



CrossMark

# Highlights from this issue

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## MENTORING AND QUALITY IMPROVEMENT STRENGTHEN INTEGRATED MANAGEMENT OF COMMON CHILDHOOD ILLNESS IN RURAL RWANDA

Integrated Management of Childhood Illness (ICMI) is the leading protocol designed to decrease under 5 mortality globally (WHO)—although its potential impact is threatened by quality of care. Magge and colleagues report the outcome of a nurse mentorship programme—Mentorship and Enhanced supervision at Health Centres (MESH) in two rural districts (21 rural health centres) in Rwanda. The detail of the intervention is described in the paper. This was a pre post study with outcome assessed through a validated index of key ICMI assessments recorded at baseline and 12 months. The index is effectively a checklist of good clinical assessment/care including items like ability to drink, presence of severe vomiting, convulsions, difficulty breathing, weight, presence of oedema and suchlike. The index increased significantly in both districts. The impact was positive across multiple health care outcomes—number of children seen by ICMI trained nurses increased from 83.2 to 100%, use of ICMI case recording forms increased from 65.9 to 97.1%, correct classification from 56 to 91.5% and correct treatment from 78.3 to 98.2%.

The data is impressive and goes to the heart of what can be achieved through a well thought out quality improvement initiative with an initial analysis of the issues, ‘package’ intervention, comprehensive assessment of the feasibility and success of the intervention, efforts to attain sustainability and longer term impact on health outcomes. *See page 565*

## AUTOIMMUNE ENCEPHALITIS

Autoimmune encephalitis is increasingly recognised as an important cause of encephalitis in adults and children. Wright and colleagues report the clinical features, management and neurological outcome of NMDAR (N-methyl-D-aspartate receptor)—Ab mediated neurological disease in 31 children in the UK (BPNSU survey 8 cases in 13 months, 23 historical cases). Diagnosis was by confirmation of the antibody to the NR1 sub unit of the NMDAR in blood and/or cerebrospinal fluid. Median age was 8 years (range 22/12–17); 23 female. 90% presented with behavioural change and neuropsychiatric features, 67% with seizure/movement disorders. Presentation was without encephalitic features in 7 (psychiatric 4, movement 3). All received steroids, 71% IVIG, 9 plasma exchange and 10 second line immunosuppression. Early diagnosis led

to full recovery in 18/23 although late diagnosis (diagnosis confirmed >6/12 after first presentation) had a significantly less favourable outcome. 7 patients relapsed, 4 requiring further treatment.

The diagnosis needs to be considered in patients who present with the above features as with prompt treatment the outcome is favourable. In an accompanying editorial the importance of this and other causes of autoimmune encephalitis are emphasised. *See pages 521 and 512*

## USING DIGITAL MULTIMEDIA TO IMPROVE PARENTS’ AND CHILDREN’S UNDERSTANDING OF CLINICAL TRIALS

Many patients have difficulty understanding clinical trial concepts and therefore struggle to make informed consent to research. The challenge is to make this better to support both research and informed decision making in clinical practice. Tait and colleagues evaluate the effect of an interactive multimedia programme on improving parents’ (n=148) and children’s (n=135) understanding of clinical trial concepts and participation. Randomisation was to the traditional paper model or an interactive multimedia programme with online exercises. Understanding and perceptions of information delivery and satisfaction were assessed before and after by semi structured interviews. All participants improved their understanding—parents equally by both strategies, children significantly better following the multimedia input with mean (SD) post intervention scores 11.6 (4.1) versus 8.85(4.1),  $p < 0.001$ ; mean pre test scores 3.97 (2.7), 3.76 (2.6), potential score 18 for complete understanding. All found the interactive package ‘easier to follow’ and ‘more effective’. In essence this is about delivering information in a more accessible way to increase interest and understanding and is relevant to all aspects of health care delivery in the increasingly digital environment we all practice in. *See page 589*

## OPTIMAL MANAGEMENT OF ALLERGIC RHINITIS

Allergic rhinitis is common, often under recognised and under treated and causes significant physical, psychological and social morbidity in children and young people. Glenis Scadding discusses the optimal management in a comprehensive review of the evidence and published guidance. It is important to make the diagnosis and consider the differential. Asthma often co-exists and can be worsened by uncontrolled allergic rhinitis. The different treatment options

are discussed including allergen avoidance. Pharmacotherapy includes a stepwise approach using saline nasal sprays, non sedating antihistamines—oral or nasal, minimally bioavailable intranasal corticosteroids for moderate/severe disease (potentially plus additional antihistamine/anti-leukotriene). Immunotherapy should be considered for refractory cases. There is no doubt that controlling allergic rhinitis is challenging but the potential impact on general health and quality of life for the individual makes it essential. *See page 576*

## WHY WAS THIS CHILD NOT BROUGHT?

In theory organisations should have a clear ‘did not attend’ (DNA) policy if children do not attend appointments, there being a significant and known link between failure to attend and child maltreatment. Arai and colleagues report that fewer than 8% of English NHS organisations have guidance in the public domain although 41% do at least have a policy—specific advice within guidance related to five categories; reflection and review, direct interaction with the family, indirect interaction with the family, liaison with the internal colleagues and external referral. The authors advocate for national guidance tailored to specific services. The vulnerability of the child is emphasised. The wider issue of how to proceed if the child fails to attend—or is not brought is discussed in accompanying editorial—Why was this child not brought? *See pages 517 and 511*

## IN E&P THIS MONTH

Yajamanyam *et al* report their experience of in situ simulation (conducting simulation in the clinical environment) as a quality improvement initiative. The trigger was the detection of a latent safety threat as a potential contributing factor in a critical incident. Latent safety threats are deficiencies in health care systems that can impact on safety. 21 sessions were carried out in accident and emergency and 8 on the neonatal unit—the process being supported by clinicians with experience in paediatric simulation and by the local trust management. Multiple latent safety threats were detected (listed in the paper) and corrected and plans put in place to prevent short, medium and long term. The authors detail the practicalities and the outcome was a significant reduction in risk when managing patients. These initiatives are important and it is helpful to have experiences and successes shared for wider implementation.