice, to lay flat on one's back, and be unable to

communicate needs? Consider that the patient's hands are tied to her sides, and she is unable to speak due to the presence of the tube in her mouth. She cannot write notes or call for assistance. She is constantly exposed to the hissing sound of the ventilator, and sounds from alarms on IV pumps, cardiac monitors and ventilators. The suction catheter threaded through the endotracheal tube stimulates the cough and gag reflexes, and leaves her gasping for air at times. Suctioning is associated with its own set of hazards, including a drop in oxygen level, increased intracranial pressure, irregular heartbeat, mucosal injury, infection and death. These hazards exist whether or not the nose/throat or the tracheostomy tube is the entry site for the suction catheter.

Many people are sedated while on a ventilator; the trend is to use the minimum amount of sedation needed. The patient may be awake and aware even while receiving low doses of sedation. The medical community recommends turning the sedation off once every 24-hours, and allowing patients to wake up in order to evaluate their behavior and level of awareness. This is particularly useful when patients have sustained head injuries. But the patient wakes up to the sights, sounds and sensations of being on a ventilator. Nurses notes frequently describe the patient as anxious or agitated during the periods of awareness.

There is no general agreement within the medical profession as to the precise number of days a patient can have an endotracheal tube in place before a tracheostomy should be performed. Weaning efforts usually occur before a decision is reached to perform a tracheostomy. The patient who becomes acutely short of breath and anxious during weaning is a candidate for a tracheostomy.

The need for a tracheostomy

Why do patients need tracheostomies? Here is why: long term mechanical ventilator use, symptom relief, improvement in patient wellbeing, facilitation of activities of daily living, optimization of long term function, airway obstruction, chronic aspiration, an acute neural insult, progressive neuromuscular decline, high quadriplegia, and an unstable or obstructed airway. Tracheostomies are usually performed in the operating room, but can be done in the critical care unit when the patient is too unstable to move into the OR. The skin over the neck is cut and dissected down to the trachea, which is then opened to permit the entrance of the tracheostomy tube. Maintaining the airway is crucial during this time. Liability is associated with performing the tracheostomy too low and too close to major blood vessels and in removing the endotracheal tube before the tracheostomy is secure.

Decannulation

There is no consensus as to when a tracheostomy tube can be safely removed. Stelfox [1] found these factors influence removal of the tube: level of consciousness, ability to tolerate tracheostomy tube capping, cough effectiveness, and secretions. There is little in the way of evidence-based recommendations for removal of the tube, including the timing of and process of removal. The clinicians Stelfox surveyed believed the best candidates for decannulation were those who were:

- Alert and interactive
- Had a strong cough
- Required minimal supplemental oxygen
- Had scant thin secretions

Choate [2] studied the rate of re-cannulation, and found that 4.8% of 823 decannulation decisions resulted in a need to re-insert the tracheostomy tube. The failure rate was highest (60%) within 24-hours after the tube was removed. The clinical manifestations of a decannulation failure include a change in vital signs, increased effort to breathe, increased pulse rate, and changes on a chest x-ray indicating accumulation of secretions. Liability is associated with failure to re-intubate a patient who cannot breathe on her own. Ventilators and tracheotomies are unpleasant but essential aspects of keeping a patient alive. Managed correctly, they save lives. Managed incorrectly, they can kill.

Implications for attorneys

1. Plaintiff attorneys should question their clients about what, if anything, they remember about being on a ventilator in the critical care unit. Note also that some medications, such as Versed, eliminate the memory of the experience. A major head injury can also wipe out awareness and memory. Did the patient experience a sense of helplessness, fear or frustration? Does the patient remember being suctioned?
2. The defense counsel should be aware of this element of damages, and focus on factors that eliminate memory of the dependency period.
3. Both sides on the case should have a legal nurse consultant or expert look at the medical records for evidence of conscious suffering. The reviewer will look for chart entries of gagging and coughing during suctioning, withdrawal from the noxious sensation of suctioning, and incidents of self-extubation.
4. Tracheostomies leave scars on the neck, which can be pronounced in those prone to keloid formation- wide, rippled scars.

References are found online at www.medleague.com