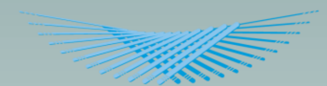
Obesity Screening in Kidz First ED

Storyboard Template



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COUNTIES MANUKAU HEALTH

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Introduction

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Aim Statement: what are we trying to achieve

To offer 2000 obese and overweight children entering Kidz First ED a pathway to community based support and assistance in achieving a healthy weight by December 2018

Storytelling:

- Parents and children not aware of the potential damaging effects of obesity on their quality of life.
- Children and families are not aware that their child is overweight / obese.
- Unless parents are told their child is OW / OB they cannot make changes.
- Health and wellbeing of their children. Mum of 8yr old reported she had no idea that her daughter was obese, thought she was a bit overweight. She was distressed that no-one had previously mentioned it or the potential health problems she might suffer if she continues to gain the weight.
- ‘Just two minutes of the doctors’ time made me realise and make changes to our lifestyle’.

The problem: the equity gap

- The prevalence of childhood obesity is increasing and Counties Manukau accounts for nearly 40% of New Zealand's children aged 2-14 years who are either overweight or obese.

- Within Counties Manukau 47% of Māori children and 56% Pacific children are either overweight or obese

- Obesity is normalised and parents are unable to accurately determine whether a child is overweight or obese. Parents are unaware of the diagnosis and unable to make changes to lifestyles

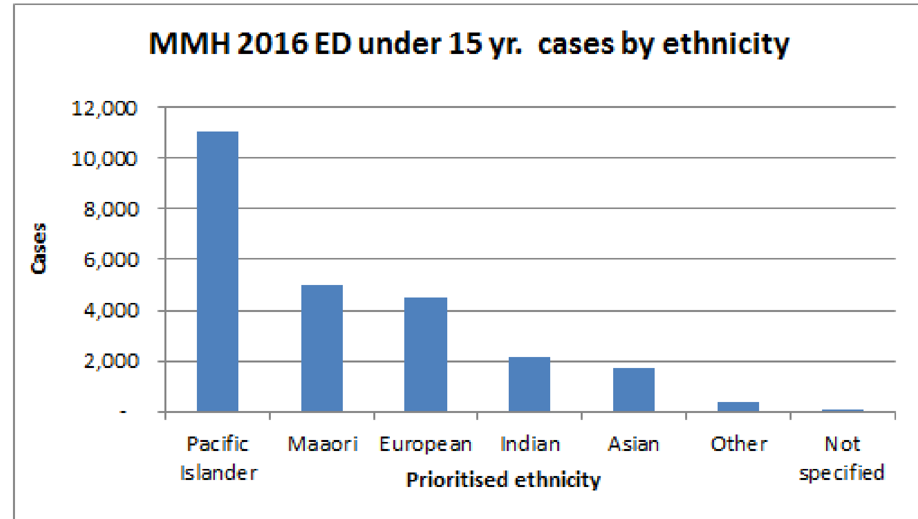
- Testing 'Be smarter' tool for assisting healthy weight conversations in Kidz First
- Understanding families opinions on 'healthy living packs'
- Increased nurse / doctor identification and discussion on obesity

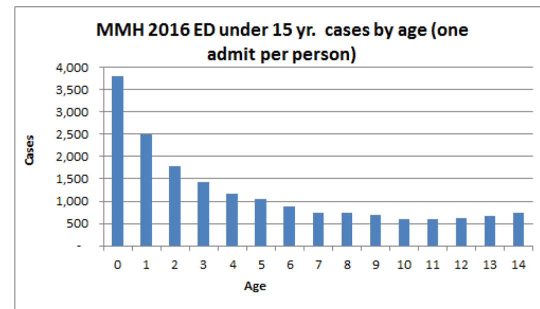
What the data is telling us?

Breakdown of admissions into Kidz First ED by ethnicity & age:

MMH 2016 ED cases under 15 by ethnicity

Ethnicity	Cases	%
Pacific Islander	11,058	44%
Maaori	5,016	20%
European	4,512	18%
Indian	2,126	9%
Asian	1,715	7%
Other	410	2%
Not specified	15	0%
Total	**24,852**	**100%**





Baseline data collection:

Baseline measures - Kidz First ED Obesity Screenings

	Unique patients between 2-15 entering ED	Screened patients	Screened %	Number of clinicians screening	Screenings detected in audit	Referrals to Active Families	GP Discharge letters (Obese & overweight)
Jan-17	1037	30	2.9	14	0	0	7
Feb-17	1115	34	3.0	12	0	2	14
Mar-17	1088	34	3.1	7	0	1	8
Apr-17	1071	33	3.1	11	0	2	7
May-17	1139					4	
Jun-17							
Jul-17							
Aug-17							

Measurement Summary

Equity gap: overweight / obese kids in CMDHB with no identification / discussion on healthy weight or referral to community services.

- Addressing this gap by through:
- opportunistic identification in KFEC,
- discussions tailored to each individual child / family using Be Smarter tool,
- referral to GP with advice
- offered referral to community support groups in their area

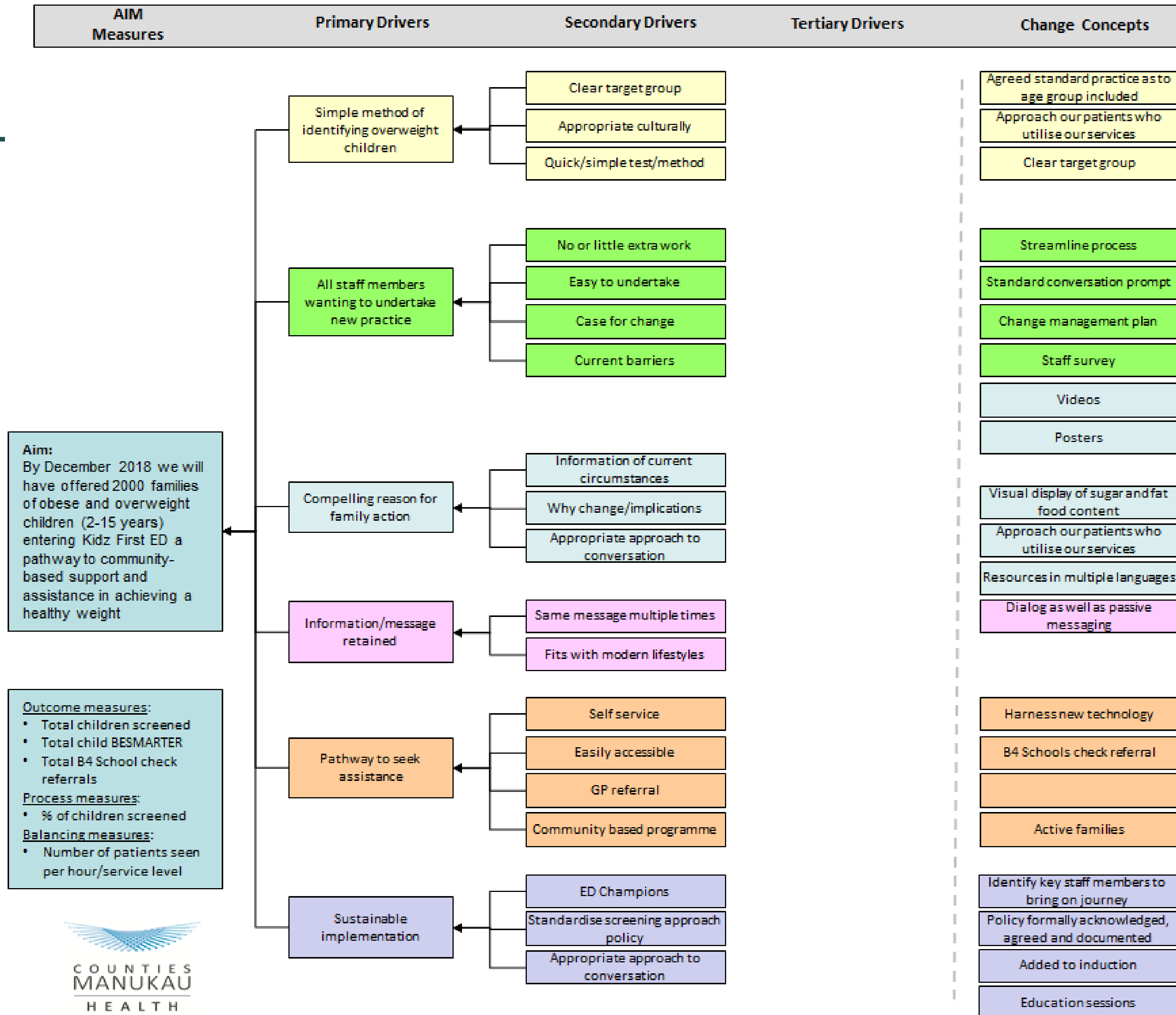
Addressing the equity gap

- Increased BMI's calculated for those children presenting to KFEC - currently 0
- Use of Be Smarter tool to have discussions with family and identify a goal
- Increase in current use of healthy weight and referral pathways to GP on Electronic Discharge letter
- Increased referrals to community groups such as Active Families and South Seas – currently 1/month
- Balancing Measure: strong relationships with these community groups who are welcoming the influx of referrals. Increased nurse / doctor time in KFEC – when using Be Smarter tool, conversation can take only 5-10 minutes and have long lasting impact on child and families health.
- Nursing / doctor preconceptions on conversations on healthy living – discussion and education and showing staff a family video where the short conversation did make a difference to the child and families life.

Outcome Measures

- Total screenings
- % Patient screenings completed

Driver Diagram



Building up a change package: an example

Parent's knowledge

- Fat / sugar poster – increased obesity awareness
- Story from mother and child on a video

Compelling reason for change

Difficult discussion

- Introduced Be Smarter tool
- Staff training and use

Healthy pack

- Parent's survey, make changes to pack
- Print recipe books and add to pack

What are you currently testing?

- **PDSA title**: Does having more nurses trained asked to use the be smarter tool increase its use in discussions with families in KFEC?

- **Plan** Change idea: Charge nurse to identify 4 nurses to use Be Smarter tool and encourage use from now to end May ‘17.
  - Change Prediction: Yes, with Charge Nurse support, and chocolate incentives, 4 nurses will be able to use the tool for 8 patients in 4 weeks.
  - Questions: is a single 1:1 learning session enough with each nurse? How much follow up in the 4 weeks are needed per nurse? Any problems whilst using the Be Smarter tool? Do they have enough confidence to use it? Any unforseen problems?
  - Data collection: Tally and interview with staff

- **Do**: 1 nurse on Annual leave for 3 weeks.
  - Initial enthusiasm, yet no tools being used
  - KFEC was VERY busy .
  - No regular drive / support from Charge nurses
  - Not seen other 2 nurses during my shifts.
  - Feedback: 1 negative response put her off – talked through different words to use for next time. More support and encouragement given.

- **Study:** At end of 4 weeks increased use of Be Smarter tool was 3, 1 of which was mine. Predictions were not confirmed. Learned that it is VERY hard to introduce a change in practice.

- **Act:** Adapt the cycle. Discuss again with Charge nurse how we can get some discussions happening. Involve Debbie Minton / Mary McManaway for further support.

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Highlights: biggest learnings

- Parents and families are receptive to discussions about their child's weight, if it is potentially detrimental to their long term health
- Small number of supportive nurses trying to make changes to their practice
- This topic is creating discussion between health professionals, some healthy and some judgmental and prejudicial.
- Video of family who were challenged and made changes once obesity identified.

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Lowlights: biggest challenges

- Changing staff attitudes
- Breaking down preconceived ideas
- Treating each family as an individual with potential
- Making electronic changes – slow
- Keeping up the enthusiasm when facing so much negativity
- Continuation of project – uncertainty of funding
- Group meetings due to shift work / annual leave

Next Steps

- Involving more senior nurses in driving the use of Be Smarter tool
- Designing teaching sessions for staff
- Show staff family video
- Work on motivating staff to make small changes to their practice.
- Making process sustainable and not time consuming