Crib Sheet for Care in Children QIP (2019-20)

Contents

Standard 1 (developmental)

STANDARD	GRADE
1. Infants at high risk of potential safeguarding presentations* are reviewed by a senior (ST4+) clinician whilst in the ED. *For the purpose of this project we are focussing on children aged 12 months and under presenting with an injury only.	D

Data required for standard 1

Inclusion criteria

Patients must meet the following criteria for inclusion:

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

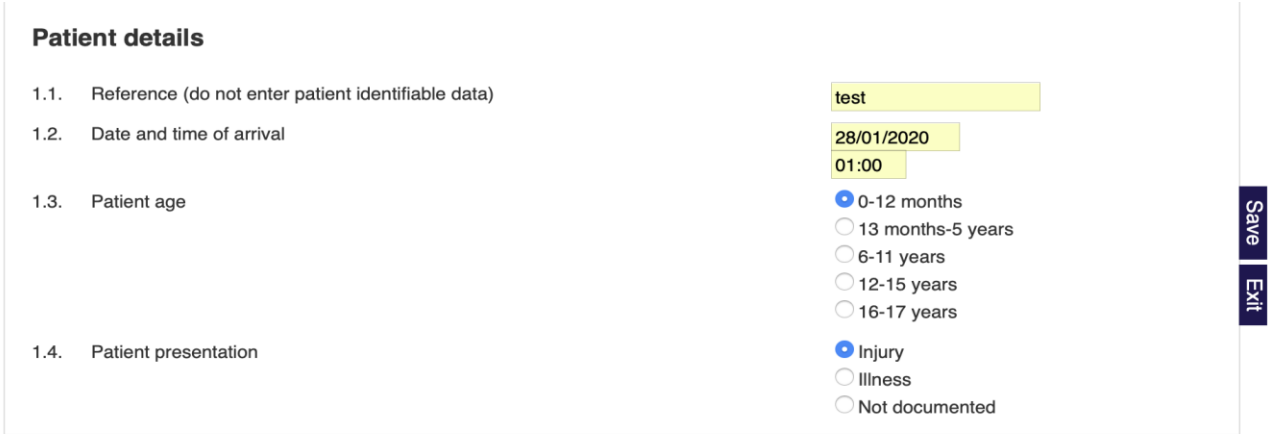
AND

Children aged 12 months and under AND presenting with an injury of any severity (e.g. fracture, bruising, burns or triaged as an injury)

You will need 5 random patients a week.

In-putting data for Standard 1:

1. First set is **CASE MIX DATA** AND IS THE SAME DATA FOR ALL STANDARDS PUT TOGETHER.



Safeguarding

2.1.	Was the patient identified in the notes as being high risk of potential safeguarding?	○ Yes ○ No ◉ Not documented
2.2.	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 ○ No (or not documented)
2.3.	Grade of most senior ED clinician to actually see and assess the patient in person?	○ Consultant / Associate specialist ○ Staff grade or specialty doctor ○ Senior clinical fellow (registrar or equivalent) ◉ ST4+ ○ Junior clinical fellow (SHO or equivalent) ○ ST1-3 ○ FY1-2 ○ Senior Advance Clinical Practitioner or Emergency Nurse Practitioner ○ Other non-medical practitioner (e.g. nurse) ○ Left before being seen
	i. Date/time	01/01/2020 01:02

2. The second set of data changes for **SAFEGUARDING** depends on which of the subsets or standards that are applied.

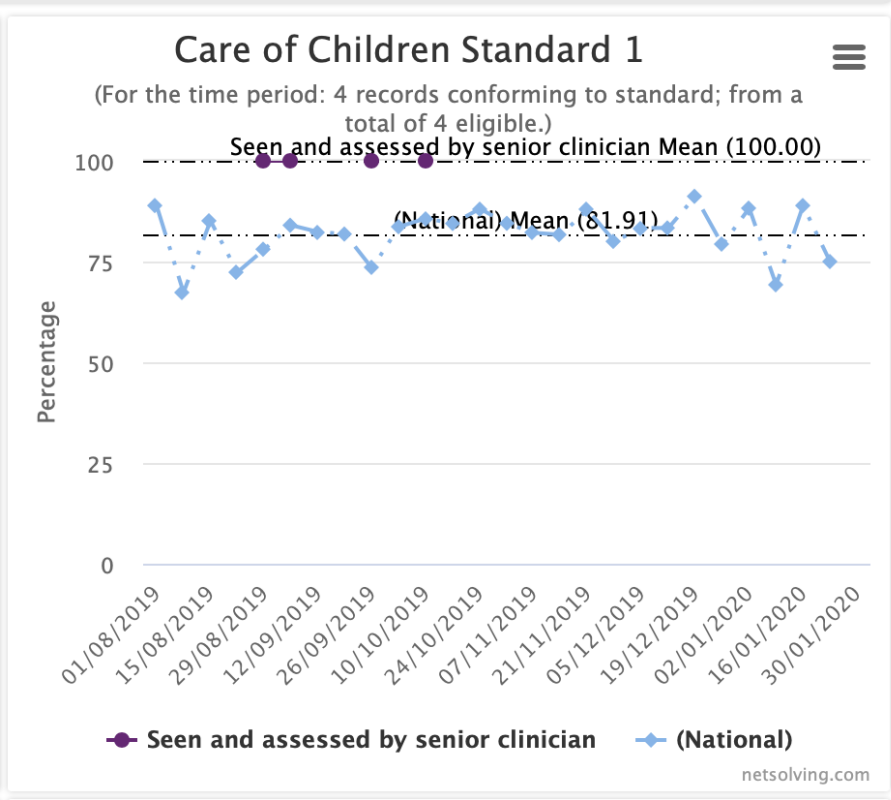
These questions will identify whether safeguarding was identified in the notes. It is likely that we will have ticked the Qu 2.1 safeguarding box and the majority will be 'no'.
The grade of the clinician and time seen will also be recorded.

2.5.	Was the patient referred for safeguarding (e.g. social care, health visitor, other local mechanism)?	○ Yes ○ No ○ Not documented
Notes.	(Optional space to record any additional notes for local use. Entries here will not be analysed by RCEM)	2000 characters left

This question will show whether a HV or SG referral was made following clinical review. It would be expected that the SG box would be ticked 'yes' for these cases but I wonder whether there are many cases that get a HV referral e.g. for accidental poisoning but will have the SG box (Qu 2.1) ticked as 'no'. Whether **further analysis** of this issue is required needs to be considered by the QIP team.

The senior clinician is defined to the RCEM 'Consultant sign off' parameters.

Expected analysis of this data:
The main Run Chart for Standard 1 for our department so far is shown here with the National data line:



Here we have only 4 infants who have been identified as at risk of safeguarding.

The run chart is defined as:

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. *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 Q1.4. Patient presentation Q2.1. Was the patient high risk of potential safeguarding? Q2.3. Grade of most senior ED clinician to actually see and assess the patient in person?	Q1.3 = 0-12 months AND Q1.4 = injury AND Q2.1 = yes (high risk of potential safeguarding)	**Chart**: SPC **Title**: Standard 1: Infants at high risk of potential safeguarding presentations reviewed by a senior clinician whilst in the ED. **Analysis**: Q2.3 = • Consultant / Associate specialist OR • Staff grade or specialty doctor OR • Senior clinical fellow (registrar or equivalent) OR • Junior clinical fellow (SHO or equivalent) OR • ST4+ OR • Senior Advance Clinical Practitioner or Emergency Nurse Practitioner

This means (assuming all the data has been inputted correctly) that we only documented that there were safeguarding risks in 4 children, under 1 year old, presenting with an injury from our random sample of 5 a week, over 26 weeks (5th Aug to 2nd February). In other words, only 4 out of 104 patients. But they were all seen by a senior clinician. Is this true? reflection?

Further Analysis recommends.
1.How many children under 1yo who present with an injury are referred for safeguarding? (Analysis of combination of Qu 1.3 <1 year, Qu = 1.4 injury and Qu 2.5 = yes).
2. How many of these were seen by a senior clinician?

PDSA

1. There is an opportunity for the QIP team to consider whether the safeguarding box in the EHR is capturing the information accurately and to improve documentation of the referral for safeguarding and the consideration of a safeguarding risk.
2. Depending on how many children were <1yo with an injury it may be necessary to include all children to get an accurate picture of numbers referred for safeguarding.
3. Do we think we under-record safeguarding concerns? **How could we use this data to show that?** Can we benchmark against the national picture with only 4 cases considering we a one of the largest departments in the country?

Standard 2 (fundamental)

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

- This is the fundamental standard for the Care in Children QIPs. It is this standard that is most likely to be reviewed as part of the College Audit/QIP data requirement by CQC and therefore the data input must be as consistent.
- It is also an area where there is room for improvement as it is recognised that there is an in increased risk to children who have attended the ED and then left without been seen.
- This standard aims to encourage departments to review the notes of these children and decide as to whether further follow up, HV review, safeguarding, GP etc. is required.

Data required for standard 2

Inclusion criteria

Patients must meet the following criteria for inclusion:

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

AND

Children aged 17 years old or under AND who left without being seen (this does not include triage)

You will need 5 random patients a week who 'left before been seen'.

In-putting data for Standard 2

1. First set is **CASE MIX DATA** AND IS THE SAME DATA FOR ALL STANDARDS PUT TOGETHER.

Patient details

1.1.	Reference (do not enter patient identifiable data)	test
1.2.	Date and time of arrival	28/01/2020 01:00
1.3.	Patient age	○ 0-12 months ○ 13 months-5 years ◉ 6-11 years ○ 12-15 years ○ 16-17 years
1.4.	Patient presentation	○ Injury ○ Illness ◉ Not documented

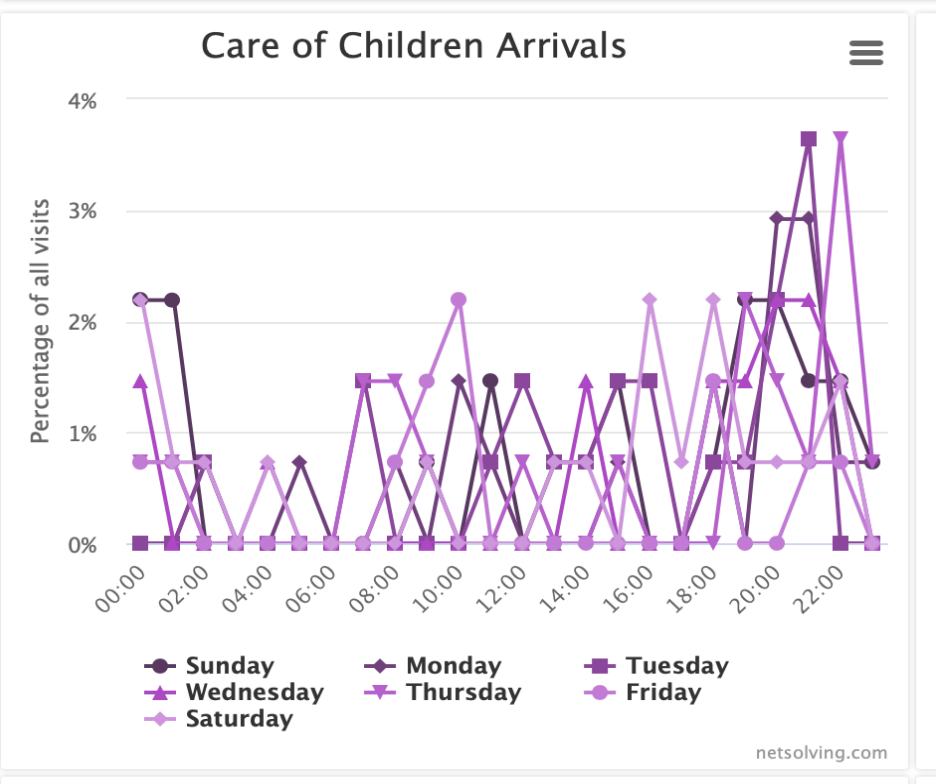
Expected analysis of this data

Example for 'test' patient. Aged 6. The 'times of arrival', 'patient age' and 'patient presentation' is representative of all patients in the whole QIP i.e. for all the standards. It has not been split into each standard.

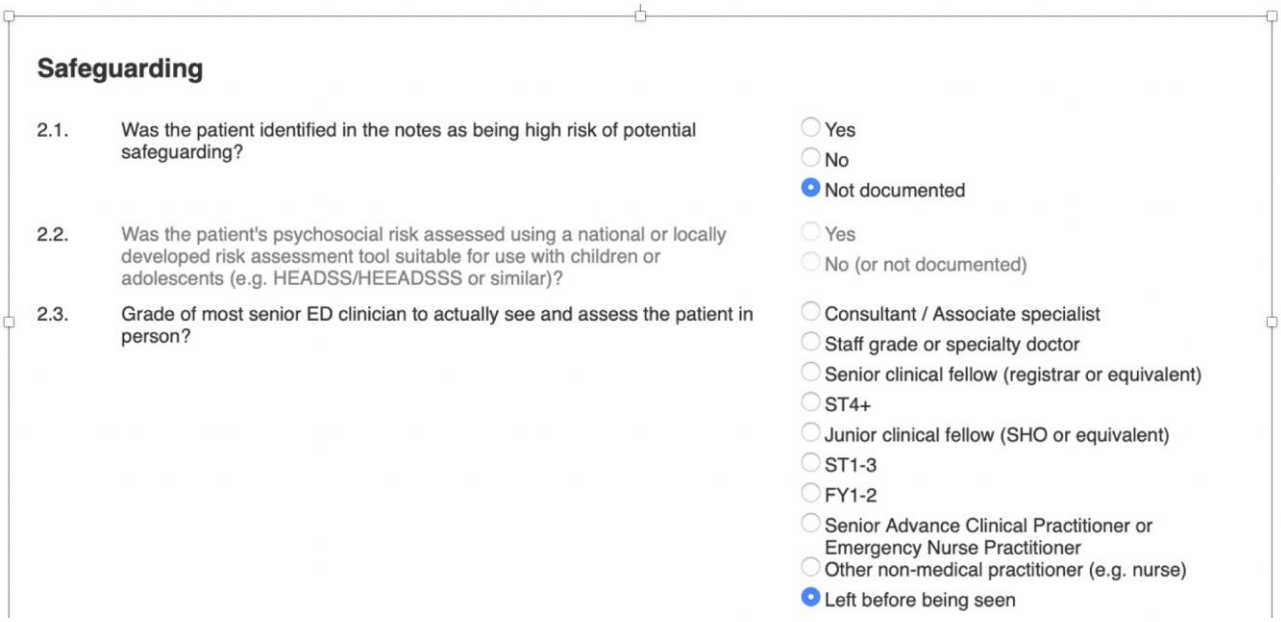
Further analysis of the case mix data for standard 2 from the raw data could be done. For instance, the following questions may be asked of the case mix for standard 2:

1. Are children with an injury more likely to 'leave without been seen'? This could highlight a need for extended ENP care in our department beyond 2030hrs.
2. Are children who 'leave without been seen' more likely to leave after midnight or after 8pm? This could be as a reflection of the consistently high numbers of children. At tendencies that we are seeing in the evenings.
3. Are children more likely to leave at the weekend? As this could reflect the problems with staffing and reduced senior cover at the weekend and could support a move to increase this. This can also be seen in the chart below.

The times and days of presentation are represented in the first Chart. (our data below). We will be able to visually compare with the National picture when the report comes out.



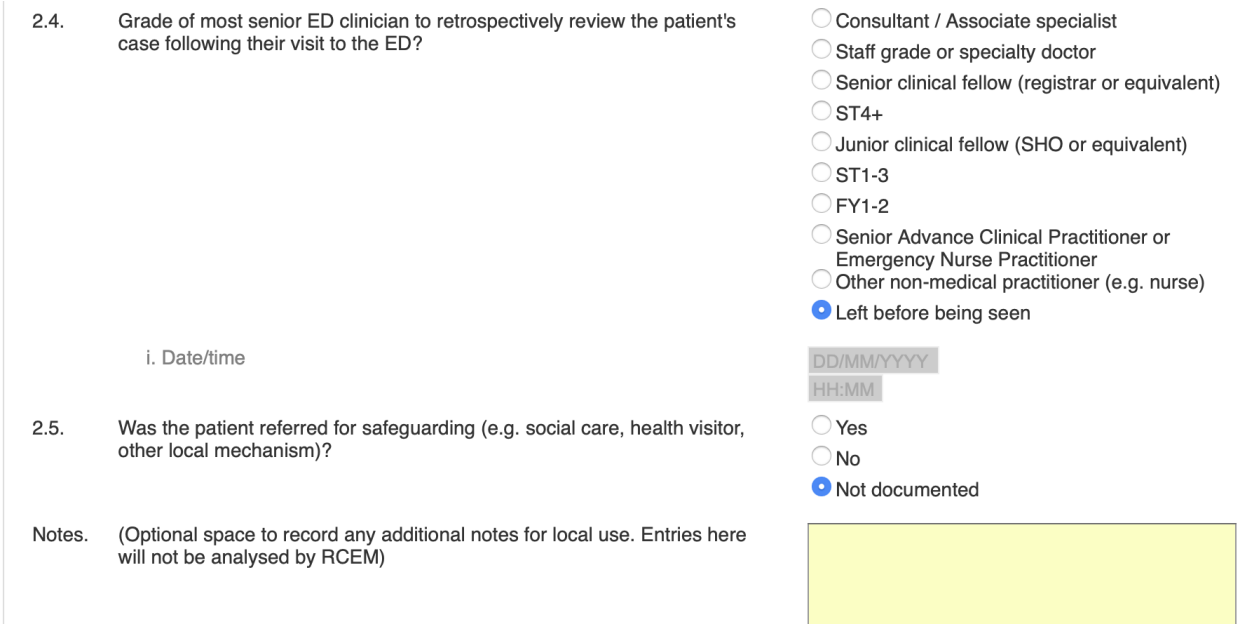
2. The second set of data changes for **SAFEGUARDING** depends on which of the subsets or standards that are applied.



Safeguarding

2.1.	Was the patient identified in the notes as being high risk of potential safeguarding?	○ Yes ○ No ◉ Not documented
2.2.	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 ○ No (or not documented)
2.3.	Grade of most senior ED clinician to actually see and assess the patient in person?	○ Consultant / Associate specialist ○ Staff grade or specialty doctor ○ Senior clinical fellow (registrar or equivalent) ○ ST4+ ○ Junior clinical fellow (SHO or equivalent) ○ ST1-3 ○ FY1-2 ○ Senior Advance Clinical Practitioner or Emergency Nurse Practitioner ○ Other non-medical practitioner (e.g. nurse) ◉ Left before being seen

- The relevance of Qu2.1 to this standard is discussed later.
- For the above test patient who is aged 6 and standard 2 the "Psychosocial section' has been greyed out. If entering and child who is aged 12 or over then you will need to answer this question as it comes before the question on 'left before been seen'. It is not expected that any analysis will be made here and is a result of the programme set up.
- You **MUST** enter the **'left before been seen'** button in order to capture this data and to enable the next screen to be revealed.

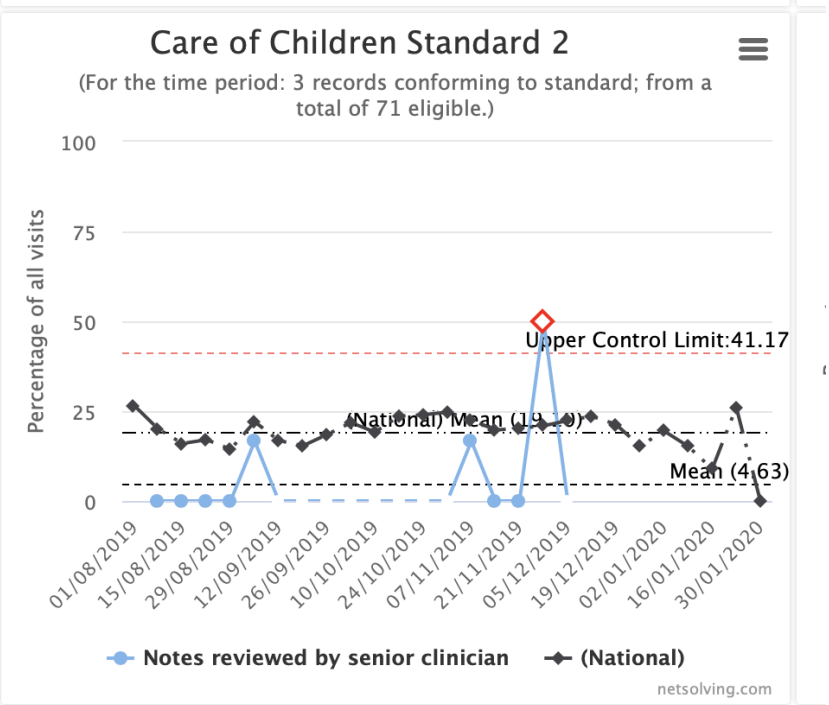


2.4.	Grade of most senior ED clinician to retrospectively review the patient's case following their visit to the ED?	○ Consultant / Associate specialist ○ Staff grade or specialty doctor ○ Senior clinical fellow (registrar or equivalent) ○ ST4+ ○ Junior clinical fellow (SHO or equivalent) ○ ST1-3 ○ FY1-2 ○ Senior Advance Clinical Practitioner or Emergency Nurse Practitioner ○ Other non-medical practitioner (e.g. nurse) ◉ Left before being seen
	i. Date/time	DD/MM/YYYY HH:MM
2.5.	Was the patient referred for safeguarding (e.g. social care, health visitor, other local mechanism)?	○ Yes ○ No ◉ Not documented
Notes.	(Optional space to record any additional notes for local use. Entries here will not be analysed by RCEM)	

The data entered here looks at whether the data has been reviewed and safeguarding issues considered following a child who has 'left before been seen'. NOTE: the 'left before been seen' button should read 'no review of notes done' and this has been fed back to the College.

Expected analysis of this data:

The main Run Chart for our department so far is shown here with the National data line:



It has been analysed as follows: if we are considering the standard of senior clinician then the SPC chart should not include "Junior Clinical fellow".

The data has included Senior ACP/ ENP as some departments may include them (although this will be very rare and we do not have any in our department) or have Nurse Consultants who will fulfil this role.

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? 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 **Title**: Standard 2: Senior clinician review of the notes is patient leaves or is removed from the department without being seen **Analysis**: Q2.4 = • Consultant / Associate specialist OR • Staff grade or specialty doctor OR • Senior clinical fellow (registrar or equivalent) OR • Junior clinical fellow (SHO or equivalent) OR • ST4+ OR
			• Senior Advance Clinical Practitioner or Emergency Nurse Practitioner

As the data CAN only be generated by clicking Q2.3 = "left before been seen" then the information from Q2.3 "grade of most senior clinician…" in column 2 below in the info book is irrelevant and should have been remove, it is causing confusion here as the child should have 'left before been seen'.

Analysis of the Run Chart:

The run chart for our department as seen above has gaps in the data submission in September and October 2019. The data needs to be reviewed to ensure the "left before been seen' button for Q2.3 was clicked. (Or the data still needs to be entered!)
The chart shows that in a few situations there has been a review of the notes!

Looking Nationally around 25% got the notes have been reviewed by a senior.

QI & PDSA thoughts:

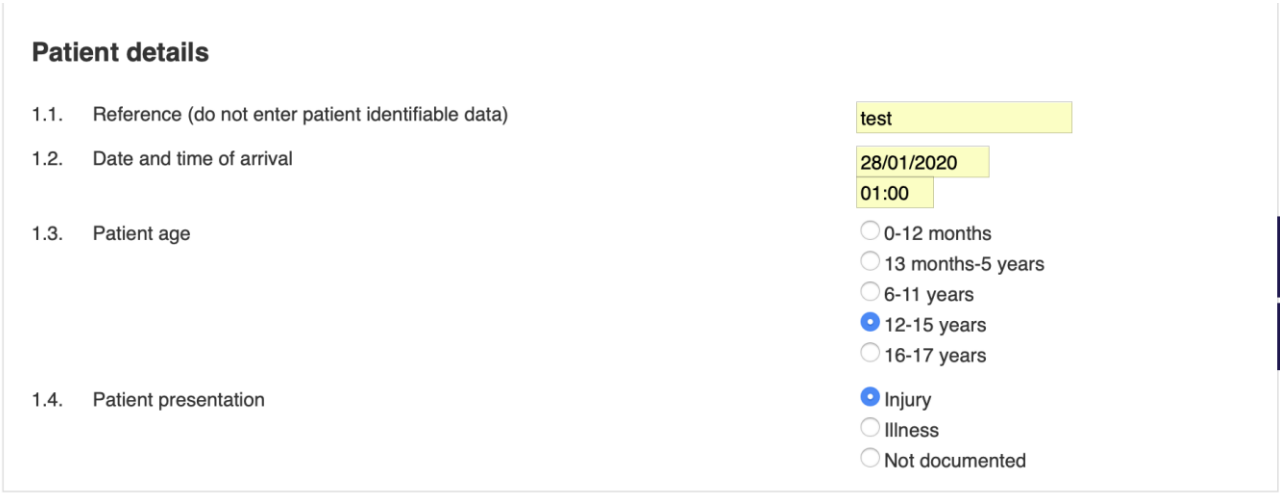
The aim of this section is to allow the QIP teams to carry out Quality improvement. It is for the team to do 'stakeholder' meetings and other QIP tools to identify who should be reviewing the notes and when. And then to continuing inputting data until there is 100% of notes reviewed by the appropriate person.
In our department the following PDSA cycles could be trailed (the decision dependent on the QIP team)

1. Ask the night NIC to identify all "Left before been seen" children from the day before in a book and the morning Registrar to review the notes similar to doing the 'urine book'.

4. Ask the HV team to review the notes (For this option to show an improvement on the run chart it must be agreed that the HV team are considered a 'senior' nurse team for the purposes of this QIP)
5. Ask the consultant to review the notes before taking the child off the screen at the time of discharge
6. Add a "Left before been seen" electronic note to the patient EHR for everyone to complete.

Further analysis of the Safeguarding data for Standard 2 could include the following:

1. What proportion of notes that are reviewed by a senior have subsequent safeguarding input? This would be a comparison of Q2.4 as per SPC chart and Q 2.5 'yes, no, not documented'. The question 2.5 about the action may be relevant to see whether there is an ongoing requirement for this process of note review and to highlight the need. In order for this question to be most useful it would be recommended that **all** patients who "Left before been seen" were entered into the system, rather than a random 5 a week, whilst the PDSA cycles are being run.
7. Were children who were identified as at high risk of safeguarding before the 'left before been seen'? Analysed as Qu 2.1 (yes, no, not documented and QU2.3 "left before been seen') The question 2.1 may not relevant to this standard unless there is a system in place to alert safeguarding or checks for safeguarding such as using CIPS before the child is seen by a clinician. **In this case "yes" means there was high risk documented, "No' means there was NO high risk and it WAS documented".** A further QIP potential would be to review this and consider whether a system should be in place to do this for children on arrival.



8. A bar chart for question 2.4 may be useful for identifying who actually reviews the notes.

Further references for Standard 2:

https://onlinelibrary.wiley.com/doi/full/10.1111/j.1440-1754.2011.02187.x
https://emj.bmj.com/content/emermed/32/9/712.full.pdf

Standard 3 (aspirational)

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

This is an aspirational standard. It gives the opportunity for children aged 12 and over to have a psychosocial assessment as part of their assessment. This would be expected for all children with self-harm but also would be relevant for children with a variety of presentation not only assaults but also headaches, abdominal pain and chest pains. It is not possible to determine which presentations this would be most valuable and therefore should be offered in all children.

Data required for standard 3

Inclusion criteria

Patients must meet the following criteria for inclusion:

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

AND

Children aged 12-17 years (any presentation)

You will need 5 random patients a week.

In-putting data for Standard 3:

1. First set is **CASE MIX DATA** AND IS THE SAME DATA FOR ALL STANDARDS PUT TOGETHER. (as above)
2. The second set of data changes for **SAFEGUARDING** depends on which of the subsets or standards that are applied.

Safeguarding

2.1.	Was the patient identified in the notes as being high risk of potential safeguarding?	○ Yes ◉ No ○ Not documented
2.2.	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 ◉ No (or not documented)
2.3.	Grade of most senior ED clinician to actually see and assess the patient in person?	○ Consultant / Associate specialist ○ Staff grade or specialty doctor ○ Senior clinical fellow (registrar or equivalent) ○ ST4+ ○ Junior clinical fellow (SHO or equivalent) ◉ ST1-3 ○ FY1-2 ○ Senior Advance Clinical Practitioner or Emergency Nurse Practitioner ○ Other non-medical practitioner (e.g. nurse)
2.5.	Was the patient referred for safeguarding (e.g. social care, health visitor, other local mechanism)?	○ Yes ○ No ○ Not documented

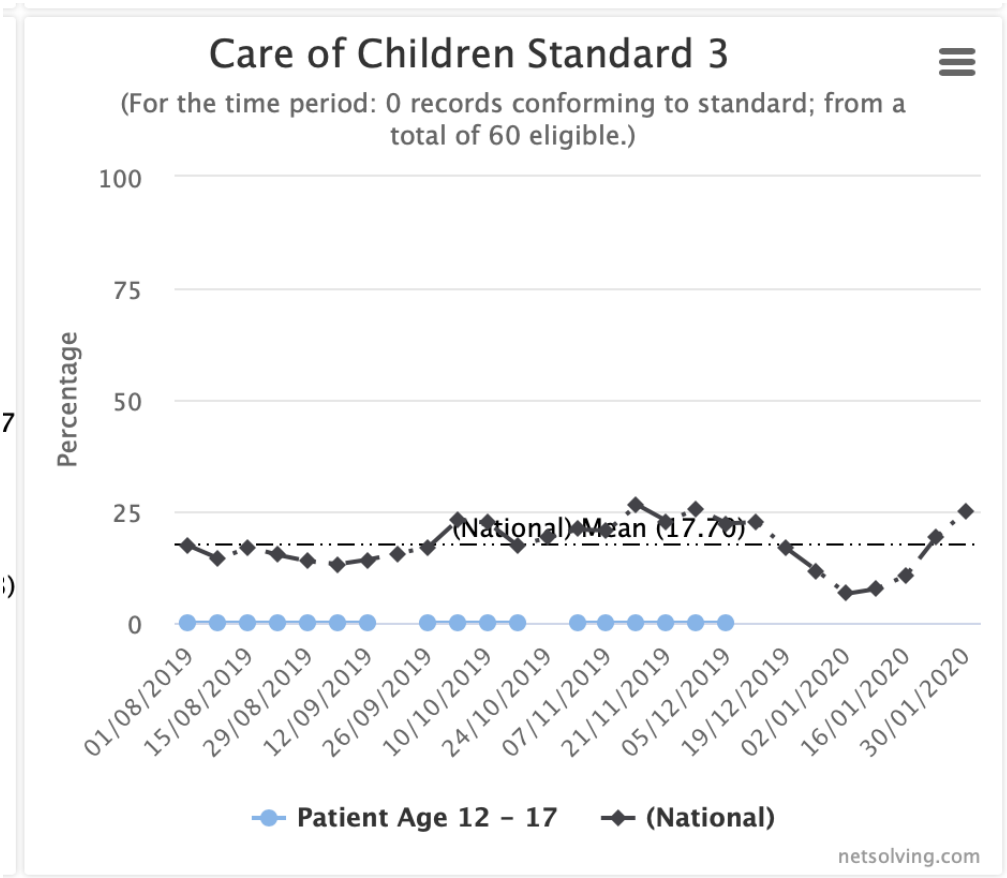
For this age group the 'Psychosocial risk' box is available. It is not expected that a full HEADSS assessment is done but that there is an assessment of the psychosocial situation is recorded for the safeguarding potential risk.

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.

Expected analysis of this data:

The main Run Chart for Standard 3 for our department so far is shown here with the National data line:



It is made up of the following data set:

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 **Title**: Standard 3: psychosocial risk is assessed using a national or locally developed risk assessment tool **Analysis**: Q2.2 = yes

Analysis of the Run Chart:

The run chart for our department as seen above shows that we have not documented any psychosocial history for any of the patients compared to a national mean of 17%. **Why?**

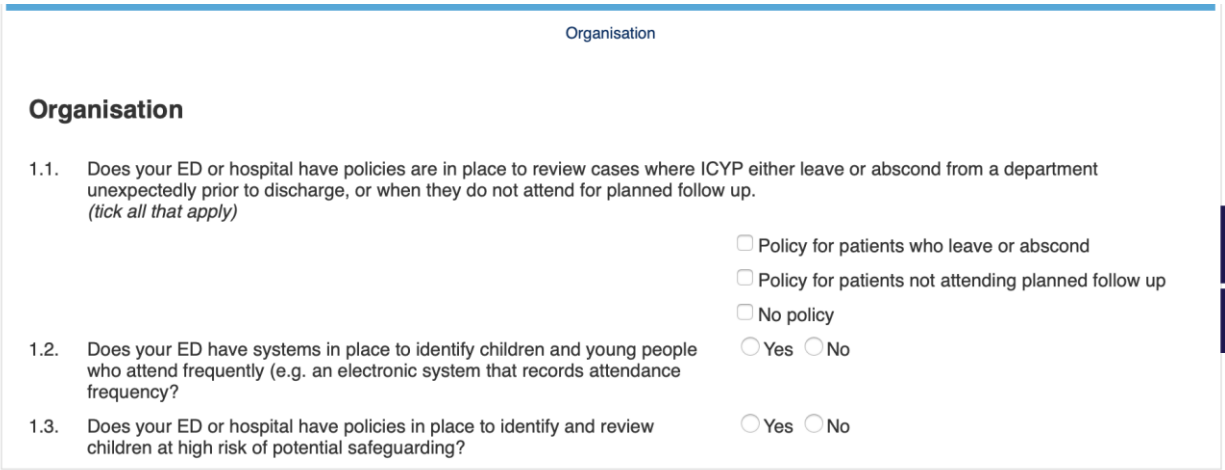
Further Analysis of the data:

1. Could we look at the number of aged >12year (Qu 1.3) and referred for safeguarding Qu 2.5). All these should at least have had a psychosocial assessment.
9. Should we also look at Qu 1.3 and Qu 2.1 for the same reasons?

QI & PDSA thoughts:

1. Do we not fill the 'social History' box either?
10. If we were to be benchmarked against the national figure there would be an expectation of some review and improvement?
11. Should we reintroduce the "HEADSS" box that uses to be part of the notes? One for a 'stake holder' discussion within the parameters of the QIP
12. Should we re-audit this for specific conditions such as assault where this would be expected?

Organisational Data



TO COMPLETE
This is about policies and only needs to be completed once per ED. From my standpoint I do not know clearly where to look this up and would ask one of the Band 7s.

From a QIP perspective I would suggest that the first improvement would be a clear ability to access all policies on a 'web page' with a good search engine. Secondly, I would ensure all members of staff know where to look for these policies which are not found on the Guidelines page.