Learning from the deteriorating child: disseminating improvements to the frontline team

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**Aim**
Identifying areas for improvement in the care of paediatric patients who deteriorate on the ward, disseminating these to staff and subsequently improving the future safety of patients.

**Background**

**Context:** Carried out as part of a larger Quality Improvement initiative focusing on safety; SAFE project (Situational Awareness for Everyone)

**Location:** Ward 6N, The Royal Free Hospital, North London, UK

**Paediatric Patient Numbers:** (Average number of children per year)
- 17 000 in A&E
- 1000 admitted to ward
- 60 required HDU care or transfer to ICU

**Method**
An adapted version of the RECALL\(^1\) (Rapid Evaluation Cardio-respiratory Arrest with Lessons for Learning) tool was used. This is a structured template that can be used to retrospectively review medical and nursing notes with the aim of identifying areas for improvement. Focussing on:

1. Assessment of patient (including recording of paediatric early warning score)
2. What escalation was carried out in response to deterioration
3. Whether clinical reviews were done at appropriate points
4. What interventions were implemented
5. Additional information (e.g. staffing levels, parental concerns)

Every month this tool is used to review the notes of the patients who have required high dependency care or have been transferred out to paediatric intensive care.

**Results**
Areas identified for improvement using RECALL tool:
- Handover of HDU patients from A&E to ward staff
- Re-review of wheezy patients after intervention implemented e.g. IV medication
- Review of all HDU surgical patients by the paediatric team
- Observation of deteriorating trends on paediatric early warning scores

**Disseminating Improvements**
- Integrating weekly learning points into daily morning safety huddles
- Displaying learning points on the new “safety noticeboard”
- Basing simulation scenarios on clinical cases
- Regular safety newsletter (see first two editions below)

**Timeline of Improvement Work**
- **Oct 14 – Jan 15**
  - First period of RECALL analysis
  - Main area of concern identified as handover from A&E to ward
- **Feb 15**
  - First newsletter published, highlighting this issue
  - SBAR (safety, background, assessment and recommendation) handover included as part of induction for new doctors
- **Feb 15 – May 15**
  - Second period of RECALL analysis
  - Handover from A&E to ward no longer identified as area of improvement
  - However new main area of concern identified as review of wheezy patients following intervention; findings highlighted in newsletter, daily huddles and used in simulation scenarios

**Future Plans**
- Continue with RECALL analysis on a monthly basis and dissemination of learning points to staff.
- Expand on ‘parental concern’ area of the RECALL analysis by creating a "safety checklist" newsletter (co-designed with parents) to educate them on recognising deterioration and empowering them to speak up if they are concerned.

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