# RCEM National Quality Improvement Project 2019/2020
# Care of Children in the ED
# Information Pack



## Introduction

Emergency Departments play an important role in safeguarding infants, children and adolescents. The ED may potentially be the first time a child at risk of abuse, neglect or other safeguarding issues comes into contact with services. Care of Children is a new National Quality Improvement Project (QIP) topic introduced in 2019/20 to help EDs measure and improve their safeguarding of young people.

Whilst there are many potential safeguarding areas, this QIP focusses on three key areas for Emergency Departments; injuries in non-mobile infants aged 12 months and under, patients under 18 who abscond or leave the ED without being seen, and appropriate assessment of psychosocial risk in 12-17 year olds.

The QIP will also look at organisational policies in place to safeguard children and adolescents; including when to review patients who abscond or leave the ED without being seen, identification of frequent attenders, and identification of children at high risk of potential safeguarding.

The standards in this QIP are part of a larger set of standards developed by the Royal College of Paediatrics and Child Health (RCPCH): Facing the Future - standards for children and young people in emergency care settings.

## Objectives

The objectives of the national QIP are:

- To identify current performance in EDs against clinical standards and show the results in comparison with performance nationally and in the ED's country in order to facilitate quality improvement.
- To empower and encourage EDs to run quality improvement (QI) initiatives based on the data collected and assess the impact of the QI initiative on their weekly performance data.

**Further information about the RCPCH Facing the Future standards**

The landscape of urgent and emergency care provision for children has changed significantly in recent years and continues to evolve at pace, albeit with much complexity and variation across the UK. The Facing the Future standards aim to ensure that urgent and emergency care is fully integrated to ensure children are seen by the right people, at the right place and in the right setting.

In total, there are 70 RCPCH standards, covering:

- an integrated urgent and emergency care system
- environment in emergency care settings
- workforce and training
- management of the sick or injured child
- safeguarding in emergency care settings
- mental health
- children with complex medical needs
- major incidents involving children and young people
- safe transfers

- death of a child
- information system and data analysis
- research for paediatric emergency care.

**RCPCH Facing the Future audit toolkit**

The RCPCH have developed an audit toolkit which is **unrelated** to this QIP. The RCPCH audit toolkit allows you to monitor your progress in implementing the Facing the Future standards.

This self-reported audit toolkit should be used by service leads to evaluate how well their children's emergency service aligns with the guidance provided by the standards. The toolkit was piloted by RCPCH in August 2018 across the UK and has been refined to support quality improvement and service development. RCPCH recommend that the audit be completed by the multidisciplinary emergency care team as a tool for quality improvement. For submission, help and support please contact the RCPCH Health Policy team: **health.policy@rcpch.ac.uk**

## Methodology

### Inclusion criteria

Patients must meet the following criteria for inclusion:

- Presenting to a type 1 ED
- Children aged 17 years old and under

Sub-samples:

Standards in this QIP look at patients in these sub-sample groups. RCEM recommendeds following the sampling guidance for patients in these sub-sample groups to .

- STANDARD 1: Children aged 12 months and under **AND** presenting with an injury of any severity (e.g. fracture, bruising, burns or triaged as an injury)
- STANDARD 2: Children aged 17 years old or under **AND** who left without being seen (this does not include triage)
- STANDARD 3: Children aged 12-17 years (any presentation)

### Exclusion criteria

Do not include patients:

- Patients aged 18 years or older

For further information about using ECDS or your ED's electronic patient record to identify relevant cases, and to extract data from your system, please see the appendix.

### Flow of data searches to identify audit cases

Using codes in the appendix first identify all patients attending your ED between the relevant dates, then by age at time of attendance, then through the other relevant criteria.

If your ED is reliably using the Emergency Care Data Set (ECDS), then your IT department should be able to a) pull off a list of eligible cases for you, and b) extract some or all of the data you need to enter. Please see appendix 1 and 2 for the list of codes they will need to identify eligible cases or extract the data.

### Forming your QIP team

RCEM recommends forming a multidisciplinary QI team; including consultants, trainees, nursing, pharmacy, SAS, triage and others as needed for the topic and to suit your local set up.

## Data entry information

### Sample size and data frequency

The RCEM clinical audits have had a major upgrade, providing you with a range of new features and quality improvement tools. These include a live data dashboard, tracking how your data changes weekly on run charts, and the ability to have your own PDSA cycles added to your charts.

**Recommended**: To maximise the benefit of the new run charts and features RCEM recommends entering **5 cases per subsample per week** for patients attending between 1 August – 31 January. This will allow you to see your ED's performance on key measures changing week by week and ensure you get the full benefit of the charts such as your mean performance, upper and lower control limits and trend analysis. Please note that if the system does not have enough weekly data points it will not be able to give a mean performance for your ED as the data will not be robust enough.

**Alternative**: If your ED will find weekly data entry too difficult to manage you may wish to enter data monthly instead, although you should still ensure that the patient records you sample include patients attending each week within that month. The system will ask you for each patient's arrival date and automatically split your data into weekly arrivals, so you can get the benefit of seeing weekly variation if you spread the cases across the month.

| Expected patient numbers | Recommended sample size | Recommended data entry frequency |
|---|---|---|
| <5 a week | All patients in each subsample | Weekly |
| >5 a week | 5 patients from each subsample | Weekly |

### Data collection period

Data should be collected on patients attending from 1 August 2019 – 31 January 2020.

RCEM strongly recommends minimising missing data in your final report by ensuring that you submit patient data for as many weeks during the data collection period as possible. This data does not been to be submitted at the same time, but you will find your SPC charts much more useful if you have data that covers as many weeks as possible between 1 August 2019 – 31 January 2020.

### Data submission period

Data can be submitted online at the link below from 26 August 2019 – 14 February 2020. You can find the link to log into the data entry site at www.rcem.ac.uk/audits

### Data Sources

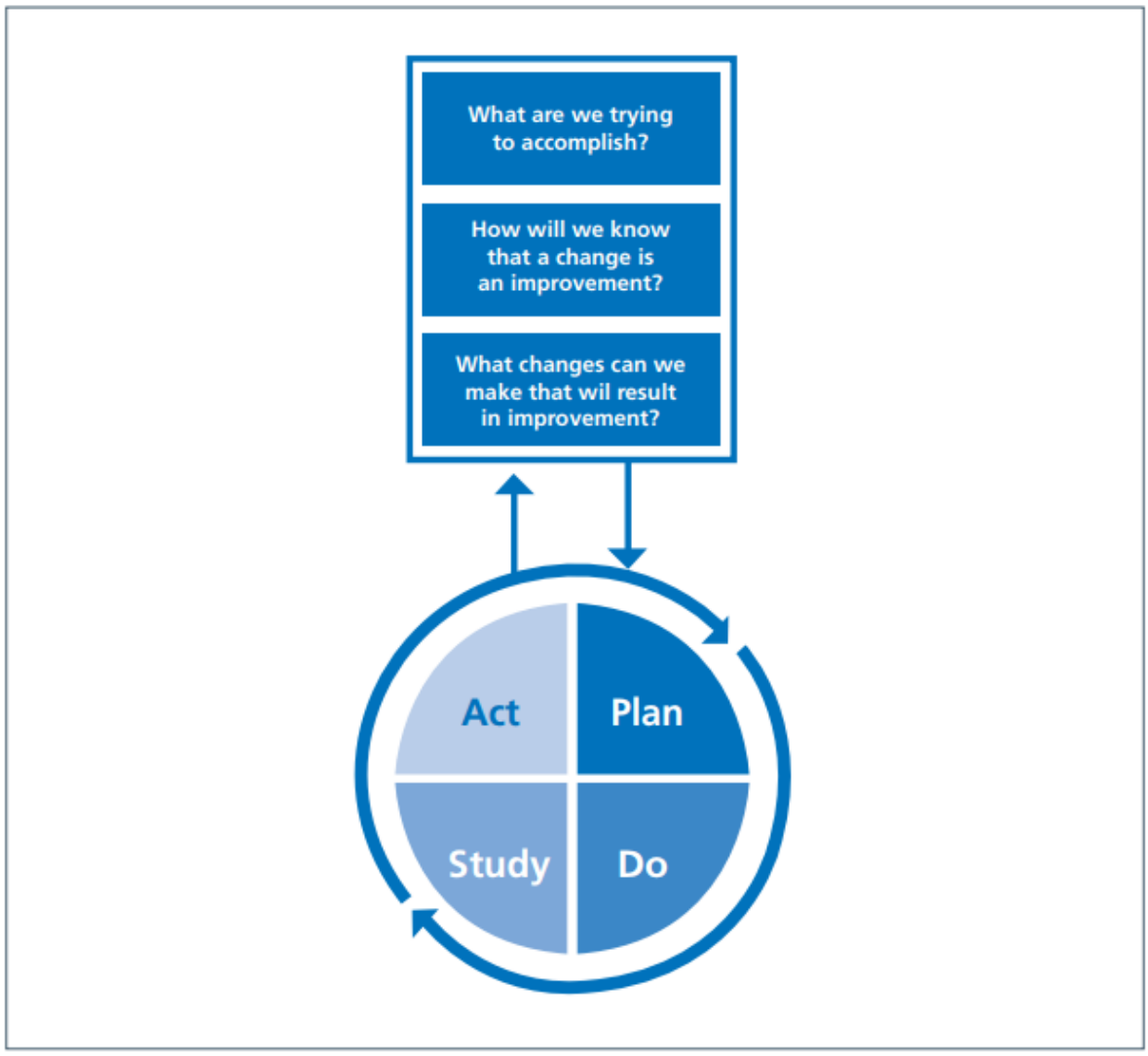
ED patient records including nursing notes (paper, electronic or both).

## Quality improvement information

The purpose of clinical audit is to quality assure and quality improve your service where it is not meeting standards. The new RCEM system allows your team to record details of quality improvement projects (QIP) and see on your dashboard how each initiative affects your data on key measures.

We encourage you to use this new feature to try out QIPs in your department. If you are new to QIPs, we recommend you follow a Plan Do Study Act (PDSA) methodology. The Institute for Healthcare Improvement (IHI) provides a useful worksheet which will help you to think about the changes you want to make and how to implement them.

**The model for improvement, IHI**



## Standards

| STANDARD | GRADE |
|---|---|
| 1. Infants at high risk of potential safeguarding presentations* are reviewed by a senior (ST4+) clinician whilst in the ED.<br><br>*For the purpose of this project we are focussing on children aged 12 months and under presenting with an injury only. | D |
| 2. A review of the notes is undertaken by a senior clinician when an infant, child or adolescent leaves or is removed from the department without being seen. | F |
| 3. Older child and adolescent psychosocial risk is assessed using a national or locally developed risk assessment tool suitable for use with children or adolescents (e.g. headss/heeadsss or similar) | A |

| ORGANISATIONAL STANDARD | GRADE |
|---|---|
| 4. Policies are in place to review cases where an infant, child or adolescent either leaves or absconds from a department unexpectedly prior to discharge, or when they do not attend for planned follow up. | D |
| 5. Systems are in place to identify children and young people who attend frequently | F |
| 6. Policies are in place to identify and review children at high risk of potential safeguarding | F |

**Definitions**

| Standard | Definition |
|---|---|
| Standard 1: high risk of potential safeguarding presentations | For the purpose of this project we are focussing on children aged 12 months and under presenting with an injury only. Injury examples can include fractures, bruising, burns or other presentations that are triaged as an injury. |
| Standard 1: infants | Patients aged 12 months and under |
| Standard 1 and 2: senior clinician | Tier 4: ST4+, senior clinical fellows, SaS, Consultant Senior Advanced Clinical Practitioner or Emergency Nurse Practitioner |
| Standard 2: infant, child children or adolescent | Patients aged 17 years or under |
| Standard 3: older child or adolescent | Patients aged 12 years and over (1) |
| Standard 4 and 5: policies | This is about your organisation's local policy. Children who leave before being seen, abscond or DNA ED follow-up all represent medical & Safeguarding risk. There should be agreed local policies to reduce the level of risk – and guide staff who may not be familiar how to manage these situations. |

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| Standard 5: attend frequently | There is no formal definition of "frequently". The thresholds will vary from setting to setting depending on a range of issues.<br><br>The area of concern is that (a) Some children present more frequently because there are underlying social or safeguarding concerns and (b) they may be attending more frequently because underlying issues in chronic illness are not being addressed adequately.<br><br>It is up to local depts to have set up systems to have attendance counts – and systems in place to review outliers. There is an overlap here with identifying re-attenders. Systems may include flagging on an electronic patient record or other systems. |

**Grade definition**

**F - Fundamental:** need to be applied by all those who work and serve in the healthcare system. Behaviour at all levels and service provision need to be in accordance with at least these fundamental standards. No provider should provide any service that does not comply with these fundamental standards, in relation to which there should be zero tolerance of breaches.

**D - Developmental**: set requirements over and above the fundamental standards.

**A - Aspirational**: setting longer term goals.

## Audit questions

### Case mix

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| 1.1 | Reference (do not enter patient identifiable data) | |
| 1.2 | Date and time of arrival | dd/mm/yyyy HH:MM |
| 1.3 | Patient age | • 0-12 months<br>• 13 months - 5 years<br>• 6-11 years<br>• 12-15 years<br>• 16-17 years |
| 1.4 | Patient presentation | • Injury<br>• Illness<br>• Not documented |

### Safeguarding

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| 2.1 | Was the patient identified in the notes as being high risk of potential safeguarding? | • Yes<br>• No<br>• Not documented |
| 2.2 | → If 1.3 = 12-15 years or 16-17 years<br>Was the patient's psychosocial risk assessed using a national or locally developed risk assessment tool suitable for use with children or adolescents (e.g. headss/heeadsss or similar)? | • Yes<br>• No (or not documented) |
| 2.3 | Grade of most senior ED clinician to actually see and assess the patient in person? | • Consultant or Associate specialist<br>• Staff grade or specialty doctor<br>• Senior clinical fellow (registrar or equivalent)<br>• ST4+<br>• Junior clinical fellow (SHO or equivalent)<br>• ST1-3<br>• FY1-2<br>• Senior Advance Clinical Practitioner or Emergency Nurse Practitioner<br>• Other non-medical practitioner (e.g. nurse)<br>• Left before being seen (this does not include triage)<br><br>dd/mm/yyyy HH:MM |
| 2.4 | → If 2.3 = Left before being seen<br>Grade of most senior ED clinician to retrospectively review the patient's case following their visit to the ED? | • Consultant or Associate specialist<br>• Staff grade or specialty doctor<br>• Senior clinical fellow (registrar or equivalent)<br>• Junior clinical fellow (SHO or equivalent)<br>• ST4+<br>• ST1-3<br>• FY1-2 |

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| | | • Senior Advance Clinical Practitioner or Emergency Nurse Practitioner<br>• Other non-medical practitioner (e.g. nurse)<br>• Notes were not reviewed<br><br>dd/mm/yyyy HH:MM |
| 2.5 | Was the patient referred for safeguarding (e.g. social care, health visitor, other local mechanism)? | • Yes<br>• No<br>• Not documented |

| Notes |
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| Optional space to record any additional notes for local use. Entries here will not be analysed by RCEM. |

## Organisational data

Please answer these questions once per ED.

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| 3.1 | Does your ED or hospital have policies in place to review cases where an infant, child or adolescent either leaves or absconds from a department unexpectedly prior to discharge, or when they do not attend for planned follow up.<br><br>*(tick all that apply)* | • Policy for patients who leave or abscond<br>• Policy for patients not attending planned follow up<br>• No policy |
| 3.2 | Does your ED have systems in place to identify children and young people who attend frequently (e.g. an electronic system that records attendance frequency? | • Yes – an electronic system<br>• Yes – another system<br>• In development<br>• No |
| 3.3 | Does your ED or hospital have policies in place to identify and review children at high risk of potential safeguarding? | • Yes<br>• In development<br>• No |

**Definitions**

| Question/term | Definition |
|---|---|
| 2.1 high risk of safeguarding | This may include a system in the ED to alert safeguarding or check for safeguarding, such as using CIPS. |
| 2.3 left before being seen | Please note that patients being triaged but having no further assessment or treatment should be counted as left without being seen. |
| 2.5 referred for safeguarding | If the patient was referred for safeguarding or some level of potential safeguarding follow up please tick yes. |

## Evidence base for standards

These standards have been checked for alignment with RCPCH Facing the Future: Standards for children in emergency care settings (2).

| STANDARD | EVIDENCE |
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| 1. Infants at high risk of potential safeguarding presentations* are reviewed by a senior (ST4+) clinician whilst in the ED.<br><br>*For the purpose of this project we are focussing on children aged 12 months and under presenting with an injury only. | Facing the future standard 38 |
| 2. A review of the notes is undertaken by a senior clinician when an infant, child or adolescent leaves or is removed from the department without being seen. | Facing the future standard 34 |
| 3. Older child and adolescent psychosocial risk is assessed using a national or locally developed risk assessment tool suitable for use with children or adolescents (e.g. headss/heeadsss or similar) | Facing the future standard 47 |

| ORGANISATIONAL STANDARD | GRADE |
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| 4. Policies are in place to review cases where an infant, child or adolescent either leaves or absconds from a department unexpectedly prior to discharge, or when they do not attend for planned follow up. | Facing the future standard 37 |
| 5. Systems are in place to identify children and young people who attend frequently | Facing the future standard 32 |
| 6. Policies are in place to identify and review children at high risk of potential safeguarding | Facing the future standard 38 |

## Appendix: Analysis plan for standards

This section explains how the RCEM team will be analysing your data. You are welcome to use this analysis plan to conduct local analysis if you wish. Analysis sample tells you which records will be included or excluded from the analysis. The analysis plan tells you how the RCEM team plan to graph the data and which records will meet or fail the standards.

| STANDARD | Relevant questions | Analysis sample | Analysis plan – conditions for the standard to be met |
|---|---|---|---|
| 1.Infants at high risk of potential safeguarding presentations* are reviewed by a senior (ST4+) clinician whilst in the ED.<br><br>*For the purpose of this project we are focussing on children aged 12 months and under presenting with an injury only. | Q1.3. Patient age<br><br>Q1.4. Patient presentation<br><br>Q2.1. Was the patient high risk of potential safeguarding?<br><br>Q2.3. Grade of most senior ED clinician to actually see and assess the patient in person? | Q1.3 = 0-12 months<br><br>AND<br><br>Q1.4 = injury<br><br>AND<br><br>Q2.1 = yes (high risk of potential safeguarding) | **Chart**: SPC<br>**Title**: Standard 1: Infants at high risk of potential safeguarding presentations reviewed by a senior clinician whilst in the ED.<br>**Analysis**: Q2.3 =<br>• Consultant / Associate specialist<br>OR<br>• Staff grade or specialty doctor<br>OR<br>• Senior clinical fellow (registrar or equivalent)<br>OR<br>• Junior clinical fellow (SHO or equivalent)<br>OR<br>• ST4+<br>OR<br>• Senior Advance Clinical Practitioner or Emergency Nurse Practitioner |
| 2. A review of the notes is undertaken by a senior clinician when an infant, child or adolescent leaves or is removed from the department without being seen. | Q2.3. Grade of most senior ED clinician to actually see and assess the patient in person?<br><br>Q2.4. Grade of most senior ED doctor to retrospectively review the patient's case following their visit to the ED? | Q2.3 = Left before being seen | **Chart**: SPC<br>**Title**: Standard 2: Senior clinician review of the notes is patient leaves or is removed from the department without being seen<br>**Analysis**: Q2.4 =<br>• Consultant / Associate specialist<br>OR<br>• Staff grade or specialty doctor<br>OR<br>• Senior clinical fellow (registrar or equivalent)<br>OR<br>• Junior clinical fellow (SHO or equivalent)<br>OR<br>• ST4+<br>OR |

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| | | | • Senior Advance Clinical Practitioner or Emergency Nurse Practitioner |
| 3. Older child and adolescent psychosocial risk is assessed using a national or locally developed risk assessment tool suitable for use with children or adolescents (e.g. headss/heeadsss or similar) | Q2.2. Was the patient's psychosocial risk is assessed using a national or locally developed risk assessment tool suitable for use with children or adolescents (e.g. headss/heeadsss or similar)? | Q1.3 = 12-15 OR 16-17 | **Chart**: SPC<br>**Title**: Standard 3: psychosocial risk is assessed using a national or locally developed risk assessment tool<br>**Analysis**: Q2.2 = yes |
| **Organisational** | | | |
| 4.Policies are in place to review cases where an infant, child or adolescent either leaves or absconds from a department unexpectedly prior to discharge, or when they do not attend for planned follow up. | Q3.1 Does your ED or hospital have policies in place to review cases where an infant, child or adolescent either leaves or absconds from a department unexpectedly prior to discharge, or when they do not attend for planned follow up. | All | Chart showing frequency of responses |
| 5.Systems are in place to identify children and young people who attend frequently | Q3.2 Does your ED have systems in place to identify children and young people who attend frequently (e.g. an electronic system that records attendance frequency? | All | Chart showing frequency of responses |
| 8.Policies are in place to identify and review children at high risk of potential safeguarding | Q3.3 Does your ED or hospital have policies in place to identify and review children at high risk of potential safeguarding | All | Chart showing frequency of responses |
| **Additional analysis** | | | |
| Additional question analysis | Number of cases entered so far<br><br>Q1.2 Arrival/triage time<br><br>Q1.3 Patient age<br><br>Q2.3 grade of most | All | Chart showing frequency of responses |

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| | Q2.5 was the patient referred for safeguarding? | | |

## Appendix: Privacy policy, terms of website use and website acceptable use policy

**Privacy policy**
The Royal College of Emergency Medicine (RCEM) recognises the importance of protecting personal information and we are committed to safeguarding members, non-members and staff (known as "The User" in this document) privacy both on-line and off-line. We have instituted policies and security measures intended to ensure that personal information is handled in a safe and responsible manner. This Privacy statement is also published on the RCEM web site so that you can agree to the kind of information that is collected, handled and with whom this data is shared with.

RCEM strive to collect, use and disclose personal information in a manner consistent with UK and European law and under the General Data Protection Regulation (GDPR). This Privacy Policy states the principles that RCEM follows and by accessing or using the RCEM site you agree to the terms of this policy.

For further information, click here.

**Terms of website use**
For further information, click here.

**Website acceptable use policy**
For further information, click here.

## Appendix: ECDS Search terms to support case identification

These codes will help you and your IT team to identify cases that may be eligible for the audit. This is not an exhaustive list and other search terms can be used. All potential patients should then be reviewed to check they meet the definitions & selection criteria before inclusion in the audit.

If you are looking for injury <1 year old, either a chief (presenting) complaint of:

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and/or a diagnosis of:

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| 1131817100 |

For patients <17 who left without being seen:
Diagnosis 1197614100
and/or
Discharge status:

| |
|---|
| 2018511111 |
| 2018512111 |
| 2018514111 |

Please note: for all CYP patients over 12 years of age, participants would simply need to search by date of birth rather than a specific diagnostic code.

## References

1. *Psychosocial assessments for young people: a systematic review examining acceptability, disclosure and engagement, and predictive utility.* **D, Bradford S and Rickwood.** 2012, Adolesc Health Med Ther, Vol. 3, pp. 111–125.

2. **Royal College of Paediatrics and Child Health.** *Facing the Future: Standards for children in emergency care settings.* 2018.