FRCEM Final QIP marking scheme (July 2018)					
			General aspects **GMC Domains:1.3, 3.1** **RCEM Curriculum Domains: CC15**		
Subject area	**Fail**	**Borderline Fail**	**Borderline Pass**	**Pass**	**Vignette**
Narrative structure of written report Identifies area needing improvement	No clarity around issue/ problem, or description of local issues and context Incoherent or unclear structure; unable to determine chronology or progress of QIP.	Describes only problem, or background; or does not link these.	Generally clear and logical narrative, with occasional areas where description 'confusing', describes both problem and background, linking clearly.	Clear problem identified, relevant description of situation/background Clear and logical structure of written report and description of process clear from inception to completion. Gives a clear narrative of the whole process to examiner.	Solution driven QIP; i.e. those that start with a defined solution and are 'retro-fitted' to a problem are likely to be unsuccessful; e.g. introduction of FIB into a department. The problem and solution are the same, and the analysis is pre-supposed. Involvement of patients in identification of issues (e.g. interviews/surveys) useful and encouraged. Note that this is a Quality Improvement Project, not Service or Cost Improvement (SIP/CIP). *

Presentation and layout including spelling and formatting	Multiple spelling mistakes, incorrect underlining/use of bold, tables poor, and to an extent that renders write up unintelligible.	Occasional spelling mistakes, grammar acceptable and minimal use of tables/diagrams to aid readability.	Rare/infrequent spelling mistakes, grammar acceptable and tables/diagrams can be understood. 'Professional' language/presentation.	No spelling or grammatical mistakes, excellent use of language, tables simple and demonstrate relevant points, creative use of diagrams etc.	Too verbose a write up, while being inclusive, runs the risk of making narrative unclear (c>6500 words), especially when duplicating text and diagrams. Limited word count (c<2000 words) may not have enough detail for all elements of write up. Stilted narratives tend to be borderline.

			Planning of QIP **GMC Domains: 2.1, 2.2, 3.2, 3.3, 3.4** **RCEM Curriculum Domains: CC8, CC15, CC16, CC21, CC22, CC25**		
Engagement and team working	No evidence of team working.	Limited or poorly unexplained selection and engagement with team, no evidence of team working.	Clearly identified team, with wide range of skills, defined roles and actions, but no clear explanation/linking of these.	Clear and extensive evidence of engagement with team, minutes of meetings, discussion of options, diary/logs. Clear rationale for why each team member selected and why suited to given role. Engagement of more than one department outside ED.	Examples of good practice include: Use of tools such as stakeholder analysis/WIIFM (what's in it for me) to identify who and how to engage useful, but pragmatism is a valuable asset in current health care structures and should not be marked down: those who are keen/able to get involved may have attributes that are more important than the ideal team roles (e.g. as described by Belbin)! Educational interventions are not team engagement per se (i.e. delivering training is not the same as engaging a team in running the project).

Analysis of problem/ Identification of actions required for QIP	No clarity in analysis of issues, unclear process of appraising potential solutions. No attempt to look for published solutions, no access to known resource for support, no critique of papers/evidence found.	Analysis performed, but key issues not considered, or not considered deeply.	Clear analysis (e.g. of resources, competencies, internal and external factors), good option appraisal and/or business plan. Good search and critical review of evidence to support change, if required, or search for solutions that have previously been attempted and suggestions for how this has successfully these have been implemented.	As before, and clear analysis using multiple tools to identify possible solutions, clearly linked to issue(s). Reviews evidence/previous attempts to resolve issue and describes clearly and pragmatically how this affects solutions identified/effect on current QIP.	This is **not** analysis in terms of systematic review of evidence (tested in other parts of FRCEM). However, this sometimes required as part of the process and will not be marked down if performed); e.g. reviewing evidence of which screening tools to use, or clinical management for pathway. * Examples of QIPs that initially started as 'solution driven(see above) but where good analysis identified a change focus required: ** Use of diagrams assists greatly with explanation.

			Performing /Implementation of QIP **GMC Domains: 2.1, 2.2, 3.2, 3.4, 4.1** **RCEM Curriculum Domains: CC 4, CC5, CC6, CC7, CC9, CC14**		
Change and quality management process planning **Iterative process**	No summary of change process.	Some summary but not clearly referenced/completely described; process unsuitable/not relevant to QIP. Limited evidence of iterative process, response to results or next steps. Cycles of implementation unclear, or closely aligned (i.e. in effect only one intervention).	Good planning of process, clearly described (e.g. further analysis such as critical path, stakeholder forcefield etc), which is appropriate to outcomes and analysis. Only 2 cycles of implementation of interventions/data collection. Clearly identifies QI methodology and discusses why chosen.	As before, additionally: Narrative clear, good use of diagrams (e.g. Gantt charts) to illustrate, balance between conciseness and completeness enables full story to be understood. Three or more cycles of interventions. Clearly delineates interventions and refinement/iteration of these interventions.	Introduction FIB into a department involves introduction of education package and equipment package. Refinement of these is not further implementation of interventions, but iteration cycle of one intervention. QI methodology may well be chosen for pragmatic reasons (ease, familiarity), this is entirely acceptable.
Structure and Implementation of QIP and change	Chaotic, unclear implementation.	Good description of chronology of process, but missing elements in description of events or change process as described in plan.	Clear implementation of changes; including description of tasks/deadlines, monitoring and managing progress; all following logically from planning stage.	As before, but identifies links between implementation and planning, team actions. Identifies own leadership role in affecting this process. Understands difference and describes how project has achieved effective cultural	Creative use of photos, emails to evidence meetings (especially workshop, informal and opportunistic meetings) is permitted. Use of change management tools including analysis (Six S, PEST, SWOT), building in rewards etc is good practice. Trainees should be advised to keep a diary from early in process,

			Outcomes of QIP **GMC Domains: 1.1, 2.1, 2.2, 3.4, 3.5** **RCEM Curriculum Domains: CC 4, CC 5,CC 7,CC 9, CC16, CC21, CC22, CC24**		
Measuring outcomes	Limited measurement or assessment of impact of QIP.	Some suggestions for assessment, but incomplete assessment or implementation.	Develops/ identifies tools to assess outcomes, identifies subsidiarity, implements this tool. Outcome, process and balancing measures identified. Good use run charts/SPC charts, data clearly mapped to interventions.	As before, but clearly explains why metrics chosen, what other metrics considered but discarded, continuous measurement of data, identifies and eliminates variation. Multiple outcome, process and balancing measures identified and continuously measured. Identifies how these data have assisted (or not) with QIP progress.	Creativity in metrics, both in choice and consideration of balancing measures is encouraged. Patient reported outcomes weighted above process measures, however pragmatic choices should be acknowledged and are acceptable. Some measures that relate to patient experience are important, but patient safety metrics also important (cf 'power' of data to detect safety issues). ***
Reflection	Limited reflection on QIP.	Some reflection, but misses either personal or local learning. Does not plan for further QIP.	Refection on both personal and institutional learning from QIP, and suggestions as to how this QIP could have been performed differently.	As before, and planning for further related improvement project. Clearly identifies areas for improvement in QIP and explains these.	

*Whilst SIP/CIP can have some similar/overlapping interventions the primary aim of a QIP is to improve patient 'care': experience or safety. Similarly, educational QIP are aimed at improving learner's experience, and whilst this does affect patient care it may be too remote from patients to satisfy examiners; educational projects often form one intervention in a QIP but not the only one. Whilst education of staff is important, there is a large 'industry' surrounding this, and though the evidence that patient outcomes is improved is strong, within the time period available to a doctor on rotation will pragmatically limit the project chance of demonstrating this. Please note that FRCEM regulations disbar projects wholly outside of the ED (i.e. PHEM).

* Example 1: A QIP aimed at improving the management of a particular cohort of patient (e.g. alcohol dependant patients, falls patients, ambulatory PE patients) establishes during the analysis that one barrier is identification, and that a screening tool is needed; an appraisal of the literature to determine which is most suited to the department processes is reasonable. Similar reviews could also be conducted on the clinical management (which are the effective interventions, for example)

** Example 1: A trainee wishes to introduce Fascia Iliac Block (FIB), considering a useful analgesia for fracture NOF. Identifies rapid pain relief as the issue, and initial data and analysis reveal that delays in triage, preforming XR, interpreting XR all prolong time to pain relief and therefore FIB; QIP then changes to a project that reduces these delays.
Example 2: Trainee reviews evidence for stiff cervical collars and decides to remove them from department. On analysis of problem, identifies that rather than discomfort of collars per se, patients report that the issue is with prolonged lie in department, and discomfort and boredom associated with this. Reduction of length of lie, provision of explanations and good nursing care become focus of QIP.

***For example, a run of adverse events (such as acrylate adhesive spillage to eyes) may lead to a QIP on reduction to these; as this is a rare event, however a metric that only looks at adverse outcomes may not pick up any in the study period. Hence other data should be collected: balancing measures could be number of patients needed specialist input for closure (as this may increase), outcome measure such as patient satisfaction with wound closure technique and result, and process measure could be compliance with correct closure and eye protection processes.

Success criteria

To be successful, a candidate must be above **'Borderline Fail'** *on average* across all the domains. Thus, if each domain is scored 1 for fail, 2 for borderline fail, 3 for borderline pass and 4 for pass; and there are 8 domains as above, the candidate must score 20 marks (Number of domains x average of 2.5 per domain)**.**