

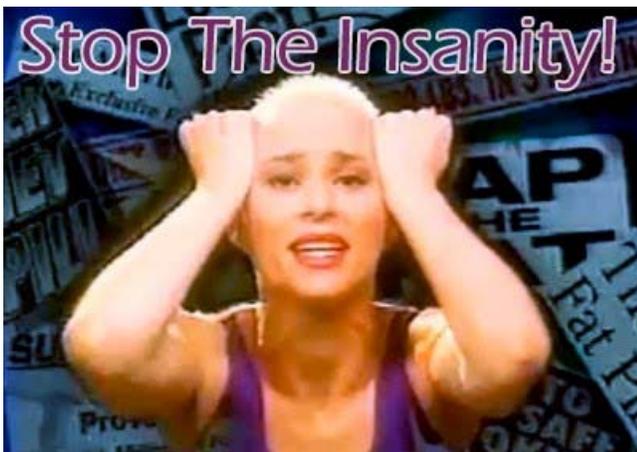
Trauma MedEd

What To Do When The Doc Won't Listen

"Insanity: doing the same thing over and over again and expecting different results."

- Albert Einstein

I know it's happened to you. Your patient is having a problem. You do a little troubleshooting, but you feel that a doctor needs to know and possibly take some action. So you page them and duly note it in the medical record. No response. You do it again, and document it. No response. And a third time, with the same result.



And now what? Call someone else? Give up and hope the patient improves?

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TRAUMA CALENDAR OF EVENTS

EMERGENCY NURSING 2015

LOCATION: ORLANDO, FLORIDA

DATE: SEPTEMBER 28 – OCTOBER 3, 2015

19TH ANNUAL SOCIETY OF TRAUMA NURSES CONFERENCE

LOCATION: ANAHEIM, CALIFORNIA

DATE: MARCH 30 – APRIL 2, 2016

What if the doctor on call is a known asshole? Are you even reluctant to call in the first place? Do you delay as long as you possibly can?

Believe it or not, I've seen many chart review cases over the years where this situation does arise. And every once in a while, the patient actually dies. Sometimes this is directly related to the lack of intervention, but sometimes it just sets the ball rolling that eventually leads to patient demise days or weeks later.

What's the answer? We all want to provide the best care possible for our patients. But sometimes social factors (or pager malfunctions) just get in the way. Here's how to deal with it.

Every hospital / nursing unit needs to have a procedure for escalating patient care calls to more advanced providers. When one of your patients develops a problem, you usually have a pretty good idea of what the possible solutions are. So call/page the proper person (PA/NP/MD) who can provide that solution. If they don't give you the "right answer", then question it. They are not all-knowing.

If they give you a good explanation, go with it, but keep your eye on your patient's progress. If they can't explain why they are giving you the wrong answer, suggest they check with someone more senior. And if they don't want to, let them know

that you will have to do this. Consider no answer the same as a wrong answer.

Don't stop going up the chain of command until you get that right answer, or an explanation that satisfies you. The hard part here is going up the chain. You may not be comfortable with this. But you do have resources that can help you who have more authority (nurse manager, supervisor, etc). If they, too, are uncomfortable, then your hospital has much bigger problems (unhealthy workplace).

Example: trauma unit nurses at my hospital will call the first year resident first, then escalate to the junior and/or chief residents. If they don't do the right thing, the in-house trauma attending gets the call. If they don't handle it, then the trauma medical director (me) gets called. And, of course, I always do the right thing (chuckle). And our nurses know that the surgeons support them completely, since this facilitates the best patient care. The residents and PAs are educated about this chain of command when they first start on the trauma service, and it makes them more likely to choose the "right answer" since they know the buck may not stop with them.

Nurse Practitioners And Physician Assistants In US Trauma Centers

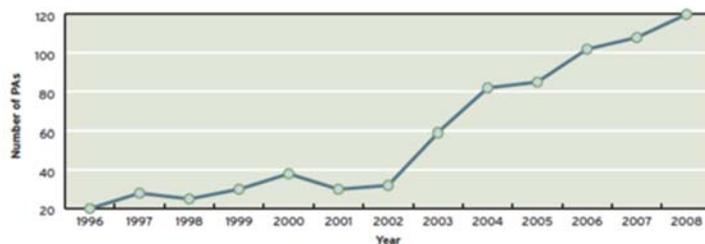
The number of physician assistants (PAs) and nurse practitioners (NPs) moving out of primary care to work in specialty areas in US healthcare is rising. Trauma programs in teaching hospitals have been affected by the work hour restrictions put into place 10 years ago. Non-teaching programs have been adding these midlevel providers to help balance workloads.

How common is the use of midlevel providers in trauma care? Nine-item surveys were sent to 464 designated or ACS verified trauma centers across the US.

Here are the factoids:

- The response rate was 53%, which is very good

- **It's too bad that Level III and IV centers were excluded.** There would have been some good data there.
- About half were ACS verified trauma centers. Also, roughly half were Level I and half were Level II.
- **35% used PAs, 33% used NPs, and 54% used residents.** There was overlap in use.
- **ACS verified centers used midlevels more frequently than non-ACS centers (62% vs 41%)**
- Level I centers used them more than Level IIs (73% vs 53%)
- Trauma centers with residents used midlevels more often than those without (66% vs 41%)
- Midlevels were utilized for the traditional tasks of a surgical provider (H&P, discharge summary, rounds, trauma resuscitation, surgical assistant)
- A third performed procedures like chest tubes, arterial and central lines
- 19% of hospitals that did not use midlevels planned to start soon



Bottom line: Midlevel providers such as PAs and NPs are being used more and more frequently in trauma care. If you look at the graph, the inflection point happened just around the time of the new work hour rules. We use them at our trauma center, and they are very prevalent at the centers I have visited. These providers are valuable clinicians and their contributions to patient care should be embraced!

As a side note (opinion), the amount of trauma slowly grows with the population. And the number of "trauma hours" spent to take care of these patients is a zero sum game. This means that resident exposure to trauma must be decreasing as midlevel provider involvement

increases. Physician training in trauma (and all other disciplines as well) is shrinking, but at least they're not tired!

Reference: Acceptance of physician assistants and nurse practitioners in trauma centers. JAAPA 23(1):35-41, 2010.

PAs And NPs At Level I Trauma Centers: Do They Help?

Trauma service staffing is important to maintaining trauma center status. Teaching centers in the US have been grappling with resident work hour rules, and non-teaching centers have always had to deal with how to adequately staff their trauma service. **What is the impact of staffing a trauma center with midlevel practitioners (MLPs) such as physician assistants and nurse practitioners?**

A state designated Level I trauma center in Pennsylvania retrospectively examined the effect of adding MLPs to an existing complement of residents on their trauma service. They examined the usual outcomes, including complications, lengths of stay, ED dwell times and mortality.

Here are the factoids:

- **ED dwell time decreased for trauma activations and transfers in**, but it increased for trauma consults. Of note, data on dwell times suffered from inconsistent charting.
- **ICU length of stay decreased significantly**
- **Hospital length of stay decreased somewhat** but did not achieve significance
- **The incidence of most complications stayed the same**, but urinary tract infection decreased significantly
- There was **no change in mortality**

Bottom line: There is a growing body of literature showing the benefits of employing midlevel providers in trauma programs. Whereas residents may have a variable interest in the trauma service based on their career goals, MLPs are professionally dedicated to this task. This study demonstrates a creative and safe solution for managing daily clinical activity on a busy trauma service.

Reference: Utilization of PAs and NPs at a level I trauma center: effects on outcomes. J Amer Acad Physician Assts, July 2011.

Forensic Nursing

Forensic Nursing combines nursing science with the investigation of injuries or deaths that involve accidents, abuse, violence or criminal activity. Sexual Assault Nurse Examiners (SANE nurses) are one of the most recognized types of forensic nurses, but they have special training in one type of injury. Forensic nursing programs typically involve a broader set of skills, encompassing some or all of the following:

- Interpersonal violence, including domestic violence, child and elder abuse/neglect, psychological abuse
- Forensic mental health
- Correctional nursing
- Legal nurse consulting
- Emergency/trauma services, including auto and pedestrian accidents, traumatic injuries, suicide attempts, work-related injuries, disasters
- Patient care facility issues, including accidents/injuries/neglect, inappropriate treatments & meds
- Public health and safety, including environmental hazards, alcohol and drug abuse, food and drug tampering, illegal abortion practices, epidemiology, and organ donation
- Death investigation, including homicides, suicides, suspicious or accidental deaths, and mass disasters

Forensic nurses find that their additional training improves their basic nursing skills, and allows them to derive greater career satisfaction from helping patient in another rather unique way.

Approximately 37 training programs exist, ranging from certificate programs that require a specific number of hours of training, to degree programs (typically Masters level programs). Many of the certificate programs are available as online training.

Reference: International Association of Forensic Nurses (<http://www.iafn.org/>)

Nursing Tips for Managing Pediatric Orthopedic Trauma

Nurses have a complementary role with physicians in caring for children with orthopedic injuries. Typically, the child will have been evaluated and had some sort of fracture management implemented. In children, nursing management is easier than in adults since a child is less likely to need an invasive surgical procedure. Many fractures can be dealt with using casts and splints alone.

Here are a few tips for providing the best care for your pediatric patients:

- **Ensure adequate splinting / casting.** You will have an opportunity to see the child at their usual level of activity. If it appears likely that their activity may defeat the purpose of the cast or splint, inform the surgeon or extender so they can apply a better one.
- **Focus on pain control.** Nothing aggravates parents more than seeing their child in pain! Make sure acetaminophen or ibuprofen is available prn if pain is very mild, or scheduled if more significant. Ensure that mild narcotics are available if pain levels are higher. Remember, stool softeners are mandatory if narcotics are given.
- **Monitor compartments frequently.** If a cast is used, check the distal part of the extremity for pain, unwillingness to move, numbness or swelling. If any are present, call the physician or extender and expect prompt attention to the problem.
- **Always think about the possibility of abuse.** Fractures are rarely seen in children under 3, and almost never if less than 1 year old. If you have concerns about the physical findings or parent interactions, let the physician and social workers know immediately.

Cardiac Contusion (For Nurses)

Cardiac contusion is an uncommon condition that is too commonly worried about. It requires **extreme blunt force** with a **significant head-on component**. The most

common mechanisms are car crashes (steering wheel) and sports injuries.

A true cardiac contusion is very rare. If a patient did not strike their chest hard enough to cause significant and lasting anterior chest pain, they probably do not have one. If the force was enough to cause a **sternal fracture**, there is some possibility they may have sustained a cardiac contusion. During ED evaluation, if a patient with a significant mechanism does not exhibit any arrhythmias, they do not have a contusion.

Diagnosis is relatively simple: **any trauma patient with a likely mechanism who has chest wall pain and a new arrhythmia or cardiac pump failure has a cardiac contusion.** Atrial or ventricular arrhythmias are significant, but a ventricular one is significant because it can degenerate into v-tach or worse. **Enzyme measurements do not indicate severity of injury or outcome and should not be obtained.**

From a nursing standpoint, you should monitor for and report the following:

- A **new arrhythmia**, especially a ventricular one. Medications or cardioversion may be ordered to treat.
- Hypotension, pulmonary congestion, or other **signs of heart failure**. An echocardiogram or vasoactive medications may be ordered.
- Remember, **true cardiac contusion is rare!** If suspected, telemetry is indicated, along with frequent vital signs. **Cardiac enzymes should not be ordered**, and any indication of **cardiac problems (arrhythmia or failure) should be reported and treated promptly.**

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