Vulnerable Children and Their Care Quality Issues: A Mixed-method Analysis of a National Database

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16th Annual International Improvement Science and Research Symposium, Gothenburg, April 12th 2016
Characterising the nature of primary care patient safety incident reports in England and Wales: mixed methods study

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Explore the **nature, range and severity** of **vulnerable children-incidents** happening in **primary care** as reported to the **National Reporting and Learning System** in England and Wales.
A report every 26 seconds

Focused search of 270k reports
### Search terms for vulnerable children

<table>
<thead>
<tr>
<th>Category</th>
<th>Key Terms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social</td>
<td>Children In Care, Social Care, Foster Care, Social Services, Public Housing, Council Housing, Social Housing, Public Authority, Agency, Social Worker, District Nurse, Low Income, Poverty, Traveller, Refugee, Minority, Looked After Children, Social Support, Homeless, Ethnic Minority, Deprived, Marginalised, Caregiver, Young, Orphan, Social Isolation, Adopted.</td>
</tr>
</tbody>
</table>
2,015 safety incident reports
Child had been placed with **adoptive parents** and adopted mum had been **advised by a social worker** to attend family practice **to complete primary vaccinations.** Mum attended surgery without parental held record, **no** other family practice or child health medical records available. Only two **immunisations** had been **recorded** in parental-held child record, remaining **immunisations given** with consent. Later informed by social services that child has **already completed** her primary immunisations.
Stage 1: Familiarisation and data coding

Stage 2: Exploratory data analysis

Stage 3: Interpretation of themes and generation of learning

A cross-sectional mixed methods study protocol to generate learning from patient safety incidents reported from general practice.

Recursive Model of Incident Analysis


Hibbert P, Runciman W, Deakin A.
Stage 1: Familiarisation and data coding

Stage 2: Exploratory data analysis

Stage 3: Interpretation of themes and generation of learning

A cross-sectional mixed methods study protocol to generate learning from patient safety incidents reported from general practice.

<table>
<thead>
<tr>
<th>Type of patient safety incident</th>
<th>Total, n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Planning</td>
<td>187 (16%)</td>
</tr>
<tr>
<td>Referrals</td>
<td>169 (14%)</td>
</tr>
<tr>
<td>Safeguarding</td>
<td>162 (14%)</td>
</tr>
<tr>
<td>Investigation and Diagnosis</td>
<td>128 (11%)</td>
</tr>
<tr>
<td>Documentation</td>
<td>111 (9%)</td>
</tr>
<tr>
<td>Transfer of Information</td>
<td>95 (8%)</td>
</tr>
<tr>
<td>Treatment and Medication</td>
<td>86 (7%)</td>
</tr>
<tr>
<td>Access to Healthcare</td>
<td>49 (4%)</td>
</tr>
<tr>
<td>Breaches of confidentiality</td>
<td>49 (4%)</td>
</tr>
<tr>
<td>Administration</td>
<td>48 (4%)</td>
</tr>
<tr>
<td>Communication</td>
<td>41 (3%)</td>
</tr>
<tr>
<td>Equipment</td>
<td>30 (3%)</td>
</tr>
<tr>
<td>Professionalism</td>
<td>28 (2%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1183 (100%)</strong></td>
</tr>
</tbody>
</table>
Stage 1: Familiarisation and data coding

Stage 2: Exploratory data analysis

Stage 3: Interpretation of themes and generation of learning

A cross-sectional mixed methods study protocol to generate learning from patient safety incidents reported from general practice.

Failure to plan or implement care/protection packages

- Failure to identify ‘at risk’ children
- Inadequate assessment
- Busy/overworked staff
- Miscommunication
- Not attending case conferences

- Failure to follow protocol
  - Lack of knowledge
  - Training
Deficient transfer of patient information

Protection proceedings
- Case conferences
- Failure to follow protocol

Referrals
- Lost/delayed
- To community teams
- Social services

Clinical deterioration
- Unmet care needs

Unknown to healthcare providers

Unknown to healthcare providers
Poor continuity of care

- Move geographically
- Poor access
  - Multiple services
  - No single POC
- Looked after child
  - Registration
- Repeated visits
  - No interpreter
- Non-English speaking

Poor continuity of care
Improved safety and quality of healthcare of vulnerable children in primary care

Planning and implementation of care packages

Efficient transfer of information between services

Continuity of care

- Decision support for referral decision-making.
- Implement electronic communications within and between care services and sectors.
- Co-produce referral and discharge documentation with hospital and community teams.
- Promote and enable a responsible adult to self-manage documentation.
- Increase attendance of case conferences.
- More accurate detection of children in need.
- Update staff knowledge on responding to safety alerts.
- Minimize errors in therapeutic and medication treatments.
- Define a personal record identifier.
- Increase fluency between health providers.
- Improve continuity of care for patients moving between geographical locations.
- Improve outreach for difficult to reach population, non-English speakers, certain racial and ethnic groups etc.

- Design guide to correctly flag a child’s protection needs
- Develop staff support mechanisms
- Mental health screener before consultations
- Educational intervention for doctors
- Screening families for IPV
- Improving nurse telephone triaging
- Computerised Provider Order Entry forms
- Pharmaceutical algorithm computerized calculator (pac2)
- Smart pumps
- Recommend Manufacturers avoiding similar naming of medication
- Support outreach and engagement
- Counsel families to minimise harms

Examine performance data improve childhood hrQoL
Critical incident reporting system for safety events foster-care.

Intensive assessment and treatment for all maltreated foster children

Single facilitator attendance for treatments.
24 Hour suicide prevention centre
Improved safety and quality of healthcare of vulnerable children in primary care
Improved safety and quality of healthcare of vulnerable children in primary care

Planning and implementation of care packages

Efficient transfer of information between services

Continuity of care
Primary drivers:

- Improved safety and quality of healthcare of vulnerable children in primary care
- Efficient transfer of information between services
- Planning and implementation of care packages
- Continuity of care
- More accurate detection of children in need
- Increase attendance of case conferences
- Update staff knowledge on responding to safety alerts
- Minimize errors in therapeutic and medication treatments
Improved safety and quality of healthcare of vulnerable children in primary care

- Planning and implementation of care packages
- Efficient transfer of information between services
- More accurate detection of children in need.
- Increase attendance of case conferences.
- Update staff knowledge on responding to safety alerts
- Minimize errors in therapeutic and medication treatments.

**Primary drivers**

- Computerised Provider Order Entry forms
- Pharmaceutical algorithm computerized calculator (pac2)
- Smart pumps
- Recommend
- Manufacturers avoiding similar naming of medication

**Secondary drivers**

- Mental health screener before consultations
- Educational intervention for doctors
- Screening families for IPV
- Improving nurse telephone triaging
- Intensive assessment and treatment for all maltreated foster children

Increase attendance of case conferences.

- More accurate detection of children in need.
- Update staff knowledge on responding to safety alerts
- Minimize errors in therapeutic and medication treatments.

Intensive assessment and treatment for all maltreated foster children

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- Intensive assessment and treatment for all maltreated foster children
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Continuity of care

Primary drivers

- Computerised Provider Order Entry forms
- Pharmaceutical algorithm computerized calculator (pac2)
- Smart pumps
- Recommend Manufacturers avoiding similar naming of medication

Secondary drivers

- Mental health screener before consultations
- Educational intervention for doctors
- Screening families for IPV
- Improving nurse telephone triaging

Interventions

- Educational intervention for doctors
- Intensive assessment and treatment for all maltreated foster children
- Increase attendance of case conferences.
- More accurate detection of children in need.
- Update staff knowledge on responding to safety alerts
- Minimize errors in therapeutic and medication treatments.
CONCLUSION

• This study explored how and why safety incidents occur for vulnerable children.

• We have demonstrated reported weaknesses in existing healthcare processes.

• Priority reported areas for improvement include care planning, information transfer and care continuity processes.
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