Patient Safety & Quality improvement
## Curriculum overview – Patient Safety & Safe Prescribing

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Establishes the importance of safe prescribing and prescribes commonly used medications in an appropriate manner; recognises when a patient has been exposed to risk and escalates care in accordance with local procedures.</th>
</tr>
</thead>
</table>
|         | - Adhere to the local process following a medication error.  
|         | - Prescribes commonly used medications safely.  
|         | - Follows the local processes for reporting serious incidents and risks.  
| Level 2 | Applies safety procedures to prescribing practice. Applies appropriate procedures to both prescribing and clinical care situations, and takes safe action when presented with a risk; identifies potential risks and plans how to mitigate them. |
|         | - Applies safety procedures to prescribing practice.  
|         | - Applies safety procedures to clinical care situations, reacting to identified risks.  
|         | - Identifies and works towards avoiding and/or mitigating potential risk.  
| Level 3 | Participates in investigating, reporting and resolving risks to patients, including through communication with patients and families or carers. Evaluates safety mechanisms across a range of healthcare settings, applying a reflective approach to self and team performance. |
|         | - Advises CYP and their families about the importance of concordance, and about medications and their side effects.  
|         | - Takes account in their practice of risks to themselves and others, including those related to personal interactions and biohazards.  
|         | - Participates in investigating, reporting and resolving serious incidents, including through communication with patients and families or carers.  
|         | - Applies the principles of the Duty of Candour.  

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[Curriculum overview](#) – Patient Safety & Safe Prescribing

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[Patient Safety & Safe Prescribing](#)
Underpinning knowledge

- Patient safety priorities and risk management
- The ethics of prescribing
- Knowledge of formularies and guidelines
- Learning from errors
## Curriculum overview – Quality Improvement

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Learning outcome</th>
<th>Key capabilities</th>
</tr>
</thead>
</table>
|         | Applies quality improvement methods (e.g. audit and quality improvement projects) under guidance. | • Demonstrates the ability to follow the local and national clinical guidelines and protocols.  
• Undertakes a quality improvement project under guidance. |

| Level 2 | Independently applies knowledge of quality improvement processes in order to undertake projects and audits that enhance clinical effectiveness, patient safety and patient experience. | • Proactively identifies opportunities for quality improvement. Applies safety procedures to prescribing practice.  
• Undertakes projects and audits to improve clinical effectiveness, patient safety, and the patient experience. |

| Level 3 | Identifies quality improvement opportunities and supervises healthcare professionals in improvement projects, and leads and facilitates reflective evaluations. | • Responds appropriately to health service targets and participates in the development of services.  
• Employs the principles of evaluation, audit, research and development in standard settings to improve quality.  
• Applies understanding of national and local regulatory bodies, particularly those involved in standards of professional behaviour, clinical practice and education, training and assessment. |
Underpinning knowledge

- Quality improvement models and theories e.g. PDCA
- Evaluation and measuring impact
- Collecting and managing stakeholder feedback
- Differences between quality assurance, management, control and improvement
Patient Safety

• “Patient safety is the avoidance of unintended or unexpected harm to people during the provision of health care”
  
  (The WHO & NHS Improvement)

Quality Improvement

• "The combined and unceasing efforts of everyone to make the changes that will lead to better patient outcomes (health), better system performance (care) and better professional development (learning)“

  (Batalden and Davidoff, 2007)
What is Quality Care?

EFFECTIVE
SAFE
PATIENT CENTERED
TIMELY
EFFICIENT
EQUITABLE

TEAM VALUES, EDUCATION TRAINING & LEARNING, ENVIRONMENT

(Crossing the Quality Chasm IOM, 2001)
Safety & Improvement Through the Ages…

Dr Ignaz Semmelweis
Puerperal fever
Monthly mortality rates 1841-1849

Chlorine handwash
To err is human, but to persevere in error is only the act of a fool.

Marcus Tullius Cicero
We’re still learning...
A Promise to Learn, A Commitment to Act

A promise to learn – a commitment to act

Improving the Safety of Patients in England

National Advisory Group on the Safety of Patients in England
So how do we know if we’re providing a ‘quality’ service?

- Patient/parent feedback
- Staff survey
- Complaints
- CQC Report
- Adverse Events
- Favourable Events ‘LfE’
- Patient Outcomes
- Audit
- Targets
Turning Safety & Quality on It’s Head…

• Safety I vs Safety II

Eric Hollnagel, EUROCONTROL, 2015

Trying to understand safety by only looking at incidents is like trying to understand sharks by only looking at shark attacks

Attributed to Bob Wears
Culture & Joy

IHI Framework for Improving Joy in Work

4. Use improvement science to test approaches to improving joy in work in your organization

3. Commit to a systems approach to making joy in work a shared responsibility at all levels of the organization

2. Identify unique impediments to joy in work in the local context

1. Ask staff, “What matters to you?”
When Something Goes Well…

#LfE

**Step 1: Collaborate**
- Share the concept with colleagues
- Build an enthusiastic team representing a range of roles and experience
- Enlist support from key stakeholders; consider including staff from IT and safety/governance
- Set a vision and some project goals
- Plan your project pilot; start small i.e. within a defined department or group

**Step 2: Report**
- Excellence reporting (ER) could be via paper, web form, voice-mail or app.
- Keep the data capture simple, quick & easy to use for busy frontline staff.
- Maintain an ER database, categorising your reports, analysing them for themes.

**Step 3: Feedback**
- Feedback to ER reporters and recipients is a key part of ER.
- LfE ER recipients receive email from governance department containing text from original ER.
- Other ER projects provide paper certificates to ER recipients (and display ERs on public notice boards.)

**Step 4: Learn**
- Select the most interesting ERs to study in more detail.

**Step 5: Share**
- Share widely what you have learned through your ERs & AI meetings
- The LfE project has a weekly e-bulletin.
- Learning can also be shared through social media, teaching programmes & guideline or policy development.

**Step 6: Amplify**
- The 4 E’s of Excellence Quality Improvement:
  - Explore
    - Choose QI project: using ERs
    - Measure baseline practice
  - Engage
    - Engage: ITIS with ER recipient + reporter
    - Design QI delivery plan
  - Enhance
    - Use ER as driver for improvement
    - Teach & share the learning
  - Evaluate
    - Re-audit practice & reflect
    - Celebrate, re-design & re-deliver

**Step 7: Nurture**
- Grow and develop your project
- Share the project with your wider organisation
- Join forces with your safety team: ERs may have similar themes to incident reports and can be used to help solve problems on the risk register
- Share your learning through publications, social media and conferences
- Visit our website to connect with other LfE-related projects and to collaborate in national development: www.learningfromexcellence.com
When Something Goes Less Well...

☐ Blame
☑ Solution

What do you know about The professional duty of candour?

Every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress.
Be the change that you wish to see in the world.

Mahatma Gandhi
# Types of Improvement

<table>
<thead>
<tr>
<th>Research</th>
<th>Audit</th>
<th>Quality Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>To generate new knowledge</td>
<td>Judgement against set standards for ‘assurance’</td>
<td>Broad aims: Improvement in any area of any organisation</td>
</tr>
<tr>
<td>Scientific methods used</td>
<td>Formalised methodologies and best-practices for data collection</td>
<td>Methods range from highly pragmatic to in-depth statistical analysis to research</td>
</tr>
<tr>
<td>Mainly clinical areas but can also be non-clinical</td>
<td>Can be based on any processes where there are clear standards</td>
<td>Any area of an organisation</td>
</tr>
<tr>
<td>Process of approval for funding and ethics approval</td>
<td>Often a planned annual programme or mandated audits for quality assurance</td>
<td>Usually identified from a service need</td>
</tr>
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</table>

**REACTIVE** **PROACTIVE**
QI builds bridges between…

Scientific Approaches, theory & knowledge

Delivery of real life medical care

Above all it is about making the changes that improve **practice** (for patients and staff)
Making Improvements

(1) Understand & Investigate the Situation

- Think 6 domains!

- Use tools eg Process map beginning to end

Identify a situation
Tools to help

Affinity/Fishbone Diagram

Process Mapping

Driver Diagram
Making Improvements

(2) Engage hearts & Minds

• Think 6 aims!

Identify A Situation

‘Diagnose’ the situation

• Process map beginning to end

• Stakeholders
• Personal perspective

Engage with Staff, Patients & Families

ask what matters to me

www.england.nhs.uk/what-matters-to-me
Making Improvements
(3) Data Drives Improvement

• Think 6 domains!

Identify A Situation

• Process map beginning to end & use other tools

‘Diagnose’ the situation

• Stakeholders
• Personal perspective

Engage with Staff & Families

• Keep it simple
• Qualitative vs quantitative
• Run charts are fab!

Collect Data

Collect Data
Pareto Chart & Run Charts
Making Improvements
(4) Making a Change

- Think 6 domains!
- Process map beginning to end & use other tools
- Identify A Situation

‘Diagnose’ the situation
- Stakeholders
- Personal perspective
- Engage with Staff & Families

Collect Data
- Keep it simple
- Qualitative vs quantitative
- Run charts are fab!

Make a change!
- Keep it SMART...
A SMART Change

- Specific
- Measurable
- Achievable
- Realistic
- Timely

congrats smarty pants!
Making Improvements

- Think 6 domains!

Identify A Problem

- Process map beginning to end & use other tools

‘Diagnose’ the problem

- Stakeholders
- Personal perspective

Engage with Staff & Families

- Keep it simple
- Qualitative vs quantitative
- Run charts are fab!

Collect Data

- Keep it SMART...

Make a change!
<table>
<thead>
<tr>
<th></th>
<th>Adequate</th>
<th>Good</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Title &amp; Abstract</strong></td>
<td>Initiative to improve healthcare</td>
<td>Patient focus</td>
<td>Provides adequate information to aid searching</td>
</tr>
<tr>
<td><strong>Introduction</strong></td>
<td><strong>Why did you start?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Aims of the project</td>
<td>Description of local problem (process mapped current process and why it was not working)</td>
<td>Available knowledge (previous studies)</td>
</tr>
<tr>
<td><strong>Methods</strong></td>
<td><strong>What did you do?</strong></td>
<td>Description of how change was set up and stakeholders involved</td>
<td>Explicitly describing how you chose your measures (outcome, process and balancing)</td>
</tr>
<tr>
<td></td>
<td>Description of change</td>
<td>Wider considerations</td>
<td></td>
</tr>
<tr>
<td><strong>Results</strong></td>
<td><strong>What did you find?</strong></td>
<td>Written description of data obtained (pre/post audit)</td>
<td>Unintended consequences (benefits, problems, costs)</td>
</tr>
<tr>
<td></td>
<td>Longitudinal representation of data (run-chart)</td>
<td></td>
<td>Details about engagement and feedback from patients and staff involved</td>
</tr>
<tr>
<td><strong>Discussion</strong></td>
<td><strong>What does it mean?</strong></td>
<td>Associations between intervention and outcomes</td>
<td>Comparing results with other publications</td>
</tr>
<tr>
<td></td>
<td>Key findings summarised</td>
<td>Limitations of project (and efforts made to minimise)</td>
<td>Embedding and sustainability</td>
</tr>
<tr>
<td></td>
<td>Relating findings to aims</td>
<td></td>
<td>Honest critique of usefulness of the work</td>
</tr>
</tbody>
</table>

Adapted by Sahar Habibollah (ST7) & Vincent Tse
“Success is going from failure to failure without losing enthusiasm.”
-Winston Churchill
Resources & Reading

- **Mid-Staffordshire Francis Inquiry Report:**

- **Berwick Report: A Promise to learn, A commitment to act:**
  https://youtu.be/xb-PjOgxHeo

- **From Safety-I to Safety-II: A White Paper:**

- **RCPCH Compass E-Learning:** https://rcpch.learningpool.com
  Quality Improvement
  Paediatric Prescribing Principles

- **RCPCH QI resources:**
  https://www.rcpch.ac.uk/work-we-do/quality-improvement-patient-safety

- **Paediatric ePrescribing (SCRIPT)**
  www.safeprescriber.org
Resources & Reading

- Staff engagement toolkit: https://www.nhsemployers.org/~/media/Employers/Documents/SiteCollectionDocuments/staff-engagement-toolkit.pdf
- Learning from Excellence: https://learningfromexcellence.com/resources-and-evidence/
- Serious Incident Framework: https://improvement.nhs.uk/resources/serious-incident-framework/
- IHI Model for improvement: http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx
- The Health Foundation: https://www.health.org.uk/
- NHS Improvement: https://improvement.nhs.uk/
Useful Conferences/Meetings

- [http://www.ihi.org/education/Conferences/Pages/default.aspx](http://www.ihi.org/education/Conferences/Pages/default.aspx)
  Next meeting **March 27–29th, 2019**  
  **Glasgow, Scotland**  
  BMJ and IHI, with strategic partners, will bring together more than 3,000 health care leaders and practitioners from 70+ countries  
  And if travelling not possible they also have virtual training modules: [http://www.ihi.org/education/WebTraining/Pages/default.aspx](http://www.ihi.org/education/WebTraining/Pages/default.aspx)

  Yearly conference with Paediatrics Day  
  **June 5th-7th, London, England**

- [https://www.fmlm.ac.uk/](https://www.fmlm.ac.uk/)
  Regular meetings with opportunities for trainees to showcase their quality improvement work

- [https://www.rcpch.ac.uk/news-events/rcpch-conference/programme-at-a-glance](https://www.rcpch.ac.uk/news-events/rcpch-conference/programme-at-a-glance)
  Quality Improvement Committee Specialist Interest Group Sessions to attend  
  **May 13th-15th May, Birmingham, England**