**Summary of QI/Safety Curriculum 2021 for Anaesthesia**

**Level 1**

Key Capabilities:

A: Describes quality Improvement theories and methodologies

B: Contrasts quantitative and qualitative analysis and the diagnostic tools used to understand the system

C: Compares audit, research and quality improvement

D: Commits to the principles of continuous quality improvement

E: Describes the common threats to patient safety problems and solutions by means of critical incident reporting and improving care through morbidity or mortality reviews

G: Understands the importance of recognising and rewarding excellence in quality and safety, not simply mistakes and errors

H: Demonstrated the importance of interpersonal skills, structured communication and the use of cognitive aids in managing critical emergencies, and recognises the role of simulation in rehearsal

J: Describes the benefits and limitations of technology and equipment in maintaining patient safety

K: Describes the requirements and processes for raising concerns

L: Explains and demonstrates the duty of candour

M: Prescribes and administers drugs safely

Examples of Evidence:

Experience and Logbook:

* Involvement in QI activities within Anaesthetics department as a minimum requirement

Supervised Learning Events:

* Understanding of quality improvement methodology (A-QIPAT for relevant projects)
* Engagement with surgical safety initiatives and departmental guidelines relating to patient safety
* Learning from critical incidents
* Learning from pre-briefs and de-briefs on own and team’s performance
* Evidence of applying good non-technical skills and effective MDT working (e.g.ALMAT)

Activities and Personal Refelctions may include:

* Attendance at QI training
* Involvement with local, regional national QI projects
* Submission of excellence and incident reports
* Simulation training e.g. crisis resource management, critical incident, resuscitation
* Attendance at local clinical governance / QI meetings
* Self directed learning regarding duty of candour
* Multi-source feedback

**Level 2**

Key Capabilities:

A: Knows when and how to apply a quality improvement science with the aim of improving services while maintaining patient safety

B: Recognises the factors influencing reliable care

C: Demonstrates knowledge of variation with respect to interpreting measurement, understanding types of variation, and differentiating between expected and unwarranted variation

D: Utilises appropriate measurement techniques for improvement, and demonstrated whether a change has occurred and its impact

E: Contrasts ‘data for assurance’ and ‘data for improvement’ and uses both data appropriately

F: Uses simple proactive safety techniques to precent harm to patients, including the assessment of likelihood and severity of risks

G: Matches expertise and resources to the level of clinical risk posed to patients

H: Describes the impact of anaesthetists’ actions on patient safety more broadly in the hospital and wider healthcare system

I: Describes the principles of medication safety

J: Explains the process of critical incident follow up

Examples of Evidence:

Experience and Logbook:

* Involvement in QI activities within Anaesthetics department and experience of hospital wide QI and risk assessment

Supervised Learning Events:

* Leadership of local QI project
* Presentation of QI project results
* Implementation of QI project outcomes recognising challenges eg sustainability, up-scaling, spreading
* A-QIPAT
* Case(s) resulting in completion of incident form
* Observance of theatre safety practices such as *Stop Before You Block*, WHO checklist

Personal Activities and Personal Reflections may include:

* Courses or eLearning: QI methodology, medicines management, human factors
* Reflection of critical incident
* Involvement with critical incident investigations
* Attendance at QI meetings

**Level 3**

Key Capabilities:

A: Identifies and supervises a quality improvement project, prioritising and evaluating measures and outcomes important to patients in a special interest area of anaesthetic practice

B: Explains how complexity theory applies to healthcare

C: Identifies levers and drivers and the principles of psychology underpinning change management that can be used to develop a shared purpose

D: Identifies and engages with stakeholders affected by potential change

E: Interprets the interplay between psychology, system, process and technical knowledge needed to implement change

F: Promotes a collaborative approach to delivering quality improvement utilising the principles of patient co-design when possible

G describes how to sustain improvement

H: Effectively evaluates the impact of a quality improvement intervention

I: Applies safety science principles and practice at individual, team and organisational and system level

J: Uses measures of process reliability to monitor and improve safety

K: Predicts how system failures will create risks to patients

L: Uses a systems-based approach to proactively assess risk and in the investigation of safety incidents

M: Acts on national regulation and findings of national case studies in patient safety

N: Explains how organsiational culture can influence failre or improvement in clinical practice

O: Analyses the strengths and weaknesses of safety interventions

Q: Quantifies the effect of contextual factors on safety

R: Addresses the limitations of the concept of ‘human error’ in incident investigations and responses

S: Mitigates against fixation error, unconscious and cognitive biases

Examples of evidence:

Experience and Logbook

* Leadership of QI activities within the Anaesthetic Department and experience of regional or national QI and risk assessment

Supervised Learning Events can be used to demonstrate:

* Leadership of local QI project and participation in regional or national QI projects (A-QIPAT)
* Presentation of QI project results
* Implementation of QI project outcomes
* Promotion of safety in theatre lists

Activities and Personal Reflections may include:

* Courses and eLearning: QI methodology, understanding risk, understanding professional interactions, change management, national patient safety legislation, human factors training, complexity theory, safety science
* Involvement with patient safety investigation such as root cause analysis
* Undertake mortality reviews
* Attendance and presentation at clinical governance meetings