An Roinn Sláinte
DEPARTMENT OF HEALTH

Medical Professionalism in Relation to Safety -Junior Doctors' Experiences in Practice

Ms Karen Egan,

Patient Representative

Dr Éidín Ní Shé,

UCD Health Systems

NATIONAL CLINICAL EFFECTIVENESS COMMITTEE

National Patient Safety Office

Oifig Náisiúnta um Shábháilteacht Othar

Medical Professionalism in Relation to Safety Junior Doctors Experiences in Practice

Karen Egan, Patient Representative,
Patient and Public Involvement in Healthcare at HSE

Dr Éidín Ní Shé, Health Systems,
School of Nursing, Midwifery and Health Systems; University College Dublin
Contact Details: eidin.nishe@ucd.ie

Imbuing Medical Professionalism in Relation to Safety

- Funded under MERG by:

- Project Partners include:

Who is Involved in this Project?

School of Nursing, Midwifery and Health Systems, UCD	Eilish McAuliffe, Professor of Health Systems Marie Ward, Senior Research Fellow Éidín Ni Shé, Postdoctoral Researcher Christian Korpos, Research Assistant
Patient and Public Involvement in Healthcare, HSE	Karen Egan, Patient Representative
St. James's Hospital	Una Geary, Clinical Lead Quality and Safety Una Healy, Risk Manager Julie O'Grady, CNM 3, Nursing Quality, Audit & Research Co-ordinator Gaye Cunnane, Rheumatology and Dir. Postgraduate Med Education Elaine Bourke, Intern Tutor Lucy Chapman, SHO Contact
St Vincent's University Hospital	Alan Watson, Clinical Director-Medicine/Emergency Medicine Alan Smith, Director of Quality and Safety Kate Murphy, Intern Tutor
Mater Misericordiae University Hospital	Catherine Holland, Risk Manager Una Cunningham, Head of Transformation
State Claims Agency	Anne Duffy, Clinical Risk Advisor
Centre for Innovative Human Systems, TCD	Nick McDonald, Professor of Psychology

Trust me I'm the Doctor

- Public View: 8 out of 10 people were very confident or fairly confident that their doctor would tell them if there had been a mistake/oversight in the course of their care.

- Doctor's View: 63% agreed that doctors should disclose all significant medical errors, but 85% of doctors surveyed admitted that they had not fully disclosed a mistake to a patient because they were afraid of being sued (Medical Council, 2014).

The primary reasons given by Irish doctors for decisions not to report concerns about a colleague were:

- "nothing would happen as a result" (44%);
- "fear of retribution" (25%);
- and "thought someone else was dealing with the problem" (19%).

Source: Medical Council, 2014:34.

Each time someone is deterred from speaking up,
*an opportunity to improve patient safety is missed.*

Imbuing Medical Professionalism in Relation to Safety

- Project Aim
  - To imbue a culture of medical professionalism in hospital culture and support junior doctors to raise issues of concern, whilst shaping a culture of trust, transparency, responsiveness and learning.

- Project Activity
  - Trialling an embedded learning approach that centres on the use of a custom designed game to encourage speaking up, as well as inclusive leadership (words and deeds by leaders that invite and appreciate others' contributions) and responsiveness in the hospital system.

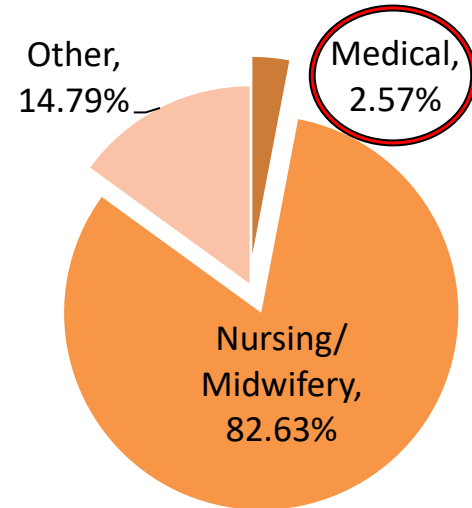# Study Sites - Incident Reporting Systems

- Hospital A:
  - Uses a computer based system.
  - 7,973 incidents between 1/1/15 to 31/12/15.
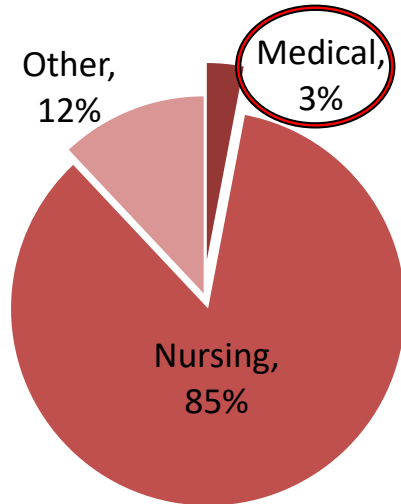
- Hospital B:
  - Uses a paper based system.
  - 3,886 incidents between 1/1/15 – 31/6/16.

Participants

- Hospital A:
  - 46 out of 56 interns.
  - 82.14% took part.

- Hospital B:
  - 35 out of 42 interns.
  - 83.33% took part.

- Data collection facilitated in both sites via Intern Teaching slots.

- Key Enablers: Protected intern teaching; Support received from the intern tutors; Support from clinical leads, directors of postgraduate medical education and from quality and safety teams within both sites.

The PlayDecide Patient Safety Game

- PlayDecide is a versatile tool that allows you to create a serious discussion game about contentious issues.

- The PlayDecide Patient Safety Game looks at Medical Professionalism, and in particular speaking up, through story, information and issues cards. At the end of the game players vote on four predefined policy statements.

Story Card ④

The power of incident reporting

Dr. Alexandru Dumitrescu is a Senior House Officer in a large hospital and is responsible for conducting electrocardiograms when on call.

The electrocardiogram machine was frequently missing, wasting time and causing delays in providing time-critical treatments to patients. Senior House Officers (SHOs) complained for years but nothing changed. I and SHOs decided that every time we were called to do the electrocardiogram and it was missing we would submit an Incident Report Form. After 1 month and numerous reports 2 additional new electrocardiogram machines were purchased and house in a dedicated central area.

Story Card ⑤

Lack of standardised protocol

Julie Smith is a mother of 3.

My eldest son requires frequent hospital admission for administration of Total Parenteral Nutrition (TPN). I observed a lot of variation in the sterile procedure protocol followed by different staff before administration the TPN. Preprepared sterile trolley and sterile gloves were often not used. The equipment and procedures for dressing changed varied. My son developed sepsis from his peripherally inserted central catheter line during one administration.

Story Card ⑥

Air in an intravenous line

Thomas Fitzgerald is a 15 year old boy with a rare disease requiring frequent hospital admission.

I was prescribed 2 litres of intravenous normal saline, the first of which finished during the night. On hearing the pump alarm, the nurse arrived with the second bag. I asked if she would like to turn on the light, she declines and changed the bag. After she left I switched the light on, noticed the line was almost entirely full of air and being aware of the danger, switched the pump off and called the nurse. She fully primed the line and restarted the pump. She was visibly shaken but said nothing.

Info card ⑬

Standardised procedures for investigating incidents

Incidents that result in death or serious harm will be investigated using a systems analysis method. Systems analysis is a methodical investigation of an incident which involves collection of data from the literature, records, interviews with those involved and analysis of this data to establish the chronology of events that led up to the incident, identifying the key causal factors that had an effect on the eventual adverse outcome, the contributory factors, and recommended control actions (HSE, 2012).

Info card ⑭

Aggregate analysis of near misses

It is the policy of the HSE that at a minimum there will be aggregate analysis of the causes of low impact safety incidents according to incident type (e.g. falls). Aggregate analysis includes analysis of near miss incidents and incidents that resulted in "negligible", "minor" or "moderate" harm. Aggregate analyses will be overseen by the local quality and safety committee or equivalent, who must have access to appropriate expertise to conduct these aggregate analyses (HSE, 2014).

Info card ⑮

Seven levels of safety framework

The seven levels of safety framework describes the contributory factors and influences on safety under the following headings: Patient, task, individual, team, environment, organisational and institutional context factors (Vincent et al., 1998). This is also described in the HSE Guidelines for the Systems Analysis Investigation of Incidents and Complaints (2012).

Issue card ⑬

The importance of learning from when things go right

Most of the time things go right in healthcare. We need to harness the learning from when things go right. Thus the purpose of incident investigations is not to lay the blame on a person or group but to develop a greater understanding of how things usually go right, since that is the basis for explaining how things occasionally go wrong. Doctors and nurses should recognise that they are a resource necessary for system flexibility and resilience.

Issue card ⑭

Using reporting as a 'weapon'

The hospital incident reporting form is meant to be used to raise genuine concerns about where safety may have been compromised ('near miss') or where it was actually compromised. Sometimes the form can be used as a 'weapon' against certain staff members or categories of staff. Is this acceptable?

Issue card ⑮

Legal proceedings

The family of a patient harmed in our hospital have said that they are going to sue us. If that is the attitude that they are taking should we take a similar attitude and not tell them anything?

IMP-S PlayDecide Positions

- Hospital A:
  - 39 interns took part.

- Hospital B:
  - 22 interns took part.

	Support		Not Acceptable	
	Hosp. A	**Hosp. B**	**Hosp. A**	**Hosp. B**
Statement 1	97.20% (35)	100% (22)	2.80% (1)	0% (0)
Statement 2	85.70% (30)	83.30% (15)	14.30% (5)	16.70% (3)
Statement 3	10.80% (4)	22.20% (4)	89.20% (33)	72.20% (13)
Statement 4	0% (0)	0% (0)	97.40% (38)	94.40% (17)

IMP-S PlayDecide – Alt Statements

- Hospital A:
  - *"Senior members should help filter the concerns of junior staff and support serious concerns."* - 90% (9) general support from a group of 10 interns.

- Hospital B:
  - *"All staff should report all* reasonable *concerns they have regarding patient safety, without fear of recrimination, in the knowledge that learning will happen and the system will be improved. Patient safety should be our top priority as healthcare professionals."* - 100% (6) general support from group of 6 interns.

Interns Playing the PlayDecide Patient Safety Game

- Majority in both hospital sites said they were unclear of the reporting process, some could not recall having received any training.

- Some felt reporting was being used against them as a threat causing fears of having a 'black mark' on their record- examples of nursing staff using it to get doctors on call to attend to patients.

- Many saw that it was nurse jobs to report and nursing staff often reported for them.

- No time to report and not a priority.

- A lack of consistency with regard protocol in wards was causing conflicts.

- Why bother? - No feedback when people did report.

Semi-Structured Interviews

- Semi-structured interviews were undertaken. The interview approach used Flanagan's (1954) Critical Incident Technique (CIT).

- CIT is a methodology for collecting and analysing data with the aim of providing solutions to practical problems (Kemppainen 2000).

- **Theme 1:** General Profile and Overall Experience.

- **Theme 2:** Interviewees understanding of an incident.

- **Theme 3:** Interviewees experience/observation of an incident.

- **Theme 4:** Suggestions for shaping a safety culture and a supportive environment.

Understanding of the reporting system

'I do remember them saying there was an incident report but it was kind of blurred in with a lot of other things.' - Carli (Hospital B).

Nursing staff reporting on their behalf

'Nurses are definitely more inclined…They would encourage each other to help each other to maybe put in the incident report form and say *'No that is definitively an incident you need to put that in. Listen you go put that in now and I will do your job'.* They are definitely more inclined.' - Janet (Hospital A).

Barriers to Reporting

'I guess other things that would put it in perspective if you are working with somebody that it was related to on a one to on basis it could cause some conflict and maybe further problems again in the future.'- Gail (Hospital A).

'If there is an incident with someone more senior to you on your team that's when you you are least likely to you know to say anything…we cannot really critique people above us as a rule. It just doesn't happen.' - Angelo (Hospital B).

'Its just I suppose a bit depressing but I feel like we cannot change the system at all that there is no point of filling out one form.' - Mia (Hospital B).

Encouraging a Culture of Openness and Accountability

- Frequent **feedback sessions** that would support learning was the most popular suggestion.

- Closing the **feedback loop:** Sharing outcomes & providing updates.

- Participants stressed the need for **changing the culture** by providing support and embedding learning.

Current Practice – Significant Impact for Policy?

- Existing system is not supporting Interns:

  - Training provided seen as a tick box exercise; Purpose is not well understood; Lack of continuing education or focus on learning.

- Lack of Visibility of Reporting by Peers:

  - 'From the point of my internship I never had a Registrar or SHO or a Consultant that would tell me that they are goanna report an incident or do one.' - Carli (Hospital B).

- Reporting Rationale? Interns don't see the Point of Reporting:

  - 'There would be a strong feeling that these forms we fill in just end up in a shredder.' - Angelo (Hospital B).

Current Practice – Significant Impact for Policy?

- Disconnect between academic teaching and the '   '
  'real world':
  - where the focus is on reducing your patients list rather than providing the best care.
- Time to reshape Medical Education:
  - Focus should be developing a safety culture that is embedded on education and learning IMP-S PlayDecide Game provides a framework to enable open discussions.
- Key is to involve interns as **key stakeholders** in any changes:
  - 'A good starting point would be well the junior doctors are to the forefront who experience incidents it isn't the higher up people that would be aware of incidents ... or that there is an awareness of what's going on….that is a general feeling amongst the junior staff.' - (Angelo, Hospital B).