Building a Better Health Service

CARE COMPASSION TRUST LEARNING

Lead NCHD Awards

June 2018

National Doctors Training & Planning

Contents

Introduction to the Lead NCHD Awards

The Lead NCHD initiative was developed in response to "a historic deficit in NCHD representation at executive level within Irish Hospitals". The MacCraith report recommended that "structured communication arrangements should be established for trainees, including engaging in solutions for patient care". The contents of this booklet demonstrate that the Lead NCHD programme continues to see excellent NCHD-led initiatives positively impacting on NCHDs on a day-to-day basis.

The Lead NCHD Awards recognise the work undertaken by Lead NCHDs during their tenure on their clinical site. The presentation of awards and this booklet are an opportunity to share examples of good practice and encourage colleagues to pursue their own projects and improvement initiatives. The variety of projects demonstrates that Lead NCHDs are promoting a culture of medical leadership, facilitating engagement with NCHDs, nurturing NCHD wellbeing and are keen participators in quality improvement with its many benefits for the health service, its staff and patients.

The projects in receipt of the third annual Lead NCHD awards are:

1st **Improving wellbeing among anaesthetists**
Dr Eoin Kelleher, University Hospital Galway

2nd **Intern handover app- Captive Health**
Dr Nikita Bhatt, Tallaght hospital, Dublin.

3rd **The little things that show we care: Staff engagement and career development**
Dr Lylas Aljohmani, St. James's hospital

I would like to acknowledge Professor Frank Murray, Director, NDTP, Dr Philip Crowley, National Director, Quality Improvement Division (QID) and Ms Rosarii Mannion, National Director, Human resources for their support of the Lead NCHD programme and these awards. In addition, I would particularly like to thank Ms Juanita Guidera, QID Lead Staff Engagement and Ms Lisa Toland, QID Lead Microsystems for their guidance and help with the Lead Programme and associated Initiatives.

This booklet includes entries from leads for the 2017-2018 period, and I would like to thank the leads all for their hard work and commitment to the programme throughout the year.

Thank you,
Louise
Dr Louise Hendrick
National Lead NCHD/NDTP Fellow
National Doctors Training & Planning

Improving wellbeing among anaesthetists in University Hospital, Galway

Kelleher E[1], McLoughlin E[1], Nee R[1]
[1] Anaesthesia NCHD, Department of Anaesthesia, University Hospital Galway

Burnout, fatigue and poor morale are problems among non-consultant hospital doctors (NCHDs) and consultants working in Irish hospitals (1). The HSE's National Doctors Training and Planning (NDTP) recommends that all NCHDs receive education on how to look after their wellbeing and have someone responsible for their wellbeing at the workplace. However, doctors receive very little formal education on how to look after their own wellbeing. We sought to address this by integrating a wellbeing education programme into the morning teaching schedule for the Department of Anaesthesia at University Hospital, Galway.

We organized a series of six morning sessions on topics related to NCHD wellbeing within the department of Anaesthesia at UHG. The topics were fatigue, mindfulness, financial planning, peer support, and a talk from the Samaritans. These were delivered by a mix of speakers from within the department, and external guest speakers. The Department of Anaesthesia facilitated the programme by giving us a slot on the education programme from 0800-0845 before operating lists commenced each Thursday for 6 weeks in February and March 2018.

In addition, the department participated in the 'Coffee and Gas' initiative from the Association of Anaesthetists of Great Britain and Ireland (AAGBI). This involved having members of the department, both consultants and NCHDs, bringing in snacks to our tutorial room and having the opportunity to relax and de-stress after a busy working day.

Following the programme, we distributed a short survey to NCHDs in the department in order to obtain feedback. A mix of consultants and NCHDs attended the sessions, representing NCHDs of all stages in training. 18/38 NCHDs returned the survey.

All respondents reported that they found the programme to be 'helpful' (58%) or 'very helpful' (42%). The sessions on fatigue and financial planning were found to be particularly helpful, with 47% and 35% respectively of respondents rating them as 'very helpful'. Almost half of respondents (47%) reported that they made a behavior change as a result of the programme. All respondents recommended that it be continue as a regular feature of the teaching programme in the future.

The department of anaesthesia was pleased with the results of the programme and will continue to run it in the future.

1. Hayes B, Walsh G, Prihodova L. National Study of Wellbeing of Hospital Doctors in Ireland. Royal College of Physicians of Ireland (RCPI), Dublin. Available from: https://rcpi-live-cdn.s3.amazonaws.com/wp-content/uploads/2017/05/Wellbeing-Report-web.pdf

Improving wellbeing among anaesthetists in University Hospital, Galway

Kelleher E[1], McLoughlin E[1], Nee R[1]
[1] Anaesthesia NCHD, Department of Anaesthesia, University Hospital Galway

Galway University Hospitals
Ospidéil na h-Ollscoile Gaillimh
UNIVERSITY HOSPITAL GALWAY
MERLIN PARK UNIVERSITY HOSPITAL

Background & Aims

Burnout, fatigue and poor morale are problems among non-consultant hospital doctors (NCHDs) and consultants working in Irish hospitals(1). Anaesthesia NCHDs are no exception to this.

The HSE's National Doctors Training and Planning (NDTP) recommends that all NCHDs receive education on how to look after their wellbeing, and have someone responsible for their wellbeing at the workplace. However, doctors receive very little formal education on how to look after their own wellbeing.

We sought to address this by integrating a wellbeing education programme into the morning teaching schedule for the Department of Anaesthesia at University Hospital, Galway.

Methods

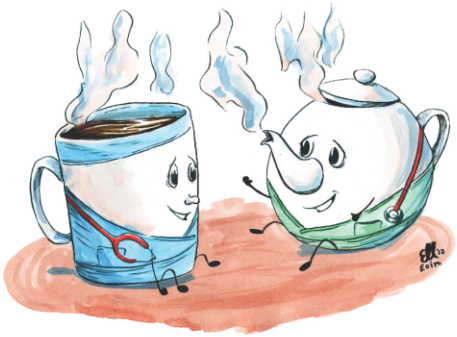

Figure 1: 'Coffee and Gas' Poster

We organized a series of six morning sessions on topics related to NCHD wellbeing with in the department of Anaesthesia at UHG. The topics were:

- **fatigue**
- **mindfulness**
- **financial planning**
- **peer support**
- **Samaritans**

These sessions were delivered by a mix of speakers from within the department, and external guest speakers.

The Department of Anaesthesia facilitated the programme by giving us a slot on the education programme from 0800-0845 before operating lists commenced each Thursday for 6 weeks in February and March 2018.

In addition, the department participated in the '**Coffee and Gas**' initiative from the *Association of Anaesthetists of Great Britain and Ireland* (AAGBI) (fig 1). This involved having members of the department, both consultants and NCHDs, bringing in snacks to our tutorial room and having the opportunity to relax and de-stress after a busy working day.

Following the programme, we distributed a short survey to NCHDs in the department in order to obtain feedback.

Results

- A mix of consultants and NCHDs attended the sessions, representing a NCHDs of all stages in training.
- 18/38 NCHDs returned the survey on the programme.
- All respondents reported that they found the programme to be 'helpful' (58%) or 'very helpful' (42%).
- The sessions on fatigue and financial planning were found to be particularly helpful, with 47% and 35% respectively of respondents rating them as 'very helpful'.
- Almost half of respondents (47%) reported that they made a behavior change as a result of the programme (fig 3)
- All respondents recommended that it be continue as a regular feature of the teaching programme in the future.
- Some SHOs suggested that the days change as the sessions clashed with teaching for the MCAI exam.

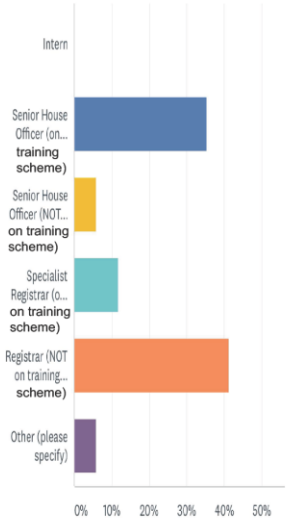

Figure 2: Survey respondents by grade.

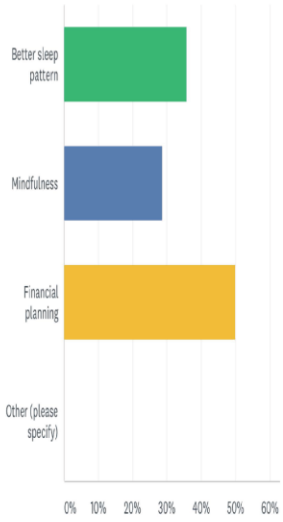

Figure 3: Self-reported behavior changes as a result of the programme

Discussion/Conclusions

• Wellbeing sessions can be successfully integrated into the teaching programme of an anaesthesia department.
• Anaesthesia NCHDs found the programme to be helpful, and almost half made changes to their behaviour as a result of the programme.
•The department was pleased with the results of the programme and will integrate it into the educational calendar .

References

(1) Hayes B, Walsh G, Prihodova L. National Study of Wellbeing of Hospital Doctors in Ireland. Royal College of Physicians of Ireland (RCPI), Dublin. Available from: https://rcpi-live-cdn.s3.amazonaws.com/wp-content/uploads/2017/05/Wellbeing-Report-web.pdf

Acknowledgements

Dr Mark Ross, Consultant Anaesthetist, Department of Anaesthesia, University Hospital, Galway provided invaluable support in facilitating the programme on the teaching schedule

Intern handover app - Captive Health

Nikita Bhatt, NCHD lead, Tallaght hospital, Dublin.

Interns are newly inducted doctors who face several challenges when they start off. We proposed to develop a user-friendly application for interns that will serve as their online handbook for clinical information, hospital related guidance like medicines guide, and provide information regarding the IT software in the hospital.

Implementation of this app was challenging, this required collaboration from IT, human resources (HR), funding and approval from the e-health committee. We were able to add this app to the Staff connect portal of the Captive health app Tallaght hospital launched last year. The requisite funding was applied for from the Meath foundation to the order of €15,000 to develop and maintain it. The NCHD lead together with the NCHDs was able to develop the actual data for the app- by interns for interns, the pharmacy added the medicines guide and IT added their features to help doctors navigate the hospital system.

This app has been seen as a welcome initiative by HR and doctors alike as it provides added support to the most junior doctors in the hospital from their point of view and thus adds to patient safety and care. Since this app was developed in collaboration with IT, the maintenance will be under their prerogative. The clinical data will be updated and maintained by the NCHD lead in Tallaght hospital each year, serving as a sustainable initiative implemented by the NCHD lead group.

The long-term aim is to implement it for other NCHDs with hospital based information they might find useful particularly during changeover. The second goal is to introduce this as a part of the HSE's new efficient national changeover policy to develop similar software/guidebook for each hospital nationwide with essential local data NCHDs may find useful during changeover. Hence, this is a simple, easy to use app that has many potential long-term applications nationwide and bodes well with the lead NCHD initiative to ultimately support NCHDs while providing quality improvement initiatives.

Intern handover app - Captive Health

Nikita Bhatt
NCHD lead, Tallaght hospital, Dublin.
Category- NCHD engagement

"I manage my life through my smartphone. Why wouldn't I want to manage my work through my smartphone too"

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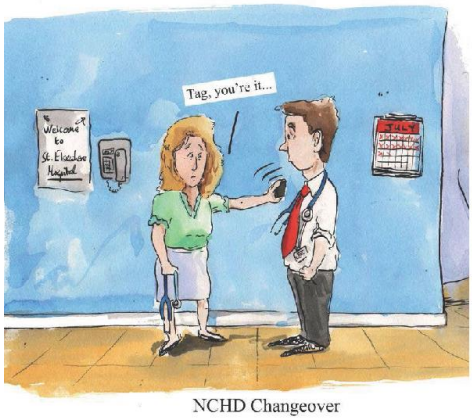


NCHD Changeover

Simple

User friendly

Practical information

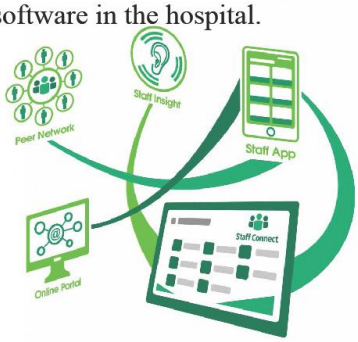
Links to already available information- unaware

Basic clinical guidance

Tax issues, payroll

Smart phone friendly

Aim to improve patient care



Staff Connect

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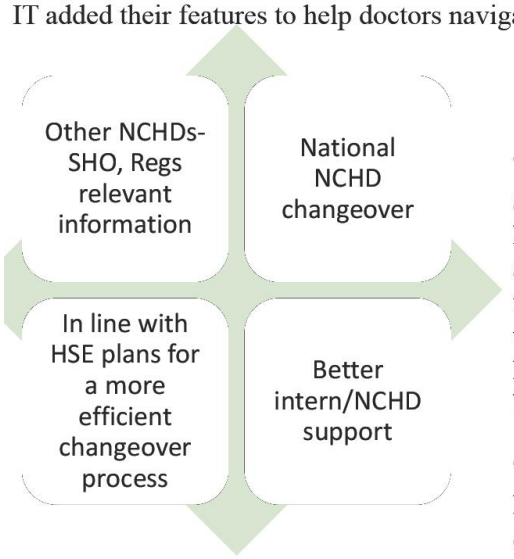

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Tallaght University Hospital | Ospidéal Ollscoile Thamhlachta
An Academic Partner of Trinity College Dr

The little things that show we care: Staff engagement and career development

Lylas Aljohmani, Lead NCHD St. James's Hospital

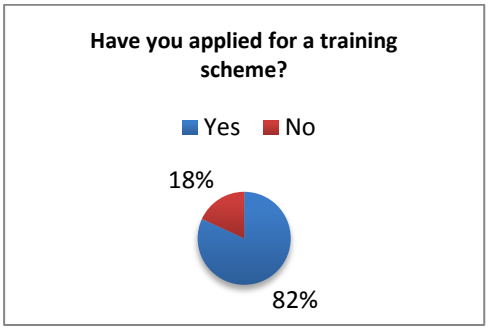
Staff development and engagement is one of the sure ways to ensure you can retain your staff, uplift moral and obtain patient satisfaction (1). At the National staff engagement forum in 2016 staff engagement was described as; "Staff are engaged when they feel valued, are emotionally connected, fully involved, enthusiastic and committed to providing a good service... when each person knows that what they do and say matters and makes a difference" (2). We all know that in some organisations, some of this ethos can be forgotten about in the busy clinical environment that NCHD's face every day. Our health care service is a dynamic and very busy environment providing thousands of patients with care from chronic to life saving treatment. Our doctors and health care professionals provide this care for patients in 12,000 acute hospital beds in the health service ranging from a wide scope of conditions costing a total of €14.5bn (3, 4). So we're in this continues stream of patient caseload and heavy "foot traffic", work environment, do you find the time and space to carve out some much needed staff engagement time? St. James's hospital located in Dublin 8 is a prime example of our health service busy bee hive where it's home to 1,010 beds and provides treatment for 25,384 inpatients, 97,672 day care patients and 229,120 outpatients on an annual bases (5). Taking the challenges of busy clinical work, we aimed to provide our cohort of NCHD's the chance to provide us with feedback on a proposed session we deemed to be of interest to NCHD's through a 3 phased survey study.

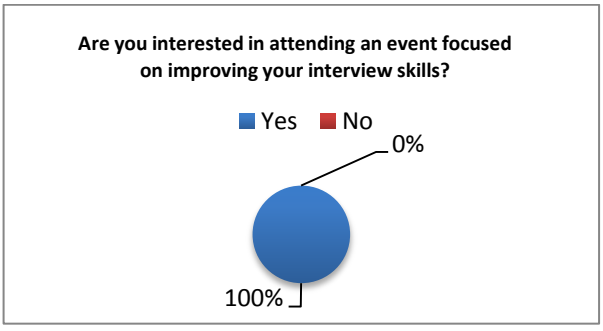
Aims:

- To identify a gap in NCHD's career development, that relevant college or hospital specific department does not provide.
- To provide NCHD's a chance to feedback on a proposed interview skills course that will run in St. James's hospital depending on NCHD demand.
- To organise multiple opportunities for NCHD's to attend sessions and obtain feedback after session have been delivered.
- To provide this at no cost to NCHDs.

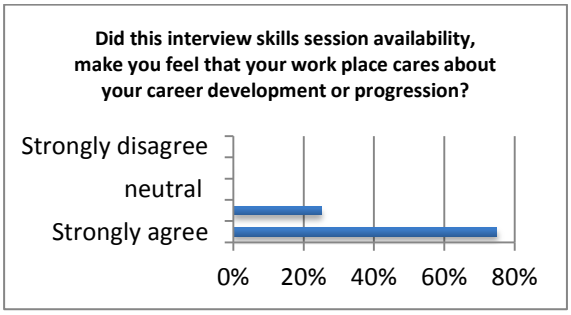
A 3-phased survey was conducted; first phase needs analysis and NCHD requirement of proposed event. Second phase survey is post event evaluation and analysis of event success and relevance. Third phase survey was aimed to estimate staff engagement and facilitate ideas for next planning phase.

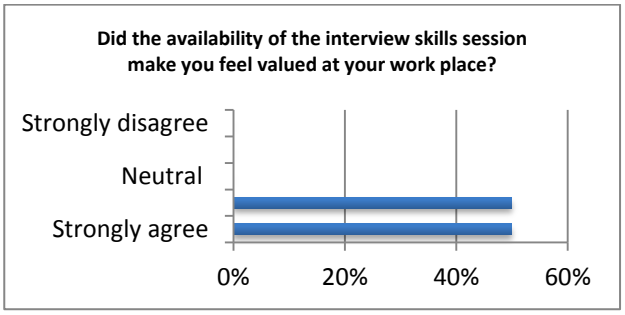
The initial survey (1st phase) was analysed to obtain a needs analysis based on response. 44 NCHD's (excluding interns) responded to the survey showing 100% of respondents willing to engage in proposed interview skills sessions. The survey aimed to investigate how many of our respondents will be using these skills in a formal interview manner. It was very evident that we successfully identified a gap in our NCHD's career development that we can fill and use as a point of contact to engage our NCHD cohort. With only 4.55% (n=2) NCHD reporting that some form of interview skills was provided by their department and only 2.27% (n=1) reporting that their affiliated training body has provided them with this a skill base. Post survey analysis 3 interview sessions were organized for St. James's NCHD's to attend based on a first come first served bases and 2 sessions for Intern group.





Funding was negotiated for and generously provided by St. James's HR and Trinity College Dublin. Separate interview sessions were organized for the intern group to address different interview skills needs based on planed interview types. A total of 47 attended with 10 doctors per session lasting 2 hours duration each. Post event survey was conducted to estimate the relevance and content of the training in NCHD's opinion. 96% (n= 45) of NCHD's strongly agreed that the content covered and time allocated to the sessions was relevant. 96% of NCHD's also a strongly agreed that it was a worthwhile event to continue as part of NCHD engagement and training. Phase 3: A staff engagement survey was conducted several weeks post event date to request feedback for future events and comments on any developments that should be taken into view for the incoming year.





Staff engagement can be a difficult endeavour without effective communication directly with your staff, gauging what interests them and what they will buy into is the easiest way to engage your efforts and yield a higher response. In a fast and ever changing HSE it's more important than ever to increase our efforts and listen to NCHD's to improve not only job satisfaction, retention but also patient satisfaction through the services we provide (1). In conclusion we can see that the success and over subscription to our events was a combination of early planning, effective communication and an enthusiastic group of receptive NCHDs.

1. Gesme DH, Towle EL, Wiseman M. Essentials of staff development and why you should care. Journal of oncology practice. 2010;6(2):104-6.
2. HSE staff engagment [Available from: https://www.hse.ie/eng/staff/resources/hrstrategiesreports/hscp-strategy.pdf
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4. HSE. HSE performance report [Available from: https://www.hse.ie/eng/services/publications/performancereports/
5. St. James's Hospital annule report [Available from: http://www.stjames.ie/AboutUs/AnnualReports/Annual Report 2017 (English)-Final Lo Res.pdf

The Little Things That Show We Care: Staff Engagement and Career Development

L. Aljohmani, Lead NCHD St. James's Hospital

Introduction

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Our health care service is a dynamic and very busy environment providing thousands of patients with care from chronic to life saving treatment. Our doctors and health care professionals provide this care for patients in 12,000 acute hospital beds in the health service ranging from a wide scope of conditions costing a total of €14.5 bn (3, 4). So were in this continues stream of patient caseload and heavy "foot traffic", work environment, do you find the time and space to carve out some much needed staff engagement time?

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Taking the challenges of busy clinical work, we aimed to provide our cohort of NCHD's the chance to provide us with feedback on a proposed session we deemed to be of interest to NCHD's through a 3 phased survey study.

Aims

1. To identify a gap in NCHD's career development, that relevant college or hospital specific department does not provide.
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3. To organise multiple opportunities for NCHD's to attend sessions and obtain feedback after session have been delivered.
4. To provide this at no cost to NCHD's.

Methods

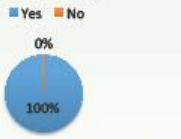
3-phased survey was conducted; first phase needs analysis and NCHD requirement of proposed event. Second phase survey is post event evaluation and analysis of event success and relevance. Third phase survey was aimed to estimate staff engagement and facilitate ideas for next planning phase.

First phase survey was an electronic 8-question survey was sent out to NCHD's in St. James's hospital to gauge interest and need for interview skills sessions to be provided. Survey was sent to 300 NCHD's in St. James's hospital. A separate form of information gathering was carried out for the intern subgroup via open discussion and voting, this was carried out before their biweekly teaching sessions to gauge interest and feedback. As their needs can be facilitated during structured teaching time carved out by Trinity college Dublin their affiliated university it was more appropriate to increase response uptake by face to face questionnaire. For the purpose of this only the NCHD responses excluding interns has been included in the 1st phase. Second phase paper based survey was given to all attendees at the sessions. Third phase was an electronic staff engagement survey sent several weeks after the event.

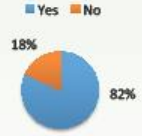
Results

The initial survey (1st phase) was analysed to obtain a needs analysis based on response. 44 NCHD's (excluding interns) responded to the survey showing 100% of respondents willing to engage in proposed interview skills sessions. The survey aimed to investigate how many of our respondents will be using these skills in a formal interview manner.

Are you interested in attending an event focused on improving your interview skills?



Have you applied for a training scheme?

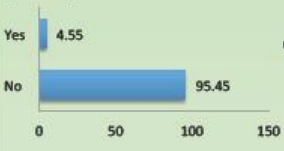


It was very evident that we successfully identified a gap in our NCHD's career development that we can fill and use as a point of contact to engage our NCHD cohort. With only 4.55% (n=2) NCHD reporting that some form of interview skills was provided by their department and only 2.27% (n=1) reporting that their affiliated training body has provided them with this a skill base.

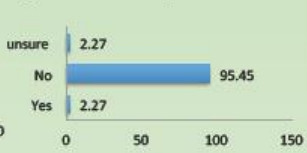
Acknowledgment: J. Campion, L. Chapman, S. Roche, O. Hannigan Co-Lead NCHD's. St. James's, HR department and David Sweeney.

Trinity College Dublin education division and intern coordinator Dr. H. Sulaiman.

Has there been a training session in your department for interviews?



Has there been a training session in your affiliated college for interviews?



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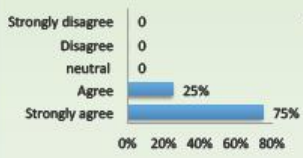
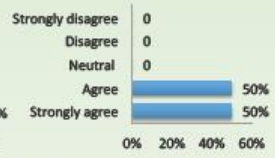
Phase 3: A staff engagement survey was conducted several weeks post event date to request feedback for future events and comments on any developments that should be taken into view for the incoming year.

Did this interview skills session availability, make you feel that your work place cares about your career development or progression?



Did the availability of the interview skills session make you feel valued at your work place?



Conclusion

Staff engagement can be a difficult endeavor without effective communication directly with your staff, gauging what interests them and what they will buy into is the easiest way to engage your efforts and yield a higher response. In a fast and ever changing HSE it's more important than ever to increase our efforts and listen to NCHD's to improve not only job satisfaction, retention but also patient satisfaction through the services we provide (1). In conclusion we can see that the success and over subscription to our events was a combination of early planning, effective communication and an enthusiastic group of receptive NCHD's.

References

1.Gosme DH, Towle EL, Wiseman M. Essentials of staff development and why you should care. Journal of oncology practice. 2010;6(2):104-6.
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Bringing clinical medical education on a paperless journey: making every patient contact count

L. Aljohmani, Lead NCHD St. James's hospital; Dr Declan Byrne, Consultant Physician, Director of William Stokes Postgraduate Centre, St James's Hospital

Introduction

Hospital based medical education is the pivotal point of knowledge and skills transfer to our medical students, who, not before long will join us as colleagues on the wards. St. James's hospital in Dublin 8 is the biggest teaching university hospital in Dublin and home to 1,010 acute patient hospital beds (1, 2).

St. James's not only is a fertile landscape for medical students learning, with access to a wide multitude of specialties but also is home to the Trinity teaching centre and numerous research facilities and labs. Giving students here one of the best opportunities in the country to gain valuable patient contact time and clinical skills. The Trinity undergraduate course is a 5 year program with clinical contact from as early as year one with a family case study and progressing to hospital medicine in year 2 until graduation in year 5. St. James's and its clinical staff facilitate for medical teaching on a daily bases with over 700 medical students being educated and examined in our hospital on a yearly bases.

Early and effective contact to the clinical world is important in motivating and stimulating medical student interest in clinical work, which is why having access to difficult patient cases of interest is so important in ensuring knowledge acquisition at an early stage in clinical teaching (3).
In a busy clinical environment, it's important to not only depend on ward cases to demonstrate the knowledge you want to teach but to also capitalise on the numerous teaching opportunities in the outpatient setting especially with a growing student and patient population. Making every patient contact count towards education regardless of where they are seen within the hospital system using electronic patient record (EPR) is vital for a more holistic approach to clinical teaching (4).

Aims

1. To make every patient contact count as a valuable teaching resource.
2. To give NCHD's the opportunity to identify patient cases with interesting signs in any clinical setting and make it easily available to the lecturing staff.
3. To improve the case load exposure for all students by identifying numerous patient cases in all specialties throughout the hospital outside the busy ward setting.
4. Reduce time spent by teaching staff looking for patient cases for clinical exams and teaching.

Current practice

Teaching staff and NCHD's flag patients with interesting signs on wards for teaching purposes using patient lists and waiting lists. This is followed by contacting patients and asking for their consent to facilitate teaching sessions and willingness to be involved in exams. This is all done using a paper based system which then requires pulling charts and augmenting patient information using the current functionality of EPR. This is very time consuming and can be facilitated by creating a better electronic function that all staff can use.

Planned future practice and design

Electronic patient record (EPR) is the current system being used to capture patient information in St. James's hospital and is being used in all specialties in different levels. From July 2018 at our staff switch over period, St. James's hospital will be going extending the functionality of project Oak to allow medical and nursing clinical notes to be taken electronically on EPR. Taking this into account we decided to design and include a function to allow medical education to feature as part of EPR. Design encompassed an easily accessible tab for physicians to comment on the reason for patient case inclusion, the sign and symptoms of interest, what kind of contact is the patient was willing to facilitate and if the patient is willing to take part in clinical exams. All physicians can add their patients to the medical education database once they have access to EPR, which is on every hospital computer in all locations. All lecturing staff will have access to patient cases that have been flagged by other physicians and can be seen by specialty to optimise teaching opportunities.

Outcomes anticipated

1. A higher yield of specific patient cases can be accumulated to facilitate teaching in a more organised fashion.
2. Lecturing staff will have easy access to specific patient cases that can augment their teaching and learning outcomes for specific teaching seminars without looking through numerous patient lists.
3. Easy contact with willing patients to facilitate teaching, and easier to plan a convenient time for patient along already scheduled visits to hospital.
4. Giving all NCHD's a chance to contribute to teaching in a busy clinical environment and share interesting patient cases with lecturers even during periods of time where their students are off the wards and clinics for other teaching requirements.

Next steps forward

- Ensure all NCHD's are aware of the new medical education electronic function built into EPR at induction in July.
- Monitor number of NCHD's contributing to it and feedback during ground rounds on the type of cases and numbers that have been submitted, to allow teams to see progression in case load contribution.
- Audit lecturers experience with new system and what improvements have been gained through the change from paper based to electronic.
- We would like to see if this can be a used to facilitate postgraduate teaching and allied health care profession teaching in the MDT setting too as the next phase develops.

References

1. St. James's Hospital annule report [Available from: http://www.stjames.ie/AboutUs/AnnualReports/Annual Report 2017 (English)-Final Lo Res.pdf
2. HSE. HSE service report [Available from: https://www.hse.ie/eng/services/publications/serviceplans/national-service-plan-2018.pdf
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4. Project Oak [Available from: http://www.stjames.ie/NewsBanner/ProjectOakLaunch/

Bringing clinical medical education on a paperless journey: making every patient contact count.

L. Aljohmani, Lead NCHD St. James's Hospital
D.Byrne, Consultant Physician, Director of William Stokes Postgraduate Centre, St James's Hospital

Introduction

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In a busy clinical environment, it's important to not only depend on ward cases to demonstrate the knowledge you want to teach but to also capitalise on the numerous teaching opportunities in the outpatient setting especially with a growing student and patient population. Making every patient contact count towards education regardless of where they are seen within the hospital system using electronic patient record (EPR)is vital for a more holistic approach to clinical teaching (4).

Aims

To make every patient contact count as a valuable teaching resource.

To give NCHD's the opportunity to identify patient cases with interesting signs in any clinical setting and make it easily available to the lecturing staff.

To improve the case load exposure for all students by identifying numerous patient cases in all specialties throughout the hospital outside the busy ward setting.

Reduce time spent by teaching staff looking for patient cases for clinical exams and teaching.

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Design encompassed an easily accessible tab for physicians to comment on the reason for patient case inclusion, the sign and symptoms of interest, what kind of contact is the patient was willing to facilitate and if the patient is willing to take part in clinical exams. All physicians can add their patients to the medical education database once they have access to EPR, which is on every hospital computer in all locations. All lecturing staff will have access to patient cases that have been flagged by other physicians and can be seen by specialty to optimise teaching opportunities.

Anticipated Outcomes

A higher yield of specific patient cases can be accumulated to facilitate teaching in a more organised fashion.

Lecturing staff will have easy access to specific patient cases that can augment their teaching and learning outcomes for specific teaching seminars without looking though numerous patient lists.

Easy contact with willing patients to facilitate teaching, and easier to plan a convenient time for patient along already scheduled visits to hospital.

Giving all NCHD's a chance to contribute to teaching in a busy clinical environment and share interesting patient cases with lecturers even during periods of time where their students are off the wards and clinics for other teaching requirements.

Next Step

Ensure all NCHD's are aware of the new medical education electronic function built into EPR at induction in July.

Monitor number of NCHD's contributing to it and feedback during ground rounds on the type of cases and numbers that have been submitted, to allow teams to see progression in case load contribution.

Audit lecturers experience with new system and what improvements have been gained through the change from paper based to electronic.

We would like to see if this can be a used to facilitate postgraduate teaching and allied health care profession teaching in the MDT setting too as the next phase develops.

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Trinity College Dublin
Coláiste na Tríonóide, Baile Átha Cliath
The University of Dublin

ST. JAMES'S HOSPITAL
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St. James's Hospital and Trinity College Dublin

What the bleep?

Lucy Chapman[1], Oisin Hannigan[1]
In Collaboration with David Sweeney[2], Aidan Turley[3], Kyle Wyley[3]

[1]Lead NCHDs, St. James's Hospital, Dublin
[2]Human Resources Department, St. James's Hospital, Dublin
[3]Facilities Department, St. James's Hospital, Dublin

Objectives
The aim of this bleep review was to objectively assess the number of bleeps in active use by NCHDs whilst assessing the reliance on mobile phones for communication with NCHDs. This review was undertaken to inform requirements for procurement of new bleeps

Methods
During one week in October 2017 all bleeps listed on the hospital bleep list (n=116) were bleeped. The bleeps answered were documented and supplemented by information such as NCHD grade, specialty as well any information relevant for procurement. A working group was established with representatives from NCHDs, consultants, Human Resources, Facilities Department and Hospital Directorates. This working group informed by the outcomes of the bleep review aimed to formalise a procurement process for new bleeps as well as a central drop-off location for NCHD bleeps.

Barriers included financial funding of new bleeps, lack of central drop-off location for bleeps as well as cultural reluctance to use bleeps amongst surgical specialities.

Results
78% of bleeps were answered and accounted for. The staff grade most likely not to answer a bleep were registrars (n=15). 51% of NCHDs are listed as being contactable via the hospital switchboard with no designated bleep.
A pilot was undertaken to trial a central drop-off location for bleeps in the hospital res for interns for the April changeover. Following this pilot a survey revealed that 100% of interns (n=33, response rate 47%) deemed the hospital res a reasonable central location for bleep drop-off. A follow-on survey of other NCHD grades was applied to assess opinions on a central bleep drop-off location.

Conclusions
Reliance upon mobile phones has emerged as bleep designation is not meeting requirements particularly amongst surgical specialties. The central drop-off point for bleeps has been a successful initiative. Funding has been agreed for new bleeps for the July changeover.

What the Bleep?

Lead NCHDs - Lucy Chapman, Oisin Hannigan
In Collaboration with David Sweeney, Aidan Turley, Kyle Wyley
St. James's Hospital, Dublin

Objectives

- The requirement for improvements in hospital communication structure is evident, as miscommunications between hospital staff are major factors in adverse events (Baker 2004).
- We undertook a bleep review to objectively assess the number of bleeps in active use by NCHDs and to quantify the reliance upon mobile phones for inter-hospital communication.
- The results informed requirements for formalised procurement of new bleeps

Methods

- All bleeps listed on the hospital bleep list (n=116) were bleeped over a 5-day period in October 2017.
- A working group was established with representatives from NCHDs, consultants, Human Resources, Facilities Department and Hospital Directorates. This working group informed by the outcomes of the bleep review aimed to formalise a procurement process for new bleeps as well as a central drop-off location for NCHD bleeps.

Results

- 78% of listed bleeps were answered
- Significant variances in answering patterns were noted amongst NCHD grades (Fig.1).
- 51% of NCHDs are contactable via switch due to a lack of bleeps.
- Regarding reasons for unanswered bleeps no obvious or temporary reason (e.g. repairs, mislaid) was apparent for 65% of unanswered bleeps.
- Surgical specialties were more likely to rely upon mobile phones as communication method (Fig.2).
- A pilot central drop-off location for bleeps in the hospital res for interns for the April changeover was trialled. 100% of interns (n=33, response rate 47%) were satisfied with the hospital res as a central location for bleep drop-off, with 90% of other NCHD grades in agreement in a separate follow-up survey.

Figure 1 - Unanswered Bleeps by Grade

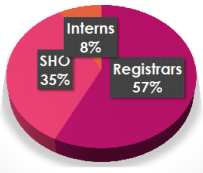
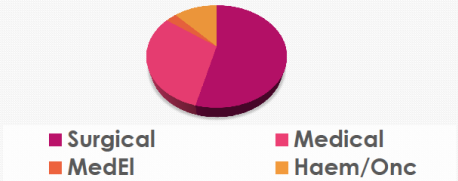


Figure 2 - Mobile Phone Use Per Specialty



Conclusions

- Reliance upon mobile phones has emerged as bleep designation is not meeting requirements particularly amongst surgical specialties.
- The central drop-off point for bleeps has been a successful pilot amongst interns.
- Review of inter-hospital communications is a valuable process improvement.

An Electronic Handover System for Weekend Review of Hospital Inpatients

Dr Lucy Chapman[1], Dr Oisin Hannigan[1], Dr Suzanne Roche[1]
In collaboration with Elizabeth Slattery[2]; Dr Grainne Courtney[3]; Dr Una Geary[4]; Dr Audrey Rice[5]; Dr Grace Kavanagh[5]

[1]Lead NCHDs, St. James's Hospital, Dublin
[2]IMS Department, St. James's Hospital, Dublin
[3]CCIO, St. James's Hospital, Dublin
[4]Quality and Safety Improvement Directorate, St. James's Hospital, Dublin
[5]Medical Registrars

Objectives
Clinical Handover is defined as "the transfer of professional responsibility and accountability for some or all aspects of care for a patients or group of patients to another person or professional group". We aimed to replace the informal paper-and-pen weekend patient handover process to the on-call registrars with an electronic handover system to handover inpatients. This aimed to facilitate safe patient care by increasing the quality and efficiency of weekend review. Furthermore, an anecdotal increase in weekend reviews was reported and the new system facilitated objective auditing of the on-call workload

Methods
A collaborative and iterative design phase was embarked upon between Lead NCHDs, the Chief Clinical information Officer and the Information Management Services department at St. James's Hospital. Two computerized provider order entries (CPOEs), for weekend handover of medical and medicine for the elderly inpatients respectively, were designed in the existing electronic medical record system. Weekend review requests are accessed by on-call registrars via an electronic message pool. A verbal handover meeting each Friday supports the electronic process. Training and implementation of the new system was delivered by Lead NCHDs.

Results
Electronic weekend review handover was successfully launched on Friday 26/01/2018. Handover meetings occur each Friday in both the medial and medicine for the elderly departments. Barriers included digital naivety of staff and difficulties for NCHDs being able to attend the verbal handover meeting. Notable enablers are the Medicine for the Elderly consultants who consistently attend the verbal handover meeting.

Conclusions
Electronic patient handover facilitates consistent, documented, transparent handover. Verbal discussion supports this process and consultant support has enabled training opportunities to arise. Our initiative's principals are transferrable and are valuable given the challenges posed by NCHD shift changeover.

An Electronic Handover System for Weekend Review of Hospital Inpatients

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St James's Hospital, Dublin

Introduction

Clinical Handover is defined as "the transfer of professional responsibility and accountability for some or all aspects of care for a patients or group of patients to another person or professional group". We aimed to replace the informal paper-and-pen weekend patient handover process to the on-call registrars with an electronic handover system to handover inpatients. This aimed to facilitate safe patient care by increasing the quality and efficiency of weekend review. Furthermore, an anecdotal increase in weekend reviews was reported and the new system facilitated objective auditing of the on-call workload.

Methods

Two electronic orders for weekend handover of medical and medicine for the elderly inpatients respectively, were designed in the existing electronic medical record system (Fig.1). Weekend review requests are accessed by on-call registrars via an electronic message pool. A verbal handover meeting each Friday supports the electronic process.

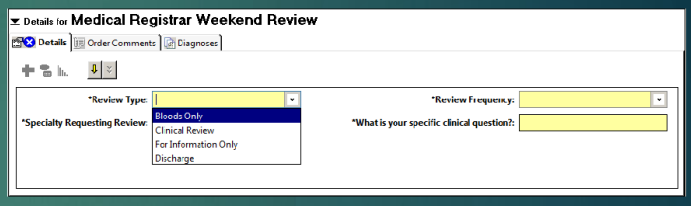


Figure 1 - Electronic Order Weekend Review

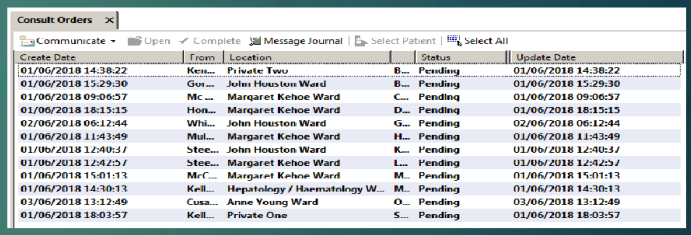


Figure 2- Electronic Pool for Weekend Review

Results

- Electronic weekend review handover was successfully launched on Friday 26/01/2018.
- Handover meetings occur each Friday in both the medial and medicine for the elderly departments.
- NCHDs positively remark on the closed loop communication system.
- Barriers included digital naivety of staff and difficulties for NCHDs being able to attend the verbal handover meeting.
- Notable enablers are the Medicine for the Elderly consultants who consistently attend the verbal handover meeting.

Conclusions

- Electronic patient handover facilitates consistent, documented, transparent handover.
- Verbal discussion supports this process and consultant support has enabled training opportunities to arise.
- We are awaiting access to data from the handover CPOE to objectively analyse the process improvement.
- Data from the medical CPOE will inform the direction of future resource distribution.
- Our initiative's principals are transferrable and are valuable given the challenges posed by NCHD shift changeover.

Farewell to the Radiology Discussion Queue

Lucy Chapman[1], Oisin Hannigan[1]John Campion[1]
In collaboration with Dr Charles Sullivan[2], Dr Doug Mullholland[2], Dr Niall Sheehy[2]
[1]Lead NCHDs, St. James's Hospital, Dublin
[2]Radiology Department, St. James's Hospital, Dublin

Objectives

Anecdotally significant NCHD time was spent in the discussion queue for inpatient radiology scans. This initiative's aim was to establish electronic vetting for inpatient radiology scans in order to maximise the efficiency of NCHD time.

Methods

An audit was undertaken during a working week in October 2017 which revealed that a total of 174 scans were discussed on inpatients. This resulted in 24.5 hours of NCHDs' time being spent waiting in the verbal discussion queue. Collaboration between Lead NCHDs and the Radiology Department allowed the appraisal of an electronic vetting process that delivered effective management and organisation of the inpatient radiology workload whilst ensuring visibility of radiology vetting outcome. Communication of the impending change was delivered by Lead NCHDs with radiology Specialist Registrars at various teaching sessions across the hospital.

Results

The initiative has been a resounding success since its launch in February 2018. Scans are vetted more efficiently by radiology registrars. NCHDs no longer wait in the verbal discussion queue each morning and are available for other clinical duties and ward round participation. Communication of the process has been incorporated into incoming NCHD induction to ensure sustainability.

Conclusions

Electronic vetting for inpatient scans offers value in terms of NCHD time efficiency both NCHDs within the radiology department and those on inpatient ward duties. The seamless integration of electronic radiology vetting was enabled by a strong institutional appetite for increased efficiency.

FAREWELL TO THE RADIOLOGY DISCUSSION QUEUE

Lead NCHDs: Lucy Chapman, Oisin Hannigan
Collaborators: Dr Charles Sullivan, Dr Doug Mullholland, Dr Niall Sheehy
Site: St. James's Hospital, Dublin

Background

The radiology discussion queue is a rite of passage in St. James's Hospital. However, anecdotally significant NCHD time was spent in the discussion queue for inpatient radiology scans.

Methods

In October 2017, an audit over the course of one week revealed that 24.5 hours of NCHDs' time being spent waiting in the verbal discussion queue (Fig.1) equating to a total of 174 inpatient scans being discussed (Fig.2).

Figure 2 - Number of Scans

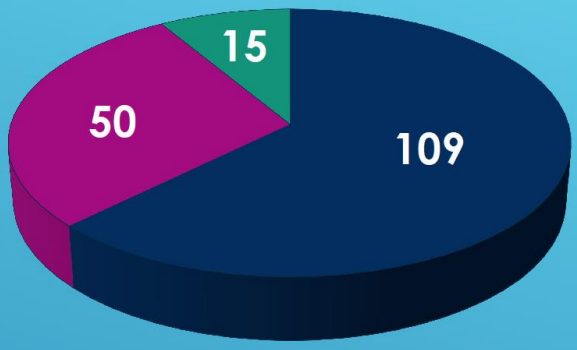
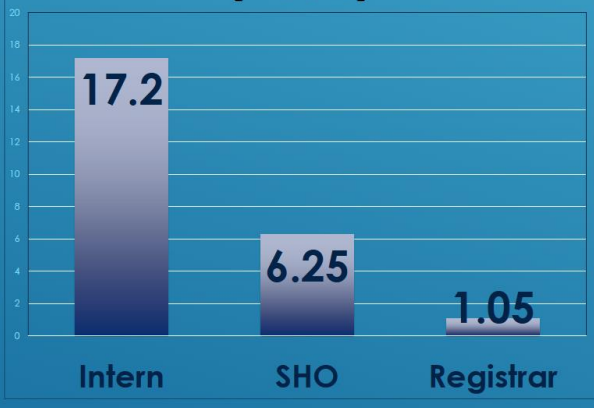


Figure 1 - Time/Week (hours)



Implementation

In February 2018, electronic radiology vetting was successfully launched. Lead NCHDs facilitated training and education for the change in conjunction with Radiology Registrars.
Radiology electronic vetting has resulted in increased efficiency for the radiology department, inpatient NCHDs and hospital inpatients.

Conclusions

- Successful seamless adoption of electronic radiology vetting was driven by an institutional desire to be more efficient and time effective
- Electronic clinical information systems offer a valuable resource for streamlining inpatient care
- This Lead NCHD initiative is an illustrative example of cross-departmental inter-institutional collaboration

Sharing of Tasks – A Prospective NCHD-Focused Review of Medical Task Reallocation

Lucy Chapman[1]
In collaboration with Dr Domhnall McGlacken Byrne[2], Dr Declan Byrne[3]
[1]Lead NCHD, St. James's Hospital, Dublin
[2]Intern Doctor, St. James's Hospital, Dublin
[3]Medical Consultant, St. James's Hospital, Dublin

Objectives
The Sharing of Tasks (SofT) initiative (also known as Transfer of Tasks) involves the transfer of phlebotomy and cannulation tasks from NCHDs to nurses in acute Irish hospitals[1]. It aims to facilitate timely patient interventions. We aimed to quantify the number of tasks performed by intern doctors and to provide a cost-benefit analysis to support the ongoing SofT initiative.

Methods
The number of phlebotomy and cannulation tasks per hospital ward performed by NCHDs over two distinct three-week period from September 25th to October 15th 2017 and March 5th to March 25th 2018 was prospectively gathered. Average times per task were obtained using observational methods. Point prevalence analysis of nurse training rates was performed at the end of data collection. Wards not involved in the SofT initiative were excluded.

Results
18 wards were included in the study. Total number of tasks performed by intern doctors (n=34 Round 1; n=42 Round 2) were 850 and 790 for Round 1 and Round 2 respectively. Average times per task were 10 minutes and 15 seconds (SD 5 minutes and 51 seconds) per phlebotomy task and 11 minutes and 8 seconds (SD 3 minutes and 11 seconds) per cannulation task respectively. Nursing training rates were correlated with number of tasks performed by intern doctors.

Conclusions
This initiative engaged the local SofT steering group in a positive way promoting communication and dialogue. Formal time and cost analysis of the data will be performed to provide a robust business case for the continued support of the SofT roles within the hospital. This initiative should be transferred to other hospital sites to allow information on SofT to be prospectively obtained. Currently progress reports on SofT typically relate to nurse training rates alone which does not reflect the full complexity and interdisciplinary integration demanded by the initiative.

Sharing of Tasks – A Prospective NCHD-Focused Review of Medical Task Reallocation

Lucy Chapman
In collaboration with Dr Domhnall McGlacken Byrne, Dr Declan Byrne
St. James's Hospital, Dublin

Background

The Sharing of Tasks (SofT) initiative (also known as Transfer of Tasks), involves the transfer of phlebotomy and cannulation tasks from non-consultant hospital doctors (NCHDs) to nurses in acute Irish hospitals. It aims to facilitate timely patient interventions and was first enacted in 2016. St. James's Hospital, Dublin instigated the process in May 2017 with a local implementation team delivering standardized training.

Methods

The number of phlebotomy and cannulation tasks per hospital ward performed by NCHDs over two distinct three-week period from September 25th to October 15th 2017 and March 5th to March 25th 2018 was prospectively gathered. Average times per task were obtained using observational methods. Point prevalence analysis of nurse training rates was performed at the end of data collection.

Figure 1 - Number of Tasks

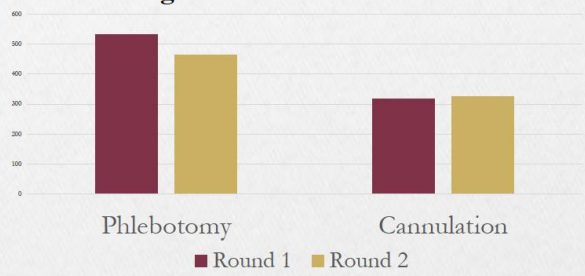
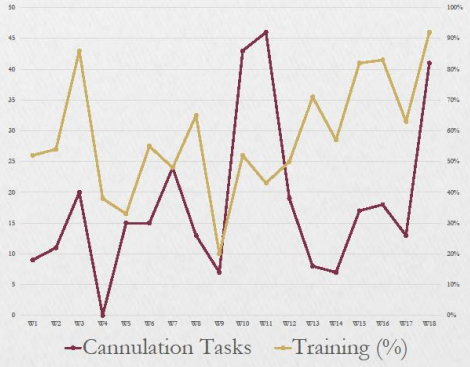


Figure 2 - Training Rates and Cannulation Tasks by Ward



Results

18 wards were included. Total number of tasks performed by intern doctors was 850 (Phlebotomy n=532, Cannulation n=318) and 790 (Phlebotomy n= 464, Cannulation n=326) for Round 1 and Round 2 respectively (Fig. 1). Average time spent by an intern doctor over a three-week period was 85.08 hours and 59.73 hours for phlebotomy and cannulation tasks respectively. Training rates per ward were also correlated with number of tasks performed by intern doctors (Figure 2 for cannulation).

Conclusion

Currently progress reports on SofT typically relate to nurse training rates alone which does not reflect the full complexity and interdisciplinary integration demanded by the initiative.
This study concept could be transferred to other hospital sites to allow information on SofT to be prospectively obtained and to provide a robust business case for the ongoing national support of the SofT initiative.

Guided Meditation App for Doctors: A Pilot Study

John Campion, Oisin Hannigan
Lead NCHDs St James' Hospital

Objectives:

We aimed to improve doctor wellbeing by piloting a mindfulness app amongst doctors in St James's Hospital. Its utility would then be measured using pre and post surveys and the usage data generated. This data will be used to see whether these doctors benefited from it and if it should be expanded locally and nationally.

Implementation:

A small preliminary trial was performed amongst a small group of NCHDs (~30) and feedback was positive. Following this and extended discussion with Headspace 150 licenses were provided for a three month period, as well as promotional materials and access to an engagement manager to help with rollout. The initiative was launched via email to all doctors in late May. A small survey was needed to be completed to gain access to the app.

Measured outcomes:

As of 5/6/18 132 doctors have completed the survey and signed up. Survey responses were captured in Survey Monkey, and anonymous usage statistics are emailed to a dedicated email account on a regular basis (every second day) from Headspace. Most have some experience of guided meditation and hope to engage in guided mediation at least twice a week. The commonest reason people gave for not meditating is lack of time, and many commented the app would allow this to do so whenever suited them. User engagement so far is high in a short span of time. Following the completion of the three month trial all participating doctors will be emailed a follow up questionnaire.

Sustainability:

The data collected from this study can hopefully be used to see if it helped doctors and whether it would be beneficial to provide this at a local and national level on an ongoing basis.

Potential transfer to other sites:

The app is accessible to anyone with a smartphone, so it can easily be implemented anywhere if effective

Guided Meditation App for Doctors: A Pilot Study

Lead NCHDs: John Campion and Oisín Hannigan,
Collaborator: David Sweeney
St James's Hospital

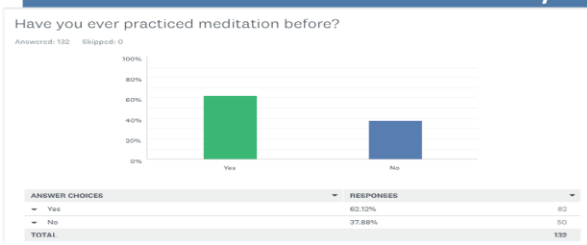
The Idea

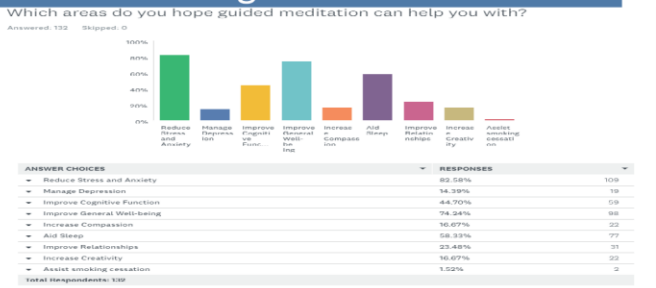
- Employee wellbeing is incredibly important and the HSE is emphasizing in particular the importance of mental wellbeing amongst its employees
- Mindfulness and guided meditation are an emerging field with a growing body of evidence to suggest that they are beneficial to us
- Many different forms of engaging in mindfulness are available, however NCHDs often find it hard to engage in organised activities for wellbeing due to rosters and regularly engaging in unscheduled overtime
- We performed a small pilot study with 30 nchds with the app "Headspace" which gave us positive feedback to trial the app on a much larger scale amongst consultants and NCHDs

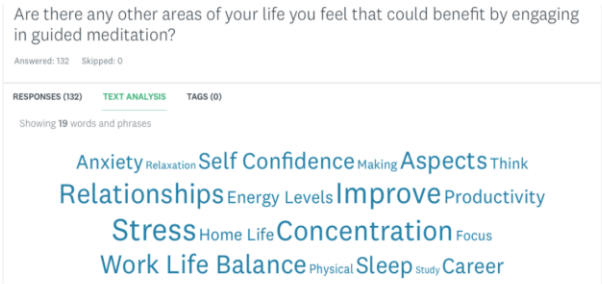
Implentation

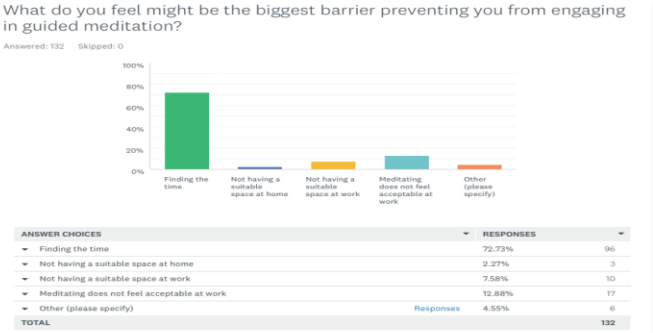
- Headspace were contacted and following extensive negotiation a three month subscription for 150 was agreed
- Headspace also provided anonymous usage data for the duration of the trial, as well as promotional literature and a campaign manager to help with implementation
- The National Doctors Training Programme agreed to cover the cost of this pilot programme (€3000) with a view to seeing its potential to be implemented on a larger scale
- In May 2018, all doctors in St James were emailed a short survey, which upon completion they received a code with 3 months of access to the complete app for free
- As of the 5th of June 2018 132 doctors have completed the survey, with many actively using headspace

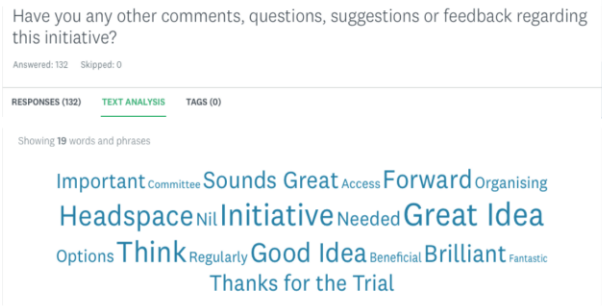
Selected Survey Results and Usage data

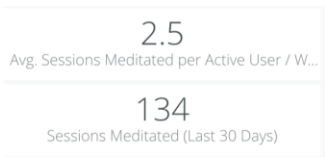












Going Forward

- To help with engagement biweekly email reminders are sent to doctors.
- We have also placed promotional materials, posters and calendars in the res and around the hospital
- Once the three month trial is completed, all participants will be emailed a further trial to gauge their engagement with the app, and to provide feedback
- Should our usage data and engagement prove that this is a worthwhile endeavor, this is something that could easily be rolled out at a national level with appropriate funding.

Anti-Bullying Awareness in NCHDs

Dr Mohammad Kashif
Lead NCHD, Drogheda Department of Psychiatry

Background

Bullying at work place is a behaviour "which is repeated", verbal or non-verbal, shown by one or more people at work place, that undermines the "individual's right to dignity" whilst they are working[1]. One in three of the trainee doctors reported to have experienced bullying of some form through their training period[2,3], however, over 50% of doctors witnessed bullying at their work place[2]. On the other hand, 22% of doctors and dentists in NHS England reported bullying in the staff survey in 2016[4], compared to 8% of the respondents reporting bullying in General Medical Council Survey in 2014[5].

Objectives

Bullying at work place is addressed by "Dignity At Work Policy" and a copy of it is available from Human Resource Department of the hospital. Lack of awareness in NCHDs of the exact definition and context of bullying and formal complaint procedures were shortfalls identified.

Methodology

Anti-Bullying awareness poster was designed that included definition of bullying in its simplest form and poster to be visible in NCHD rooms at different locations. This poster was introduced on induction day of NCHDs in January 2018 with details provided for support contact person and complaint procedure. A survey was conducted to measure the effectiveness of poster and that if NCHDs are now better informed.

Outcome

This resulted in marked increased awareness with 100% of NCHDs knowing who to contact if required compared to 40% before the campaign. Similarly, NCHDs showed better understanding of what constitutes bullying which is increased from 80% to 100%.

Transferability

This poster can be used in other hospitals for Anti-Bullying awareness/education of NCHDs with site specific contact details of support person. The cost effectiveness of the project is invaluable with optimum results involving printing cost of A3 poster only.

Acknowledgement: I would like to acknowledge Dr Fionn Kelly, Consultant Psychiatrist and Clinical Supervisor, and Human Resource Department for their support and input.

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[1] Health and Safety Authority Bullying – Employee perspective. Health and Safety Authority, 2018

[2] Irish Medical OrganisationIMO joins with HSE and Irish Postgraduate Training Forum to launch anti-bullying campaign. Irish Medical Organisation. News and Press release, 2017.

[3]Kavanagh.P and O'Hare.S. A safe place to work and learn? Trainee-reported perceptions of bullying behaviour in the clinical learning environment in Ireland. Irish Medical Council, 2014.

[4] British Medical Association. Workplace bullying and harassment of doctors, a review of recent research. British Medical Association, 2017.

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Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

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Objectives

Bullying at work place is addressed by "Dignity At Work Policy" and a copy of it is available from Human Resource Department of the hospital. Lack of awareness in NCHDs of the exact definition and context of bullying and formal complaint procedures were shortfalls identified.

Barriers

- No contact support person
- Lack of awareness about bullying
- Lack of awareness of policy and procedures
- Accessibility of the policy

Initiatives

Anti-bullying awareness poster included:

- Definition of bullying in its simplest form and is easily understandable
- Support contact person details agreed with HR Department to be displayed on the poster
- Poster to be visible in NCHD rooms at different locations
- The poster to be introduced on induction day of NCHDs in January 2018

A survey to measure the effectiveness of poster and that if understanding of NCHDs is increased.

Results

Before Poster Awareness:

- 80% of NCHDs were aware what constitutes bullying
- 40% of NCHDs knew whom to contact

After Poster Awareness:

- 100% of NCHDs had better understanding of bullying
- 100% of NCHDs knew whom to contact

Recommendations

- This poster can be used in other hospitals for Anti-Bullying awareness/education of NCHDs with site specific contact details of support person.
- The cost effectiveness of the project is invaluable with optimum results involving printing cost of A3 poster only.

References

1. Health and Safety Authority. Bullying – Employee perspective. Health and Safety Authority, 2018.
2. Irish Medical Organisation. IMO joins with HSE and Irish Postgraduate Training Forum to launch anti-bullying campaign. Irish Medical Organisation. News and Press release, 2017.
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Positive Presentations in Portiuncula

Ciara McCormick[1], Bryony Treston[1], Claire Murphy, Sinead Flynn, Marita Fogarty, Kiren Govender
[1]Lead NHCDs, Portiuncula Hospital

Objectives

Research is the fundamental foundation that underpins our current practice. Through research and audit, current practice is challenged, and patient outcomes can be evaluated and enhanced. Current practices can be strengthened, and new ways of working emerge.

Our objective was to create an opportunity for all staff to share learning and continue to improve patient centred care; optimise service delivery and strive to ensure best practice healthcare.

Implementations

This event revived huge support from nursing and medical management as well as from the hospital research committee. The 'Ballinasloe Bake Off' was incorporated into the day to make the event more accessible and attractive to NCHDs and other hospital staff who did not have a piece of research to submit. This was judged by the catering staff from the hospital canteen. The bake off helped to entice more spectators to the event as well as creating a friendly, festive atmosphere

Outcomes

The Inaugural Research and Audit Event on the 15th December 2017

There were 28 submissions for poster displays and 9 oral presentations. There was representation from nursing, medicine, surgery, obstetrics, paediatrics, emergency medicine, physiotherapy and pharmacy.

All participants received a certificate of participation and trophies were awarded to the best oral and poster presenters.

Sustainability

Poster boards have been erected in the hospital corridors to display the work presented at the research day. The second annual research day is due to be held this year on November 30th. By participants completing their valuable research we hope that this will encourage other staff to engage in research projects next year.

Potential transfer to other sites

Plans to extend the initiative to include nearby GPs and hospitals are already underway. This event could be easily transferred to other sites.

Positive Presentations in Portiuncula

McCormick C[1], Treston B[1], Murphy C, Flynn S, Fogarty M, Govender K

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This event revived huge support from nursing and medical management as well as from the hospital research committee

An NCHD bake off was held during the Research day to provide sustenance to the poster viewers. Representatives from the kitchen kindly attended the day as expert judges

Dr Cahill, Dr Neenan, and Dr Curan enjoying the posters

Presenters Aiden Fallon and Dr Hock with their trophy

The Inaugural Research and Audit Event on the 15th December 2017
There were 28 submissions for poster displays and 9 oral presentations. There was representation from nursing, medicine, surgery, obstetrics, paediatrics, emergency medicine, physiotherapy and pharmacy.

All participants received a certificate of participation and trophies were awarded to the best oral and poster presenters.

Staff attending the afternoon oral presentations

Poster boards have been erected in the hospital corridors to display the work presented at the research day. The second annual research day is due to be held this year on Novmber 30th. By participants completing their valuable research we hope that this will encourage other staff to engage in research projects next year.

Workplace morale and staff relationships are improved with shared facilities: A happy accident

[1]Dr. Sarah Marie Nicholson, Dr. Una Conway
[1]Lead NHCD, University Hospital Galway

There has been an increase in emigration of healthcare staff. Poor working conditions leading to poor morale is cited as one of the main reasons to leave Ireland. There is a goal to improve the wellbeing of staff, working environment, and morale of those within the HSE.

A refurbishment of the gynaecology residence in University Hospital Galway had led to temporary shared res space between doctors, nursing, midwifery, and other staff. Whilst physical space has not been plentiful, there is an anecdotal improvement in staff relationships. The aim of this study was to assess whether shared res space improved attitudes and morale within the workplace.

In order to fully examine this and whether it may play a part in improving the workplace environment, a questionnaire was created. This assessed attitudes, interpersonal relationships between staff, and general morale. A total of 20 questionnaires (Fig1) were handed out to staff who were directly affected by the res arrangement. The distribution is illustrated graphically (Chart 1).

The results concluded that the overall response was positive. Negative, positive and neutral feedback data are demonstrated graphically in Charts 2, 3 and 4 respectively. Overall 90% would continue using shared facilities (Chart 5). A word cloud (Fig 2) demonstrates the most frequent feedback themes.

Improving the working conditions and morale is no small task, however some reasonably achievable goals such as availability of a shared res between staff may improve relationships. Negative written feedback addressed cramped space and facilities. The ability of all staff to socialise outside of the ward may lead to less friction, and an overall supportive workplace, as well as minimising the ‘us and them’ approach within the working environment.

Workplace morale and staff relationships are improved with shared facilities

A happy accident

Dr. Sarah Marie Nicholson, Dr. Una Conway

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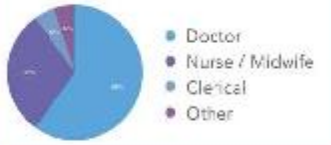
The distribution is illustrated graphically in Chart 1.

Figure 1

Chart 1: Respondents



Results

The results concluded that the overall response was positive.

Negative, positive and neutral feedback data are demonstrated graphically in Charts 2, 3 and 4 respectively. Overall 90% would continue using shared facilities.

A word cloud (fig 2) demonstrates the most frequent feedback themes.

Chart 2: Negative Feedback

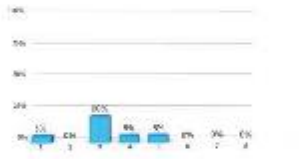


Chart 3: Positive Feedback

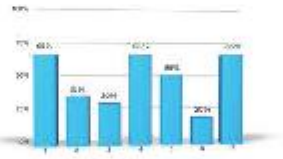


Chart 4: Neutral Feedback

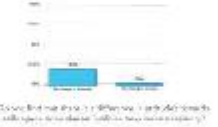
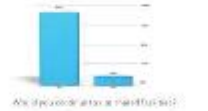


Chart 5: Continued Use



Conclusions

Improving the working conditions and morale is no small task, however some reasonably achievable goals such as availability of a shared res between staff may improve staff relationships.

Negative written feedback addressed cramped space and facilities.

The ability of all staff to socialise outside of the ward may lead to less friction, and an overall supportive workplace, as well as minimising the 'us and them' approach within the working environment.

The "Network and Learn" Sessions: The NCHD GP Leads' Educational Sessions

Dr. Maitiú Ó Tuathail CH0 7, Dr. Ahmeda Ali CH0 5
Dr. Máirtín Ó Maoláin CHO 2, Dr. Olivia Murphy CHO 6
NCHD GP LEADS

Introduction

Traditionally few opportunities exist for GP Registrars to meet Registrars on other GP Training schemes. No forum exists whereby GP Trainees can organise their own teaching sessions to address topics that would normally not be covered by the GP curriculum.

Objectives

1. To provide GP Registrars with the opportunity to get to know Registrars on other schemes and to meet them on a regular basis.
2. To allows GP Registrars get exposure to topics that would not traditionally be covered in the GP curriculum.

The Sessions

Format: 50% Educational: 50% Networking.

GP Leads Working Together

The four GP Leads worked together to organise each session. Weekly conference calls and bimonthly meetings occurred in each of the Leads' CHOs. The meetings allowed the GP Leads to get to know one another and form collaborative working relationships which crossed over into other projects.

Transfer to Other Sites

The plan for the future is for the sessions to occur on a monthly basis in venues across the country. Each GP Lead will host a session in their CHO, with the support and input of their co-Leads.

Session 1

The first educational session occurred on the 21st of April. There were 30 trainees in attendance. Dr John Cullen discussed the new GOLD guidelines and Dr Deirdre Waterhouse discussed the management of heart failure. Feedback was universally extremely positive.

Session 2

The second session occurred on the 21st May and over 70 trainees attended. The event was titled "The Business Side of General Practice" and speakers included solicitors, accountants and financial planners who gave advice to GPs on setting up in general practice. Trainees also heard from 2 GPs who had recently set up in practice.

Conclusion

The sessions have addressed two problems which GP Registrars have identified with their training successfully.

The "Network and Learn" sessions

The NCHD GP Leads Educational Sessions

Dr. Maitiú Ó Tuathail, Dr. Ahmeda Ali

Dr. Máirtin Ó Maoláin, Dr. Olivia Murphy

NCHD GP LEADS

Introduction

Traditionally few opportunities exist for General Practice Registrars to meet their counterparts on other GP training schemes.

There are currently 14 GP training schemes, separated geographically, in which all training is delivered.

There is no forum whereby GP trainees can organise their own teaching sessions to address topics that would normally not be included on the General Practice curriculum.

GP Leads Work Together

The four NCHD GP Leads worked together to ensure each educational session succeeded.

Weekly conference calls took place with bimonthly face-to-face meetings in each of the Leads' CHOs.

The frequent meetings allowed the GP Leads to get to know one another and form collaborative working relationships which crossed over into other projects.

Teamwork was key.

Session 1

The first educational session occurred on the 21st of April.

There were 30 trainees in attendance from 5 different schemes.

Dr John Curley from Tallaght discussed the new GOLD guidelines and Dr Deirdre Waterhouse of the Blackrock Clinic discussed the management of heart failure in the community.

Feedback was universally positive, with all attendees rating the session as highly worthwhile and beneficial.

Objectives

To provide General Practice Registrars with the opportunity to get to know GP Registrars on other schemes and to meet them on a regular basis.

To allow General Practice Registrars to get exposure to topics that would not traditionally be covered on the General Practice curriculum.

To be fun and enjoyable experiences.

Session 2

The second session occurred on the 21st May and over 78 trainees from right across the country attended the event.

The event was titled "The Business Side of General Practice" and speakers included solicitors, accountants and financial advisors who gave advice to GPs on setting up in general practice

Trainees also heard from 2 GPs who had recently set up in practice.

Educational Sessions

It was decided to organise monthly sessions, using the format of the CME meetings that GPs attend once qualified for CPD.

It was agreed the format would be 50% educational and 50% networking.

The ICGP lended their support to the idea and provided for administrative back up as required.

Transfer to Other Sites

The plan for the future is for the GP networking and educational sessions to continue to occur on a monthly basis.

The location will change month by month and the plan is for the sessions to take place in venues across the country.

As more NCHD Leads are recruited to GP, each Lead can host a session in their own CHO.

Conclusion

The GP Networking and Educational Sessions have addressed two problems which GP Registrars have identified with their training.

It allows GP Registrars to meet Registrars from outside of their scheme on a regular basis, providing a valuable networking opportunity for them.

It provides Registrars with exposure to topics that would normally not be included in the GP training curriculum

The GP Registrar Out of Hours Experience

Dr Ahmeda Ali, Dr Olivia Murphy, Dr. Máirtín Ó Maoláin, Dr. Maitiú Ó Tuathail
GP Registrar Leads

Aim:

To assess the GP registrar experience of and attitude towards the out of hours system and requirements while training.

Background:

As part of the GP training scheme each trainee must complete 120 hours in an out of hours setting. This can be in the local co-operative run by local GPs, it can be in-house in a practice that offers appointments outside of the normal 9-5 schedule or it can be in varying other forms such as the doctor on duty on the bus run by Safety Net which provides emergency medical care to the homeless services in Dublin. Anecdotally GP trainees find that the standard of the supervision and training during this time can vary.

Methods:

A survey was designed through the Survey Monkey website, the questions were piloted with a number of GP registrars and then the final survey was sent to all GP registrars.

Results:

100 GP trainees responded to the survey, 57 from 3rd year and 43 from 4th year. The trainees felt in general that the supervision was appropriate and good for learning, especially the case based discussions. The out of hours experience was helpful in developing clinical and organisational skills. The systems in general were easy to navigate with appropriate access to clinical rooms and equipment. The trainees felt however that the log books did not contribute to the learning or accurately capture the experience. 80% of trainees felt that 120 hours was a superfluous number to have to achieve in a year.

Conclusion:

GP registrars value their time in out of hours from the point of view of clinical learning but the current requirement of 120 hours is not necessary. This research will be presented to the ICGP, Post Graduate Training Committee and also to the National Co-Ordination Committee for Training.

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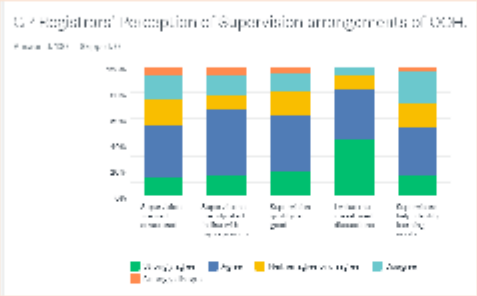

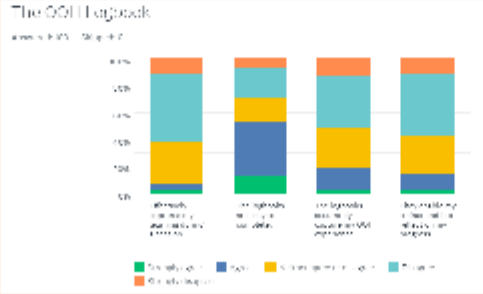

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The trainees felt however that the log books did not contribute to the learning or accurately capture the experience. 80% of trainees felt that 120 hours was a superfluous number to have to achieve in a year.

Regarding Out of Hours:
"Difficult to achieve in many parts of the country and low yield educationally"
"30 x 4hr shifts is incredibly difficult to fit in when also working full time and competing with other regs for shifts. "
"very repetitive and similar to daytime consultations"

Conclusion:
GP registrars value their time in out of hours from the point of view of clinical learning but the current requirement of 120 hours is not necessary.
This research will be presented to the ICGP, Post Graduate Training Committee and also to the National Co-Ordination Committee for Training.

The hospital discharge experience in primary care and introduction of national discharge recommendations

Dr Olivia Murphy, Dr Ahmeda Ali, Dr. Máirtín Ó Maoláin, Dr. Maitiú Ó Tuathail
GP Registrar Leads

Aim:
To assess issues experienced by GPs regarding discharge summaries and prescriptions from hospitals. To develop an information sheet to be included in intern packs at induction nationwide to improve the communication at discharge and reduce risk.

Background:
One of the most dangerous times for a patient is the transition between in-patient care and community care (1). The most common source of unsafe care is medication-related incidents (1) which cause significant morbidity and mortality (2), of these the most prevalent are medication omissions (3). In order to reduce this risk, good inter disciplinary collaboration and communication between hospital doctors, GPs and pharmacists is crucial (3, 4). Eliminating paper prescriptions has also been shown to reduce risk (3,4).

Methods:
A survey was sent to all GP registrars to assess the frequency and nature of issues they experience regarding hospital discharge summaries and prescriptions. The survey was both qualitative and quantitative. Based on the survey results a document was drawn up for distribution (via the NCHD Lead NCHD/NDTP Fellow) to all interns at induction in July.

Results:
100 survey responses; 11 from 2nd year, 47 from 3rd year and 42 from 4th year. There was a spread of responses from all 14 training schemes. 93% encountered issues with hospital discharges at least monthly. 94% came across discharge prescription inaccuracies, medication omission was the most common. 64% contacted hospital teams monthly or more regularly regarding discharges and 69% said contact is mainly regarding medication clarification.

Conclusion:
Issues with communication are common at transition from hospital to community care, this puts patients at risk. In highlighting to interns the most important points to include in a discharge summary and prescription we hope to reduce this risk. The survey will be repeated in 1 year to assess if the recommendations resulted in improved communication.

1. Cooper A, Edwards A, Williams H et al. Sources of unsafe primary care for older adults: a mixed-methods analysis of patient safety incident reports. Age Ageing. 2017. 1;46:833-839.
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4. Ensing HT, Koster ES, van Berkel PI et al. Problems with continuity of care identified by community pharmacists post-discharge. J Clin Pharm Ther. 2017. 42:170-177

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Dr Olivia Murphy, Dr Ahmeda Ali, Dr. Máirtín Ó Maoláin, Dr. Maitiú Ó Tuathail

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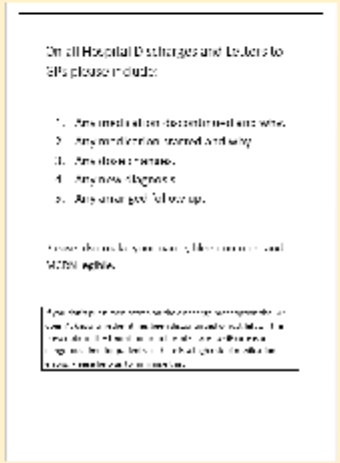

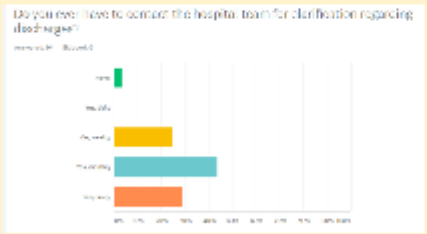

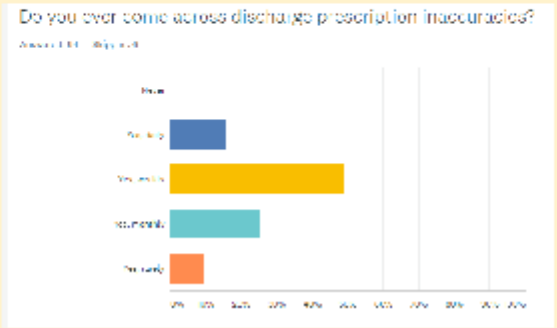

Results:
100 survey responses; 11 from 2nd year, 47 from 3rd year and 42 from 4th year. There was a spread of responses from all 14 training schemes.
93% encountered issues with hospital discharges at least monthly. 94% came across discharge prescription inaccuracies, of which medication omission was the most common. 64% contacted hospital teams monthly or more regularly regarding discharges and 69% said contact is mainly regarding medication clarification.

"If a medication is not on the script, or if a dose is different, I cannot tell if that is intentional or an error"

"Medications or diseases changed during hospital admission but no mention of changes on discharge summary or prescription so very difficult to clarify what patient should be on"

Conclusion:
Issues with communication are common at transition from hospital to community care, this puts patients at risk. In highlighting to interns the most important points to include in a discharge summary and prescription we hope to reduce this risk. The survey will be repeated in 1 year to assess if the recommendations resulted in improved communication.

Treating the Fever: A Focus on NCHD Wellbeing in the UL Hospital Group

Maria Costello, Peter O Reilly, Aisling O'Riordan, Michelle Canavan
NCHD Co-Lead UL Hospital Group

Background

Former UL Hospital Group Lead NCHDs undertook a survey of the NCHDs across all disciplines entitled "Taking the Temperature." This survey aimed to identify the main issues for NCHDs locally and several areas were highlighted.

Objectives

We aimed to address the issues highlighted in the NCHD survey, focusing on three key areas: wellbeing, career development and communication.

Implementation

Employee Wellbeing

An evening was held to discuss work-life balance and employee burnout. Later in the year we organised a wellbeing evening with speakers from occupational health, the Practitioner Health Matters Programme and experienced UL Hospital Group consultants. In conjunction with the occupational health department, we drafted an employee handout on supports available to NCHDs experiencing work-related stress or mental health issues.

Career Development

In order to focus on NCHDs in non-training posts we organised a careers evening where specialist registrars and consultants across various specialities discussed future career options with NCHDs. We convened interview skills workshops for those progressing to higher specialist training posts.

Communication

We ensured NCHD representation on all the key hospital committees. This has contributed to a number of positive outcomes including restructuring of the drug kardex, development of QI and Audit support for NCHDs with drop-in support clinics, training of NCHD hand hygiene champions, restructuring of NCHD induction and development of IT eReferral systems.

Sustainability and Transferability

We have put in place a framework that can be built on by future Lead NCHDs and many of these projects can be repeated in other sites.

Outcome and Conclusions

Through our lead NCHD role, specific changes based on the needs of NCHDs were implemented. These encompassed a spectrum of sustainable initiatives that will improve the working environment within the group. Currently we are measuring the impact of these changes by repeating the "Taking the Temperature" survey.

TREATING THE FEVER: A FOCUS ON NCHD WELLBEING IN THE UL HOSPITALS GROUP

Maria Costello, Peter O Reilly, Aisling O'Riordan, Michelle Canavan

Lead NCHDs UL Hospitals Group 2016 to 2018

Background

Former UL Hospital Group Lead NCHDs undertook a survey of the NCHDs across all disciplines entitled "Taking the Temperature." This survey aimed to identify the main issues for NCHDs locally and several areas were highlighted.

Objectives

We aimed to address the issues highlighted in the NCHD survey, focusing on three key areas:

- Wellbeing
- Career development
- Communication

Plan

Specific	• Key themes to improve NCHD satisfaction identified
Measurable	• Repeat survey looking at contributors to workplace stress following initiation of specific events
Achievable	• Specific changes through NCHD events addressing key themes
Realistic	• Draw on available resources within the hospital group
Timed	• Over course of lead NCHD role 2017-2018

Implementation

Employee Wellbeing

An evening was held to discuss work-life balance and employee burnout. Later in the year we organised a wellbeing evening with speakers from occupational health, the Practitioner Health Matters Programme and experienced UL Hospital Group consultants.

In conjunction with the occupational health department, we drafted an employee handout on supports available to NCHDs experiencing work-related stress or mental health issues.

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Career Development

In order to focus on NCHDs in non-training posts we organised a careers evening where specialist registrars and consultants across various specialities discussed future career options with NCHDs.

We convened interview skills workshops for those progressing to higher specialist training posts.

Transferability

Many of these projects can be repeated in other sites. We are happy to share our experiences with future Lead NCHDs.

Sustainability

We have put in place a framework that can be built on by future Lead NCHDs.

Next year the schedule of NCHDs events can be repeated and expanded further.

We have collected information on all the committees with NCHD members and we will share this with the next NCHD Leads to ensure continuity of NCHDs on these committees.

Outcome and Conclusions

Through our lead NCHD role, specific changes based on the needs of NCHDs were implemented encompassing a spectrum of sustainable initiatives that will improve the working environment within the group. Currently we are measuring the impact of these changes by repeating the "Taking the Temperature" survey.

Acknowledgements: Many thanks to Deirdre King De Montano and Professor Paul Burke

Incident reporting and the trainee

Dr Mohammed Elbadry Ali
Lead NCHD Mayo University Hospital

Aim and background

Incident reporting though poorly named is one of the pillars are of patient safety. Non-Consultant Hospital Doctors (NCHDs), while actively involved in patient care contribute minimally to incident reporting overall. This study evaluated NCHD knowledge of the incident reporting process and undertook an education module

Methods

All NCHDS at Mayo University Hospital were invited to participate. Three scenarios were devised, reflective of actual cases, in conjunction with the authors and the quality improvement department. These cases were weighed and considered by the NCHD committee to ascertain clinical relevance for the trainees. A formal small group 30-minute instructional lecture with case discussion and actual case inputting was developed lead by the quality improvement team. Pre and post-test questionnaires on the reporting process were devised that had a direct relevance and trainee perceptions on the training process and barriers to reporting were elicited through thematic evaluation of the post training discussions which were recorded.

Results

Forty (48%) trainees volunteered 23 SHO and 17 Registrars. The mean knowledge scores were 52 pre-test and 67 post-test. Trainees uniformly enjoyed being ‘walked through’ the reporting process and actually having a test opportunity to complete made it more real. Thematic evaluation suggest that trainees are not clear as to what constitutes an incident, have misconceptions of the incident reporting process and operate in an environment that is not conducive to reporting. Patient safety and incident reporting are not viewed as being interconnected.

Conclusions

This educational module enhanced trainee knowledge, corrected misperceptions on its role and suggests that they are more likely to report on clinical incidents. The reporting tool, however, is not geared to the end user which is a hindrance in reporting and the language used facilitates a negative connotation.

Incident reporting and the NCHD

Elbadry Ali MH, Reidy B, O'Neill MB

Mayo University Hospital - Castlebar

AIM AND BACKGROUND

Incident reporting though poorly named is one of the pillars are of patient safety. Non-Consultant Hospital Doctors (NCHDs), while actively involved in patient care contribute minimally to incident reporting overall. This study evaluated NCHD knowledge of the incident reporting process and undertook an education module

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This educational module enhanced trainee knowledge, corrected misperceptions on its role and suggests that they are more likely to report on clinical incidents. The reporting tool, however, is not geared to the end user which is a hindrance in reporting and the language used facilitates a negative connotation.

ACKNOWLEDGEMENT

The authors would like to thank Quality and Patient Safety Officers; Carmel O'Neill and Grainne Guiry Lynskey and the Lead Trainer Assistant - Deirdre Masterson and Dr Mohammed Ali, Medical SHO who played an important role in mobilizing NCHDs to participate in the sessions

The power of listening: Understanding others through reflective practice and collaboration

Dr. Maitiu O Tuathail (CHO7 GP Lead), Dr. Margaret Gallagher, Dr. Niamh McCarthy (CHO9 and CHO6 Mental Health Leads), Dr. Mairead Doyle (Senior Clinical Psychologist)

Introduction

Reflective practice is essential for professional development. Balint groups are a structured, recognised method of addressing the emotional content of the doctor patient relationship, allowing participants a safe platform to reflect. We conducted a needs analysis and identified a lack of availability of Balint for GP registrars and set out to address this. Our aim was to establish a monthly interdisciplinary Balint group. This was to be a collaborative measure, to proactively support the emotional wellbeing of NCHDs, through creating a deeper understanding of the conscious and subconscious aspects of the doctor patient relationship.

Planning

The leads began researching and planning the Balint groups in October 2017. We sought expert consultation from Dr Doyle, a senior clinical psychologist. Her guidance was integral to the success of the project. The format was modelled on the guidelines from The Balint Society, UK. GP registrars from the UCD GP scheme and psychiatry registrars from CHO 6 were invited to attend.

Sessions

Balint groups took place in Saint Vincent's University Hospital, approved by the ECD for psychiatry CHO 6. The groups were co - facilitated by Dr Doyle, and Dr McCarthy. The cost of the psychologist was covered by the NDTP. 11 NCHDs were signed up as Balint attendees. The first group was held on April 17th, and continued monthly thereafter. After each group feedback was obtained, and Dr Doyle circulated literature relevant to the emotional themes raised. Through feedback, we demonstrated that Balint has a positive effect on the well-being of attendees in their professional life.

Conclusion and Sustainability

Balint allows NCHDs to reflect together in an open and safe environment, which can help prevent burnout. The need for such sessions will continue as long as there are patients to be seen. The initial three balint groups were run as a pilot. We have created a framework which can be easily reproducible, and adaptable across other sites nationally. Ultimately our aim is for future GP and psychiatry leads to use this as a platform to make Balint more widely available for NCHDs. As an example of cross speciality and interdisciplinary collaboration, we hope this provides inspiration for future projects. It also serves to create a deeper understanding of both the conscious and unconscious factors affecting both the patient and physician, as well as combining the variety of experience offered by both psychiatry and GP trainees, under the supervision of clinical psychology.

"The power of listening"

Understanding others through reflective practice and collaboration

Dr Maitiu O' Tuathail, Dr Margaret Gallagher, Dr Niamh McCarthy, Dr Mairead Doyle
CHO 7 GP Lead NCHD , CHO 9 and CHO 6 Psychiatry Lead NCHDs, CHO 6 Senior Clinical Psychologist

Introduction

Reflective practice is an essential component of professional development. Balint groups are a structured, recognised method of addressing the emotional content of the doctor patient relationship, allowing participants a safe platform to reflect. Michael Balint, a psychoanalyst, first introduced the idea to GPs in the UK in the 1950s. It is now a worldwide movement, and mandatory in psychiatry training. We conducted a needs analysis and identified a lack of availability of Balint for GP registrars and set out to collaboratively address this. Our aim was to establish an interdisciplinary Balint group, as a collaborative measure, to proactively support the emotional wellbeing of NCHDs.

Sessions

Balint groups took place in Saint Vincent's University Hospital, approved by the ECD for psychiatry CHO 6.

The groups were co - facilitated by Dr Doyle, and Dr McCarthy. Dr Doyle, has over 10 years experience of running Balint groups for NCHDs. Dr McCarthy, has 5 years experience of Balint group participation. The cost of a facilitating psychologist was covered by the NDTP.11 NCHDs were signed up as Balint attendees, and were communicated with via email. The first group was held on April 17th, and continued monthly thereafter.

At each session, feedback was obtained from attendees, using a standardised form from The American Balint Society (ABS). To aid reflective practice, after each group Dr Doyle circulated literature relevant to the emotional themes that the case may have raised.

Objectives

1. Establish a monthly Balint group, available to registrars in GP and psychiatry
2. Address the emotional impact of the doctor- patient relationship
3. Create a deeper understanding of the conscious and subconscious aspects of the doctor patient relationship
4. Foster good interdisciplinary relations between GP, psychiatry and psychology
5. Proactively support NCHD wellbeing and help address burnout

Sustainability

It is established in the literature, and demonstrated in our feedback, that Balint has a positive effect on the well being of attendees in their professional life. It also allows NCHDs to reflect together in an open and safe environment. The need for such sessions will continue as long as there are patients to be seen.

The initial three Balint groups were run as a pilot. We have created a framework which can be easily reproducible, and adaptable across other sites nationally. Ultimately our aim is for future GP and psychiatry leads to use this as a platform to make Balint more widely available for NCHDs. This is an example of cross speciality, interdisciplinary collaboration which we hope might act as inspiration for future projects.

Planning

A collaborative approach was adopted. The leads began researching and planning the Balint groups in October 2017. We sought expert consultation from Dr Doyle. As a senior clinical psychologist, her guidance was integral to the success of the project. The format was modelled on the guidelines from The Balint Society, UK. GP registrars from the UCD GP scheme and psychiatry registrars from CHO 6 were invited to attend.

Feedback

Leader's Evaluation Forms

Form 1. Group Members
Providing Model Behaviour x=4.42
e.g. 'sat comfortably with uncertainty'
Creating atmosphere of safety x=4.65
e.g.' respected all points of view'
Observing Group Process x =4.55
e.g. 'noted themes avoided by group'
Form 2. Presenter (of clinical case)
Evaluation of Presenter's feedback
x =4.2 e.g.' I now feel I can relate to the patient differently'
(X is a rating scale where 1= never and 5 = always)

Conclusion

By addressing the emotional impact of the doctor- patient interaction, it aims to address the uncomfortable emotions raised by clinical interactions, which may lead to burnout. It also serves to create a deeper understanding of both the conscious and unconscious factors affecting both the patient and physician, as well as combining the variety of experience offered by both psychiatry and GP trainees, under the supervision of clinical psychology.

"It's about time!" Changing culture and increasing EWTD compliance; a pilot rota in a community mental health service

Dr N. McCarthy[1], Dr L. Feeney[2]
[1]Lead NCHD, [2]Clinical Director Mental Health, Community Health Organisation 6

Introduction

The EWTD was written into Irish law for NCHDs 14 years ago. It was agreed, 5 years ago, that no NCHD would work more than a 24 hour shift. As lead NCHD, I became aware of a local off-site call rota where there was an increase in NCHDs being needed on-site overnight. There was no culture or provision in place for NCHDs to go home after 24 hours on-site. We set out to address this.

Method

This was a collaborative project, between the lead NCHD and the CD of the local service. In community mental health, NCHDs have individual patient case loads with clinics booked that cannot be cancelled at short notice. The barriers to EWTD compliance are complex; therefore the project was divided into 3 steps.

- Step 1: a communication pathway from NCHDs, to local management was developed.
- Step 2: from this pathway, the pilot rota was established.
- Step 3: feedback was discussed at monthly NCHD-consultant meetings.

Results

After the first month of the pilot, when NCHDs were needed on site after 9pm; 25% of calls NCHDs went home at 9am, and 25% of calls NCHDs went home at lunch time. No patients were cancelled. For 100% of calls, the consultant was communicated with regarding post call arrangements. The overall impression of the pilot was "good". The most frequent barrier to EWTD was identified as culture change.

Conclusion

We successfully increased EWTD compliance. By establishing a communication pathway, we increased understanding of barriers to change, raised awareness and effected change. There is more to be done, changing culture takes time. This pathway remains in place and the EWTD remains on the agenda at monthly NCHD-consultant meetings. We've shown how the lead NCHD can have a pivotal role in improving policy and processes. This role was introduced in mental health in 2017. For future leads, this provides a framework for change that is transferable to other services and could be applied to other NCHD needs.

"It's about time!"

Changing culture and increasing EWTD compliance; a pilot rota in a community mental health service.

Dr N. McCarthy, Dr L. Feeney
Lead NCHD, Clinical Director
Mental Health, Community Health Organisation 6

Introduction & Aim

The EWTD was written into **Irish law for NCHDs 14 years ago**. It states, NCHDs are entitled to 11 hours rest every 24 hours, or equivalent compensatory rest. Little change occurred until NCHDs took industrial action **5 years ago** and it was agreed that **no NCHD would work more than a 24 hour shift**.

As lead NCHD for CHO 6, I became aware of a local off-site call rota where there was a sudden and **significant increase in NCHDs being needed on-site overnight**. However, there was **no culture or provision in place for NCHDs to go home after 24 hours of on-site work**.

In a community mental health service, NCHDs have individual patient case loads with **clinics booked** that cannot be cancelled at short notice. However, **the barriers to EWTD compliance** are not limited to clinics and are **multifaceted**.

We set out to address this, and run a new pilot rota which would aim to increase EWTD compliance.

Objectives

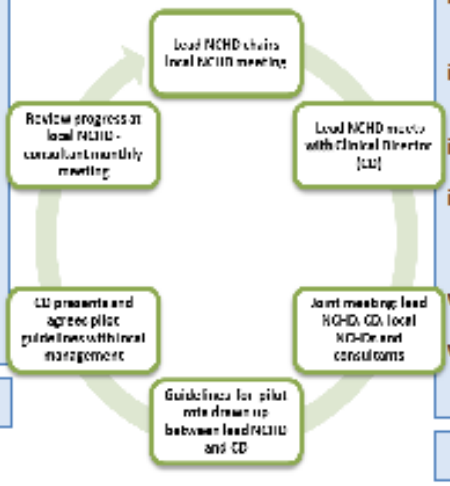
24 NO MORE

1. Develop a local **communication pathway** between NCHDs, consultant colleagues, clinical director (CD) and management
2. Gain **understanding** of the local barriers to EWTD compliance
3. Establish a **new pilot rota**
4. Gather regular **feedback** from NCHDs and discuss this using the pathway above
5. Raise **awareness**, and try to effect a **culture change** within the service

Method

Attendance at lead NCHD Leadership Workshops, the National EWTD Learning Day, and supervision with the executive clinical director (ECD) for Mental Health CHO 6 helped to guide and create a framework for the project. At a local level, this was a **collaboration** between the lead NCHD for CHO 6 and the CD of the local community mental health service.

Step 1. Communication Pathway



Step 2. Pilot rota established

Principles of the rota

i) Remain as an **off-site rota**, with suitable **flexibility** afforded to it

ii) If the NCHD is required to be **on-site after 9pm, they go home** at 9am the next day

iii) NCHDs and their supervising consultants, **agreed 2 week days** when it was not feasible in their role to be absent e.g. outpatient clinic days

iv) NCHDs are **no longer rostered** to be on call the **night before** these 2 week days

Step 3. Feedback and Awareness

A monthly survey is distributed to NCHDs. The results are presented and discussed at monthly NCHD–consultant meetings. This allows for **collaborative troubleshooting**, and it **keeps EWTD compliance firmly on the agenda** for the service.

Results

After the first month of the pilot, when on-site after 9pm prior to a week day:

i) **25%** of calls, NCHDs went **home at 9am**

ii) **25%** of calls, NCHD went **home at lunch time**

iii) **No patients were cancelled**

iv) **100%** of calls, consultant was **communicated** with regarding post call arrangements

v) Overall **impression** of pilot: **good**

vi) Most frequent **barrier to EWTD: culture change for consultants and NCHDs**

Conclusion

We successfully increased EWTD compliance. By establishing a communication pathway, we increased understanding of barriers to change, raised awareness and ultimately effected change. There is more to be done, **changing culture takes time**. This pathway will remain in place and the EWTD will remain on the agenda at the monthly NCHD-consultant meetings. We've shown how the lead NCHD can have a **pivotal role in improving policy and processes**. This role was only introduced in mental health in 2017. For future leads, this provides a **framework for change** that is **transferable** to other mental health services and could be **applicable to other NCHD needs.**

“Helping Hands”-The NCHD handbook

Dr. Margaret Gallagher (NCHD lead CH09), Dr. Reham Eldissougi, Dr. Carol Norton.

Introduction

Psychiatry as a speciality is unique to other medical and surgical specialities, and for many, transition to the speciality can be anxiety provoking and a major challenge. There is a reliance on GP trainees and non-training registrars, with psychiatry trainees accounting for only 35% of registrars in CH09. Difficulties with NCHD retention and burnout are particularly prevalent in psychiatry. It was hoped an NCHD handbook would improve the quality of induction, reduce NCHD stress and reduce burnout.

Planning

A qualitative needs analysis survey was performed initially to establish the degree of need and major areas of deficit.

Objectives

1. Concise
2. User friendly
3. Site specific
4. Practical

Design

All mental health staff were informed at the planning stage of the handbook and advice was sought from those across disciplines. A particular focus was placed on those new to the Irish System/ psychiatry. It gives a user an outline of some of the more basic psychiatric skills including history taking, common presentations, a comprehensive drugs, alcohol and forensic history, catchment areas, as well as other local resources for those in psychological distress due to psychosocial issues. The aim was to have standardised sections for all sites (i.e. mental health act checklist) with more site specific information where necessary.

Results

Two out of three sites have a completed handbook, one in use in the Mater hospital since November 2017. The handbook in the third site, Connolly hospital is near completion.

Potential applications

Not only does this project have the potential to grow within CH09 itself, it could easily be transferred as standard practice for each CHO in mental health, with only minor alterations required to make it site specific.

Conclusion

This is a pro-active, collaborative, NCHD lead means to address the deficiencies in induction using the unique experiences and insight of NCHDs. Not only will it improve the quality of NCHD induction but also serve to reduce NCHD stress and lead to improved patient care.

"Helping Hands" The NCHD handbook-

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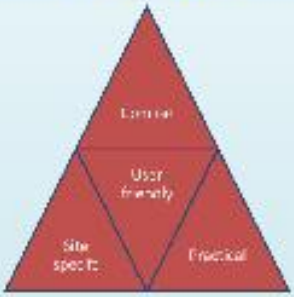
Introduction

Psychiatry as a speciality is unique to other medical and surgical specialities, and for many, transition to the speciality can be anxiety provoking and a major challenge. There is a reliance on GP trainees and non-training registrars, with psychiatry trainees accounting for only 35% of registrars in CH09. Difficulties with NCHD retention and burnout are particularly prevalent in psychiatry. It was hoped an NCHD handbook would improve the quality of induction, reduce NCHD stress and reduce burnout.

Planning & Design

All medical, nursing and MDT staff were informed at the planning stage of the handbook and advice was sought from those at all levels. A particular focus was placed on those new to the Irish system as well as GP trainees. It was decided to focus first on sites with access to emergency adult presentations.

Objectives



Needs analysis survey

85%-"Felt very unprepared for first on call shift".
100%-"Induction could be improved"-
"I had no knowledge of alcohol/drugs"
Most challenging areas identified- mental health act, local resources, catchment areas

Potential applications

Not only does this project have the potential to grow within CH09 itself, it could easily be transferred as standard practice for each CHO in mental health, with only minor alterations required to make it site specific.

Collaboration

The overall success of this project depended engaging all NCHDs as well as a variety of stakeholders. NCHDs who had not gone to medical school in Ireland were particularly important and offered unique insight.

Results

Two out of three sites have a completed handbook, one in use in the Mater hospital since November 2017. The handbook in the third site, is awaiting senior approval. The handbook was trialled in the Mater intake in Jan 2018 with positive results.
Engaging NCHDs in this project also served to improve morale amongst the NCHD cohort.

Conclusion

This is a pro-active, NCHD lead means to address the deficiencies in induction. This will serve as a means not only to improve NCHD induction, reduce levels of NCHD stress and improve patient care, but empowering NCHDs to use their experience to educate each other.

Breaking Barriers: Improving Communication between NCHDs, Nursing staff and Hospital Management in Mullingar Regional Hospital

Danielle McCollum[1], Hilary Cronin[2], Shona Schneemann[3], Sharon Gorman[4], Kay Slevin[5]
[1.]Lead NCHD, MRH Mullingar [2.]Clincal Director, MRH Mullingar [3.]General Manager, MRH Mullingar [4.]Clincal Quality and Patient Safety Manager. MRH Mullingar [5.]Operations and Clinical Services Manager, MRH Mullingar

Introduction

Midlands Regional Hospital Mullingar is a Level III facility, which cares for all age groups across a wide variety of disciplines including Medicine, Surgery, Paediatrics, Obstetrics and gynaecology, Emergency Medicine and Critical Care. Within the hospital there are approximately 100 NCHDs and over 300 WTE nurses. It is important that everyone is involved; there is open communication and mutual respect for each other. This will in turn result in improved patient outcomes.

Aim

The aim was to improve communication between staff through the implementation of initiatives such as an NCHD committee, Bleep Policy and Weekend Handover Meetings.

Methods

An NCHD committee was set up at the start of the year with each speciality represented by an NCHD. Our first project was the introduction of a “Bleep Policy”. Following discussion at a medical/nursing forum, there was pilot period on a medical ward and approval by PPPG committee. Our next initiative was the introduction of Weekend Handover Meeting. Members of each clinical team/on-call teams meet with the Nursing Administration team to discuss possible weekend discharges. It is currently being developed to include a medical handover of patients who may become more acutely unwell.

Results

The introduction of the NCHD Committee provides a closer of sense of community within a hospital with multiple services. Many NCHDs feel that the “Bleep Policy” has improved patient care and resulted in better communication between staff. The Weekend Handover Meeting has been noted to help with the flow of patients through the hospital, appropriate timely discharge and highlights required clinical work.

Conclusion

The barriers have begun to be broken down with improvement of communication between NCHDs, nursing staff and hospital management. These are projects that will continue to be practiced in Mullingar Regional Hospital and are easily transferable to other institutions.

Breaking Barriers: Improving Communication between NCHDs, Nursing staff and Hospital Management

Danielle McCollum[1], Hilary Cronin[2], Shona Schneemann[3], Sharon Gorman[4], Kay Slevin[5]
[1.]Lead NCHD, MRH Mullingar [2.]Clincal Director ,MRH Mullingar [3.]General Manager, MRH Mullingar [4.]Clincal Quality and Patient Safety Manager. MRH Mullingar [5.]Operations and Clinical Services Manager, MRH Mullingar

Introduction

Midlands Regional Hospital Mullingar is a Level III facility, which cares for all age groups across a wide variety of disciplines including Medicine, Surgery, Paediatrics, Obstetrics and gynaecology, Emergency Medicine and Critical Care. Within the hospital there are approximately 100 NCHDs and over 300 WTE nurses. In order for an organisation to function effectively it is important that everyone is involved, there is open communication and mutual respect for each other. In turn, in a hospital setting, this will result in improved patient outcomes.

Aims

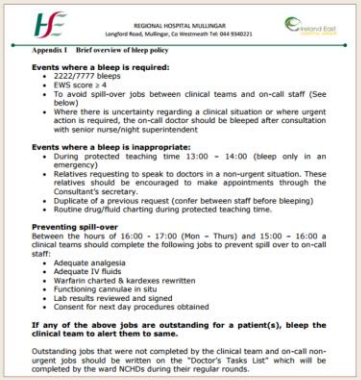
The aim was to improve communication between staff through the implementation of initiatives such as an NCHD committee, Bleep Policy and Weekend Handover Meetings.

Methods

An NCHD committee was set up at the start of the year to discuss potential initiative and projects within the hospital which would help to improve the working environment. Each speciality was represented by an NCHD and we met on a monthly basis.

It provided a forum to discuss NCHD issues and provide feedback to each of the specialties of activities within the hospital.

Our first project was the introduction of a "Bleep Policy" which was aimed to provide guidance on the bleep system within the hospital, to secure protected teaching time for NCHDs and to provide support for nursing staff should any issues need to be escalated. This initiative was discussed at a Medical and Nursing Forum, before a draft policy and pilot process was carried out on one of the medical inpatient wards. Following the pilot period and further discussion, a suitable bleep policy was agreed upon by medical and nursing staff; which was subsequently approved by Policy, Procedures and Guidelines Committee. It was circulated within the hospital for use all clinical staff.



REGIONAL HOSPITAL MULLINGAR
Longford Road, Mullingar, Co Westmeath Tel: 044 9348221

Appendix I Brief overview of bleep policy

Events where a bleep is required:

- 2222/7777 bleeps
- EWS score ≥ 4
- To avoid spill-over jobs between clinical teams and on-call staff (See below)
- Where there is uncertainty regarding a clinical situation or where urgent action is required, the on-call doctor should be bleeped after consultation with senior nurse/night superintendent

Events where a bleep is inappropriate:

- During protected teaching time 13:00 – 14:00 (bleep only in an emergency)
- Relatives requesting to speak to doctors in a non-urgent situation. These relatives should be encouraged to make appointments through the Consultant's secretary.
- Duplicate of a previous request (confer between staff before bleeping)
- Routine drug/fluid charting during protected teaching time.

Preventing spill-over

Between the hours of 16:00 - 17:00 (Mon – Thurs) and 15:00 – 16:00 a clinical teams should complete the following jobs to prevent spill over to on-call staff:

- Adequate analgesia
- Adequate IV fluids
- Warfarin charted & kardexes rewritten
- Functioning cannulae in situ
- Lab results reviewed and signed
- Consent for next day procedures obtained

If any of the above jobs are outstanding for a patient(s), bleep the clinical team to alert them to same.

Outstanding jobs that were not completed by the clinical team and on-call non-urgent jobs should be written on the "Doctor's Tasks List" which will be completed by the ward NCHDs during their regular rounds.

Our most recent initiative is the introduction of Weekend Handover Meeting in the newly designed "Navigational Hub" . Members of each clinical team/on call teams meet with the Nursing Administration team to discuss possible weekend discharges. It is currently being developed to include a medical handover of patients who may become more acutely unwell.

Results

The introduction of the NCHD Committee provides a closer of sense of community within a hospital with a large scope of services. It enables NCHDs to be more involved in and aware of the running of the hospital and encourages NCHDs to be support initiatives.

On a review of the bleep policy, many of the NCHDs currently working in the hospital feel that its implementation has improved patient care and resulted in better communication between themselves and nursing staff.

The Weekend Handover Meeting has been noted to help with the flow of patients through the hospital, discharge to appropriate community or home settings and highlights clinical work required prior to or over the busy weekend period.

Conclusion

Over the last year, as a result of our initiatives, the barriers have begun to be broken down with improvement of communication between NCHDs, nursing staff and hospital management

It's the little things: giving NCHDs an opportunity to voice their opinions and ideas

Dr Teresa Sweeney
Lead NCHD, Our Lady of Lourdes Hospital, Drogheda

NCHDs rotate throughout different hospitals on a six monthly or yearly cycle. The transient nature of their employment can result in disengagement with their establishment. My aim was to give NCHDs an outlet to voice their opinions regarding the hospital and ask for ideas on improving the NCHD experience as well as hospital services.

A survey of NCHDs was performed with an approximately 40% response rate. The survey asked questions regarding the wellbeing of NCHDs, their opinions on the facilities provided to them and what could be done to improve conditions. In addition due to a perceived lack of collegiality within the hospital questions on professionalism and collegiality were asked.

The results of the survey were collected and discussed at our NCHD committee and brought forward to hospital management. The survey has been the starting point for improved NCHD facilities as well as a greater awareness by management of the difficulties faced by NCHDs.

It's the little things – letting NCHD's have their say

Teresa Sweeney

Lead NCHD Our Lady of Lourdes Hospital Drogheda

Introduction

- NCHD's rotate throughout different hospitals on a six monthly or yearly cycle
- The transient nature of their employment can result in disengagement with their establishment.
- They are often given feedback but rarely asked for their opinions.
- NCHD's have the experience of working in a variety of hospitals and therefore should be seen a a valuable resource to management when looking for ideas on improving hospital services and staff experience.

Aims and Objectives

- My aim was to give NCHD's an outlet to voice their opinions regarding the hospital and ask for ideas on improving the the NCHD experience as well as hospital services
- In addition due to a general atmosphere of low morale among NCHD's within the hospital I asked for their view on wellbeing and collegiality

Implementation

- A 23 question survey was circulated to all NCHD's
- The survey was open for one week and NCHD's were advised that the survey was anonymous
- After one week 59 response's had been generated

Results

- Overall 40% response rate
- 58% NCHD's said they enjoyed their job, but 47.5% said morale among NCHD's was low
- 64% felt that OLOL hospital does not value NCHD's
- Respondents stated that being paid for every hour and free parking were some of the positives about OLOL
- No access to healthy food and poor on call facilities were some of the most negative things about OLOL

"No problem getting paid overtime"

"Nursing and other staff generally friendly"

"Very poor quality food in the canteen"

"Canteen hardly ever open especially at weekends"

Wellbeing

- With regard to wellbeing NCHD's reported the following
- 48% reported good physical health while 58% reported good mental health
- 10% reported poor physical and mental health
- 71% said their jobs did not allow enough time or energy for family and friends
- 81% said their job did not allow enough time or energy for exercise
- 78% said they had come to work while ill or injured with 58% saying they feel judged by peers or management if they called in sick
- 66% say they feel management of OLOL does not care about NCHD wellbeing

"is it going to take one of us to fall asleep at the wheel before something changes? "

Retention of staff

- 41% of NCHD's said they would work in OLOL in the future with 42% saying they would they would only choose to work in the hospital again if no other post was available
- 63% said they would not recommend working in OLOL to a friend

Training and teaching

- 40% of respondents felt teaching in OLOL was of good quality
- 37% of respondents felt the training in OLOL was of good quality
- 59% felt the access to training was unequal

"Priority is given to SPRs"

"Irish trainees given better access"

"Very little study leave allowed"

Professionalism and collegiality

- 66% of respondents felt that NCHD's act professionally while 34% felt the opposite
- 60% felt there was very poor collegiality among NCHD's in OLOL

"Terse and disrespectful dynamic"

"Very poor collegiality, bullying going on"

"The most toxic environment I ever worked in"

Outcomes

- The above survey is due for discussion with the clinical director and general manager
- The survey has highlighted four key areas that require improvement in order to improve the NCHD experience in OLOL
- Improvements are required in post call facilities e.g – sleep it off areas post call before driving home
- Improved access to food and better food quality particularly at weekends
- Enhanced security especially in car park areas and on call res
- Better access to training for all NCHD's not just those on schemes

MN-CMS - Changing the Way We Train

Armstrong, Sean[1,2], Carroll, Ciara[2,] Parvanov, Parvan[2], Shanahan, Ita[2]
[1]Lead NCHD; [2]The Rotunda Hospital

Introduction

The MN-CMS is an electronic healthcare record which is currently being rolled out to 19 maternity units across the country. In the Rotunda, we wished to analyse and improve NCHD eChart training methods.

Objectives

- To obtain the views of NCHDs on their training methods
- To redesign the training process to reflect NCHDs needs
- To enact a process that encourages continuous improvement of training with future changeovers

Implementation

Feedback from 34 NCHDs outlined that the previous didactic teaching methods were inadequate, and that there was appetite for online learning and pre-changeover workshops in order to familiarise doctors with the eChart. With this information, we collated a working group of NCHDs from the three departments within the hospital (Neonatology, Anaesthetics and Obstetrics/Gynaecology). Under consultant supervision, we set out to design instructional videos for tasks commonly performed in each department. Accompanying these videos were “cheat sheets” designed for use on the go (and within the NCHD Rotunda app).

The Workshops:

- Sandbox style scenarios
- Task orientated training
- Medication session run by Pharmacy staff

Barriers to change:

- Coordinating a redesign across three departments
- Lack of funding/extra supports
- Encouraging a culture of positive engagement amongst NCHDs/consultants

Enabling factors:

- Culture of Quality Improvement in Pharmacy Department
- NCHD Committee/Clinical Lead
- MN-CMS Back Office Support

The Future

This initiative is sustainable as it replaces previous training plans, and requires small, half-day workshops run by local staff. There are minimal costs associated with the project. As all 19 maternity units will experience regular influxes of untrained staff, this pilot training project could be rolled out to all sites.

MN-CMS – Changing the way we train NCHDs

Armstrong, Sean[1,2], Carroll, Ciara[2], Parvanov, Parvan[2], Shanahan, Ita[2]
[1]Lead NCHD
[2]The Rotunda Hospital

Introduction

The MN-CMS electronic chart will be rolled out across all 19 maternity units in Ireland as the electronic healthcare record for both mothers and babies. The Rotunda had its "Go Live" initiation in November 2017, supported by the external IT vendor and the national MN-CMS project.

Supports included:

- Mandatory 2-3 day paid training sessions for all staff
- Supernumery "SuperUsers" (staff with extra training) rostered for 24/7 support for the initial 2 week period of "Go Live"
- "FloorWalkers" – staff from the external IT vendor rostered for 24/7 support for 2 weeks
- Considerable Back Office Support in a reducing capacity for 2 months from "Go Live"

Now that the EHR is embedded in clinical practice within the Rotunda, the obvious challenge is to integrate new staff into the system without compromising patient safety, within the constraints of the local support network.

Challenges:

- Optimising the NCHD training process
- Minimising stress for new staff
- Reducing error rates during changeover periods
- No extra supports available for future changeover periods

Aims

- To analyse and obtain NCHD feedback on the "Go Live" training process
- To establish a working group to redesign the training process, reflecting NCHD feedback
- To create a process of refining training methods based on continuous feedback at every changeover

Implementation

1. **To analyse and obtain NCHD feedback on the "Go Live" training process**

36 NCHDs were surveyed on the Go Live training process. Doctors from all three departments (Anaesthesia, Neonatology and Obstetrics/Gynaecology) responded to a 10 point questionnaire.

- Over 90% felt that the "Go Live" training process was inadequate. Individual comments criticised the didactic, lecture based approach. Training needed to be "hands-on".
- Over 65% of NCHDs surveyed wanted a workshop prior to changeover (as educational leave).
- Over 80% wanted cheat sheets.
- Over 60% wanted instructional videos.

The overwhelming message from the survey was that radical overhaul of the training process was needed.

2. **To establish a working group to redesign the training process, reflecting NCHD feedback**

- In February 2018 we recruited volunteers from the three departments to develop videos and cheat sheets for specific tasks NCHDs would face.
- Workshops were redesigned to a sandbox type model, where incoming NCHDs would practice common tasks and familiarise themselves with the EHR, rather than listen to lectures
- Videos were recorded using local IT support
- Incoming NCHDs were **invited** to one of three workshops in June or July. Attendance is not mandatory.

Nonetheless, discussions were held with senior consultants from all departments, and the Executive Management Team of the hospital, to allow for further training during the week of induction.

Barriers

- Coordinating a redesign across three departments
- Lack of funding/extra supports
- Encouraging a culture of positive engagement amongst NCHDs/consultants

Enabling Factors

- Culture of Quality Improvement in Pharmacy Department
- NCHD Committee/Clinical Lead
- MN-CMS Back Office Support

Survey Findings

How did you find the EHR training prior to MN-CMS "Go Live"?

Workshops

- 3 per department (Anaesthesia and Obs/Gyn combined)
- Run by NCHDs, SuperUsers and Pharmacy staff – 4 hours per workshop
- 2 hours Sandbox time (task orientated learning) and 2 hours Prescribing
- Feedback sessions at end

Target Outcomes

- **>80% attendance at workshops per department**
- **>90% satisfaction rate with workshops (participant feedback)**
- **100% documented participation in online instructional videos (signed confirmation)**

Sustainability

3. **To create a process of refining training methods based on continuous feedback at every changeover**

- Fixed agenda item on every NCHD committee meeting (6 weekly) - examine feedback and initiate changes to training
- One nominated NCHD per Department to run workshops
- Formal endorsement by HSE/MN-CMS to allow for Educational Leave application
- Culture of mandatory workshops

- A further 15 maternity units will begin to use MN-CMS over the next few years. This pilot project can easily be rolled out to all sites, no matter the size.

Promoting Collegiality: A Multi-Targeted Approach

Emer Ryan, Aine Mitchell
Lead NCHDs, Sligo University Hospital

Introduction

Collegiality in healthcare forms a cornerstone of effective teamwork and ultimately results in improved staff morale, patient safety and care. Discussion with NCHDs and NCHD committee members highlighted key targets for promoting collegiality. The development of interpersonal relationships across specialties, professions and disciplines was regarded as the most significant factor. Easy induction and welcoming of non-permanent staff as well as recognition and rewarding positive interactions were both also considered to be important in terms of maintaining positive collegial relationships. With this in mind a multi-targeted approach was adopted with three initiatives incorporating one overall aim.

Development of Interpersonal Relationships – A Social Event

We organized an event for all hospital staff with an emphasis on social interaction that was both inclusive and easy to attend. Our aim was to encourage members of staff to engage with each other on a personal level. We hosted a table quiz within the hospital after work to facilitate maximal engagement. We encouraged mixing of departments and specialties within teams.

Locum Welcome Booklet

In order to introduce and welcome locum staff them to the work environment and subsequently ensure effective teamwork and interaction, specialties that frequently work with locums developed a guidance document to be distributed prior to arrival.

'Sligo Stars' Awards

With emphasis frequently placed on negative outcomes and near misses within the hospital environment, 'Sligo Stars' aimed to provide a balance by both recognizing and rewarding positive interactions. We asked NCHDs to nominate anyone within the hospital they believed deserved recognition, for being diligent, easy to deal with, friendly, helpful or any other quality they believed to be worth thanking. Nominations were made anonymously and included a written example of behaviours that deserved to be highlighted. We encouraged nominations from across all members of multidisciplinary team in an effort to promote unity and inter disciplinary collegiality. Sligo Stars is an initiative that is ongoing with nominations still being received and is currently planned as a solitary award event. However we hope that it is an initiative that will continue more regularly in SUH.

Conclusion

We used a multi-targeted approach to collegiality improvement to ensure not only its success but also its sustainability, as our aim was to maintain a harmonious inter-professional working environment.

Promoting Collegiality: a Multi-targeted Approach

Emer Ryan, Aine Mitchell
Sligo University Hospital

Introduction

Collegiality in healthcare forms a cornerstone of effective teamwork improves staff morale and ultimately results in better patient safety and care[1].

Aim – To encourage and maintain good personal and professional relationships between hospital staff in order to improve morale, teamwork and patient care.

Targets Highlighted by NCHDs

- Development of Interpersonal Relationships
- Easy induction and welcoming of non-permanent staff
- Recognition and rewarding positive interactions

Three initiatives were simultaneously developed for each target.

Initiatives

A Social Occasion – A Festive Event

An event for all hospital staff that was both inclusive and easy to attend was organized, with an emphasis purely on social interaction. The aim was to encourage members of staff to engage with each other on a personal level. A table quiz was hosted within the hospital after work to facilitate maximal engagement. Mixing of departments and specialties within teams was encouraged.

We encountered difficulties with engagement of staff and found that social media and word of mouth were the most successful means of communication, via a delegated spokesperson from each department. We also experienced difficulty with regards funding and more specifically appropriate sources of funding for NCHD events. This is an area that has been clarified throughout the year.

The event was well attended, facilitated intra-disciplinary introductions and collaboration and was thoroughly enjoyed by all.

A Staff Table Quiz, SUH, Dec 2017

Locum Welcome Booklet

Each department that frequently worked with short term locum staff was asked to produce a short document with clear guidelines about the main requirements of the department. Focus within the document was not only on the technical aspects but also placed emphasis on interactions with other specialties and other members of the MDT. The aim was to ensure ongoing effective teamwork and consistent communication between staff despite intermittently transient non permanent staff while also ensuring that locum staff felt welcome and easily induced into their role.

Sligo Stars Awards

'Sligo Stars' awards aimed to recognise and reward positive interaction and behavior. In an environment in which negative events and 'errors' are frequently highlighted for learning purposes, we feel that Sligo Stars offered a balance and highlighted the equal value of learning from excellence and recognizing excellence in its many forms. NCHDs were asked to nominate anyone within the hospital as a 'Sligo Star' that they believed deserved recognition, for being diligent, easy to deal with, friendly, helpful or any other quality they believed to be worth thanking. Nominations were encouraged from across all members of multidisciplinary team in an effort to promote unity and inter disciplinary collegiality.

Sligo Stars is an initiative that is still ongoing with nominations still being received and is currently planned as a solitary award event at the end of the year. However it is hoped that it is an initiative that will continue more regularly in SUH.

Conclusion

We used a multi-targeted approach to collegiality improvement to ensure not only it's success but also it's sustainability, as our aim was to maintain a harmonious inter-professional working environment.

We encountered minor barriers such as NCHD engagement and found that people were our most effective resource. Word of mouth and social media were the most useful means of communication and ensuring an enthusiastic, well connected spokesperson was nominated from each specialty was essential.

References

1- Jones, A. and Jones, D. (2011) 'Improving teamwork, trust and safety: An ethnographic study of an interprofessional initiative', *Journal of Interprofessional Care*. Taylor & Francis, 25(3), pp. 175–181. doi: 10.3109/13561820.2010.520248.

Improving Patient Safety with High Quality Clinical Handover

S Lewis[1], J Tan[1], J Coveney[2], J Beamish[2]
1. Lead NCHDs, 2. Department of Paediatrics, Temple St Children's Hospital

Clinical handover involves the transfer of care of a patient to another person or professional group and is a high-risk time on the patient journey. Implementation of a handover programme has been shown reduce the medical error rate by 23% and the rate of preventable adverse events by 30%[1]. The aim of this quality improvement project was to bring clinical handover in Temple St Hospital in line with current national guidelines[2].

1. PDSA Method:
    - Iteration 1: Review of existing handover. Feedback sought on existing handover, with overall response that improvements were needed. Encouragement by CD to consultant/NCHDs to attend handover. Venue and times selected.
    - Iteration 2: Target morning handover, link made with NCH working group. Initial audit and small group discussion. New venue, fixed time and duration.
    - Iteration 3: Email communication, posters, presentation at morning teaching. Use of Clinical Portal for electronic patient list. Formal feedback questionnaire. Planning for Grand Rounds session.
    - Iteration 4: Grand Rounds multi-disciplinary ISBAR3 teaching, (May 2018), posters, lanyards, allied with senior management. Re-audit ongoing June 2018. Hand over needed to incoming lead NCHDs & registrars to ensure sustainability and continued progress.
2. Stakeholder map
3. Small group discussion
4. Feedback questionnaire

Formal audit carried out after Iteration 1, over a 10-day period showed that handover happened in the agreed location 10/10 days, at the pre-specified time 9/10 days, with median duration 14 minutes (range 6-24 minutes). All admitted patients were discussion. No communication tool was used. Attendance varied from 100% for the post-call and on take-registrar to 70% for the medical consultants. A repeat audit was performed after the third iteration, which demonstrated that handover occurred on 11/12 days, in the agreed venue on 10/12 days, with use of a formal handover tool on 10/11 days. The median time was 20 minutes (range 8-25 minutes). There is an audit on-going following recent Grand Rounds, to assess the use of the ISBAR3 communication tool.

Morning medical handover has been improved in-line with national guidelines, with significant buy-in from clinicians across all grades and with positive clinician feedback. In order to ensure improvements are sustained, we have ensured buy-in from senior hospital management and allied with NCH clinical handover working group.

1. Changes in medical errors after implementation of a handoff program. Starmer AJ1, Spector ND, Srivastava R et al,. New England Journal of Medicine. 2014 6; 371 (19)
2. Department of Health. Communication (Clinical Handover) in Acute and Children's Hospital Services. National Clinical Guideline No. 11 November 2015. ISSN 2009-6259

‘Improving Patient Safety with High Quality Clinical Handover’

S Lewis[1], J Tan[1], J Coveney[2], J Beamish[2]
1. Lead NCHDs, Temple St Children’s Hospital
2. Department of Paediatrics, Temple St Children’s Hospital

Introduction & Aims

Clinical handover involves the transfer of care of a patient to another person or professional group and is a high risk time on the patient journey. Implementation of a handover programme has been shown reduce the medical error rate by 23% and the rate of preventable adverse events by 30%[1]. The aim of this project was to bring clinical handover in Temple St Hospital in line with current national clinical guidelines[2].

Methods

Iteration 1

Plan: Review of existing clinical handover.

Do/Study: Feedback on existing handover system, with the overall response that improvements needed.

Encouragement by CD to consultant/NCHDs to attend handover, promoted at morning teaching.

Act: Venue CD office, times 08.15/08.45

Iteration 2

Plan: Target morning handover, new venue, fixed time, link with NCH working group

Do/Study: see below (Table 1, Box 1), small group discussion

Act: New venue, fixed time (08.00), fixed duration (00:25)

Iteration 3:

Plan: Email communication, posters, presentation at morning teaching

Do: trial of new venue, fixed time, duration (00:30), use of clinical Portal electronic patient list

Study: (table 2), formal feedback questionnaire (box 2)

Act: Planning for Grand Rounds session

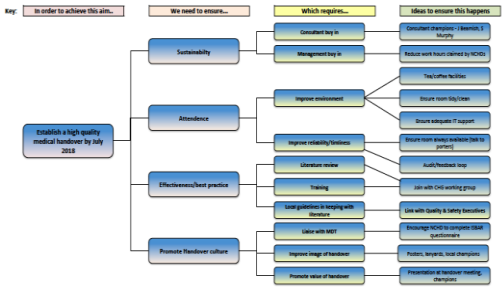
Iteration 4:

Plan: Grand Rounds multi-disciplinary ISBAR3 teaching, (May 2018), posters, lanyards, attendance at external audit meetings

Do/Study: Re-audit ongoing June 2018

Act: Hand over project to incoming lead NCHDs & registrars

Identifying Stakeholders



Results

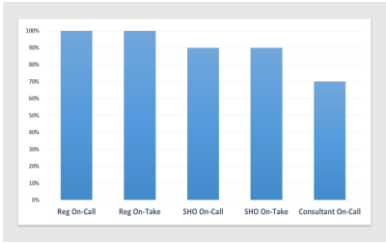


Table 1. Attendance at morning medical handover meeting, stratified by position (n=10 days)

Agreed location 10/10 days

Set time 9/10 days

Median duration 14 mins (range 6-24)

All patients discussed

No communication tool

Box 1

Small group discussion:

- Variable attendance, suboptimal communication with not all parties in agreement or informed
- Location: Room locked, too far from ED, computer issues, no printer, handover tending to occur in ED
- Times confusing, not enough time, ran into teaching
- Handover variable, MROC→ consultant, MROC → registrar, MROC handing over twice
- Variation in content and format of handover
- Inconsistent use of paper or electronic handover list

Box 2: Formal feedback questionnaire

14 clinicians, across grades SHO, registrar and consultant responded to the questionnaire.

Frequently cited positive effects of change in handover

1. The ability to formally highlight patient concerns or outstanding tasks.
2. Consistent location and time.
3. Perceived improved patient safety.

Frequently cited negative effects:

1. Earlier start to the working day.

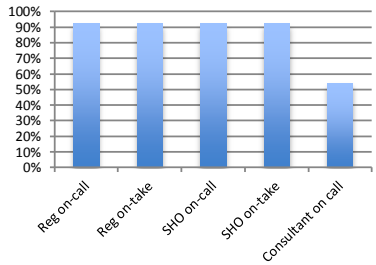


Table 2. Attendance at morning medical handover meeting, stratified by position (n=12 days)

Handover occurred 11/12 days

Venue: NCHD room 10/12 days, Res 1/12 days

Duration: Recorded 10/12 days, median 20 min (range 8-25 min)

Handover tool used: 10/11 days

PEWS discussed 7/11 days

Conclusion

Morning medical handover has been improved in-line with national guidelines, with significant buy-in from clinicians across all grades and with positive clinician feedback. In order to ensure improvements are sustained, we have ensured buy-in from senior hospital management and allied with NCH clinical handover working group.

References:

1. Changes in medical errors after implementation of a handoff program. Starmer AJ1, Spector ND, Srivastava R et al,. New England Journal of Medicine. 2014 6; 371 (19)
2. Department of Health. Communication (Clinical Handover) in Acute and Children’s Hospital Services. National Clinical Guideline No. 11 November 2015. ISSN 2009-6259

Together Let's Reach New Heights: Transforming Healthcare through Relationship-Centred Communication at South Infirmary Victoria University Hospital, Cork

[1]Siddique Muhammad, Shaffi Rubeena - SIVUH, Cork
[1]Lead NCHD, SIVUH

Background:

Research shows that nothing impacts patient experiences more than the quality of communication. While beneficial, the latest in cutting-edge technology and techniques aren't enough to ensure the best possible care for patients. The key to better healthcare outcomes is meaningful communication. National Patient Experience Survey 2017 was the first real effort to hear patient's perspective. Eight major findings were identified and almost all of them involved a lapse in communication in one way or the other.

- 40% stated they did not get enough time to discuss their treatment and care with the relevant doctor.
- 36% said they were not involved in decisions regarding their care and treatment.
- 43% stated their family and friends did not have enough opportunity to talk to the doctor.
- 49% said they could not find a member of the hospital staff to talk about their worries and fears.
- 46% said they were not given any written information about what to do after leaving the hospital.
- 40% said they did not get enough information about the side effects of medication.
- 43% said they did not get sufficient information to manage their condition after discharge from the hospital.

Aims:

The primary objective of this project is to implement a patient centred service at SIVUH to deal with the following communication related findings identified in the first National Patient Experience Survey May 2017.

- In-patient care : General, Ward, Examination, diagnosis and treatment,
- Discharge /Transfer to Community care.
- Medication related information.

Methods:

Various strategies and techniques have been devised and implemented over the past few months to improve interaction amongst the hospital staff and patients, to enable better quality of patient care and staff well-being.

- Campaign to improve staff introduction
- Hello, my name is…campaign: promoted amongst staff in the hospital designed to improve communications between healthcare professionals and patients, it was developed by a patient to improve patients' experience of hospital care.
- Wearing of Name Badges amongst the staff.
- Promotional Campaign to increase awareness in relation to support available to patients who want to speak to someone about their worries and concerns.

- Improve communications between healthcare professionals and patients with regards to Examination, Diagnosis and Treatment: especially decision making treatment procedures both medical and surgical.
- Improve communication and information for patients as in-patients and when they are being discharged from hospital.
  - Access to patients for information about going home from hospital is being improved through verbal communication and written documented information.
  - We ensure that all patients know who to contact if something goes wrong.
  - We provide information to patients on medication side effects if commenced on new medication or if current medications are affected by procedures.
  - We have improved the overall discharge planning process.
  - "Open Disclosure" training is in place to educate staff on being open and honest when something goes wrong.
  - Communication with patients via internet and via digital technology to be improved where possible
  - Feedback for Staff
    - Daily feedback from in patients.
    - Two weeks post discharge survey.

Conclusion:

SIVUH is committed to improving patient's experience, has been working diligently with all staff to recuperate effective communication with patients to touch-up patients' journey in and out of the hospital. This is a gradual process with a time scale of 1-3 years and a multi-disciplinary approach involved before the beneficial effects could be witnessed in full. However at the end of the day we all strive to better communication, better relationships, and better care – together let's reach new heights.

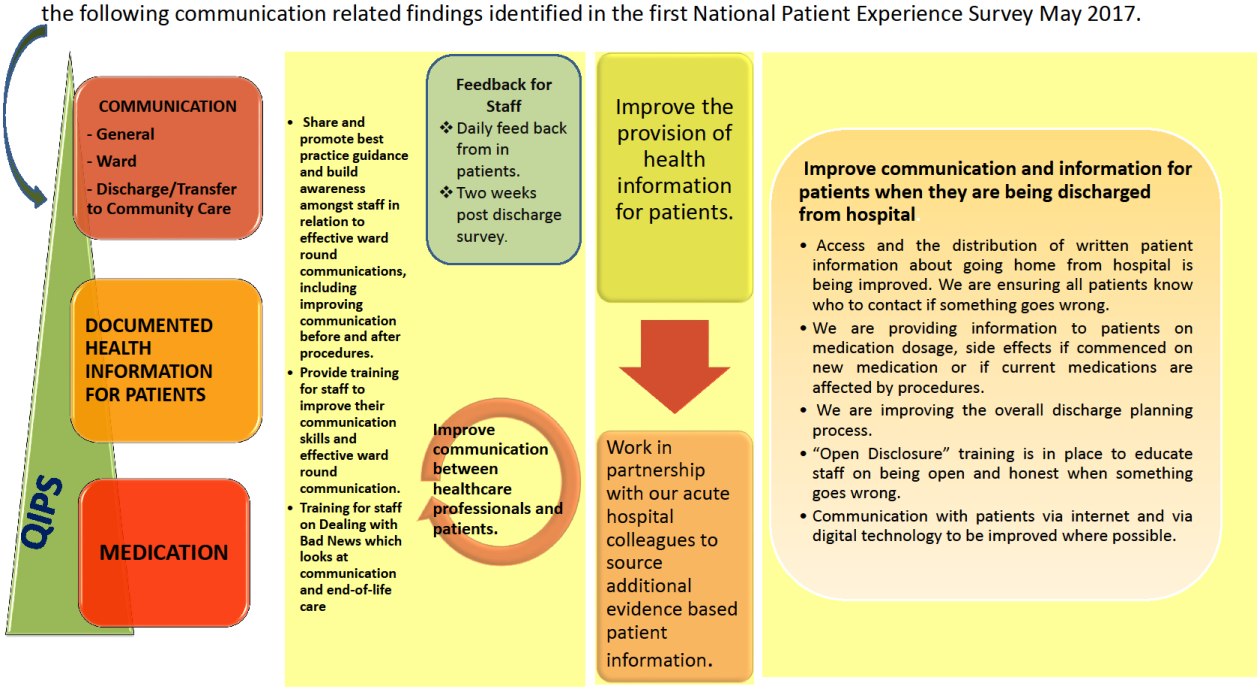
TOGETHER LET'S REACH NEW HEIGHTS

Transforming Healthcare Through Relationship-Centered Communication at South Infirmary Victoria University Hospital, Cork.

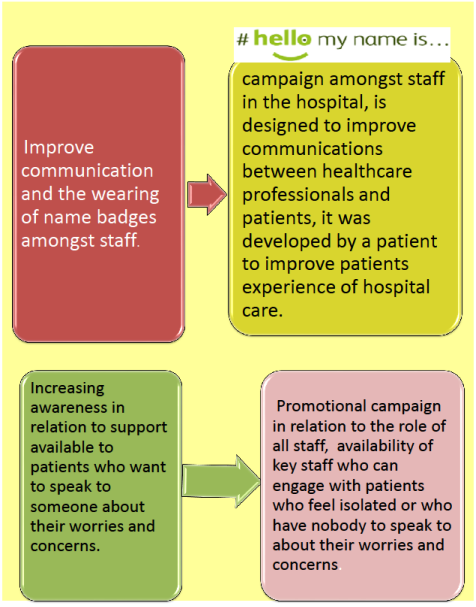
Siddique Muhammad, Shaffi Rubeena - SIVUH

BACKGROUND: Research shows that nothing impacts patient experiences more than the quality of communication. While beneficial, the latest in cutting-edge technology and techniques aren't enough to ensure the best possible care for patients. The key to better healthcare outcomes is meaningful communication.

OBJECTIVES: The primary objective of this project is to implement a patient centered service at SIVUH to deal with the following communication related findings identified in the first National Patient Experience Survey May 2017.



METHODS:



CONCLUSION:

SIVUH is committed to improving patient's experience, has been working diligently with all staff to recuperate effective communication with patients to touch-up patients' journey in and out of the hospital. This is a gradual process with a time scale of 1-3 years and a multi-disciplinary approach involved before the beneficial effects could be witnessed in full. However at the end of the day we all strive to

BETTER COMMUNICATION, BETTER RELATIONSHIPS, BETTER CARE……