Patient safety - resources

Clinical Standards and Quality Improvement team
Patient safety, like child protection, is everyone’s business. The RCPCH supports, educates and develops paediatricians, and the wider child health workforce and services, to deliver high quality safe care for infants, children and young people.

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What the College is doing on this topic

Developed following the work around our report, Why Children Die, and the Berwick review into patient safety listing ‘Safe’ as one of its six aims for the health care system, our Quality Improvement (QI) Strategic Framework seeks to support clinicians to improve children and young people’s experience of healthcare whilst reducing harm and avoidable incidents.

NHS Patient Safety Strategy
According to the NHS, patient safety is about maximising the things that go right and minimising the things that go wrong. This is integral to the NHS definition of quality in healthcare, alongside effectiveness and patient experience.

The NHS Patient Safety Strategy outlines what the NHS will do to achieve its vision to continuously improve patient safety.

Below are some useful links to further information:

- Scottish Patient Safety Programme (SPSP)
- NHS Improvement Patient Safety
- Patient Safety Wales
- HSC Safety Forum
- RCPCH Safe system framework for children at risk of deterioration
- RCPCH Situation Awareness for Everyone (S.A.F.E) toolkit

**Paediatric Early Warning Scores (PEWS System)**

In June 2018, NHS England & NHS Improvement, the RCPCH and the Royal College of Nursing (RCN) came together to establish a joint National PEWS System programme board for England. We recognised that Scotland has a single system in place and the other nations were working toward a single system.

Our ambition is to develop a consistent approach and common language to promptly recognise and respond to the acutely ill or deteriorating infant, child or young person. We have seen great success in the roll-out of National Early Warning Scores (NEWS2) for adults and are keen to mirror this for children and young people. But we recognise they are a very different population group with very different needs.

*More information coming soon*

**Serious Hazards of Transfusion (SHOT)**

SHOT is the UK independent, professionally-led haemo-vigilance scheme. Paediatric SHOT cases comprise all reports for patients under 18 years of age, subdivided by recipient age groups:

- Neonates are less than or equal to 28 days
- Infants are aged between 28 days and 1 year old
- Children are over 1 year to less than 16 years
- Those aged 16 to 18 years

Paediatric cases make up about 8% of the total reported to SHOT. They are disproportionately represented in these error categories:

- Incorrect blood component transfused-wrong component transfused (IBCT-WCT)
- IBCT-specific requirements not met (IBCT-SRNM)
- Avoidable, delayed or under transfusion (ADU)
This partly reflects the increased complexity of paediatric transfusions. Neonates and children are vulnerable patient groups and may have special transfusion requirements.

Read the annual SHOT Report 2018 or find out more about SHOT

Work with specialty groups

The College is affiliated with a number of paediatric specialty groups and special interest groups.

At the June 2019 RCPCH Specialty Board meeting, we asked specialty groups to identify their top three patient safety concerns. Scotland has a single system in place and the other nations were working toward a single system.

Feedback has been received from the British Society for Allergy and Clinical Immunology (BSACI), British Association of Paediatric Nephrology (BAPN) and British Association of Perinatal Medicine (BAPM) to date, and we are investigating how to provide support and resources around these raised concerns. In summary, their patient safety concerns are:

- Correct use of auto-injectors, knowledge of the emergency management of anaphylaxis, and easier access to allergy clinics for children at a higher risk of anaphylaxis
- Staffing (ie training, recruitment and retention)
- Data systems to ensure safe, efficient and effective care (ie sharing clinical data between units, electronic prescribing)
- Reduction of morbidity relating to equipment not designed for small children, including equipment access
- Equipment capacity (ie cot capacity for the ongoing improvement in survival for preterm infants requiring extended neonatal unit stays)

Information for parents on first seizure safety netting

In response to a tragic case, we've produced an information leaflet for parents and carers of children and young people who have had a first seizure not considered to be a ‘febrile convulsion’.

Our aim is to ensure families have correct early information, and that initial patient journeys are appropriately described and improved. We endeavour to have this resource available to parents, carers, children and young people with single or multiple episodes at first emergency department, GP or acute paediatric presentation pending first non-acute paediatric assessment via their healthcare professional.

Situation Awareness for Everyone (S.A.F.E) toolkit

Situation awareness takes the perspective of everyone involved in a child’s healthcare at hospital so that the clinical team can take the best decisions. It requires a shared understanding of what is happening. This needs non-hierarchical information and communication. There is no single intervention that can implement situation awareness in a
single go. However, there are many different tools and techniques that together can deliver situation awareness in a paediatric or other healthcare setting.

The **S.A.F.E toolkit** provides many, but not all, of the tools you might consider using. It's organised into four main themes, which reflect how S.A.F.E has been implemented elsewhere. You can identify which chapter you wish to start from, depending on the experience of your organisation.

**Safe System Framework**

This framework aims to improve recognising and responding to children at risk of deterioration. A safer system can work in partnership with families and patients, develop a patient safety culture and support ongoing learning.

**Paediatric Care Online (PCO UK)**

**PCO UK** is the UK's only clinical decision-support tool on child health and safeguarding, for any health professional who sees children and young people at the point of care.

This innovative tool provides immediate access to clinically assured information to inform decisions at point of care, together with a repository of supporting reference material and patient information. Accessible on a website and as a mobile app, PCO UK is available anytime, anywhere.

**Patient safety alerts**

**Central Alerting System / Medical Device Alert**

The Medicines and Healthcare products Regulatory Agency provides alerts about medications, delivery and devices.

[See alerts and recalls for drugs and medical devices](#)

**Patient safety investigations (HSIB)**

The **Health Safety Investigation Branch (HSIB)** conducts independent investigations of patient safety concerns in NHS-funded care across England.

Current HSIB reports include:

- Investigation into undetected button / coin cell battery ingestion in children
- Management of acute onset testicular pain
- Inadvertent administration of an oral liquid medicine into a vein
- Failures in communication or follow-up of unexpected significant radiological findings
- Wrong patient details on blood sample

**Coroner reports and serious case reviews**
Prevention of Future Deaths (PFD)

Upon receipt of a PFD report, an incident in 2019 highlighted the need to raise awareness on how serious allergies can be and the importance of auto-injectors in children and young people.

As a College response, we're working with the Specialty Groups to raise awareness around auto-injectors - see above.

We've also been made aware of several child deaths with similar learning points identified, including:

- Increased public and clinical awareness around the signs of sepsis in children (RCPCH Paediatric sepsis podcasts)
- Provision of a National Safer Sleep campaign for infants
- Inclusion of advice on calling 999 and not self-transporting the child to an emergency department if the child is unresponsive or not breathing
- An offer of free / affordable resuscitation training for all parents, with a targeted offer to those with twins / triplets, premature infants and other infants identified as at a greater risk of Sudden Infant Death
- Increased awareness among children and families who speak English as a second language of the Emergency 999 procedures within the UK, and the NHS111 translation service

External links
Human Factors & Ergonomics in Health & Social Care Hub
NHS Improvement Patient Safety (videos)
NHS Improvement Patient Safety Alerts
Paediatric Care Online (PCO UK)
Paediatric International Patient Safety and Quality Community (PIPSQC)
Re-ACT: the Respond to Ailing Children Tool (video)
WHO Patient Safety