Quality Improvement Activity- Assessment & documentation of children with special needs

A 4-year-old girl was admitted to the pediatric floor from the Pediatric Emergency Department with neutropenia. She is also an oncology patient who is actively receiving chemotherapy. She has a history of cerebral palsy, and autism and is non-verbal. She came in with weakness and fever. After doing blood work they discovered she had a low white blood count. She was placed on neutropenic precautions on the Pedi floor. A nursing student observed the patient's night shift nurse coming in and out of the patient's room without any proper PPE or washing their hands. The night shift nurse also had another patient who was positive for entero rhinovirus and RSV. As the day went on, the nurse did not get a proper head-to-toe assessment of her and seemed to be in a rush. The patient seemed to be very uncomfortable, but it was unknown because the nurse did not establish with the parent what the patient's baseline was or do a proper assessment. The student nurse noticed that the nurse also did not properly wash their hands or wear gloves when coming into contact with the child. A couple of days went on and the patient seemed to be very uncomfortable and had a productive cough and fever. After 4 days, the child was tested, and it was found that the child had contracted entero rhinovirus.

Describe the scenario. In what way did the patient or environment lack? Is this a common occurrence?

In the scenario above the patient was admitted for neutropenia. After being transferred to the pediatric unit, neutropenic/contact precautions were not taken which led to the patient getting sick in the hospital. Neutropenic precautions are very important and are put in place for people whose immune systems are weakened. The patient was actively going through chemotherapy which is another reason to be extra cautious. The improper full assessment the nurse performed resulted in the staff not knowing what the patient's baseline was which led to the patient being sick and uncomfortable for a couple of days before something was done. Children with special needs cannot always verbalize and tell us what is wrong. Establishing a good baseline after communicating with the caregiver is what we need to know when something is out of the ordinary. The nurse should have utilized the FLACC pain scale. The nurse should have followed protocol with the proper isolation and assessment procedures. In addition, the student should have spoken up and advocated for the patient in every way. The number one priority in this scenario should have been preventing infection.

What circumstances led to the occurrence?

The circumstances that led to this occurrence were the nurse not performing a proper assessment or using the correct PPE. The student not advocating for the patient when the nurse did not take her time to do things properly is also a contributing factor.

In what way could you measure the frequency of the occurrence? (interviewing nurses, examining charts, patient surveys, observation, etc)

Patient surveys could measure the frequency of this occurrence. Teaching the parents why the precautions are being placed could help them be able to understand the importance of them and allow them to speak up for their children when nurses are not doing things the correct way. Teaching the parents, the importance of the need for the nurse to establish a baseline for their children could help prevent the discomfort and missed diagnosis that comes from not knowing how the child feels. If the patients are taught what needs to be done, the patient surveys could help hold the nurses accountable for not taking the correct measures when it comes to children with special needs who can't always speak for themselves. Observing the nurses could also be a good way to measure the frequency of the occurrence. Under pressure, nurses are more to follow the correct protocol.

What Evidence Based ideas do you have for implementing interventions to address the problem?

The most important thing in preventing infection is proper hand hygiene. Taking it to the next step, those with neutropenia are placed on contact precautions because they do not have a strong immune system. Also, it is standard protocol to get a full head-to-toe assessment on newly admitted patients. Having weekly meetings with the staff on the importance of these measures could have a great impact on how things are handled for patients with special needs and contact precautions. Reinforcing the proper measures that need to be taken at shift change could help prevent infection. Assessments being more enforced and mandatory at the beginning of a shift could also help establish a proper baseline for children with special needs. Having a meeting

with education on how to care for children with special needs could help the nurse better care for the patients. Working as a team and giving each other proper feedback can also address the problem. For example, seeing a coworker going into a contact isolation without properly washing hands and talking to them about the importance of why they need to wash their hands.

How will you measure the efficacy of the interventions?

Measuring the efficacy of these interventions can be accomplished by having nurses teach back to the nurse educator or manager every quarter. Having the charge nurses make rounds on patients and asking parents how they are being taken care of and educating them on their care can help check the efficacy of interventions. Also, having the charge nurse check assessments and question anything that does not seem right could help. Checking the number of patients that come in with special needs and seeing if they acquired an infection prior to discharge can also help assess the efficacy of the interventions.