



For Every Event, Please Document

Case: Late one evening a 23-year-old female presented to a community hospital emergency department with complaints of wheezing and difficulty breathing. She had a history of asthma with two admissions to the hospital in the last 12 months. She had recently completed a course of steroids. Upon examination by the emergency room physician she was found to have moderate to severe wheezing throughout all lung fields, a heart rate of 130 bpm and an oxygen saturation of 89% on room air.

Over the next hour the patient was treated with IV steroids, IV magnesium as well as albuterol and Atrovent by handheld nebulizer. At the end of the hour long treatment the patient reported improved symptoms and her oxygen saturation had increased to 93% on room air, but her heart rate remained at 130 bpm. At this point the attending physician documented the patient's improvement, but also recorded the patient's tachycardia and continued hypoxia. The attending physician elected to observe the patient in the emergency department and repeat albuterol treatments.

Vital signs reported by the nursing staff over the next eight hours reflect a continued tachycardia between 125 and 135 bpm and oxygen saturations that declined from the low 90s to the upper 80s. The next note by the attending physician was nine hours after patient's arrival where he noted that patient showed signs of respiratory failure and that emergent intubation was indicated. The intubation was complicated by large volume emesis. After intubation the patient's oxygen saturation did not rise above 92%. The attending physician made arrangements to transfer the patient emergently to a hospital where she would be under the care of a pulmonologist.

Upon arrival at the receiving hospital the patient remained hypoxic and never regained consciousness. Life support was withdrawn 48 hours later. Autopsy demonstrated large amounts of mucous in the patient's small and medium size airways as well as bronchial hyperemia.

Analysis: Challenges for defending this case included the ER physician's failure to address lowering O2 saturation levels appropriately prior to intubation. While the patient was being observed in the emergency department the physician's documentation was not clear as to what aspects of the patients presentation were being observed nor did they reflect the physician's judgment or thought process.

Action items: When observing patients it is important to document:

- What is being observed: Vital signs, response to therapy, etc.?
- What the plan is: What are the events that will trigger either an admission or discharge?
- How is the patient responding: Improving? Declining? No change?

In Conclusion: Observation remains a powerful tool for the treatment and assessment of certain emergency department patients. It is important for the attending physician to document the plan and goals for observation as well as the patient's response to the treatment plan. This is in the best interest of the patient and can provide protection for the provider if there is an unexpected outcome.



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