Module 2 – Risk Management Paper

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FNP Group 4

Presented to

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In Partial Fulfillment

Of the Requirements for the Course

GNRS 5350: Professional Roles and Business Principles

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June 10, 2013

Introduction

The management of a sick child is a difficult task that needs a very astute and observant provider. The provider must be able to listen to the history of not only the child, but also the parent; then, with the addition of the physical exam, piece together what diagnoses the child may have; A more difficult task when the child is not presenting to the clinic while having a sick episode, but appears well despite an underlying disease process. A prime example of how astute and observant the provider for a child must be is showcased in T.G’s story. Unfortunately for T.G and for his healthcare team, this was a sentinel event; however, it was one that could have easily been avoided if the management of the practitioners had been more precise and diligent.

Perception

T.G was a child who had made several visits to his doctor’s office where he was seen by a pediatrician and family nurse practitioner for “blacking out” and “fainting spells” during play and exercise. The child would experience these episodes while at school running, playing soccer, rugby, and baseball. During one traumatic occasion, T.G was running while playing rugby. He ran into a pole, walked a few steps, and then fainted. During subsequent encounters, T.G suffered more blackouts and seizure-like activity. In the end, T.G went into cardiac arrest while swimming in a pool with his parents; he later went into a vegetative state and expired. In this case the child was the ultimate victim. T.G endured many ill episodes which were never properly diagnosed and, he ultimately perished due to his misdiagnosed and/or undiagnosed condition. T. G’s perspective in this ordeal is one of an innocent child who put his trust in his parents. He trusted that his parents would take care of him and that whomever they trusted would also care for him appropriately. By default, he also placed his innocent trust in the care provided by his healthcare providers. He just wanted to be a normal child who could play and run without “blacking out”. The parents perspective was protective and of concern for their child. They wanted an answer and a cure to what was occurring to their child. They believed that their healthcare provider could do just that, give answers and find cures. People seek the help of their doctors and FNP’s because there is an innate trust placed in them that they can properly diagnose and treat people who are ill. They are seen as experts in healthcare delivery and those with the answers to healthcare needs. When the parents felt that there was a breech in this trust, due to the misdiagnosis and death of their child, they sought retribution because as parents they felt their child was harmed due to the acts of the providers. This led T.G’s parents to sue the MDs and FNP who managed their son’s condition.

The perspective of the healthcare providers was probably not one of malicious intent in the improper management or treatment of T.G’s condition. The providers more than likely felt that they handled this case properly and within their scope. The pediatrician, during the second visit, was wise to refer the patient to cardiology and was wise enough to realize that this case was more than likely out of his scope. The cardiologist in turn did an echo and treadmill test on the child which came back normal. It seems that the cardiologist saw these normal results and felt that the child would grow out of these spells which he felt were benign vaso-vagal syncope episodes. He was on a good track by providing the patient, school nurse, and parents with signs to look for if the child were to have another episode. The FNP, during the first traumatic visit, did well by ordering a CT to help rule out any acute head injury. During the second visit to the FNP, the child presented with a history from the school nurse that included convulsive movements and was properly sent to a specialist, the pediatric neurologist.

FNP Options

No matter whose perspective we are taking into consideration, the fact of T.G’s case study is that he was misdiagnosed and died after numerous visits to his clinician’s office. Upon examination of this case one has to ask if there was negligence on the part of the providers, specifically, the FNP. Negligence, by definition, is the failure to act in a reasonable way as a healthcare clinician (Hamric, 2009). It can be argued that the FNP was negligent because she did not heed the rules to avoid malpractice as stated by Hamric (2009); she did not take into consideration the “red flag” complaints and conditions. She was presented with this child not once, but twice, who had an extensive history and a curious unresolved condition. She had the reasonable option of passing this patient on to the pediatrician and seeing T.G as out of her scope of practice. She could have requested that the child be seen by the pediatrician. By having the pediatrician see T.G., continuity of care would have been maintained. Continuity of care is an essential element of good primary care. Other elements include concepts such as coordination of care, patient-centered care and integration of care. Continuous care of a patient, especially chronically ill patients, by a physician is central to effective care and good patient outcome. The rationale being that the pediatrician is familiar with his case and its complexity. Also, the FNP could have more thoroughly evaluated the history of the child and worked in collaboration with the pediatrician; she would not have been the primary provider but could have offered more insight and a new set of eyes on this complex case. She could have prudently reviewed the history and advocated for the patient by requesting more in-depth cardiac workup. The FNP, as a nurse, could have helped to coordinate care with the various physicians involved in T.G’s care and made recommendations accordingly based on practice clinical guidelines of management of syncopal episode, arrhythmia, long QT interval, and IHSS. According to Walraven, Oake, Jennings, & Foster (2010), the patient’s continuity of care, which encompasses provider continuity, enhances good patient outcomes. Also, during the visits where she personally saw T.G., she never thought to refer out to the emergency department for a more intensive workup during the episode where the child ran into a pole and fainted. It is unclear if the patient fainted because he hit his head or did he hit his head because he felt like he was going to faint. This was a major trauma for a child with an extensive history which should have been prudently sent to the emergency department for an extensive workup. Another extensive work up and referral to the emergency department was warranted for the second FNP visit where the child was witnessed by the school nurse as having jerky, seizure like movements, blacking out, and incontinence which were new to the patient and not seen before in previous visits.

SOAP Quality

The FNP also did not follow Hamric’s (2009), rule to avoid malpractice of auditing charts for mistakes and omissions. Some deficiencies seen in the FNP SOAP notes include the lack of proper vital sign documentation, which is important for any visit and especially in this case since the child had vital signs that were on border line normal for heart rate and hematocrit, and came in with complaints of trauma, suspected seizure activity and syncope. Another deficiency is that the SOAP notes lacked subjective data; she could have been more detailed in her questioning and assessment. She could have used mnemonics such as OLDCARTS to thoroughly document vital pieces of information. She also did not accurately assess the systems that were critical for this patient such as cardiac and neuro therefore lacked in objective data recording. In a large retrospective series describing children who presented to an emergency department with syncope, exercise related syncope has cardiac etiology (Coleman & Salerno, 2012).

Although these were focused exams, the systems which were important lacked proper documentation. Additionally, in SOAP note #2, the NP documents that the patient's heart rate and rhythm was regular, free of murmurs, this is inconsistent with the previous documentation done by the pediatrician and cardiologist. One might assume that the FNP did not read the patient's history in great detail because then she would have realized that the patient had a murmur.

Communication

The quality of communication and follow up by the FNP and the other providers is disturbing, superficial, and poor. The communication was scant and inconsistent amongst all of the providers. The FNP again neglected Hamric’s (2009), rules of avoiding malpractice by not revisiting unresolved problems until resolved and by not following up on definitive diagnosis and rule outs for diagnostic tests and referrals that were ordered. She did not question the cardiologist on the possibility of prolonged QT syndrome, lack of baseline EKG for the first cardiac visit, lack of mention of QT length, lack of discussion of the abnormal EKG findings by the pediatrician, lack of follow up after three years of the cardiologist stating that it was a vaso-vagal response that should self-resolve and the cardiologist’s indifference and minimization towards the child’s symptoms. These were all red flags and examples of poor management and lack of follow up. The pediatrician also showed poor documentation and follow-up. Written documentation for the cardiologist stressing the pediatrician’s concern about the long QT interval should have been sent to the specialist. As pointed out by Piterman &Koritsas (2005), in as much as a practitioner may discuss a patient’s case with a specialist during referral, it is more acceptable to write a letter explaining the reason for the referral. Written notes help to form paper documentation lines which aid in the protection of the patient and asking provider should it go to court and it also helps paint a full picture for the specialist to help direct his or her care. Written documentation also serves as a good tool to bring details to memory.

Differential Diagnosis

This poor follow up and communication also leads into the poor differential diagnosis which was given by each of the providers and the lack of follow up for the differentials that were noted in the charts. Here again, the FNP did not follow Hamric’s (2009), rule of ruling out the worst possible diagnosis first. Minimal differential diagnoses were made by the FNP and, no differential diagnosis was made by the cardiologist. The pediatrician did make three differential diagnoses with the most severe being prolonged QT but there was a problem. The differential diagnosis of prolonged QT intervals was forgotten and never touched upon again by the providers and instead the more benign diagnosis of vaso-vagal response was given. Also, the SOAP notes should include reasoning why certain diagnosis are included and support as to why certain diagnoses were ruled out; this was not seen in the SOAP notes of the providers. Differential diagnosis is the cornerstone of any treatment plan. By comparing the patient's symptoms to symptoms associated with known diseases, the physician attempts to identify the disease or diseases that best explain the facts of the patient's case (Kent, 1999). For any follow up and any differential diagnosis it is important for the provider to note if all diagnostic tests and referrals were ordered, done, the results recorded and, if abnormal, were the results followed up with a definitive diagnosis or rule out (Hamric, 2009).

Referrals

A primary care provider should be aware, astute, and prudent enough to realize when a case is out of their scope of practice and when to refer to a specialist. Not all specialists are worthy of being used as referrals, as showcased in T.G’s story, therefore it is important for the primary care provider to locate the proper specialist. The specialist should have the clinical competency, competency in applying the consultation process, interpersonal skills, and professionalism needed to effectively manage a difficult patient (Hamric, 2009). When one is referring to a specialist the provider should be aware of the specialist’s strengths and weaknesses. The specialist should also be open to listening to the complaint of the patient and requesting provider. The specialist should be aware of the best clinical guidelines and current evidenced based practices. One key factor when referring out is that the primary care provider needs to be cognizant and in constant communication with the specialist, should the specialist not be fulfilling the need of the patient, then the primary provider needs to be strong enough to find a second opinion and a different specialist. It is also imperative to make sure that referrals are documented in order to keep records for memory and paper lines in case the chart is reviewed.

Conclusion

It is important that the primary care provider provide the best care possible that any prudent provider would give in order to avoid being negligent. Sentinel events such as the one seen in T.G’s case can easily be avoided with proper history taking, physical examination, thorough documentation, formation of top different diagnosis ruling out or in the most severe first, the ability to know when to locate a suitable specialist and following up on all aspects of the patients care. Remembering the cardinal rule of nursing, which is to be the advocate for the patient, will always point the providing FNP in the right direction for the best patient care.

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