

Innovating for Improvement

Safer care patient checklist: a co-designed intervention to promote safe, high quality practice and improved outcomes

University Hospital Southampton NHS Foundation Trust/University of Southampton



About the project

Project title: Safer care patient checklist: a co-designed intervention to promote safe, high quality practice and improved outcomes

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Part 1: Abstract

Healthcare organizations strive to deliver safe, high quality care that meets the needs of patients. Adverse event reports, complaints and feedback indicate areas where proactive involvement of the patient could improve patient experience, through better understanding, reduced anxiety and potentially reduction in avoidable harm.

At University Hospital Southampton NHS Foundation Trust we developed a simple patient-administered intervention that aimed to empower patients to be more active in their own care. It prompted real-time feedback and encouraged patients and professionals to address any concerns together at the point of care.

We co-designed two forms with patients and staff - one for Emergency Department (ED) 'walk in' attenders, and one for young people admitted to Paediatric wards. We tested using these forms in each setting to compare the effect in contrasting environments.

The intervention was positively received by patients and staff, but did not fully deliver the desired patient empowerment. We successfully created a 'case for change' but discovered that this particular solution may not be suitable for all patients or staff. The project provided powerful insights about patient care journeys, care practices and real world challenges to improvement. We are spreading this learning.

How have you gone about testing your intervention?

We worked with patients and staff to co-design the forms and think about the best ways to administer them. We spent time explaining the purpose of the intervention, and training clerical and clinical staff to give out and use the forms.

We tested using the forms for 6 weeks in each setting. We analysed routine data on complaints, satisfaction, errors, and activity before and after the intervention to see what, if any, changes had occurred. We calculated completion of forms against eligible patients and used qualitative observations and interviews with staff and patients to explore whether patients and staff were likely to use the forms. We administered NOMAD (a survey developed from Normalization Process Theory) to assess 'buy in' and explore how the checklist might need to be adapted to embed in everyday practice.

What has gone well?

We developed a strong interdisciplinary team that combined clinical and academic knowledge, and expertise on methods. This was the basis of considerable shared learning.

Co-design proved valuable and underscored the importance of engaging with staff and patients early in the development of this kind of intervention. This learning will inform future work. We created a network of people interested in co-designed checklists to improve care.

What have the challenges been and how have these been addressed?

Despite changes intended to streamline the system, the HRA/ NHS ethics process proved laborious. It took 6 months to gain approval, despite having prior Trust sign off. We were able to undertake some service improvement work which allowed us to make progress while waiting for approval.

The main challenges were patient empowerment and practice change. Intensive effort by senior clinicians ensured that forms were handed out and collected. However our process evaluation suggested that while staff and patients were very positive about the idea, the form itself was not used to drive up the quality and safety of care. This finding reinforced:

- the need to systematically test interventions before rushing to implementation
- the value of process evaluation in explaining what happens to an intervention

What are your outcomes and what is the impact of this?

We co-designed two forms (Your Visit and Your Stay) with patients and staff and tested these the Emergency Department and Paediatric inpatient wards. In the ED 40% of forms were returned, and in Paediatrics forms were returned by 11% of eligible patients. In such a short test period there was little impact on the chosen outcome measures - complaints, satisfaction and errors. These findings and the process evaluation has convinced us that we should not roll out the intervention in its current form but we are using our learning from this project to inform practice.

What you have learnt?

- the necessity of co-design with patients and staff at an early stage;
- the importance of testing interventions in different real world settings;
- process evaluation is vital. Qualitative observation (seeing how an intervention 'really' works) has a big part to play, and NOMAD can be used to understand why an intervention is/isn't working;
- co-designed checklists are viewed positively but are difficult to enact consistently in these two healthcare settings;
- improvers must attend to socio-organisational factors, such as culture and leadership, which impact on how interventions are received and adopted;
- initiative fatigue is a significant barrier to improvement.

Part 2: Progress and outcomes

THE INTERVENTION

The Emergency Department 'Your Visit' form

This form was based on ideas in Gawunde's Checklist Manifesto. A trial in the Emergency Department (ED) showed promising results with a prototype (figure 1).

Figure 1: pilot checklist

We developed the form using co-design with patients and staff in the ED, exploring their experiences and thoughts about the idea. We produced a prototype (figure 2) and incorporated their feedback on this into a new form (figure 3).

Figure 2: example of patient feedback

Figure 3: Your Visit form

Examples of learning implemented from the co-design:

- ask nurse to demonstrate use of the form using questions 1&2, this reinforces good practice regarding pain relief/explaining wait times;
- removed yes/no tick boxes;
- added significant medications list;
- added ‘what is important’ prompt;
- layout and design adjusted;
- renamed as ‘Your Visit’ following staff concerns about ‘checklists’.

Paediatric Wards ‘Your Stay’ form.

This was one of a number of improvement initiatives introduced within the department under a strategy to reduce avoidable harm to patients. Specifically, it aimed to encourage young people to become more actively involved in their care to improve safety and quality.

Working with the Southampton Children’s Hospital Young People’s Forum (SCHYP), a pre-existing group of patient representatives, we developed a prototype using ‘think aloud’ and focus group techniques (figure 4), with input from playworkers and nurses.

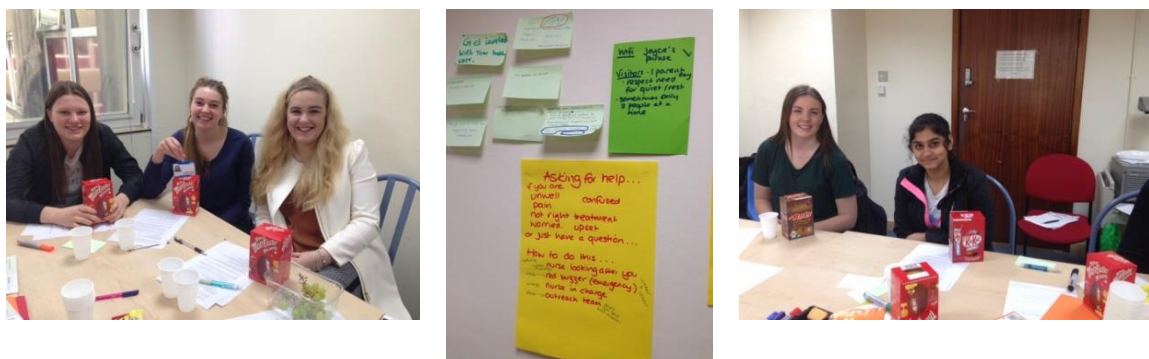


Figure 4: SCHYP at work co-designing the form

The co-design took 5 months, and produced several iterations of the form (figure 5).



Figure 5: versions of the Your Stay form

Learning from the co-design included:

- focus on 11yrs+ as most likely to engage;
- patients uncomfortable interrupting staff - developed an additional insert (figure 6);
- incorporate primary colours and 'sneakers' design to echo Hospital logo;
- brand as 'Your Stay'; emphasise form is individual to the patient and not for assessing staff;
- back page (figure 7) - concern that contact numbers would result in 'escalation' (NB: no calls made during the trial);
- reduced questions and adjust subheadings for clarity;
- negotiating what matters to young people (e.g. access to wifi) and what matters to staff (e.g. medication errors)



Figure 6: 'I have a question' insert

Got a question?

You'll find some useful information about wi-fi, what you can wear, visitors, where you can go and what you can do displayed on the walls, or on the back of the mats on the tray that your meals are brought on.

Need help?

Sometimes, people get more unwell after they've come into hospital. If you or your family feel that something's not right, please tell us.

This is especially important if:

- You start to feel more unwell
- You're in pain
- You don't think you're getting the right treatment

1 Speak to your nurse. If you can't get up, press the call button next to your bed.

2 If you're still worried after speaking with a nurse, then ask to speak to the nurse in charge of the ward.

If that hasn't helped, you can call one of the following numbers:

3 If we're not meeting your expectations of your hospital experience, call our 'Tell Us Today' line on 07766 778082.

If it is about a safety concern, your medical condition or treatment, call the patient outreach team on 07771 551508.

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Figure 7: escalation information

DATA USED TO EVALUATE THE INTERVENTION

We collected qualitative and quantitative data before and after the trial.

- **Complaints**, including concerns resolved before formal complaint, and feedback to Trust website. Source: Trust complaint records. Relatively rare so change unlikely to be statistically meaningful but can highlight areas of concern e.g. waiting times.
- **Patient satisfaction**: i) adapted Picker survey in ED. Source: www.nhssurveys.org validated and reliable. ii) Friends and Family Test in Paediatrics. Source: www.nhs.uk. Short, anonymous feedback used across the NHS.
- **Errors and safety**: i) ED Adverse Event Reports. ii) Paediatric medication errors. Source: Clinical Directorate reporting. These rare events may be indicative of areas of concern.
- **Activity during trial**: Numbers of ambulatory patients attending the ED and Paediatric inpatients aged 11 and over. ED length of stay and attendance. Source: Clinical Directorate reporting. Calls to Paediatric outreach. Source: Outreach lead.

Process evaluation: numbers of forms handed out and returned; observed /interviewed patients and staff; administered NOMAD survey to assess embedding and sustainability.

FINDINGS

Complaints: formal complaints in both settings are rare and not an accurate measure of success for this intervention.

- ED: Numbers of complaints relating to patients treated in ED minors for the preceding 9 months and 6 weeks after the intervention (note potential time lag in the complaints process): there was one complaint every 7.4 days before, and one every 7.8 days after the intervention.
- Paediatrics: 28 complaints in 2016. 18 related to outpatients/day care were excluded. Nine related to ward issues, one concerning a cancellation. 2/9 were about staff attitudes. The remaining 7 included lack of information on discharge, poor communication and perceived inadequate care. 2/7 complaints received (but not necessarily occurred) in the study period – one focused on the attitude of consultant, the other about the experience of care when transferred from high care area to ward.

Patient satisfaction: satisfaction in both settings already high and no effect detected.

- Picker survey in ED: no real differences before and after the intervention (data not subjected to statistical significance testing because of small numbers). Over 80% of patients report sufficient time to discuss problems, receiving pain relief and coherent explanations, and being involved decisions. Total difference was -1 over the 13 survey items (see appendix 1.1 for more detail).
- Friends and Family Test in Paediatric wards: no real differences before and after the intervention.

Errors and safety: adverse events in ED and medication errors in paediatric settings are rare and not useful as a measure of success of this intervention.

- ED Adverse Event Reports (AERs): safety and communication events reported by staff in minors 6 weeks before and after the intervention were compared. There were 29 AERs before and 31 after.
- Paediatric medication errors: (figure 8) these are low frequency events and while there appears to have been some reduction in the higher level errors this is unlikely to be statistically significant.

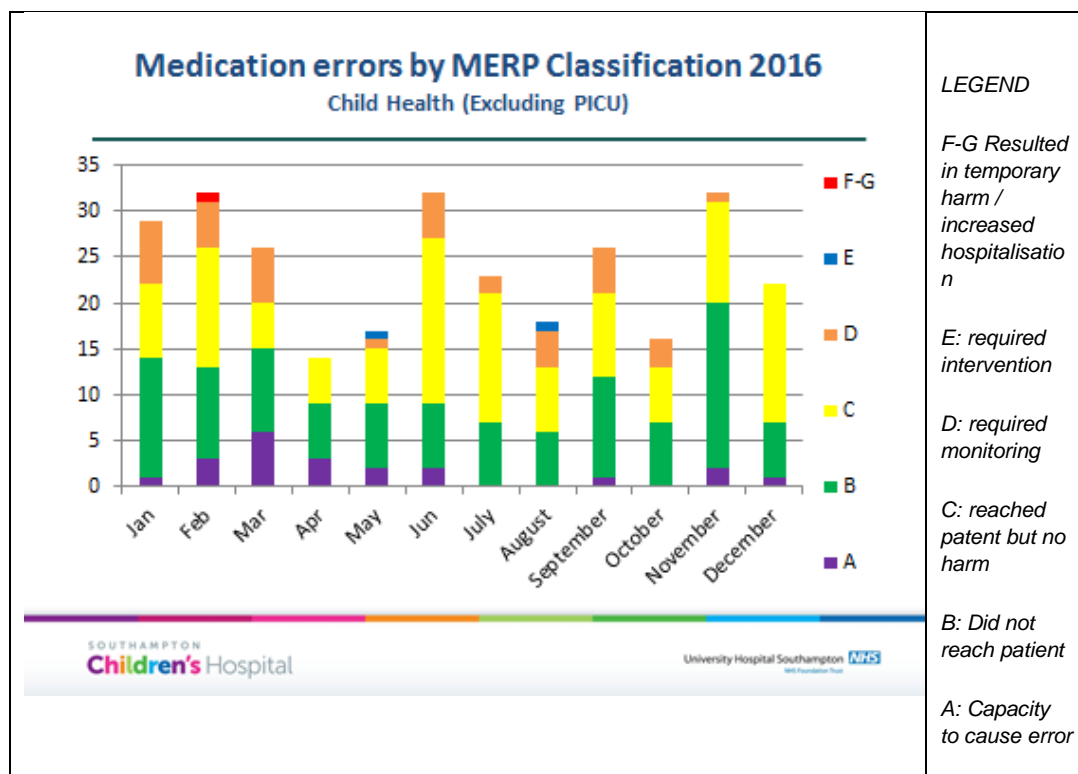


Figure 8: medication errors (Paediatrics)

Activity

- Forms completed/returned in ED (Table 1): Just under half the patients triaged to minors received the Your Visit form. Those who did not included those who were intoxicated; had language difficulties or deemed clinically inappropriate (e.g. significant mental distress/disability preventing completion). Forms were collected in 40% of cases.

Table 1: Eligible patients and forms returned ED

Week	Number of patients	Number given out	Number returned
1	461	344/ 74.6%	90/26%
2	512	258/50.3%	139/ 53%
3	385	161/41.8%	102/ 63%
4	444	209/47%	123/58%
5	487	151/31%	63/41%
6	450	164/36%	90/54.8%
Total	2739	1287/ 47%.	517/40%

- Average length of stay was expected to increase if the intervention led to more discussion with patients, but this was not the case (figure 9).

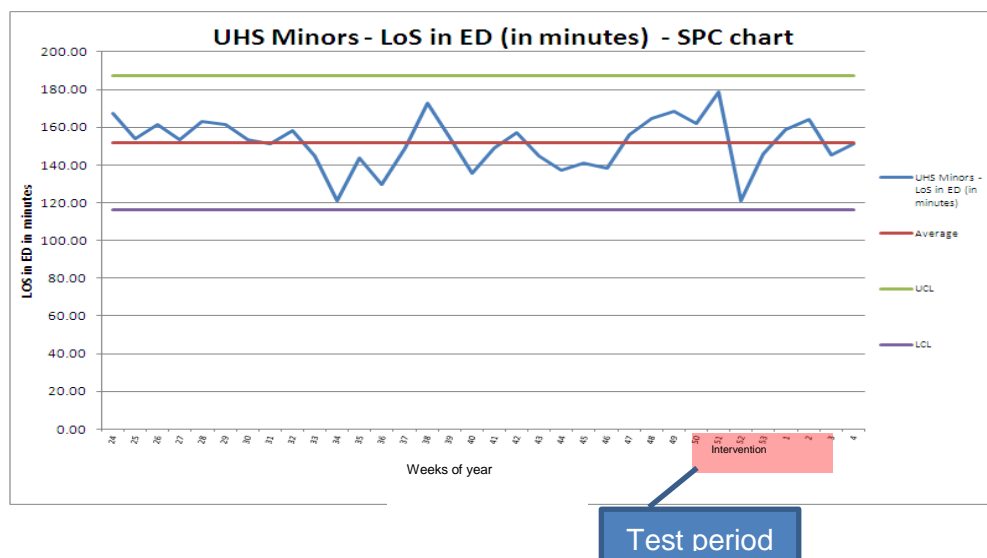


Figure 9: ED Length of stay

- Reattendance rates (figure 10): anticipated reduction due to better communication, but this too showed no change.

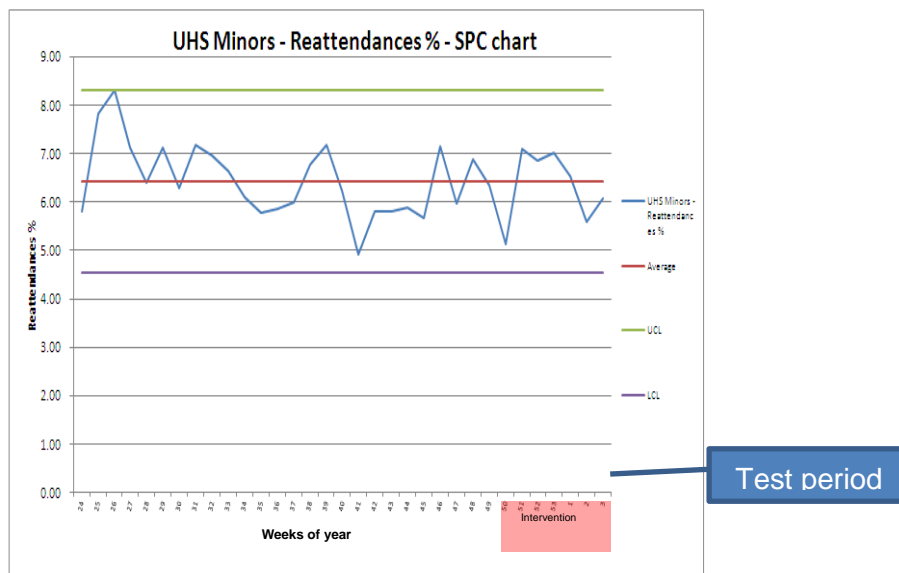


Figure 10: ED attendances

- Forms completed/returned in Paediatrics: a total of 180 forms were supplied to wards. Forms were returned by 11% of eligible patients (15% of forms given out). Forms were retained by patients/not collected and it was not possible to quantify this.

Table 2: Eligible patients and forms returned Paediatrics

<i>Test period</i>	<i>Eligible</i>	<i>Returned</i>
<i>G2 NEUROSURGERY</i>	<i>5</i>	<i>0</i>
<i>G3 PAEDIATRICS</i>	<i>157</i>	<i>6</i>
<i>G4 NEPHROLOGY</i>	<i>21</i>	<i>0</i>
<i>G4S SURGERY</i>	<i>21</i>	<i>6</i>
<i>PMU</i>	<i>35</i>	<i>10</i>
<i>PIAM BROWN</i>	<i>6</i>	<i>1</i>
<i>Unknown</i>	<i>-</i>	<i>4</i>
TOTAL	245	27 (11%)

Part 3: Cost impact

As our project was primarily developmental, the economic aspects were not our primary focus.

The services studied are locally commissioned and we kept our commissioners informed about the project.

Improved quality of care may not immediately translate into improved health outcomes and patient satisfaction in both settings was high to begin with. Reduced errors and complaints are low frequency events in both settings and the costs of these are highly variable. These factors make costs difficult to assess. Informal discussions with clinical directorate staff suggested that there are likely to be potential savings in staff time costs when complaints are avoided. A complaint may involve between 3-6 different staff members, as well as patients and family members. Meetings and reporting can take 20 person hours. Interventions which address attention to areas of concern for patients may mitigate these costs.

If the intervention was rolled out and embedded it would become part of routine practice. Giving out the forms was incorporated into initial triage in ED, and admission /general nursing care in paediatrics, where it took less than 1 minute. Had patients asked lots of extra questions because of the forms this could add to staff time costs - however we found that staff and patients did not use the forms in this way and these costs were not incurred.

Training and familiarisation for the implementation used Consultant grade input (MC and KP) supported by experienced researchers (CP KL and UR). This was supported by additional funding provided in the research grant which would not otherwise be available. We calculate that training and debriefing took approximately 50 person hours (a researcher and Consultant provided training together on some occasions). We used planned meetings to induct and reduce time demands on staff and training would not necessarily take as long now that the process has been tested. Training could be delivered by a single, and possibly less senior, staff member.

Some of the design and development costs of prototype forms were borne by the Trust as part of ongoing improvement activity. The cost of design and print of the Your Visit forms was £836 which is approximately 0.40 per form (250 first run, and two batches of 1000). The cost of design of the Your Stay and I have a question forms and associated posters for display in the ward areas was £800. The print run of 250 of each form was £125 or 0.25 per form.

Part 4: Learning from your project

Achievements and Enablers

Project Team

The project team, particularly the balance of clinicians, academics and expertise - clinical as well as in improvement/research, enabled us to successfully complete the project despite some frustrating delays and challenges outside our control. Having a shared vision, clarity of roles and learning ethos ensured that despite set backs every member feels this has been an extremely valuable project both individually and for the organisation.

Co-design

We were successful in co-designing two forms with patients and staff, and trialling them in both settings. Co-design was central to the project, allowing us to develop the intervention with patients and staff, and helping us to understand *why* people were supportive or resistant to the intervention. For example, when presented with an early version of the Your Visit form a senior doctor commented *“this is absolutely pointless and a waste of time”*. Further discussion identified that the doctor had misunderstood the intervention as an audit, rather than a tool for engaging patients. This type of feedback informed the training about the intervention. One parent provided blunt feedback: *“What numpty thinks this is a good idea. As if nurses don't have enough to do. I have never found nurses not [to] be able to answer my questions. The money spent on this form should be spent on the people who deserve it - nurses!”* Conversely another parent valued the form for recording concerns relating to the long-term care of her child with learning disabilities.

Explaining the intervention

Before the trials we spent time promoting the project to staff, attending a range of meetings including mandatory training, handovers, and departmental events. We refined the description of the project and obtained valuable feedback that improved the intervention. During the trial we spent time in the settings to support staff and patients, making sure they knew what was happening and what was required of them. On the Paediatric wards we provided a pack including:

- a supply of the forms
- information sheet on how to use it/explain to patients (see appendix 1.2)
- pens for patients

In the ED we provided a script for the triage nurse (appendix 1.3), displayed reminder posters and prompt cards for consulting clinicians (figure 11).

Remember to review the patient's Your visit form

- when you first see the patient
- and again before they leave

Then place the completed form in the patient's notes.

Figure 11: Prompt card in ED

Getting key people on board

Not all staff were engaged with the project, and the support of key people within each setting significantly impacted on the intervention. In the ED, the influence of a senior and well-respected clinician was key to the use of the forms. Staff handed out the forms “*because Mike asked us to*”. More forms were handed out in ED than on Paediatric wards, however this did not mean that staff were working with patients to address concerns in real time. On one Paediatric ward the ward manager championed the form, ensuring it was given out on admission. On other wards lead nurses appeared ambivalent, or opposed to the intervention, and few forms were given out. A quiz at the end of the trial period highlighted the lack of familiarity with the intervention (appendix 1.4) and ward observations showed that often forms were misplaced. Ward clerks and playworkers championed the project, although we had originally designed the form to be given out by clinical staff.

Challenges

- HRA/Ethics approval: We had to draft multiple consent forms and information sheets. The transfer to a new HRA process produced delays.
- Pressures facing the NHS: Acuity of patients and winter bed pressures reduced the numbers of eligible patients and increased staff workloads in Paediatrics. Alert status, overcrowding and mandatory targets, especially in ED made the intervention low priority.
- Project team disruptions: periods of significant ill health and compassionate leave (and a more joyful maternity leave for one member).
- Significant unplanned, urgent refurbishments in Paediatrics delayed the trial start and dented morale and engagement. It also meant instead of a small trial with several PDSA cycles, before roll out to whole children's hospital we had to start the intervention across the whole children's hospital. This reduced ability to support the intervention as it was diluted across many clinical areas.
- Whilst there was apparent support for empowering patients, the majority of patients don't want to take the step of actively engaging. This was revealed by the co-design work and the process evaluation. Articulate/confident

patients feel they can ask questions without the form. Many trust staff do their best and do not want to appear critical. Others 'cannot be bothered' or are distressed/in pain which prevents them from engaging.

- Initiative fatigue: this was one of a number of competing Trust improvement activities and staff felt overloaded (see appendix 1.5). One nurse explained "*It is just another bloody form*". In Paediatrics there were projects looking at patient reported experience and outcome measures, improving sleep, introducing HUDDLES, sepsis trigger tools, appropriate PEWS recording and escalation, work on conflict resolution, appreciative inquiry, home before lunch, shared paperwork, signing in and out books, and a matron's helpline as just a few attempts to improve care and practice. In the ED there was a CQC inspection during the test period as well as projects to improve older people's care, manage sepsis, improve hygiene and recycling.
- Ward level leadership hindered the project in Paediatrics. Three wards didn't have a ward leader and one had an interim matron - this reduced day to day leadership and championing of the project. Senior nurses in the ED did not champion the intervention, seeing it as a medically-led initiative.
- Our ambition to create a patient forum for the ED was not realised. Advertising (appendix 1.6) and personal invitations did not result in sufficient interest to establish this. We conducted co-design pragmatically in the ED waiting room which proved successful.

Specific learning on introducing and sustaining innovations in the NHS

- Great ideas need testing in your setting - the logic behind checklists appears sound, and the idea is very positively received by patients and staff but they do not use them in the ways you hope they will. The intervention was a 'brilliant idea' for this ward or other patients but 'not for me/us'.
- Process evaluation in addition to analysing outcome measures is essential to fully understand what happened to the intervention (lots of completed forms did not mean that patients and staff were resolving concerns as intended)
- Co-design with patients, families and staff is vital - they told us what mattered to them, showed us what we got wrong, and continue to inform our work.

Part 5: Sustainability and spread

Will your intervention be sustained in your organisation beyond the funding period?

We recommend that the intervention in its current form is not continued - but we are using the learning from this project to improve care in both settings. Below we summarise this learning.

PROCESS EVALUATION.

The qualitative research and NOMAD survey explored attitudes towards the intervention and how it might work in practice. (see appendix 1.7 for a more detailed analysis). NOMAD is a tool developed from Normalization Process Theory (NPT), consisting of 23 questions exploring coherence, enrolment of staff and patients, the work of the intervention and reflexive monitoring (monitoring and adaptation to keep the intervention in use).

Table 3: Completed NOMAD by professional group in both departments.

	Paediatric Department		Emergency Department	
	Frequency	Percent	Frequency	Percent
Consultant	7	6.5	16	16.3
Junior doctor	12	11.2	17	17.3
Senior Nurse (band 7+)	9	8.4	17	17.3
Band 6 nurse	12	11.2	7	7.1
Band 5 nurse	59	55.1	34	34.7
Health Assistant/student nurse	3	2.8	0	0
Ward Clerk	2	1.9	0	0
Play worker	1	.9	0	0
Total	105	98.1	91	92.8
Missing	2	1.9	7	7.1
Total	107	100.0	98	100.0

ED staff views of the Your Visit Form

The ED NOMAD scores improved slightly in some the NPT mechanisms at the end of the trial and were positive in most of the domains (figure 11).

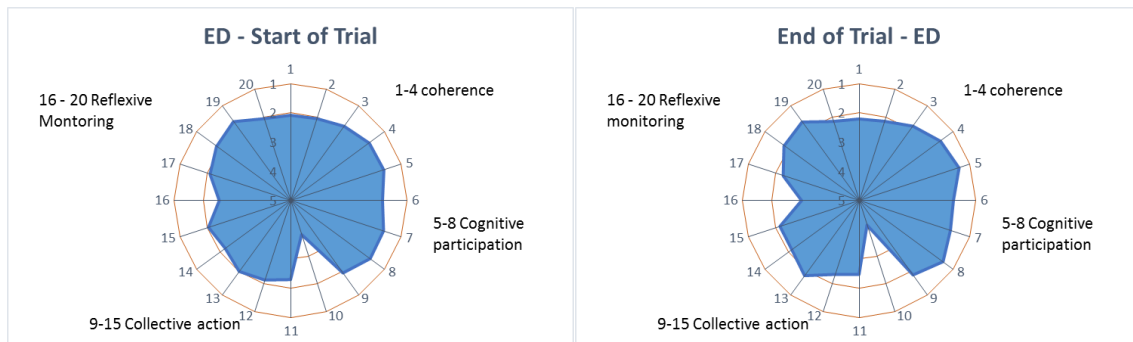


Figure 11: NOMAD plots before and end of trial - ED

Although staff attitudes were fairly positive at the beginning, this decreased during the trial period (figure 12).

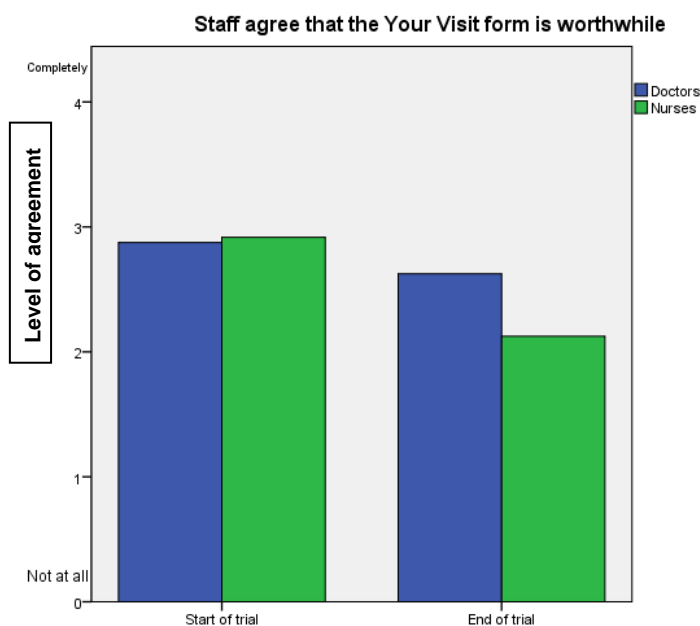


Figure 12: comparison of Nurse and Doctors valuing of the form

Paediatrics : Staff views of the Your Stay Form.

Staff attitudes towards the intervention starting positively but diminished throughout the trial (figure 13). Staff accept the problem of patient care as conceptualised, but reject the Your Stay form as the right intervention to address this.

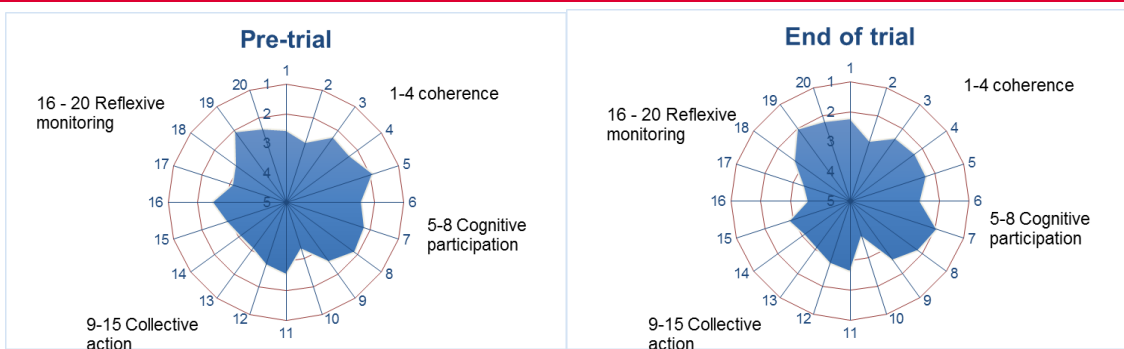


Figure 13: NOMAD plots before and end of trial - Paediatrics

Coherence diminished over the trial - the form was seen as something to capture data retrospectively; it became *“just another data collection exercise”*. Other constructs also dipped over the trial - the nurses found it difficult to fit the form into their work, and did not see the value for their patients. Doctors valued the form more but did not use it (figure 14). Playworkers and ward clerks valued the form and may be more appropriate in delivering the intervention.

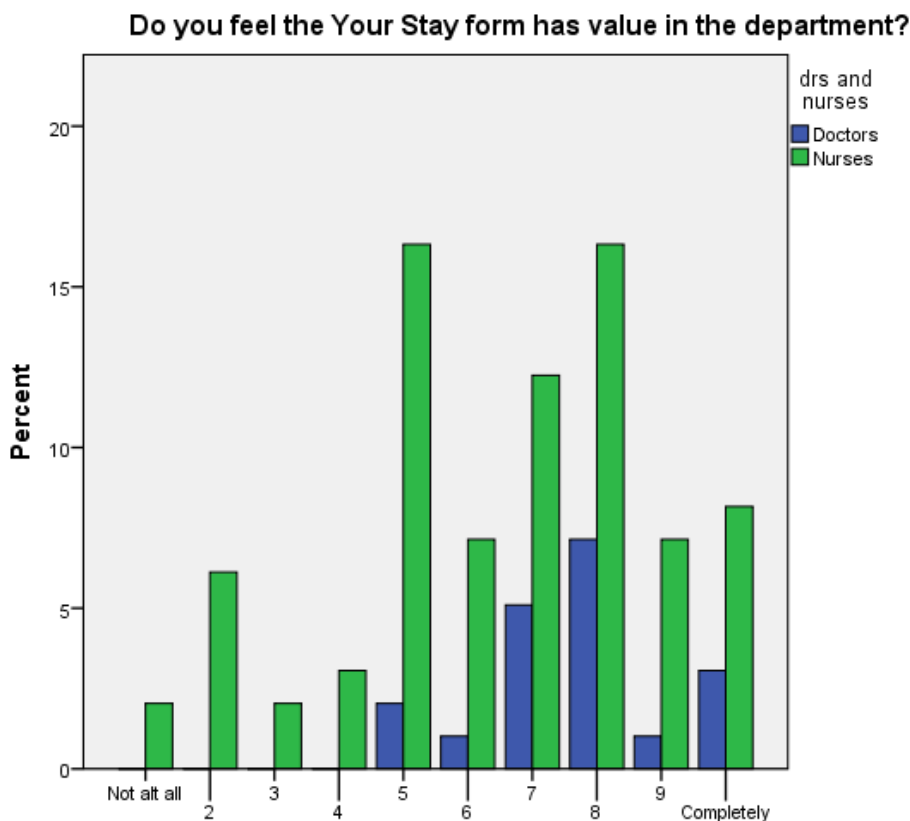


Figure 14: comparison of Nurse and Drs valuing of the form

FUTURE PLANS

The Your Stay and Your Visit forms will not be rolled out in their current format, but the learning from this project will be applied as follows:

1. Redesigning admissions paperwork in Paediatrics - observations suggest there are redundant elements and failures to capture relevant information efficiently. A BMedSci student has been identified to take this forward in 2017;
2. Investigating priorities for nurses, doctors, parents, and patient on admission to the ward. Another BMedSci student has been identified to take this forward in 2017;
3. Team learning days for band 5 and 6 Paediatrics Nurses to explore leading improvement (to address concerns that QI is imposed by senior managers or doctors) are planned for 2017;
4. Escalation processes in Paediatrics: continue to develop outreach team work, feedback to staff that providing patients and families with contact numbers of matron and outreach team does not overload these staff;
5. Targeted information giving in ED: developing a Polish version of Your Visit explaining how ED work and the core information that patients need to provide;
6. Explore how to make significant medicines information available to the consulting clinician in a timely and reliable way;
7. Developing a poster for ED waiting room based on Your Visit, encouraging patients to ask questions and share important information. Using further co-design to exploring the use of video in waiting room areas to prompt patients to ask questions when they see the clinician.

External interest and recognition

- Atul Gawunde commented *“What terrific work. I loved the poster which let me see the actual ED patient checklist for patients and the kinds of initial results you’ve generated. I’m so impressed you actually followed through and did so as systematically as you did.”* (personal communication)
- Checklist interest group initiated at Health Foundation Q event, May 2016.
- Contact with Dr Sam Vaillancourt St Michaels Hospital, Toronto doing qualitative work on patient perspectives.
- Shared checklist with Kath Evans, head of Patient Experience, NHS England, Dr Ronny Cheung at Evelina London Children's Hospital, Dr Jane Runnacles, Consultant Paediatrician Royal Free Hospital, London, Dr

Nancy El-Farargy, NHS Education for Scotland KV Grisan. Institute of Mental Health, Singapore.

- Dr Jonathan Burton, Clinical Director of Emergency Medicine asked for the pilot checklist to test at Western Sussex Hospitals NHS Foundation Trust. July 2016.
- National interest through Royal College of Paediatrics and Child Health (RCPCH) and other paediatric care improvement networks - York Hospitals and Royal London have implemented checklists, without evaluation of their impact.
- NHS England cited the Your Stay form as an example of good practice in their Safer Systems work 'Parents and providers as a team: how to prevent and reduce deterioration in children's health
- KP invited to present findings of this project to RCPCH Annual Meeting, May 2017.

Awards/ Conferences/ Media interest

- MC attended International Forum on Quality and Safety in Healthcare, Gothenburg Sweden 2016 with a poster (appendix 1.8).
- You tube video: <https://www.youtube.com/watch?v=TIQ-YaVeNZE> (with Emma Redfern).
- Grace Chapin (medical student) awarded RSM. Emergency Medicine Section: Research and innovation prize 2016 for her poster & presented at the Association for the Study of Medical Education annual scientific meeting, Belfast, 2016 (appendix 1.9 & 1.10)
- MC presentation at the Royal College of Emergency Medicine Annual Scientific Conference, Bournemouth, 2016 (appendix 1.11)
- CP spoke at Health Foundation Q event London, May 2016. Storyboard poster subsequently displayed in Departments and at NHS is Fab public engagement event at UHS. (see appendix 1.12 & 1.13).

Appendix 1: Resources and appendices

APPENDICES (attached)

- 1.1 Picker Survey ED details
- 1.2 Information sheet for Your Stay Paediatrics
- 1.3 Script for triage nurses (ED)
- 1.4 Intervention quiz for staff in paediatrics
- 1.5 Initiative fatigue
- 1.6 ED Forum poster
- 1.7 NOMAD analysis
- 1.8 International Forum Q&S in Healthcare Poster
- 1.9 Grace Chapin ASME Poster
- 1.10 Grace Chapin Personal Reflections
- 1.11 Patient centred care in the ED RCEM PPT
- 1.12 Storyboard
- 1.13 Safer Care Checklist summary for Q event
- 1.14 Literature and references about checklists and co-design
- 1.15 Co design 'lesson' plan for work with SCHYP forum
- 1.16 Your Visit script for introducing the form
- 1.17 Summary of learning in ED
- 1.18 Summary of learning Paediatrics
- 1.19 Paediatrics summary feedback
- 1.20 ED summary feedback