RCPCH Progress domain resources: Patient safety and quality improvement

Quality and Standards team
Quality improvement (QI) needs to encapsulate all aspects of patient care - not just the clinical experience but service development, review and evaluation. These resources can help you ensure your practice prioritises patient safety, and that it strives to improve the experiences and outcomes of your patients and their families.

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These resources are related to two domains: 7 - Patient safety (including safe prescribing) and 8 - Quality improvement. These were developed with current trainees and supervisors, RCPCH Officer for Health Promotion as well as children and young people.

What children, young people and families say
We asked 225 parents of children with complex health needs about their concerns on patient safety and, in particular, safe prescribing. Here's what they told us:

- Communicating with other carers and healthcare professionals about their child's medication
- Remembering which medication to give and when
- Their child's response to receiving the medication
- How to administer the medicine and how much to give

Our [Medicines for Children resource](#) gives practical and reliable information to parents. Following calls from parents, it's now developing an app to help them manage their children's medicines.

You can download our [full CYP flyer (PDF)](#).

**Overview and teaching resource - presentation**

Underpinning the knowledge:

- Patient safety priorities and risk management
- Learning from errors
- Knowledge of formularies and guidance
- Ethics of prescribing

You can download our [presentation (PPTX)](#), which you might use for a teaching session, for more detail.

**How paediatricians use this domain in their everyday practice - videos**

Dr Vincent Tse, the College clinical lead for QI and patient safety, talks about how QI and
safety measures can easily be incorporated into everyday clinical practice.

Dr Drew Maxted at Nottingham University Hospital talks about a QI activity that resulted not only in improved care for patients but also more efficient working practices for clinicians.

Dr Amanda Newnham at Leeds General Infirmary discusses how a QI project has improved patient and family services, increased efficiency and better use of clinician time, involved other health professional staff and has now changed practice across the whole hospital.

These three case studies give examples of evidence that could be used to demonstrate contribution towards the domain learning outcome.

**Closing the gaps - case study**

Have a member of the consultant team support you in your efforts

Setting: Hospital inpatient ward

**How did the opportunity arise?**

You have realised that the system for checking outstanding microbiology investigations isn’t working after microbiology ring your ward with updated sensitivities on a urine MC+S. The patient is currently on partially sensitive antibiotic.

**What happened?**

Escalate and manage the clinical situation appropriately and arrange appropriate treatment and follow-up for the child.

Using the [Institute for Healthcare Improvement toolkit](https://www.ihi.org/resources/Pages/Tools.aspx), you explore the causes of the system failure and create a PDSA (Plan Do Study Act) worksheet with a multidisciplinary team of colleagues, constantly measuring the impact of change.

**How did this support your development?**

You gain experience in working with - not just alongside - your multidisciplinary colleagues to effect long term change that they can support long after you’ve moved on. You learn through completing the cycle how to successfully undertake a quality improvement project and approach/manage the human factors hurdles.

Your project has a positive impact on the care of all children and young people in your workplace and inspires colleagues to undertake other projects.

**Any practical tips?**

Have a member of the consultant team support you in your efforts and recruit champions from each professionals’ group involved to constitute long term change.

**A simple error - case study**
Through learning how to prevent your own errors you can teach others to spread improvement

Setting: Inpatient ward

**How did the opportunity arise?**

The nurse informs you of an accidental overdose of gentamicin that you prescribed.

**What happened?**

Make sure the patient is safe. How do you do this?

You have a duty of candour to the patient and their parents. Be honest about the error and inform them of the format and timescale of investigation or the error. Answer any questions they may have and direct questions you are unable to answer to an appropriate colleague or patient advice and liaison service (PALS).

Report the error on your local reporting system. Ask your local patient safety lead to be involved in the investigation; think about why the error may have happened. Incorrect weight on the drug chart? Incorrect dose calculation? Was it on a night shift? Two patients with the same name? Distracted whilst prescribing?

Learn how to disseminate learning to colleagues and prevent it happening again. You may consider undertaking further training on safe prescribing utilising the paediatric SCRIPT resource.

**How did this support your development?**

Through following the investigation of a serious incident you learn about the investigatory process and human factors. Through doing this you learn how to practice safely and prevent errors in your own practice. Through learning how to prevent your own errors you can teach others to spread improvement.

**Any practical tips?**

Get to know your local clinical governance lead in order to follow this investigation through. Go to the local clinical governance meetings and Doctor Foster reviews.

**A true story - case study**

Survey your colleague’s opinions after you implement an idea

Setting: Inpatient

**How did the opportunity arise?**

During my everyday role I was noticing opportunities to improve my team’s learning and patient care by improving knowledge of guidelines, new courses, learning from DATIX incidents and near misses, possible system improvements and areas for quality
improvement work within the team.

**What happened?**

I thought about how I could share this information with my colleagues and how we could promote a culture of clinical excellence, quality improvement and patient safety.

I needed a platform that was free and accessible to everyone within the team. I therefore decided to start a weekly learning points email to illustrate:

- Clinical learning points of the week with links to guidelines, Child Protection Evidence, Archives, 15 minute consultation and other educational resources
- Quality improvement and patient safety:
  - near misses and DATIX feedback (incident reporting) for wider learning
  - prescribing pitfalls for the team
  - promotion of local QI initiatives - for example, Medicine Reconciliation Audit, Continuous Quality Improvement to Meet Gold Standard of Growth Monitoring in Acute Admissions
- Feedback on QI results – how can we do better as a team? Over time this has expanded to include:
  - Quote of the week: "Don't aspire to be the best on the team. Aspire to be the best for the team."
  - Feedback from Paediatric Emergency Team training for wider learning: including system challenges for example activating major haemorrhage protocol, where to find the treatment for local anaesthetic toxicity.

To make this endeavour sustainable, I sought the support of the Departmental Clinical Lead and the Associate Director of Medical Education while recruiting colleagues to help lead.

**How did this support your development?**

Not only did I develop my clinical knowledge and leadership skills but I was able to influence the culture of my department and lead or supervise a number of QI projects and information dissemination.

The weekly learning point’s MS Word document was also used to tag curriculum learning on RCPCH ePortfolio (Kaizen).

**Any practical tips?**

Motivate your team.

Recruit colleagues to help implement your ideas and carry it forward when you move posts. This ensures sustainability.

Survey your colleague’s opinions after you implement an idea. If people do not like something or you do not tailor your idea to encompass other members of the team’s ideas then it will not last.

You can download a poster summary below.
Do not hesitate to contact Natalie Bee, RCPCH QI Representative, if you need any help or inspiration at nataliebee04@gmail.com.

The College's QI programmes

Our QI framework looks at how we support, educate and develop paediatricians and the wider child health workforce to deliver high quality care.

And, we have several resources to support your learning in QI - from eLearning that helps you understand the 'jargon' to our S.A.F.E toolkit that helps clinical teams develop a 'situation awareness' programme on their unit.

Take a look at our Quality improvement and patient safety section for our resources!

Special thanks and acknowledgement to Drs’ Fiona Hignett, Aless Glover, James Dearden and Natalie Bee and to all who contributed in providing the content for this domain.

Downloads
RCPCH Progress - patient safety and QI - CYP voices (PDF)312.66 KB
RCPCH Progress - patient safety and QI - presentation.pptx3.62 MB
Patient Safety &amp; QI case study 3 poster summary487.48 KB