



TODDLER REQUIRES SURGERY AFTER DELAY IN FOREIGN BODY DIAGNOSIS

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DESCRIPTION

Miscommunication and failure to follow protocol results in a decomposing button battery being surgically removed from a two-year-old patient's nose.

CLINICAL SEQUENCE

A parent brought their toddler to an urgent care facility for a swollen nose and nasal trauma after reportedly running into a screen door. The child had no significant medical history, and X-rays were performed at the visit. The following day, the radiologist noted a foreign body resembling a battery in the child's right naris with no evidence of fracture. The urgent care facility called the parents and advised them to have their child evaluated by their pediatric provider. A handwritten note on the X-ray documented that the parent was informed of the foreign body, but the parent denies receiving this information.

A nurse practitioner (NP) at the pediatric office saw the patient; however, the NP did not have access to the urgent care notes and did not attempt to obtain the visit records. The parent told the NP about the patient's recent injury and stated the X-rays from the urgent care visit were normal. Relying on the parent's report, the NP's exam noted swelling and bruising around the right eye and the bridge of the nose. The NP ordered follow-up facial, orbital, and skull X-rays and to return for a follow-up visit in three days. The parent reported the wait in radiology was too long, so the X-rays were never completed. The child and parent never presented for the scheduled follow-up visit.

Two weeks later, the parent brought their toddler back to the pediatrician reporting intermittent nose bleeds. The pediatrician documented a normal exam, except for dried blood in the right naris. The pediatrician diagnosed the child with nosebleeds due to dry weather and nose-picking. The parent was instructed to use nasal saline and Vaseline and to follow up in one week. The parent denied being given these instructions.

Nine weeks later, the parent returned to the pediatrician's office because the child had been experiencing malodor and nasal discharge for one week. A different pediatric provider documented

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purulent green discharge from both nostrils and referred the family to an ear, nose, and throat (ENT) physician. The parent claimed they were not aware of this referral.

The following day, the child was brought to the emergency department (ED) with significant nosebleeds. A nurse practitioner in the ED referred the family to an ENT.

Six days later, the child's insurance approved the ENT referral, and an ENT evaluated the child 11 days after that. The ENT confirmed there was a foreign body in the naris and performed surgery five days after the evaluation to remove it. The ENT found multiple pieces of a button battery in both nares. The battery had decomposed and leaked acid, which had damaged the nasal septum and part of the bone, which caused a large anterior nasal septal perforation. As a result, the child may require additional surgery for cosmetic issues related to the perforation.

ALLEGATION

The parent alleged a delayed diagnosis of a foreign body in their child's nose caused preventable nosebleeds, nasal infection, nasal septal perforation, and need for surgery. The claim was brought against the pediatric group, two pediatricians, and the pediatric nurse practitioner.

DISPOSITION

The case was settled in the low range (<\$200,000).

ANALYSIS

Failure to follow policy: The NP's failure to follow the pediatric group policy for obtaining medical and visit records contributed to a misdiagnosis.

Inadequate patient assessment: The NP did not review prior medical records and relied on the parent's report, which contributed to misdiagnosis and inappropriate treatment.

Vague documentation and communication: Unclear documentation of X-ray results and discussion with parents regarding the need for urgent intervention led to increased severity of the child's condition.

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Case Study

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ANALYSIS

Inadequate referral: After identifying the need for critical intervention, the urgent care facility did not advise the parent to seek appropriate care and consultation at the ED or from an ENT.

Failure to follow-up: The urgent care facility's failure to close the loop of communication with the parent regarding the abnormal X-ray results led to a delay in diagnosis. The pediatric office also failed to follow up with the parent regarding the missed appointment and not receiving the ordered follow-up X-ray results.

ADDITIONAL RESOURCES

1. What are your facility's follow-up communication protocols for test results?
2. What protocols are in place to ensure providers obtain a patient's medical history and records?
3. How does your organization ensure patient referrals are clearly communicated?



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