

Safe prescribing

1. What % of reported errors are medication related?

A. 5%

B 15%

C 20%

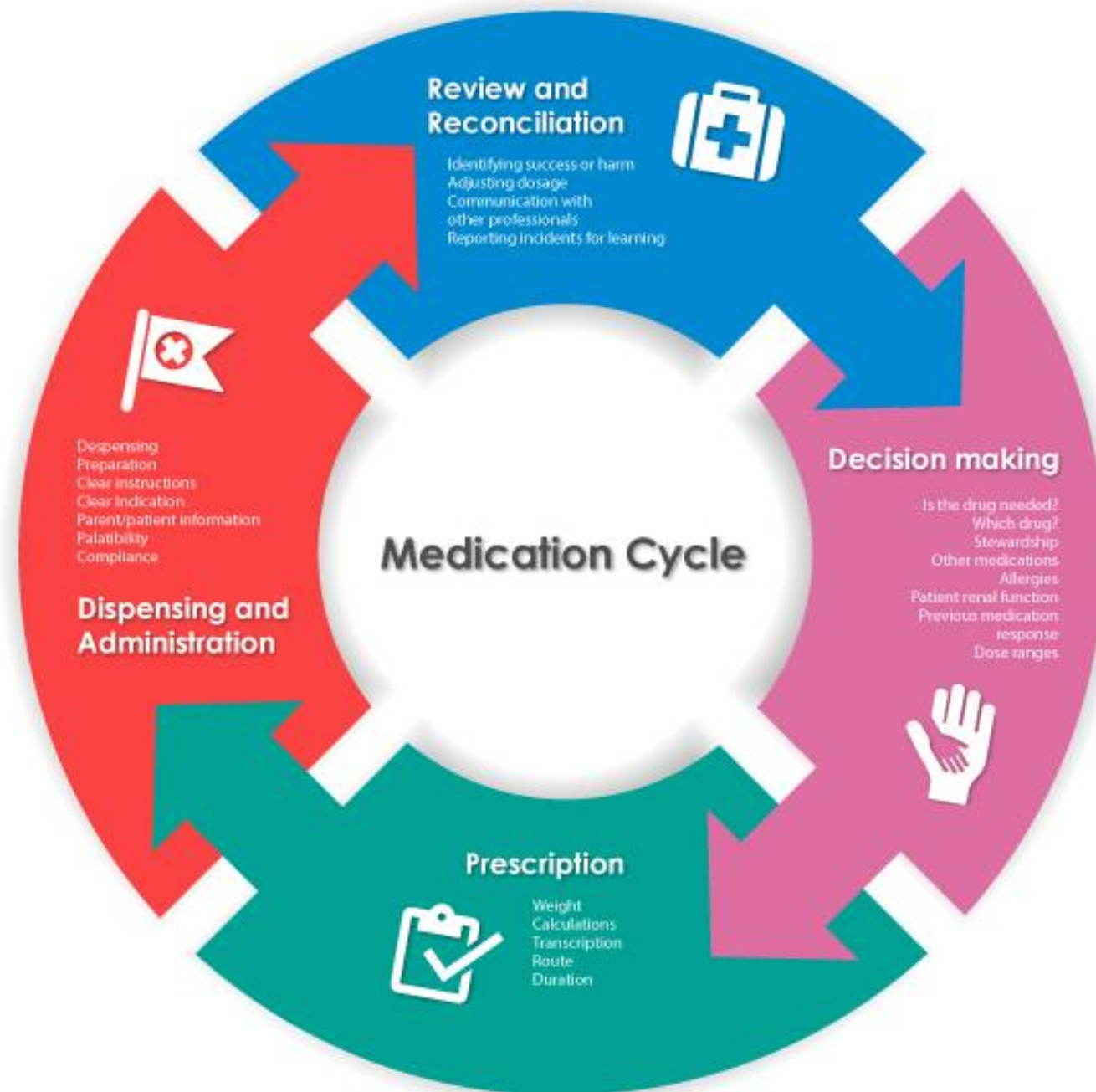
2. What is the frequency of harm from medication errors in children compared to adults?

A. Equal

B. x3

C. x5

what we think is happening vs what is actually happening



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Parental Concern Within PEWS: Auditing and Exploring Current Practice

Thematic Analysis of the Experiences of Parents and Carers of Children in Hospital

'Cook and Count' - Virtual Cooking Classes and Carbohydrate Counting for Young People


RCPCH **QI Central**

Home Resources Projects Collaboratives News

QI Central

The RCPCH quality improvement sharing hub where you can find resources and examples of interventions in a number of clinical practice areas.

[Start QI journey](#) [Share a project](#)



Starting Your Quality Improvement Journey

In collaboration with expert quality improvement trainers working in paediatrics, this is the first in a new series of short modules introducing healthcare professionals to quality improvement methodology. In Module 1, we look at the Four Sciences, how QI mirrors clinical journey, developing an improvement mindset and share how paediatric trainees have explored QI across different levels of the Progress curriculum.

[Go to Module 1](#) →

News and Blogs

Wellbeing and Health Action Portal

The RCPCH social determinants portal in partnership with the Wellbeing and Health Action Movement to unite, inspire and inform healthcare professionals working to create equalities in child health and wellbeing.

We each have a vital role in identifying the social determinants of health and reducing the impacts of health inequalities for every child and young person we see in our clinical practice. By identifying families in need, advocating for child health priorities and connecting to community resources, we can encourage local engagement and empower families to thrive together.



[Evidence](#)
Data and research
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Voices from the frontline
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[Quality Improvement](#)
How to take action
[Read more](#) →

Social determinants activity in the UK

The role of the paediatrician is continually evolving and addressing the impact that social determinants have on the health and wellbeing of our patients and their families is

Resources

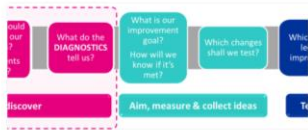
Discover resources from the paediatrics and improvement community across categories including QI education, patient safety, patient-centred care, systems of care, sustainable healthcare and medicines safety.



Starting Your Quality Improvement Journey

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An Introduction to Improvement Science

Learning how to improve using a robust change method is a skill we can take with us throughout our career. This second module in the QI series explores the science that underpins improvement, the challenges of starting small, and delves deeper into diagnostic and improvement methodology. Start small and see how we can bring QI within our reach alongside our busy and demanding schedules.

[Go to Module 2](#) →

QI Central

Patient Safety Portal

Home Resources Reports Alerts

Patient Safety Portal

The RCPCH central online hub for patient safety in paediatrics and child health. Supporting improvements in patient safety with resources and shared learning on safety culture, human factors, situational awareness, and event reporting.

[Resources](#) [Reports](#)

Latest news and alerts

Episode 1 – Our QI Collaborative Journey, with Sheffield Children's Hospital

In our first episode, consultant paediatrician Dr Carrie Mackenzie reflects on her team's journey throughout the QI Collaborative programme and offers recommendations to teams wishing to embark on quality improvement projects of their own.

Episode 2 – Reflections from QI Champions

Dr Dita Aswari, Dr Carrie Mackenzie and Dr Fiona Campbell talk with Dr Megan Peng and Dr Tricia Woodhead about their team's involvement in the early waves of the QI Collaborative.

Episode 3 – Developing a transition service

We speak with the team at Warrington and Halton NHS Trust on how they have developed their transition service through applying quality improvement (QI) methods, engaging with children and young people and gaining feedback from parents and carers.

RCPCH **National Diabetes QI Collaborative**

Home QI journey Projects Podcasts Webinars

Quality Improvement in Children's Diabetes Services

Supporting multidisciplinary teams with the tools to identify, design and analyse their own interventions specific to the needs of the children and young people and their families that they care for.

[Log in or register to start your QI journey](#)

Your QI journey

The National Diabetes QI Collaborative has supported multidisciplinary paediatric diabetes teams by providing a 6-month course of training in quality improvement methodology since 2017. Access resources and recorded materials from Phases 1-4 of training and start your own QI journey.

[Start QI journey](#) →

Team projects

Between 2017 and 2022, 16 waves of the National Diabetes QI Collaborative have involved over 100 paediatric diabetes teams. We invite you to explore their team journeys and resources on pages dedicated to team projects.

RCPCH EQIP **Epilepsy QI Programme**

Home About us News Pre-Course materials Teams QI Jour

Quality Improvement in Children's Epilepsy Services

Our RCPCH Epilepsy Quality Improvement Programme (EQIP) collaborative supports multidisciplinary teams working in paediatric epilepsy services to identify sustainable improvements within their services for children and young people with epilepsy.

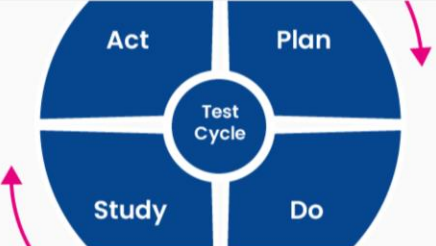
This site has been produced primarily for those working within services that are part of the RCPCH Epilepsy Quality Improvement Programme (EQIP). Teams can login to explore programme resources, training webinars and documentation.

2022 RCPCH EQIP - Innovations to improve care for paediatric epilepsy patients event

On 17 March 2022, almost 20 paediatric epilepsy service teams took us on their quality improvement journey, celebrated their achievements, explained what they've learned and how they adapted under the ongoing pressures of the pandemic.

Access the event posters and presentations on the day from EQIP teams that shared their learning from their project interventions which covered a variety of QI topics.

[Access the event presentations and posters](#) →



Starting Your Journey

In collaboration with expert... the first in a new series of sh... improvement methodology... clinical journey, developing... have explored QI across differ...

[Go to Module 1 →](#)


News and Blogs

May 26, 2022 · Webinar

Getting It Right First Time Webinar: Children and Young People's Mental Health

May 5, 2022 · News


Spotlight QI: NHS England National Paediatric Accelerator Programme



Safety

A focus on improving patient safety including resources and projects on safety culture, human factors, situational awareness, event reporting and preventing deterioration.


[Read more →](#)



Patient centred care

Patient experience and the voices of children and young people, ensuring that the care we provide is respectful of and responsive to individual patient preferences and needs.


[Read more →](#)



Systems of care

Ensuring quality within our systems of care looking at improving efficiency to avoid waste, effective integration of services and QI educational approaches for child health professionals.

[Read more →](#)




MedsIQ

Medication errors are a significant but preventable cause of harm to children and young people. MedsIQ aims to bring together tools and improvement projects that have been developed to address this problem. It is our vision that child health professionals will be able to use this resource to support their own improvement work and learn from the experiences of others. At the same time, MedsIQ is bringing together organisations across the UK and beyond to ensure that medication safety remains a priority for paediatric research and practice.

[Find out more →](#)

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Royal College of Paediatrics and Child Health

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QI Central is a programme of the Royal College of Paediatrics and Child Health

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Home » MedsIQ

MedsIQ


Medication errors are a significant but preventable cause of harm to children and young people. MedsIQ is an RCPCH programme focused on improving medication safety.



Safe Prescribing

Resources and projects to reduce prescribing errors in paediatrics including dosage calculators, apps, prescription charts, guides and workbooks.


Read more →



Medicines Safety

Resources and projects to support improvement in paediatric medicines safety including guidance, tools, apps, workbooks and care bundles.

Read more →



Patient Support

Resources and projects to support families on medicines education and management including information leaflets and public awareness campaigns.

Read more →

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QI Central

HomeResourcesProjectsCollaborativesNews

Home » Resources » Safety » Medicines Optimisation in Specialist Schools

Medicines Optimisation in Specialist Schools

A relatively new area for medicines optimisation where pharmacy workforce transformation can make a huge impact to support, tackle and raise awareness of health inequalities in the special education needs or disabilities sector, with a particular focus on improving medication safety standards and processes at school.

The Problem

Special schools are those that provide an education for children and young people (CYP) with a special educational need or disability (SEND). On 1st September 2014, Section 100 of the Children and Families Act 2014 placed a duty on governing bodies of maintained schools, proprietors of academies and management committees of pupil referral units (PRUs) to have in place arrangements to support pupils with medical conditions at their school.

Reducing health inequalities and improving health and wellbeing are major priorities for pharmacy. Pharmacists' and pharmacy technicians' skills of listening, explaining, advising and questioning are all highly relevant to help identify and support the medicines optimisation needs of CYP with complex health needs in special schools.

Within the collaborative commissioning structure between the NHS and Local Authorities for special schools, there has never been a formal pathway to promote or support the need for a pharmacy led medicines optimisation service in special schools. Hence, huge variations exist nationally on how this model is being delivered. Community health services play a key role in the future of health and care systems.


Aims

The primary aim of this project is to promote:

1. Increased patient safety in schools through the development of a bespoke medicines optimisation service that allows for the improvements to upskill the unregistered teaching workforce in medicines administration, and a reduction in errors - e.g. omitted doses through medicines reconciliation provision

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Medicines Safety

Prescription of Paracetamol as an Antipyretic in Paediatrics: Analysis of Practices in a National Teaching Hospital

Prescriptions of paracetamol for paediatric inpatients at Mater Dei Hospital, a national acute and teaching hospital in Malta, were analysed for sources of error with the British National Formulary for Children used to establish the correct prescribing standard. 54.5% of prescriptions we found to not follow the correct standard leading to incorrect dosing. Of these [...]

View →




Medicines Safety

CRIT: Children Receiving Immunosuppressive Therapy - A Cross-specialty Review of Practice at a Tertiary Children's Hospital

Immunosuppression is integral to the management of a wide range of childhood illness. Multiple paediatric sub-specialties initiate and monitor different immunosuppressive therapies. We undertook a review to understand existing variations in care.

View →




Medicines Safety

Reducing Paracetamol Errors in Children

A paediatric multidisciplinary team work together to reduce the number of paracetamol errors reported in clinical areas by staging a number of interventions based on the reported incident trends


View →



RCPCH

Improving Efficacy of Hydrocortisone Prescriptions in Paediatric Sickle Cell Disease

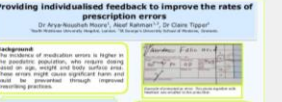
Alongside Sickle Cell Disease, the commonest hereditary red blood cell disorder, is the most common cause of acute chest syndrome in children.



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Inter-professional tripartite alliance to reduce medication errors in children

Background: The incidence of medication errors is higher in the paediatric population, who require dosing based on age, weight and body surface area. These errors might cause significant harm and could be prevented through improved prescribing practices.



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Providing individualised feedback to improve the rates of prescription errors

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