



Traumatic Eye Injuries

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DISCLAIMER

Recommendations presented here should not be considered inclusive of all proper methods of care or exclusive of other methods of care reasonably directed to obtain the same results. The ultimate judgment regarding the propriety of any specific procedure or treatment must be made by the ophthalmic in light of the individual circumstances presented by the patient. This information is intended solely to provide risk management recommendations. It is not intended to constitute legal advice and should not be relied upon as a source for legal advice. If legal advice is desired or needed, an attorney should be consulted. This information is not intended to be a modification of the terms and conditions of your OMIC policy of insurance. Please refer to your OMIC policy for these terms and conditions.

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Allegations of failure to diagnose are common in medical malpractice lawsuits against ophthalmologists. This document will focus on traumatic eye injuries, and follow a patient who was referred to an ophthalmologist with a history of being struck in the eye with metal when a screwdriver shattered a screw. There was a delay in diagnosing a metallic foreign body. The resulting endophthalmitis could not be successfully treated, and the patient required an enucleation and prosthesis. The risk management recommendations offered here can help promote patient safety and reduce liability exposure.

Telephone screening of ophthalmic problems

Making medical decisions on the basis of the limited information obtained over the telephone is a risky—albeit necessary—aspect of ophthalmic practice. To safely recruit your staff's assistance, develop and implement a telephone screening protocol. Elicit a careful history when taking after-hours calls, and document your discussion. "Telephone Screening of Ophthalmic Problems" contains a risk analysis, screening guidelines, and sample contact forms for staff and physicians. It can be found on the OMIC website at www.omic.com; click on "Risk Management Recommendations" in the middle section of the homepage for an alphabetical listing of documents.

The diagnostic process

Ruling out the worst possible diagnosis is a proven axiom of healthcare risk management. One of the simplest, but most helpful, formulations of this advice comes from Carolyn Buppert in "A Witty (WIT-D) Approach to Avoiding Mistakes", Gold Sheet 4(6), 2002.

- W = worst thing (identify it, rule it out). Asking yourself “What is the worst thing the patient could have with this presentation?” guides you in establishing a prioritized differential diagnosis.
 - In this case, the worst thing is a retained foreign body, which could lead to traumatic endophthalmitis.
- I = information (needed to rule the worst thing in or out). Knowing what information to seek will guide you in performing the History & Physical, ordering studies, and asking for consultations.
 - When a patient presents with a traumatic eye injury, it is important to obtain and document an exact description of the mechanism of the injury. Review all referral requests, notes made by staff, and talk to the patient.
 - To rule out a foreign body, order an x-ray or CT. In this case, the plaintiff alleged that doing so would have expedited removal of the foreign body and prevented the resulting endophthalmitis and enucleation.
- T = tell someone (about the worst thing). What information should you share—with the patient and other involved healthcare providers—to ensure that you are notified of all signs and symptoms that could help establish the diagnosis and determine the treatment plan?
 - Enlist the patient’s help by encouraging him to immediately tell you of any change in vision.
 - If the patient is hospitalized, write explicit orders for nurses on signs and symptoms you want reported to you at once.
 - Share your decision-making process and differential diagnosis with, for example, Emergency Department physicians, all consultants, and the patient’s Primary Care physician.
 - Traumatic eye injuries Make sure patients understand that you are concerned that they might develop an infection. Explain that a severe infection can progress rapidly and lead to blindness or even loss of the eye. Tell them exactly what symptoms to watch for, and encourage them to call you as soon as they notice any changes.
 - Although the ophthalmologist did inform the patient to return to the office if his symptoms worsened, the patient waited several days before seeing the physician.
- D = document. Documenting your decision-making process is crucial for both continuity of care and in order to defend your actions should your care later be questioned.

Documentation of the decision-making process

Carefully document key components of the decision-making process. While ophthalmologists do not explicitly use a SOAP format in their charting, the documentation should include these elements.

- S = Subjective. When possible, use the patient’s own words to document the presenting complaint, including onset, severity, duration, how it affects vision, and whether the patient has contacted another healthcare provider about it.
 - If the patient has cataracts, include information on how the cataract affects the patient’s ability to perform activities of daily living.

- With traumatic injuries, carefully elicit and document the mechanism of the injury.
- O = Objective. Document the history and diagnostic process, examinations performed, and whether the pupils were dilated. Chart all pertinent positive and negative findings.
- A = Assessment. Include your differential diagnosis.
- P = Plan. Include further diagnostic work-up, treatment, follow-up plans, and any instructions given to the patient about when to call you and when to return.

Warning signs of a missed diagnosis

- Diagnosis does not account for all symptoms and findings
- Decision-making process did not rule out worst case scenario
- Patient not responding to treatment
- Recurring complaint
- New or evolving complaint
- Repeat visits or phone calls
- Phone calls to multiple providers

Re-diagnosis process

- Start again
- Obtain records from other providers
- Read all prior chart notes
- Account for all symptoms and findings
- Ask for consultation or referral as needed
- Use WIT-D approach, SOAP-type documentation

Follow-up systems

In order to monitor results of diagnostic procedures, compliance with treatment recommendations, and appointments, schedule appointments before the patient leaves the office and create a tracking system for:

- Missed or cancelled appointments
- Patients you send for consultations and referrals
- Diagnostic tests and procedures performed by another provider
- Requests for consultations/referrals
 - From the Emergency Department
 - From other providers

See “Noncompliance: A Frequent Prelude to Malpractice Lawsuits” for risk management recommendations, sample follow-up systems, and sample “missed appointment” and “noncompliance” letters. It can be found on the OMIC website at www.omic.com; click on “Risk Management Recommendations” in the middle section of the homepage for an alphabetical listing of documents.

OMIC policyholders who have additional questions or concerns about practice changes are invited to call OMIC’s confidential Risk Management Hotline at (800) 562-6642, extension 641.