



Pediatric epidemic crisis: Lessons for policy and practice development

David B. Nicholas^{a,*}, Robin E. Gearing^b, Donna Koller^a,
Robyn Salter^a, Enid K. Selkirk^a

^a *The Hospital for Sick Children, 555 University Avenue, Toronto, Ontario, Canada M5G 1X8*

^b *Columbia University School of Social Work, New York, New York 10027, United States*

Abstract

Objectives: This research study addresses health policy and patient care considerations, and outlines policy and practice implications resulting from a crisis in a pediatric setting. This crisis, an epidemic outbreak of Severe Acute Respiratory Syndrome (SARS), dramatically impacted the delivery of health care in Canada. Despite the passage of time since the last diagnosed case of SARS in April 2004, researchers have warned the global community to be prepared for future outbreaks of SARS or other infectious diseases.

Methods: Qualitative interviews were conducted with 23 participants representing key stakeholder groups: (a) pediatric patients with probable or suspected SARS, (b) their parents, and (c) health care professionals providing direct care to SARS patients.

Results: Participants conveyed key areas in which health policy and practice were affected. These included the development of communication strategies for responding to SARS; easing vulnerability among all stakeholders; and the rapid development of practice guidelines.

Conclusion: Given the continuing threat of current and future airborne viruses with potential for epidemic spread and devastating outcomes, preparedness strategies are certainly needed. Effective strategies in pediatrics include practices that provide family centered care while minimizing disease transmission. Toward this end, lessons learned from previous outbreaks merit consideration and may inform future epidemics.

© 2007 Elsevier Ireland Ltd. All rights reserved.

Keywords: Severe Acute Respiratory Syndrome; Policy development; Pediatrics; Qualitative research; Epidemic; Chaos theory

The delivery of health care was confronted by the outbreak of Severe Acute Respiratory Syndrome (SARS) in Toronto, Canada, in 2003. The SARS-associated coronavirus (SCV) which has been

identified as the primary aetiological agent of SARS is rapidly progressive and sometimes fatal, particularly among adults [1]. While the first known cases of SARS occurred in Guangdong province, China, in November 2002, SARS became recognized as a global threat in mid-March 2003 [2]. The condition transcended borders quickly after this date, as a patient traveled to Hong

* Corresponding author. Tel.: +1 416 813 6789;
fax: +1 416 813 6746.

E-mail address: david.nicholas@sickkids.ca (D.B. Nicholas).

Kong and infected other travelers, who then journeyed internationally to countries such as Vietnam, Singapore, Germany, and Canada. By July 2, 2003, SARS had claimed 812 lives and affected 8445 individuals, across 30 different countries [3,4].

The SARS outbreak of 2003 was characterized by its unprecedented rapid, airborne, and global transmission; however, its localized impact was particularly felt within health care facilities [5–7]. Infection control leaders and researchers have warned the global community to be prepared for future outbreaks of SARS or other widespread infectious diseases [8,9]. While several studies have identified biomedical data and psychosocial impacts, lessons learned from SARS for both health policy and patient care, have received little research attention. Accordingly, this paper addresses this gap in the literature and outlines policy and practice implications of SARS, specifically from a pediatric perspective. This research was achieved through a series of descriptive qualitative interviews with key stakeholders, including pediatric SARS patients, their parents, and health care providers who provided direct care to SARS patients.

1. Background

SARS presented a health care crisis, within affected regions, by requiring rapid responses to unknown questions, with devastating consequences for patients, health care providers, and health care systems. As new struggles emerged on a daily basis, responses and implementation were immediately necessitated. Policy considerations that affected day-to-day patient care comprised infection control and patient care protocols as well as integrated change and in some cases a sense of systematic chaos. Virus spread was ultimately contained in hospitals through restricted entry as well as limited movement within and between health care facilities. Screening processes elicited information about individual exposures, symptoms, and epidemiologic links to SARS [5], and hospital entry was restricted on the basis of this reported information. Visitors to hospitals were largely eliminated except for immediate family members of critically ill, dying, birthing or pediatric patients [5]. Even in these critical situations, pediatric patients were limited to only one parent visitor at a time, although in some cases, children had no visitors.

To limit virus transmission, health care providers deemed ‘non-essential’ were restricted from pediatric care. ‘Essential’ hospital caregivers were permitted to work at only one health care facility to reduce the risk of virus transmission, and were required to wear protective masks and gowns in patient care areas [5,6]. When treating patients with suspected or probable SARS, double isolation gowns, hair caps, masks, face shields, and gloves were required [5]. Negative pressure isolation rooms with antechambers were used for patients thought to have SARS, and staff were required to remain outside negative pressure isolation rooms as much as possible [10]. Clearly, SARS resulted in substantial changes to health care practice and frequent shifts in infection control requirements, with health care providers reporting substantial frustration and anxiety [6].

Direct face-to-face clinical communication between physicians and families was interrupted and replaced by increased reliance on the telephone as the primary mode of communication [11]. World regions varied in terms of methods and policies implemented to foster communication. Visitation restrictions in an identified Asian hospital were mitigated through video conference and e-mail technology [12], while Canadian hospitals generally relied on telephone communication [13]. In pediatric care, some children with SARS reportedly kept the phone line open with parents and families over extended periods of time. Phone connection emerged as a key factor in reducing isolation and despair yet even with phone support, children often and dramatically suffered extended negative psychosocial symptoms [12,14].

Systems of health care delivery were dramatically affected by the SARS crisis; however, few studies have focused on the policy and practice implications of the outbreak. To address this gap, a descriptive, qualitative investigation was conducted to examine the experiences, impacts, and implications of SARS-related health care policies for patients, parents, and health care providers.

2. Methods

Given the limited research in crisis response within pediatrics, a descriptive qualitative study was conducted in determining issues of salience that emerged

Download English Version:

<https://daneshyari.com/en/article/4198805>

Download Persian Version:

<https://daneshyari.com/article/4198805>

[Daneshyari.com](https://daneshyari.com)