Child Death and Deterioration Review Group

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Background

In order to improve outcomes for acutely unwell children and young people it is essential to learn from those cases in which children deteriorate and die.

In our trust there was no universal record of child deaths or deteriorations and no over view of cases to identify learning – either positive or developmental.

What is CDAD?

- The child death and deterioration (CDAD) review group was formed to enable a rapid multi-disciplinary timely review of every child death and unplanned PICU admissions.
- It allows concerns related to the care or cause of death to be identified, identifies need for more detailed reviews, investigation of adverse events and noting of good practice.

What happens in CDAD?

- The CDAD group includes senior doctors and nursing staff, palliative care, risk and education team and CDOP.
- Weekly meetings review cases from the preceding week.
- Cases are allocated 15 minutes and the patient's team (ideally medical and nursing) presents.
- Trainees (from all disciplines) are encouraged to attend. (Can be viewed used as CBD for trainees)
- Cases are discussed, actions generated and graded 1-6 according to standard of care given (see table 1).
- We are now collecting data from families regarding their experiences of unplanned PICU admissions.

Results

- Since commencing in September 2015 CDAD has reviewed 38 child deaths and 132 unplanned PICU admissions.
- Various data including demographics, clinical area admitted from, appropriate PEWS activation, involvement of outreach, cause of death/deterioration and clinical grading are available.
- Positive and negative practices as well as action plans are collated and fed back via care groups QuEST meeting.

Table 1

Grade
1 The care provided was less than adequate; and different management would reasonably be expected to have altered the outcome.
2 The care provided was less than adequate; and different management may have altered the outcome.
3 The care provided was less than adequate; however different management would not reasonably be expected to have altered the outcome. (e.g. preventable complications present which may have contributed to the outcome)
4 The care provided was adequate but processes could be improved, a different management would not reasonably be expected to have altered the outcome
5 Appropriate/adequate care provided.
6 Better than adequate (good/excellent) care provided

Figure 1: Unplanned PICU admissions by month

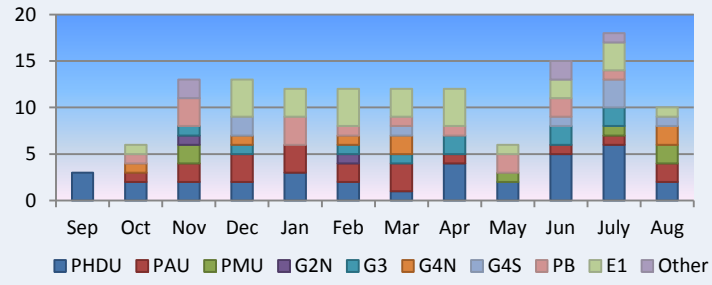


Figure 2: Classification of deaths by month

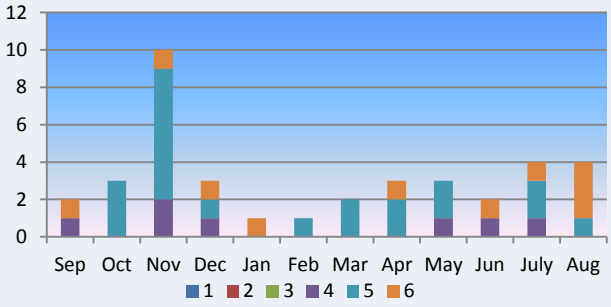
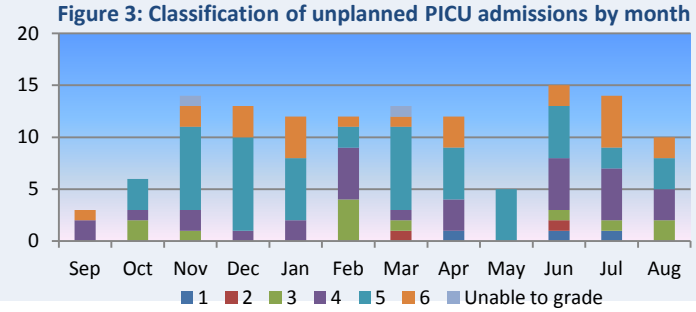


Figure 3: Classification of unplanned PICU admissions by month



Lessons for practice?

- Good discussion between professional groups and different specialities occurs including consideration of number areas of non technical elements.
- This has identified system, human interaction, equipment, environment and personal factors (including knowledge) that can be improved.
- Areas of good practice for spread and adoption.
- Administrative support would facilitate wider more rapid dissemination of learning.

SOUTHAMPTON Children's Hospital

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