Net Gains:
Improving Safety-netting in PAU

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BACKGROUND

Clear Safety Netting Advice:
- Provides parents with specific information on when to seek further medical attention
- Reduces the risk of missed or delayed diagnoses
- Prevents unnecessary reattendances

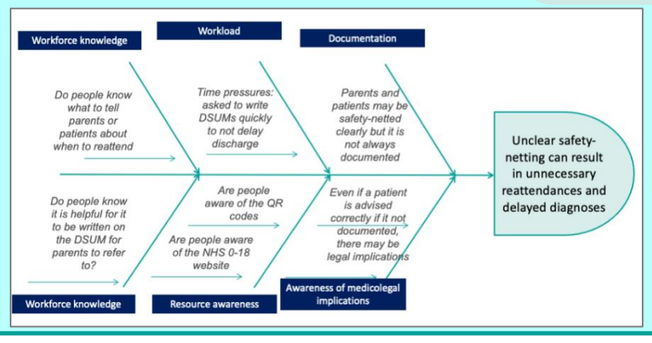
Documentation of Safety Netting:
- Ensures consistent communication of follow-up instructions
- Serves as a medicolegal record of the advice given

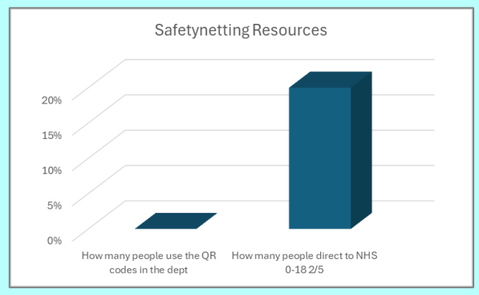
PROBLEM

Safety-netting advice is **inconsistently documented**. This poses medicolegal risk, and inappropriate or delayed responses to children at risk.
It generates **anxiety for patients** and families and stress for staff concerned.

DIAGNOSTICS

Patient consultation → *Patient and parents are clearly safety-netted* → *They might be directed to resources e.g. QR codes in dept or 0-18NHS website* → *This is documented in the notes* → *This is documented in the discharge summary*





AIM & MEASUREMENT DEFINITION

Aim: To accurately document detailed safety-netting advice given for all children seen on the Paediatric Assessment Unit by end of September 2025.

Measurement
1. Was safety-netting advice documented?
2. Was it specific?
3. Was it in the notes or the discharge summary?

Maximum score of 5 for detailed documentation, 1 point for 'patient safety-netted', directed to QR codes, or directed to healthier together website

Inclusions
Discharged home from PAU by paediatric team
Exclusions
Strike days, non-paediatric team patients e.g. surgical patients, ortho patients

CHANGE IDEAS

Informal chats +/- formal focus group to establish facilitators and barriers

Survey to ask people what would help

Teaching sessions

Add to huddles / after ward round when planning discharges

Posters near the computers where we tend to write the discharge summaries

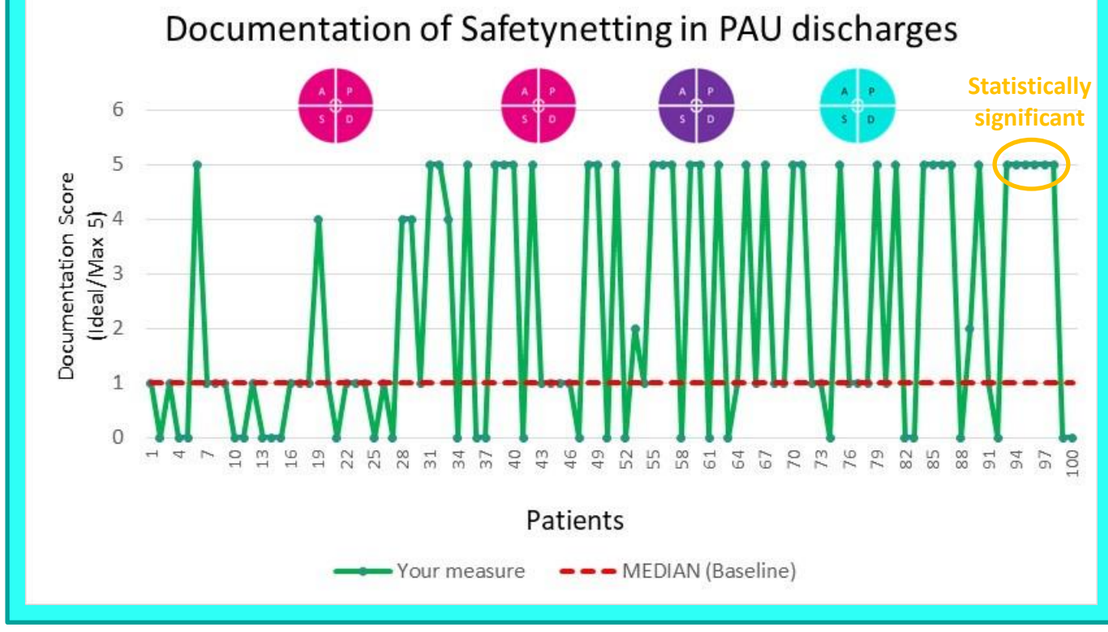
Safety-netting for common conditions as pre-populated options in discharge summaries

Text messaging service direct to parents / patients

PDSA Cycles

PDSA Test #	PLAN	Do	STUDY	ACT
1	**Share and learn** informally with colleagues about improving documentation of safety-netting	Shared and discussed baseline data in the PAU office and at handover	Colleagues suggested reminders, and clarification of what is needed	**Extend and Adapt:** Share more wildly, gather feedback, identify barriers and clarify for resident doctors the required standard of documentation
2	**Formalise information sharing:** Create poster explaining importance of clear documentation of safety-netting	Poster designed and displayed near PAU computers where notes and discharge summaries are written	Documentation of safety-netting improved but was still inconsistent. Poster feedback: not eye-catching enough, easy to overlook	**Adapt and Extend:** Redesign poster to be clearer and more visible, highlight why safety-netting is vital for patient safety.
3	**Share and learn**: Reinforce message via WhatsApp group reminder to resident doctors	Message sent to resident doctors on the WhatsApp group	Raised awareness but not sustainable – messages infrequent and easily missed	**Abandon / Adapt:** seek more reliable and ongoing way to sustain documentation focus
4	Incorporate safety-netting in daily discharge planning huddles	Resident doctor at huddle reiterates safety-netting documentation at huddles	Regular reminders are effective, and help to improve consistent documentation	**Adopt –** email sent to PAU manager to permanently embed safety-netting documentation prompts into PAU huddles when discharges are discussed
PDSA Test #	PLAN	Do	STUDY	ACT
	Update the poster: make it snappier, mention medicolegal and patient safety importance; print it in colour	Display updated poster	Improvement in documentation sustained; discussed with colleagues; poster better received	**Adopt**: Keep improved design; highlight importance of safety-netting more widely

Run Chart



CONCLUSIONS:

Whilst we did not achieve our aim to accurately document safety-netting for all children, the run chart includes one run of 6 data points showing a statically significant change. Initially, documentation of safety-netting was low and inconsistent, however the run chart demonstrates more standardised documentation, underscoring the importance of system-level interventions for achieving sustainable change. Ultimately, strengthening these processes supports not only documentation quality but also enhances patient safety by ensuring clear and reliable communication at the point of discharge.
Iterative PDSA cycles, interventions were tested and refined based on colleague feedback to identify facilitators and barriers to improvement. While posters raised awareness, they do not generate lasting behavioural change. Greater impact can be achieved through embedding reminders into existing processes, such as discharge huddles, which encourage consistent, reliable practice.

REFLECTIONS & LEARNING:

This project emphasised the limitations of stand-alone educational tools and static reminders in driving sustained improvement. I did not run a teaching session as enthusiasm from staff was low and my 'hunch' was that this would not help; leading me to conclude that small visible reminders can be more effective than teaching sessions. Enduring change is fostered when prompts are embedded within daily workflows, such as discharge huddles. These integrated interventions reduced reliance on memory or individual motivation, instead fostering collective accountability and supporting a culture where safety-netting is recognised as a core component of safe discharge practice. Future PDSA cycles should focus on reinforcing these systemic supports, such as incorporating examples of high-quality safety-netting into discharge templates, to further embed best practice. In doing so, the project contributes to both culture change and improved patient safety, ensuring that safety-netting is consistently and reliably communicated to protect children and families after discharge.

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Change CHAMPION