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Turning a blind eye: How lack of communication with ER nurses nearly cost a patient permanent vision loss

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Abstract

This narrative presents a case in which a patient was treated for conjunctivitis, but a breakdown in several layers of communication (between the hospital and the patient, and between hospital personnel) resulted in multiple medical errors that nearly cost the patient permanent vision loss. This real-life case underscores how simple communication errors may lead to life-altering consequences. Recommendations for improving communication to ensure similar errors do not happen to others are provided.

Keywords

Patient experience, patient communication, patient-centered, personal narrative, hospital policy, quality improvement

Background

Americans make over 130 million visits to emergency rooms each year.¹ In fact, as many as 1 in 5 return to the ER within 30 days after they received care,² primarily due to fear and uncertainty surrounding their condition.³ Return visits are very costly, as reports have indicated 20% of Medicare patients alone return to the ER, resulting in costs approximating \$20 billion annually.⁴ While the reasons for ER return visits are highly variable, many also are avoidable. One critical component for reducing costly return visits involves communication between the patient and provider, as communication can have a direct impact on health outcomes. The following presents a case illustrating how a breakdown in communication nearly cost a patient permanent vision loss. The case is followed by an analysis of the communication issues between the patient and the provider. The paper concludes with a series of recommendations for improving communication that will enhance patient care and health outcomes.

The first author of this article presented to an Urgent Care clinic with severe conjunctivitis, including significant pain and swelling, extreme light sensitivity, and difficulty opening the eye. Because his vitals were elevated far above normal levels (heart rate exceeding 130 beats per minute and blood pressure of 177/111), he was asked to leave and immediately visit the local Emergency Room (ER). Upon arrival at the ER, the patient described his symptoms in detail, provided laboratory samples and was treated by a physician. The physician seemed to imply that the ailment was very minor stating, “pinkeye is easy to treat”, and attributed the elevated vitals to pain and stress/worry. The physician prescribed erythromycin salve to treat what she

diagnosed as bacterial conjunctivitis. The patient’s discharge documents stated the patient should call the ER immediately with any questions or if symptoms worsen.

After two days of using the antibiotics as prescribed, the conjunctivitis continued to worsen in severity with the onset of extreme pain and loss of vision. The patient wondered if laboratory results were available and if the medication was the appropriate treatment. Therefore, the patient phoned the ER facility to inquire, as directed in the discharge papers. Upon speaking with ER staff, he was informed that only one individual at the hospital was authorized to speak with patients regarding follow-up care—the “follow-up nurse”—who worked a limited schedule between the hours of 9:00 a.m. to 1:00 p.m. each day. Because ER visits are expensive and laboratory work was pending, the patient opted to communicate with the treating ER hospital before seeking additional care. For three days, the patient attempted to contact the follow-up nurse during the designated hours to no avail. The nurse neither answered the phone nor had voice messaging to receive messages. The patient also spoke with another ER nurse to explain the seriousness of the situation and also explained his unsuccessful attempts at reaching the follow-up nurse. The ER nurse was unable to take his name and phone number to pass along to the follow-up nurse citing hospital policy. Thus, the patient could not reach the follow-up nurse to obtain laboratory results and guidance for further care.

After multiple, unsuccessful attempts to reach the follow-up nurse and the continually worsening eye condition, the patient contacted an ophthalmologist who graciously offered to accommodate this medical emergency. The ophthalmologist immediately recognized the conjunctivitis

was viral in nature. Scar tissue had eroded a deep hole into the patient's cornea costing him complete loss of vision in the affected eye. After scraping the scar tissue, placing a splint into the eye, and prescribing pain medication the patient was finally on the path to recovery, which took approximately one month before vision completely returned to the affected eye.

Patient Reflection

Upon reflection, the patient noted several important errors made at the hospital. First, the physician misdiagnosed the conjunctivitis as bacterial, and thus believed it posed no serious threats. Next, the physician prescribed an antibiotic, which the ophthalmologist noted was both inappropriate for a viral infection and inappropriate for preventing secondary bacterial infections. Additionally, the unnecessary use of antibiotics could contribute to multi-drug resistant infections that compromise the patient's health in the future.

Perhaps more disturbing to the patient, though, was the lack of communication with the treating facility. It is concerning to have only one individual designated to speak with patients who present to the ER 7 days a week, 24 hours a day. The inability to contact the follow-up nurse for consultation was incredibly frustrating. The patient endured excruciating pain awaiting the opportunity to review laboratory results and determine if the appropriate medication had been prescribed. With each passing day that the patient was ignored his situation became increasingly worse and may have cost him permanent loss of vision had he not sought specialist care in time.

As individuals who work in the field of medical education, we believe the lessons learned from this unfortunate case could prove beneficial to health professionals. To be sure, the underestimation of conjunctivitis and adverse impact of antibiotic prescription are important, but perhaps the most significant lesson from a patient perspective involves communication.

Communication and Patient Health

This case illustrates the impact that poor communication had on patient health. Despite making a full recovery, the extreme centralization of communication to one follow-up nurse with limited contact hours, coupled with a complete lack of communication regarding the results of diagnostic testing was extremely damaging. The patient's vision was compromised, his stress levels were elevated, and he experienced physiological distress as a result of numerous failed attempts to communicate with the appropriate personnel. Existing systems of communication failed; voice messaging was not available and other personnel refused to document and relay patient information for prompt attention, citing prohibitive hospital policy.

This case illustrates how interpersonal, group, and organizational communication failures adversely impacted patient health, with the potential for irreversible damage. Often, we think of the impact of communication in terms of patient satisfaction, medical errors and adverse events, and adherence to treatment recommendations. The narrative we presented illustrates the profound impact communication can have on health outcomes. Interpersonal communication between the patient and provider, including the physician's remark about pink eye being "easy to treat" and associated discharge instructions, represent the first relevant communication issue. Written correspondence between physician and patient is an extension of medical care. Discharge instructions relay pertinent information about the visit including a summary of the encounter, diagnosis, and patient instructions.⁶ In this case, the patient was instructed to call the ER immediately with any questions, or if symptoms worsened. The patient followed these instructions when, after two days of taking medication as prescribed, the conjunctivitis continued to worsen.

Adherence to recommendations in the discharge instructions was a turning point for interpersonal communication breakdowns between nursing staff and the patient. Lack of accessibility of the follow-up nurse resulted in worsening of an untreated viral infection that could have led to permanent vision loss. The overarching organizational policy designating one follow-up nurse with limited availability and no possibility of relaying a message within the nursing group exacerbated an already compromised situation.

Recommendations for ER Hospitals and Nursing Departments

Given the interplay between organizational policy, group procedures, and interpersonal patient-provider communication, we offer specific recommendations for improved communication to enhance patient care and health outcomes. We begin by offering recommendations for emergency room administrators and personnel involved at the policy level. Presumably, policies and procedures are developed after careful thought and consideration for how to maximize work efficiency, while also providing optimal patient care. Periodic policy review is imperative, especially in the event of a breakdown in care, as exemplified by this case. While it may be efficient to have one designated follow-up nurse with specified hours, the centrality of communication mandated by this policy directive is antithetical to quality patient care. Not only is it frustrating for patients following discharge instructions, it is also detrimental to the patient-provider relationship.

- We recommend careful policy review to ensure that efficiency is not at odds with patient care, especially in light of patient discharge instructions.

Furthermore, if only a single individual is available for questions, adequate communication systems must be in place to streamline this process.

- We recommend that hospital administrators review existing messaging systems to ensure calls are routed to appropriate personnel in an efficient manner for timely communication with patients.

With appropriate policies and procedures in place, we also offer recommendations for enhanced group communication between nursing personnel. While we certainly appreciate the delicate balance between attending to inpatients and those seeking follow-up care, hospital staff should adhere to their specific roles for efficient health care delivery. As such, emergency room nursing teams should have clearly defined roles and responsibilities.

- We recommend periodic review of how the team is functioning, both behind the scenes, and when working with doctors and patients, to improve interdependence and collaboration. On a micro level, daily team huddles, which designate roles and expectations for the day, will allow for improved coordination, communication, and patient care.

Finally, we offer recommendations for improved interpersonal communication between patients and providers.

- We advocate for a relationship-centered approach⁶ that will result in patients feeling attended to and respected. Relationship-centered care also decreases anxiety for patients and increases trust in providers, resulting in potentially better health outcomes. With respect to the issues presented here, a relationship-centered approach means listening and empathizing—specifically, being accessible and responding to patient inquiries in a timely manner. The follow-up nurse should be available during designated hours, as this is a specified role. He/she should respond to daily messages. Additionally, other nursing personnel should be encouraged to take a message in the event that voice messaging is unavailable.

In summary, this case highlights how communication—specifically, the interplay between organizational policy, group procedures, and interpersonal patient-provider communication—can directly affect patient care and health outcomes. It is our hope that sharing this story can mitigate potential breakdowns in communication and positively impact both patients and hospital personnel.

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