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Medical Council

Policy Brief on Medical Professionalism in Relation to Patient Safety

Research Findings Summary

1. The *Medical Professionalism in relation to Patient Safety PlayDecide Game* is an open access embedded learning serious game.

2. Game content was co-designed to include diverse perspectives and was played in two hospital sites with 101 junior doctors.

3. A majority of junior doctors (98%) supported Position 1 that all staff should report all concerns.

4. The current system is not supporting junior doctors to speak up about patient safety.

5. Suggestions for shaping a safety culture include closing the feedback loop through frequent feedback sessions; changing the culture by providing support and embedding on-going learning.

6. This research highlights the need to reshape Medical Education. Focus should be developing a safety culture that is embedded on education and learning the *Medical Professionalism in relation to Patient Safety PlayDecide Game* provides a framework to enable open discussions.

Introduction

Medical Professionalism is "a set of values, enacted through behaviours and relationships, which underpin the public's trust in doctors" (Medical Council, 2014; p.13). A recent survey of the Irish public revealed that approximately 8 in 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 (Medical Council; 2014). However doctors were more mixed. The main reasons given by doctors for not reporting a concern are 44% felt "nothing would happen as a result"; 25% had a "fear of retribution"; and 19% "thought someone else was dealing with the problem" (Medical Council, 2014; p.34). In 2014 across Ireland there was a total of 53,108 patient related incidents reported by acute hospitals. The Health Information and Quality Authority (2012) have emphasised the importance of a culture of quality and safety that promotes openness and transparency, teamwork, open and effective communication. Encouraging such a culture needs to start from an understanding of the factors that make it difficult for doctors and other health professionals to be open about errors.

Study Aim

The focus of the study is to determine whether a customised educational intervention (PlayDecide) with junior doctors (interns and senior house officers (SHO's) can imbue a culture of medical professionalism in relation to patient safety while supporting junior doctors to raise issues of concern, whilst shaping a culture of trust, transparency, responsiveness and learning.

Study Methods

This was a mixed method study over 9 weeks consisting of 4 weeks of baseline data collection, followed by the PlayDecide intervention and 4 week's post intervention data gathering. The following instruments were used:

- Questionnaire capturing Leadership Inclusiveness and Psychological Safety (Nembhard & Edmondson, 2006);
- Questionnaire on Safety Concerns that Interns witnessed based upon the Irish Medical Council's (2014) eight domains of good professional practice;
- PlayDecide Intervention is a serious card based game with a role-playing component;
- Semi-Structured Interviews using Flanagan's (1957) Critical Incident Technique.

Study Sites

- Hospital A is an acute adult care hospital in an urban area. In 2015 the hospital introduced the electronic National Incident Management System (NIMS) which is accessible on the hospital internet system. Between 1/1/2015 and the 31/12/2015 there was 7,973 incident reports.
- Hospital B is an acute adult care hospital in an urban area. The hospital incident reporting system is paper based which is logged within the hospital and then manually entered onto the State Claims Agency NIMS system. Between 1/1/2015 and the 30/6/2016 there was 3,886 incident reports.

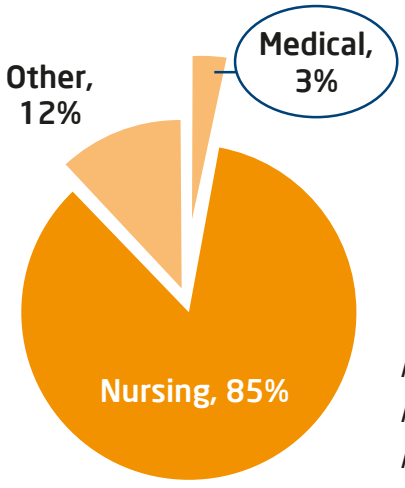

Figure 1: Reporting in Hospital A.

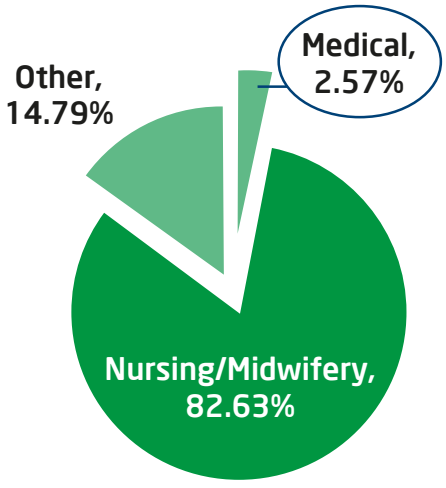

Figure 2: Reporting in Hospital B.

Results

In Hospital A 46 out of 52 interns took part (82.14%) and 31 out of 52 senior house officers (SHOs) took part (59.62%). In Hospital B 72 out of 86 interns took part (83.72%).

- Out of the 224 Questionnaires on Safety Concerns gathered in Hospital A 70 (32%) witnessed an incident in the last week with 43 (61.4%) witnessing 1 incident a week.

- In Hospital B out of 195 questionnaires gathered 65 (34.2%) stated they witnessed an incident in the last week with 72.6% interns witnessing 1 incident a week.

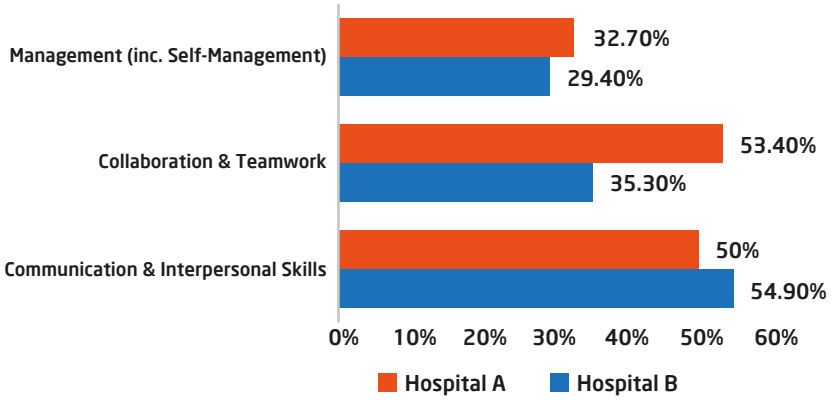

Figure 1: Top three contributory factors to incidents identified by junior doctors

- In Hospital A, 70 (32%) junior doctors witnessed an incident but only 23 (32.9%) formally reported it.

- Out of the 65 (34.2%) that witnessed an incident in Hospital B 20 (30.3%) formally reported it.

- A majority indicated that they informally talked about their concerns to colleagues - Hospital A, 48 out of 67 valid responses (71.6%) and in Hospital B, 46 out of 62 (74.2%).

PlayDecide Results

- A total of 101 Junior Doctors played the *Medical Professionalism in relation to Patient Safety PlayDecide Game*
- Hospital A: Out of the 77 that signed up 57 (74%) took part in the PlayDecide game
- Hospital B: Out of the 72 that signed up in Hospital B 44 (61%) took part.
- Participants voted on four different statements regarding patient safety (Table 1)

Table 1: Position statements voted on by junior doctors.

Position 1	All staff should report all 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 out top priority as healthcare professionals.
Position 2	All staff should report only serious concerns they have regarding patient safety without fear of recrimination, in the knowledge that learning will happen, and the system will be improved.
Position 3	All concerns regarding patient safety should be reported, but only by senior members of staff. Reporting by more junior members of staff is less likely to be effective.
Position 4	Staff cannot be expected to report safety concerns because they are too busy providing care. There is no value in reporting safety concerns if a patient wasn't harmed or placed at risk. It is just a waste of people's time and resources.

Table 2: How junior doctors voted for each position statement.

	Position 1	Position 2	Position 3	Position 4
Support	98% (n = 97)	76.3% (n = 71)	13.4% (n = 13)	1% (n = 1)
Not Acceptable	2% (n = 2)	23.7% (n = 22)	86.6% (n = 84)	99% (n = 97)

Note: Missing data and abstains were excluded from the analysis.

Table 3: Alternative PlayDecide position statements.

Hospital A	
Alternative Position	*Comment*
Senior members should help filter the concerns from junior staff and support serious concerns.	An intern group (n = 10) came up with the alternate position and received support from 60% group.
All staff should be comfortable/able to report without fear of recrimination, and all staff should make time to report.	A SHO group (n = 7) came up with the alternate position and received support from 100% of the group.
Hospital B	
Alternative Position	*Comment*
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 out top priority as healthcare professionals.	An intern group (n = 6) came up with an alternate position and received support from 100% of the group.

Interviews with Junior Doctors

A total of 15 junior doctors were interviewed (7 in Hospital A; 8 in hospital B).

1. Understanding of the Incident Reporting System

A majority in both hospital sites said they were unclear of the incident reporting process, some could not recall having received any training. Interviewees stressed that they often had no time to report and it often was not a priority for them. Many saw that it was a nurse's job to report and nursing staff often reported for them. Junior Doctors noted that they also frequently observed nursing staff creating an enabling environment to report:

> *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)**

This was in contrast by a lack of visibility of reporting by their 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)**

2. Barriers to Reporting

Participants were unclear of the rationale for reporting:

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

Many questioned why they would bother reporting when often no feedback was provided when people did report:

> It's 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)**

Junior doctors outlined that there was an 'informal' culture amongst them where they discussed concerns. Participants noted a reluctance to report on senior colleague:

> If there is an incident with someone more senior to you on your team that's when 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)**

A source of frustration in both sites was the lack of consistency with regard protocols in wards which was often causing conflicts.

3.How to encourage a Culture of Openness and Accountability?

Frequent feedback sessions that would support learning was the most popular suggestion. Closing the **feedback loop** was also stressed:

> *'People want to see the reporting loop closed when you report and seeing on outcome on that…and I think sometimes there is not enough feedback on that in any environment I don't think Hospital A is different to any other hospital or any large institution'*
> **Monika (Hospital A)**

Participants stressed the need for **changing the culture** by providing support and embedding learning. Central to any change would be to involve junior doctors as key stakeholders.

Impact for Policy and Practice?

- Existing system is not supporting Junior Doctors to recognise their role in shaping a safety culture;
- The training that is provided is seen as a tick box exercise and the purpose is not well understood;
- Disconnect between academic teaching and the ''real world'. There is a lack of continuing education or focus on ongoing learning about safety.
- The research highlights the need to reshape Medical Education. Focus should be developing a safety culture that is embedded on education and learning *Medical Professionalism in relation to Patient Safety PlayDecide Game* provides a framework to enable open discussions.

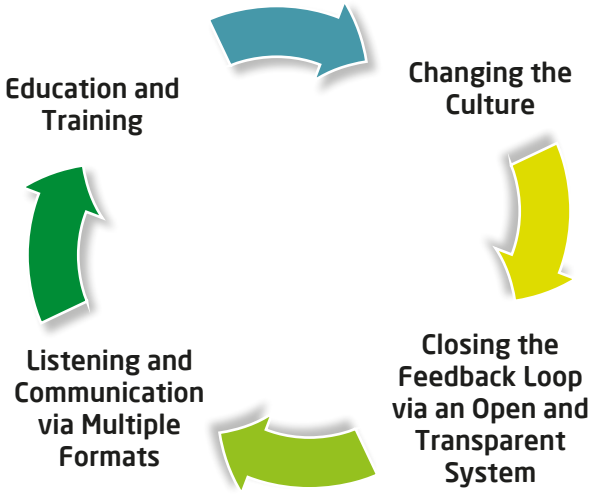

Figure 2 Identified Areas for Improvement

Knowledge Exchange Activities

17th January 2017
Presentation on the Medical Professionalism in relation to Patient Safety PlayDecide Game to Dr Daragh Fahey, Director of Quality Safety & Risk Management, Tallaght Hospital

7th December 2016
Dr Éidín Ní Shé and Karen Egan delivered presentation on Medical Professionalism in Relation to Safety: *Junior Doctors' Experiences in Practice* at the *1st National Patient Safety Office conference* on 7th and 8th December 2016 at the PrintWorks Dublin Castle. Please *click here* to view the presentation.

7th December 2016
Christian Korpos et al. presented a poster on *Medical Professionalism in Relation to Safety: The experinces of interns across two acute hospitals in Ireland* at the *1st National Patient Safety Office conference* on 7th and 8th December 2016 at the PrintWorks Dublin Castle.

23rd November 2016
Training on the Medical Professionalism in relation to Patient Safety PlayDecide Game to St James Hospital Quality and Safety Improvement Team

27th October 2016

The UCD Health Systems team were invited by the Medical Council to facilitate two workshops of PlayDecide as part of the Medical Council Patient Safety and Leadership Conference held on the 27th of October 2016 at the Radisson Blu Royal Hotel Golden Lane Dublin 2. A total of 64 people played the PlayDecide game at the workshop.

7th November 2016

Christian Korpos et al. presented a poster on *Medical Professionalism: Preliminary results of the experiences of interns about speaking up and reporting safety concerns in St. Vincent's University Hospital* at the St. Vincent's University Hospital Nursing Conference Poster on 7/11/16 to 11/11/16.

7th December2015

Dr Marie Ward and Karen Egan delivered presentation on *Developing a serious game 'PlayDecide' for supporting junior hospital doctors to speak up about safety concerns* at the National Patient Safety Conference on 7th and 8th December 2015 at the PrintWorks, Dublin Castle.

7th December 2015

Dr Marie Ward et al. presented a poster on *Medical Professionalism: Developing a serious game 'PlayDecide' to encourage junior hospital doctors to speak about and report safety concerns* at the National Patient Safety Conference on 7th and 8th December 2015 at the PrintWorks, Dublin Castle.

Academic Outputs

- Ward M. McAuliffe E. Ní Shé É. Duffy A. Geary U. Cunningham U. Holland C. McDonald N. Egan K. Korpos C. 'Imbuing Medical Professionalism in Relation to Safety: A study protocol for a mixed-methods intervention focused on trialling an embedded learning approach that centres on the use of a custom designed board game' *BMJ Open *Under Review**
- Ward M. McAuliffe E. Egan K. Holland C. Geary U. Robinson K. O'Grady J. Ní Shé É. Hamza M. Korpos C. 'Developing the 'PlayDecide Patient Safety Game' Health Professions Education *Under Review**

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Who was involved in this project?

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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*

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