



Patient-Centered Cancer Care: Using the APRN Role to Decrease Delays



■ Patricia Griffith, MSN, APN-BC; Aliene Crane, MNsc, ACNP-BC; Sheila Cox-Sullivan, PhD, RN; and Victoria Major, MD

ABSTRACT: This paper discusses the creation of an Abnormal Radiology Findings position for an advanced practice nurse in the imaging department. The Abnormal Radiology Finding position assisted with the decrease in number of days from study to decision of care for our veterans. Any veteran who had an imaging study with a suspected malignancy was followed until a decision of care was determined. Since the implementation of this position at Central Arkansas Veteran Healthcare System, the number of days from study to decision of care decreased from an average of 38 to an average of 7 days. The Abnormal Radiological Findings advanced practice registered nurse role decreased the delays associated with follow-up care and allowed for decisions regarding the veteran's care to be made in a timely manner. This is one more way advanced practice registered nurses can provide excellent and patient-centered care. (*J Radiol Nurs* 2015;34:83-87.)

KEYWORDS: Diagnostic imaging; Delayed diagnosis; Nurse practitioner.

BACKGROUND AND PROBLEM

According to the American Cancer Society, cancer affects more than 12.5 million Americans ([American Cancer Society, 2013](#)). Receiving a diagnosis of cancer is anxiety provoking for any patient, and, for most patients, presents an unknown future relative to treatment choices and fear of death. Although there is no guideline for the ideal time between an abnormal imaging finding and the onset of treatment, providers and patients alike agree less time is better ([Billing & Wells, 1996](#)).

Patricia Griffith, MSN, APN-BC, is a Medical APRN for Substance Use Disorder Clinic, Central Arkansas Veterans Healthcare System; Aliene Crane, MNsc, ACNP-BC, is a Falls Prevention Coordinator, Central Arkansas Veterans Healthcare System; Sheila Cox-Sullivan, PhD, RN, is an Associate Director for Associate Health Education and Evaluation, VISN 16 Geriatric Research Education and Clinical Center, North Little Rock, AR; Victoria Major, MD, is an Associate Chief Radiology Services, Central Arkansas Veterans Healthcare System.

Presented as an oral presentation at the Arkansas Nurses Association conference in Little Rock, Arkansas in October 2012.

This project received no financial support or grant support.

Corresponding author: Patricia Griffith, Eugene J. Towbin Healthcare Center, 2200 Fort Roots Drive, #170-3L North Little Rock, AR 72114. E-mail: Patricia.Griffith@va.gov

1546-0843/\$36.00

Published by Elsevier Inc. on behalf of the Association for Radiologic & Imaging Nursing.

<http://dx.doi.org/10.1016/j.jradnu.2014.12.003>

In the United States, delayed diagnosis of cancer is a frequent cause of litigation for diagnostic errors. [Billing and Wells \(1996\)](#) found that statistically, a delay in diagnosis of less than 3 months is acceptable in the eyes of a jury. However, a delay of 6 months or more seems to be the threshold for negligence. At Central Arkansas Veteran Healthcare System (CAVHS), a significant delay in diagnosis and treatment of cancer in a veteran patient led the facility to initiate a root cause analysis (RCA). The medical center director established the RCA team to review the possible causes in the delay of diagnosis and treatment for an abnormal radiological finding. At the time of review, the veterans at our facility encountered wait times of approximately 30 days or more for onset of treatment. Our providers, including the Chief of Staff (COS) and the radiologists, desired an improvement to the process because they were not content with the results from the RCA.

LITERATURE REVIEW

Numerous studies assess the significance and impact of delays in diagnosis and treatment of cancerous growths. The body of literature on this subject is primarily quasi-experimental or qualitative because ethical principles would prohibit random assignment to delays of treatment. Furthermore, a basic assumption in all the studies is that diagnostic delays are positively correlated to decreased quality of care ([Jenkins, 1978](#)). The delay in patient notification and decision

of care has been an ongoing concern for decades. Jenkins described these concerns as far back as the 1970s before electronic medical records (EMRs). More recent studies show that delays remain a concern in health care with the evolution of technology and widespread use of EMRs (Wahls & Cram, 2007).

The literature divides the etiology of delays into patient delay and system delay. Patient delays are primarily because of denial that a problem may exist (Jenkins, 1978), failure to recognize symptoms or to equate symptoms to cancer (Jensen et al, 2002), and procrastination because of financial concerns. It should be noted that many times these patient delays are documented based on patient recall, which may lend itself to bias. Other socioeconomic reasons for delay may include ethnicity and urban versus rural environment (McConigley, Platt, Holloway, & Smith, 2011). Dworkin, Killackey, and Johnson (1998) found that a lack of understanding rather than access prevented women from seeking attention to grossly visible cervical tumors.

Jenkins (1978) notes that most delays are because of the system but does not identify the exact area where these delays occur. The literature subdivides system delays into delays before consultation with a provider and delays after consultation (Box 1). Additionally, the EMR may prolong discovery of abnormal results (Wahls & Cram, 2007). Finally, the type of cancer influences the speed of diagnosis and treatment planning (Table 1). Breast cancer was the subject of three studies, and the delay for these women ranged from 7 to 35 days. Colon cancer by far suffered the most delay, averaging 336 days; however, this included both patient and system delays.

A delay in weeks to months may not mean a significant difference in overall outcome of staging of cancer or even prognosis (Myrdal et al, 2004), but from the pa-

Table 1. Delays in types of cancer

Author(s)/year	Cancer type	Length of delay (days)*	Type of delay
Billing and Wells, 1996	Lung	109	System
Abdel-Fattah et al., 1999	Breast	35	Patient
Abdel-Fattah et al., 1999	Breast	7	System
Caplan et al., 1996	Breast	28	System
Wallace et al., 2002	Bladder	110	Combined
Stower, 1988	Bladder	126	Combined
Goodman and Irvin, 1993	Colon	336	Combined
Bosl et al., 1981	Testicular	10	System
Allgar and Neal, 2005	Multiple types	56	Combined

*All reports converted to days. If reported as weeks, the table reflects the number of weeks multiplied by 7 days.

tient's perspective, this time frame cannot be acceptable because of the disruption of life during this time. During a diagnostic workup for cancer, there are multiple provider appointments, scans, diagnostic testing, and various other interventions taking place leading to increased anxiety and decreased tolerance for delays.

ALERT SYSTEM

As a result of the RCA, the medical center director created a medical center memorandum (MCM) providing a procedure for alerting the clinical staff of abnormal radiological findings and defining an appropriate response. This MCM designates a coordinator responsible for tracking the abnormal radiological findings that receive a special code, designating that the result is suspicious or highly suggestive of a new malignancy. This code is intended to alert providers so that appropriate medical follow-up is provided in a timely manner. The medical center director determined an advanced practice registered nurse (APRN) should be the coordinator for these alerts. This special code requires the radiologist to electronically notify the ordering provider of the abnormal finding. This MCM also defines the responsibilities for each provider role. According to the MCM, appropriate clinical follow-up includes notifying the patient of this abnormal finding and documenting the notification in the patient's EMR. Responsibility lies with the provider to ensure documentation of the follow-up plan for each of the abnormal findings. The service chief is ultimately responsible for ensuring that all the alerts are properly processed. When the ordering provider is not available, the service chief is responsible for ensuring that appropriate clinical action is initiated for this finding. If the ordering provider does not act on an abnormal finding alert within the time frame designated in the MCM, a notification is sent by the Abnormal Radiological Finding Coordinator, who is an imaging service APRN. This notification includes

Box 1. Categories of System Delays.

Preconsultation delays

Inability to secure appointment in a timely manner.

Delay related to diagnostic recognition of a growth.

Delay in notification of patient.

Postconsultation delays

Delay in access to provider.

Severity of patient presentation.

Missed results related to the electronic medical record.

Download English Version:

<https://daneshyari.com/en/article/2670896>

Download Persian Version:

<https://daneshyari.com/article/2670896>

[Daneshyari.com](https://daneshyari.com)