CHILD CASE STUDY

In accordance with the Nursing and Midwifery Council's guidance on confidentiality (2004) all information that may enable identification of the patient has been altered or withheld.

Rosie is a 4 year old girl who was bought to A&E by her mother and grandmother with a 2 hour history of ear pain. She was assessed by A&E staff and referred to the out of hours doctor's service at 22:00. On calling them in I ensured I offered a warm and friendly invite, addressing both Rosie and her relatives so as to initiate a good rapport with both. This is because, when dealing with young children it is vital that the practitioner is able to gain information from both the child *and* carer in order to aid in diagnosis and management and therefore needed to establish a sound rapport with both. Within the first minute or so of the consultation I had identified that Rosie was alert, coherent and mobilizing normally. She was dressed in nightwear but had an appropriate amount of outer clothing in addition (DFES 2003). She was not crying but did not appear happy and was holding her left ear. I opted to use a combination of open and closed questions (Dains et al 2012, Gleadle 2012) which enabled me to establish that Rosie lived at home with her mother and attended nursery. She had experienced a cough, rhinorrhea and a sore throat last week, but her symptoms, apart from a little rhinorrhea, had resolved now. This evening however, she seemed quieter to mother and did not finish her dinner and she went to bed slightly earlier than usual as she seemed irritable. At around 20:00 Rosie woke screaming stating her ear hurt and mother was so concerned at the persistency of her distress some 90 minutes later and despite paracetamol (180mg given at 20:15) that she rang her own mother to get a lift to A&E. By the time they arrived at A&E Rosie had stopped crying and revealed her ear felt "a bit better". It was difficult for Rosie to describe the altered hearing sensation she was experiencing but she did recognize that it was not normal. It was determined that apart from 2 upper respiratory tract infections since joining nursery Rosie had no other medical or surgical history and was on no regular medications, with no known allergies. During the history taking phase Rosie demonstrated an age appropriate level

of verbal communication and comprehension and there were no concerns with her social skills or interactions with family members. This was considered, as every encounter with a child can offer an opportunity to identify issues regarding the development or wellbeing of a child and as healthcare professionals we have a duty to protect children from harm through observations, assessments and sharing of relevant information (DFES 2003).

After obtaining the history the most likely cause of Rosie's ear pain was thought to be otitis media. Otitis media is commonly seen in children under 10 years of age and typically presents with an acute onset of otalgia with some degree of hearing loss and fevers or irritability (NICE 2009, SIGN 2003). With any symptoms relating to the ear a clinical examination is likely in order to confirm a diagnosis. Having engaged Rosie in conversation regarding her likes and dislikes as well as her symptoms I had gained a level of trust when it came to the examination. After checking her temperature, which was 37.2 °c, Rosie agreed for me to examine her throat, chest and neck. I felt examination of these areas was important due to the recent history of an upper respiratory tract infection and also to assess for signs of mastoiditis, a rare condition but one that can present as otalgia (NICE 2009). It was noted that Rosie had evidence of blocked nasal passages with some rhinorrhea, but all other findings were normal. On examination of the ears with the otoscope, I found the right ear canal to have a small amount of wax, there was no signs of inflammation and the tympanic membrane appeared normal. The left external canal was clear of discharge, no foreign body was seen and there was a very small amount of wax. On visualizing the tympanic membrane it was intact, but was very red and bulging slightly. I considered my findings, in conjunction with the history gained. I decided that otitis media with effusion was not the cause due to the acute onset of symptoms and obvious signs of inflammation, there was no evidence of mastoiditis, no foreign body and no ongoing signs of a general upper respiratory tract infection. Tympanic membranes can appear red in children who are crying, but as Rosie had stopped some time ago and the right side appeared normal this was ruled out as a cause (American Academy of Pediatrics 2004). I concluded that the most likely cause of Rosie's otalgia was an acute otitis media. Although her temperature was not

high I acknowledged that she had recently received an antipyretic agent so may have an underlying fever, which is often seen in otitis media.

I explained to mother that the cause of Rosie's ear pain was an infection of the inner ear and that this may have occurred as a result of the virus she had the previous week (SIGN 2003). I reassured her that it was a common condition in children that usually resolved by itself within 2 – 4 days, with long term complications being rare (such as mastoiditis, long term hearing loss). I advised giving Rosie regular paracetamol for pain or if she felt unwell with a fever (NICE 2007). As she is 4 years and 7 months I suggested giving her 240mg up to four times a day, the safe dose for 4 – 6 year olds (British National Formulary 2013). If this was not effective I encouraged mother to try ibuprofen instead. I also explained that at this stage the likelihood of antibiotics reducing the symptoms or length of time Rosie is ill is very small and in fact she is more likely to suffer unpleasant side effects from antibiotics than she is to get any benefit from them (American Academy of Pediatrics 2004, NICE 2008, Johnson and Hill-Smith 2012). Mother said that was ok and that she had plenty of paracetamol at home. She then asked what to do if Rosie didn't improve. I explained that if, after 48-72hrs her symptoms were not improving then we could start an antibiotic as there is a small chance it will help (NICE 2009). In terms of whether to issue a delayed prescription or have the patient re-attend there seems to be no preference, so on this occasion I offered the choice to the mother. This was based on the fact that she did not have her own transport and had a 4 year old who was not feeling well, so an additional trip to her GP may have been a struggle. Mother seemed happy with the consideration but said that her GP surgery was within walking distance and she never had any difficulty getting an appointment with the nurse so was happy to just see how Rosie went. I explained that the pain is caused by a build up of pressure behind the tympanic membrane and that this might perforate causing a leaking of fluid. I advised that should this happen, Rosie should see the nurse for consideration of antibiotics (Johnson and Hill-Smith 2012, NICE 2009). In addition, she should be seen if she becomes systemically unwell, her symptoms are not improving after 48-72hrs or resolved within 4 days, or if she has persistent hearing problems after 14 days

(SIGN 2003). General advice on hydration during a viral illness was also discussed and between mother and grandmother they were able to re-cap on the advice given. Both said they were happy with the plan and mother then apologized for taking up my time, but said she was worried when Rosie was screaming for so long. I reassured her that when a child is that distressed it's only natural to be concerned and that she did the right thing to seek help. I asked if she knew about the out of hours service, which she didn't, so I explained how she can contact us and the national telephone advice line.

For the purpose of this case study I asked if it was ok to contact the mother in 5 days to see how Rosie was doing, which she agreed to. During that call I learnt that Rosie had continued to experience pain for the next 3 days and had also had mild fevers. Her symptoms had been controlled with regular paracetamol during the day and ibuprofen if she woke in pain at night. She reported that Rosie had developed no new or worsening symptoms so had not required a follow up and that now she was well. Mother did state that she could not remember all of the things that would need a follow up with their own GP so was not sure if she needed to take Rosie for a check up. I acknowledged that I had given them a large amount of information to retain and apologized for not giving them follow up advice in written form, but confirmed that as she had fully recovered there was no need for her to be seen again.

On reflection I felt the diagnosis and management plan were evidence based and consideration was given to personal circumstances. However, following the telephone conversation with mother I realized that I had not considered the volume of information I had given her and whether it was likely that all of that detail could be retained easily. I acknowledge that professional advice is only of value if it is retained, or can be located by the patient or carer so ensuring patients/carers remember the advice is vital. In future situations I will offer to provide the individual with written instructions to take with them, acknowledging to them that it is a lot to expect them to remember it all. Overall, I believe that my effective communication and interpersonal skills,

along with providing a clear rationale for a non prescribing strategy meant that an agreed management plan was reached and the mother's satisfaction with the consultation and outcomes were good (Harrison et al 2007, Kurtz, Silverman and Draper 2005, Little et al 2001).

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