M23: The Challenges of Paediatric Safety
Monday 9 December 2013
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Presenters have nothing to disclose

Setting standards: A view from the UK
Peter Lachman
Learning objectives

• Identify the risks facing children in health care
• Develop a framework for pediatric patient safety and access tools that can be used in safety programs
• Utilize novel ways to protect children, led by parents and caregivers

The foundation of effective and safe care is the setting of the standards that one needs to attain.

This requires the understanding of what should be achieved in patient care, what can be achieved, and the way one meets the set standard of care.

“Of all the forms of inequality, injustice in healthcare is the most shocking and inhumane.”

Martin Luther King, Jr.

Second National Convention of the Medical Committee for Human Rights – Chicago, March 25, 1966
An ambition in England

Our shared ambitions are that:

1. Children, young people and their families will be at the heart of decision-making, with the health outcomes that matter most to them taking priority.

2. Services, from pregnancy through to adolescence and beyond, will be high quality, evidence based and safe, delivered at the right time, in the right place, by a properly planned, educated and trained workforce.

3. Good mental and physical health and early interventions, including for children and young people with long term conditions, will be of equal importance to caring for those who become acutely unwell.

4. Services will be integrated and care will be coordinated around the individual, with an optimal experience of transition to adult services for those young people who require ongoing health and care in adult life.

5. There will be clear leadership, accountability and assurance and organisations will work in partnership for the benefit of children and young people.

The reality

NCB reported in Observer 24 August 2013

- The number of children in relative poverty – defined as those living in families with income below 60% of the median after housing costs have been factored in – has increased by 1.5 million since 1969.

- A child from a disadvantaged background is still far less likely do well in their GCSEs at 16 than one from a more privileged home.

- Children living in deprived areas are much more likely to be obese than those living in affluent areas.

- Children from disadvantaged backgrounds are more likely to suffer accidental injuries at home.

- Children living in the most deprived areas are much less likely to have access to green space and places to play.
In England and Wales in 2005, babies in the Asian and Black groups accounted for 11% of live births but 17% of infant deaths.

Deaths in those aged less than a year are rare but are particularly high in the Pakistani and Caribbean groups.

This difference is due to a combination of differences in the social and economic environment, lifestyle factors, access to services and genetic differences.
HOW LONG YOU LIVE IS = WHERE YOU LIVE

http://www.endchildpoverty.org.uk/why-end-child-poverty/key-facts

<table>
<thead>
<tr>
<th>A boy in Manchester can expect to live seven years less than a boy in Barnet.</th>
</tr>
</thead>
<tbody>
<tr>
<td>A girl in Manchester can expect to live six years less than a girl in Kensington Chelsea and Westminster.</td>
</tr>
<tr>
<td>Poor children are born too small</td>
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<tr>
<td>birth weight is on average 130 grams lower in children from social classes IV and V.</td>
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<tr>
<td>Low birth weight is closely associated with infant death and chronic diseases in later life.</td>
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</table>

“Variation is a thief. It robs from processes, products and services the qualities that they are intended to have.... Unintended variation is stealing healthcare blind today.”

Don Berwick
Map 11: Percentage of children aged 0–15 years in the National Diabetes Audit (NDA) with diabetes whose most recent HbA1c measurement was 10% (86 mmol/mol) or less by PCT
1 January 2009 to 31 March 2010

Domain 2: Enhancing quality of life for people with long-term conditions

LONDON

Map 22: Rate of elective tonsillectomy in children per population aged 0–17 years by PCT
Directly standardised rate: 2009/10
Domain 2: Enhancing quality of life for people with long-term conditions

LONDON
Highlighting unwarranted variation can be a lever to change the clinical practices of child health professionals.

For policymakers, highlighting existing variation can aid the public to gain a greater understanding of the risks inherent in the existing system, and challenge commissioners to maximise the value, quality and equity of child health services today.

When different physicians are recommending different things for essentially the same patients, it is impossible to claim that they are all doing the right thing.

David M Eddy 2005 Evidence Based Medicine: A Unified Approach

The case for standards
Hospitals and providers should constantly assess performance and learn from experience to reduce errors and harm.

IN HEALTH CARE...

1/3 of hospitalized patients are harmed during their stay.

1/5 of Medicare patients are re-hospitalized within 30 days.

IN OTHER INDUSTRIES...

THE AVIATION INDUSTRY learns from past performance and adjusts operations to ensure safe flights.

“Every system is perfectly designed to achieve exactly the results it gets.”
Reasons for variation

Differences in patient and/or clinician choice of therapy “preference sensitive care”.

Variation in the utilisation of services based on the capacity to deliver a particular treatment in that locality “supply sensitive care”.

Variation in resource utilisation

Essential standards

- Blood transfusion
- Transplantation
- Health Care Facilities
- Health Informatics
- Labels and packaging
- Medical Devices
- Medical Laboratories
- Sterilization

Drug labels

National Standards

- Standard 1: Governance for Safety and Quality in Health Service Organisations
- Standard 2: Partnering with Consumers
- Standard 3: Preventing and Controlling Healthcare Associated Infections
- Standard 4: Medication Safety
- Standard 5: Patient Identification and Procedure Matching
- Standard 6: Clinical Handover
- Standard 7: Blood and Blood Products
- Standard 8: Preventing and Managing Pressure Injuries
- Standard 9: Recognising and Responding to Clinical Deterioration in Acute Health Care
- Standard 10: Preventing Falls and Harm from Falls
NICE Standards

- The primary purpose of NICE quality standards is to describe high-priority areas for quality improvement, which are aspirational but achievable, in a defined care or service area.
- NICE quality standards do not provide a comprehensive service specification.
- They define priority areas for quality improvement based on consideration of the topic area.
Purpose of standards 1

Patients, service users, carers and the public can use the quality standards as information about what high-quality care or services should include.

Purpose of standards 2

Provider organisations and practitioners can use the quality standards

• to monitor service improvements;

• to show that high-quality care or services are being provided and highlight areas for improvement;

• and to show evidence of the quality of care or services as described in a quality standard through national audit or inspection.
Purpose of standards 3

Health and social care professionals and public health practitioners can use audit and governance reports to demonstrate the quality of care as described in a quality standard, or in professional development and validation.

Purpose of standards 4

Commissioners can use the quality standards to ensure that high-quality care or services are being commissioned through the contracting process or to encourage provider performance.
Measures

Each NICE quality standard contains a concise set of quality statements and associated measures.

The quality statements describe key markers of high-quality, cost-effective care for a particular area of care.

These statements may address prevention, as well as elements of health and social care, and will promote an integrated approach to improving quality.

Quality measures accompany the quality statement and aim to improve the structure, process and outcomes of health and social care.

But make standards reasonable and easy to convert to daily action
Examples

- medicines
- escalation
- vte
- infections
- falls
- handover
- records

Harm free care
Taking the standards to the front line

<table>
<thead>
<tr>
<th>Problem</th>
<th>Patient 1</th>
<th>Patient 2</th>
<th>Patient 3</th>
<th>Patient 4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pressure Ulcer</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>0</td>
</tr>
<tr>
<td>Catheter UTI</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>0</td>
</tr>
<tr>
<td>VTE</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>0</td>
</tr>
<tr>
<td>Falls</td>
<td>1</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
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</tbody>
</table>

But to only improve transactional standards may decrease standards of care

Domain 5
Treating and caring people in a safe environment and protecting them from harm
1. Develop a strong governance structure for quality and safety with a systems approach to quality and safety
2. Maintain high levels of medication safety
3. Decrease and eliminate hospital acquired infections
4. Improve reliability in clinical handover and patient documentation
5. Eliminate all pressure injuries occurring in hospital
6. Recognise and respond to unexpected deterioration of children
7. Decrease unnecessary delay in all processes
8. Develop clear measures of clinical outcomes to provide evidence of Top 5 Children’s Hospitals status
9. Measure and continually improve the experience of children and families

Types of measures at GOSH

- Friends and family
- CVL
- Pressure Ulcers
- Antimicrobial stewardship
- Care pathway advanced disease
- Transfers out of area from PICU
- Transition to adult carte
- Communication on HIV status
- Access to clinical nurses in cancer service
- Joint scores in haemophilia and haemtrack monitoring
- Upload to renal registry
- Well being of patients and optimising pathways
Summary

\[ S + P = O \]

- **S**: structure
- **P**: process
- **O**: outcome

Clinical Standards

**Evidence based care**

Improvement

**Patient**

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