



QI TALK TIME

Building an Irish Network of Quality Improvers

PlayDecide: Patient Safety - a new "serious game" learning tool for health professionals to discuss patient safety and error reporting

***1pm Tuesday November 27th
2018***

Connect

Improve

Innovate

Speakers

Steve Mac Donald:

a global health researcher and communicator. A member of the UCD Health Systems Team working on dissemination of the PlayDecide: Patient Safety game and research findings, and other projects.

In addition he works independently on interventions to reduce self-stigma among people living with TB and HIV in low- and middle-income countries, in collaboration with Irish and international NGO



Karen Rotherham-Egan:

an independent patient safety representative who has been involved in numerous initiatives in the area of effective healthcare delivery. Over the past four years, she has assisted the Health Systems team at UCD in the development of PlayDecide.

She is currently involved in the dissemination of the research findings to encourage system-wide use of PlayDecide as an educational tool. She also delivers patient perspective lectures across numerous health professional education programmes.



Instructions

- Interactive

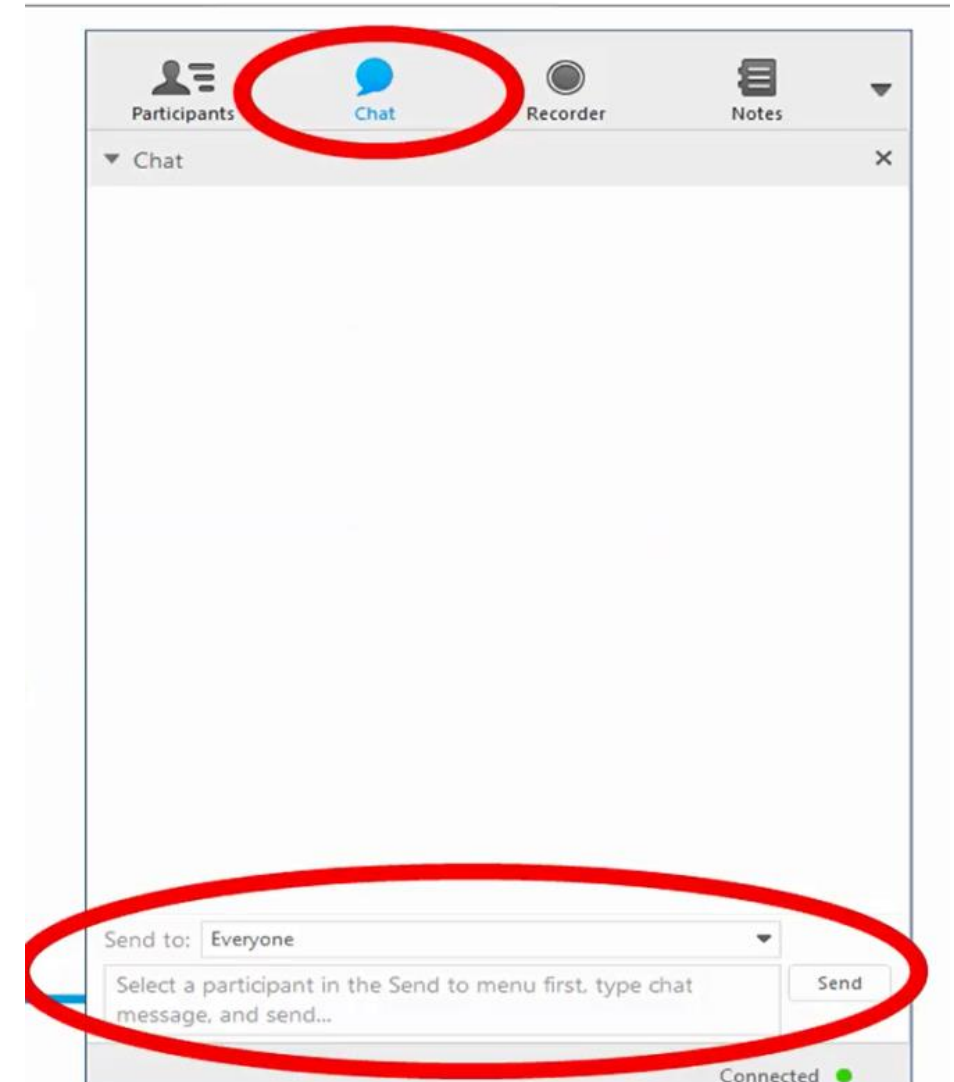
- Sound:

Computer or dial in:

Telephone no: 01-5260058

Event number: 846 914 224#

- Chat box function
 - Comments/Ideas
 - Questions
- Keep the questions coming
- **Twitter: @QITalktime**



PlayDecide: Patient Safety

A “serious game” learning tool
to discuss medical professionalism in relation to reporting and patient safety



UCD School of Nursing, Midwifery and Health Systems
UCD College of Health and Agricultural Sciences

Karen Rotherham-Egan
Patient Safety Representative

Steve Macdonald
Research Scientist

A photograph of an operating room with surgeons in green scrubs and masks, illuminated by large overhead surgical lights. The image has a teal color cast.

Supporting professionalism and patient safety

Building strong safety cultures in healthcare helps patients and staff

Blame culture and other barriers can pose a challenge to creation of supportive environments

Current landscape

Open disclosure and mandatory open disclosure¹
Patient-related incidents are sometimes unavoidable²
Errors or incidents may be being under-reported³

1) Government of Ireland. *Patient Safety Bill*. Dublin: Government of Ireland; 2018

2) 53,000 incidents at acute hospitals across Ireland in 2014 (State Claims Agency, 2016)

3) Rafter et al., 2016. The Irish National Adverse Events Study (INAES): the frequency and nature of adverse events in Irish hospitals—a retrospective record review study. *BMJ Qual Saf.* 2017 Feb;26(2):111-119

Reasons for not reporting

Fear of retribution

Believing someone else is dealing with the problem

Thinking that nothing will change after reporting

A new tool

PlayDecide: Patient Safety

Professionalism
in relation to
patient safety



UCD School of Nursing, Midwifery and Health Systems
UCD College of Health and Agricultural Sciences



Oireachtas na hÉireann
National Treasury Management Agency



Comhairle na nDoctúirí Leighis
Medical Council

PlayDecide: Patient Safety

A young child with blonde hair is lying in a hospital bed, looking up at medical equipment. The child is wearing a patterned hospital gown. The bed has a white sheet and a brown blanket. Medical equipment, including a monitor and control panels, is visible in the background.

Discuss patient safety issues
Exchange perspectives
Formulate group position

What is PlayDecide: Patient Safety?

“Serious game”

Educational focus
Discussion-based
Interdisciplinary exchange



www.playdecide.eu

Co-development process



UCD School of Nursing, Midwifery and Health Systems
UCD College of Health and Agricultural Sciences



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Health Service Executive



Gníomhaireacht Bainistíochta an Chisteáin Náisiúnta
National Treasury Management Agency



Comhairle na nDochtúirí Leighis
Medical Council

Co-development process (contd.)

11 key stakeholders with diverse perspectives on patient safety

Content created over 6 workshops across a 6-month period

Synthesis:

- Lived experiences of participants
- State Claims Agency reports
- National & international literature
- Systems analysis of incidents
- Medical professionalism
- The importance of speaking up

First iteration of the game

13 story cards, 22 information cards, 22 issue cards, 4 position statements

Story Card ⑦

Recognising clinical deterioration can occur without abnormal observations



Noor is a nurse working night shifts in a hospital ward.

A patient with a rare disease had a peripherally inserted central catheter line in situ during an admission. During the day he had his nasojejunal tube replaced. His mother reported he felt a 'little off' afterwards. Nurses did his observations throughout the day and reported he was fine. During the night he collided with a drip stand en-route to the bathroom, and this brought me into his room. He looked tremulous and reported feeling a 'bit off'. I checked his observations at 2 minute intervals. His temperature increased by 3 degrees in about 10 minutes from a low base. I suspected sepsis, which was confirmed, and started treatment immediately.

Info Card ⑨

Safety measures – Early warning scores

Longitudinal patient monitoring systems, for example the Early Warning Score (EWS), are recommended to detect the deteriorating patient in many countries (Griffiths & Kidney, 2012; Smith et al., 2013). In Ireland we have the National EWS recommended for use on the wards in hospitals.

Issue Card ⑦

Rare conditions/Atypical presentations

Patients with Rare Diseases/undiagnosed conditions may present in an atypical way in terms of baseline clinical parameters for heart rate, blood pressure, temperature, and reactions to medication. These presentations, whilst not occurring frequently, are possible. In the case of a diagnosed rare condition, it may well be that the patient or family member is more familiar with the condition than members of their healthcare team. In these situations, should we engage with and listen to the patient or family member in order to prevent unnecessary mishaps or patient deterioration?

Positions

1

All staff should report all concerns they have regarding patient safety, without fear of recrimination, in the knowledge that learning will happen and the system will be improved. Patient safety should be our top priority as healthcare professionals.

2

All staff should report only serious concerns they have regarding patient safety without fear of recrimination, in the knowledge that learning will happen and the system will be improved in relation to serious concerns.

3

All concerns regarding patient safety should be reported, but only by senior members of staff. Reporting by more junior members of staff is less likely to be effective.

4

Staff cannot be expected to report safety concerns because they are too busy providing care. There is no value in reporting safety concerns if a patient wasn't harmed or placed at risk. It is just a waste of people's time and resources.

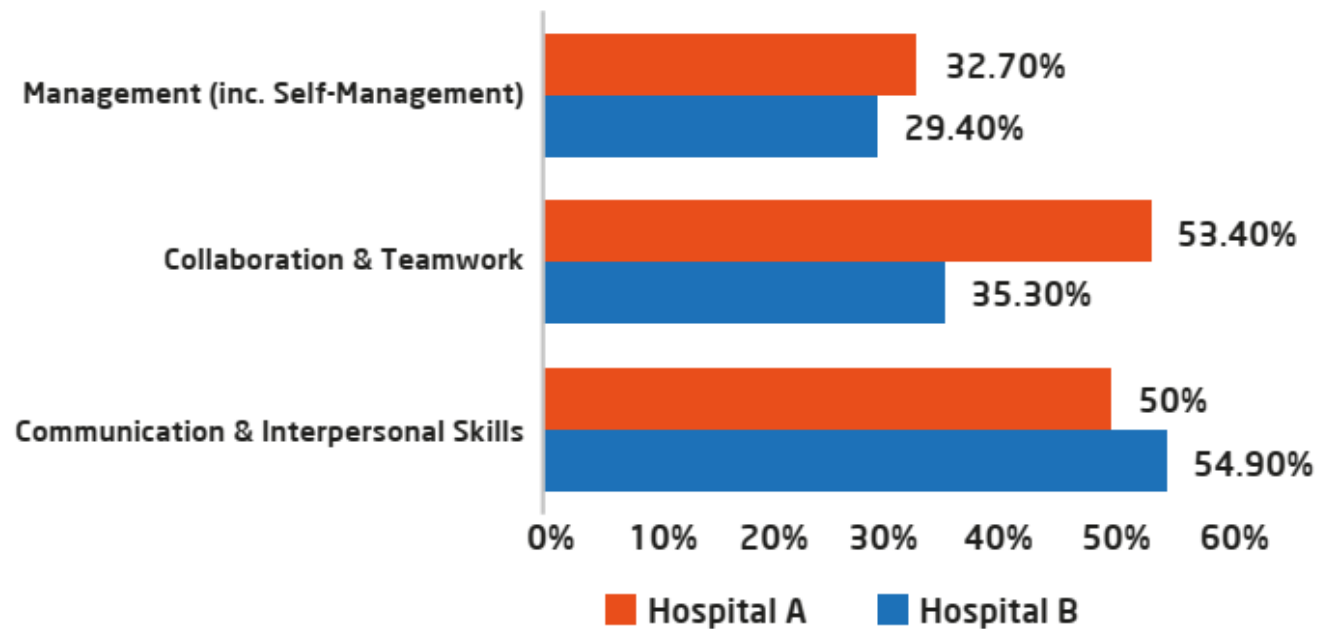
Testing the game

Over 100 junior doctors took part in PlayDecide workshops at two hospital sites.

Investigating whether the game would be a useful addition to support medical professionalism in relation to patient safety.

Examined leadership inclusiveness and psychological safety¹; safety concerns based on Medical Council's eight domains of professional practice²; and semi-structured interviews.

Top 3 contributory factors to incidents identified by junior doctors³



Reporting rates among junior doctors at the study sites were low – ~31% of those who had witnessed an incident had reported it.

1) Nemhard and Edmondson. *Making it safe: the effects of leader inclusiveness and professional status on psychological safety and improvement efforts in health care teams*. J Organ Behav 2006;27:941–66

2) Medical Council. *Talking about Good Professional Practice, views on what it means to be a good doctor*. Dublin: Medical Council; 2014

3) McAuliffe et al. *Policy brief on medical professionalism in relation to patient safety*. 2017. www.patientsafetydiscussions.ie

PlayDecide session outline

Session timing: **50min – 1hr**

Group size: **4 – 8 (+facilitator)**



1 Information gathering

2 Discussion

3 Group response formulation

How to play

1 Information gathering

Story Card ⑧

Ignored patient



John is an intern in a large hospital on surgical rotation.

On a Registrar-led ward round with my team we came to Tom's bed. It was obvious he needed intervention. Tom was lethargic, and had not taken oral fluids or eaten in the previous 24 hours, on a background of chronic diarrhoea. His skin was dark purple and his face was bloated. The Registrar said that Tom was no longer our patient, his care had been transferred to the medical team, so we moved to the next patient. I wanted to intervene, but was afraid what the Registrar might say. Tom died that night.

Info Card ②④

Serious patient safety incidents must be reported

Serious patient safety incidents are defined in the Patient Safety Bill 2018 as those which result in death or shortening of life expectancy; permanent damage or lasting impairment of bodily, sensory, motor, physical, or intellectual functions; necessitate increased treatment or cause lasting pain or psychological harm; or require treatment to avoid death or the aforementioned harms. (Government of Ireland, 2018)

Issue Card ③

Should we speak up about safety concerns?

Interns and Senior House Officers worry about the impact on their careers if they speak up. There needs to be a shared commitment to support and encourage all those who raise honestly held concerns about safety. This will sometimes require acceptance by staff that their performance may be the subject of comment, and that this needs to be seen as an opportunity to learn than a source of criticism. I appreciate this is not always easy (Francis Report, 2015).

How to play

2 Discussion



Story Card 8

Ignored patient



in a large hospital on

Issue Card 3

Should we speak up about safety concerns?

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Info Card 24

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How to play

2 Discussion (contd)

Challenge card

Tell the group who you think pays (in terms of resources, or consequences), and in what ways.

Guidelines Yellow Card!

Use the yellow card to help the group stick to the guidelines. Wave it if you feel a guideline is being broken or if you do not understand what is going on.

How to play

3 Group response formulation

Policy positions for Medical Professionalism in relation to Patient Safety

Positions

1

All staff should report all concerns they have regarding patient safety, without fear of recrimination, in the knowledge that learning will happen and the system will be improved. Patient safety should be our top priority as healthcare professionals.

2

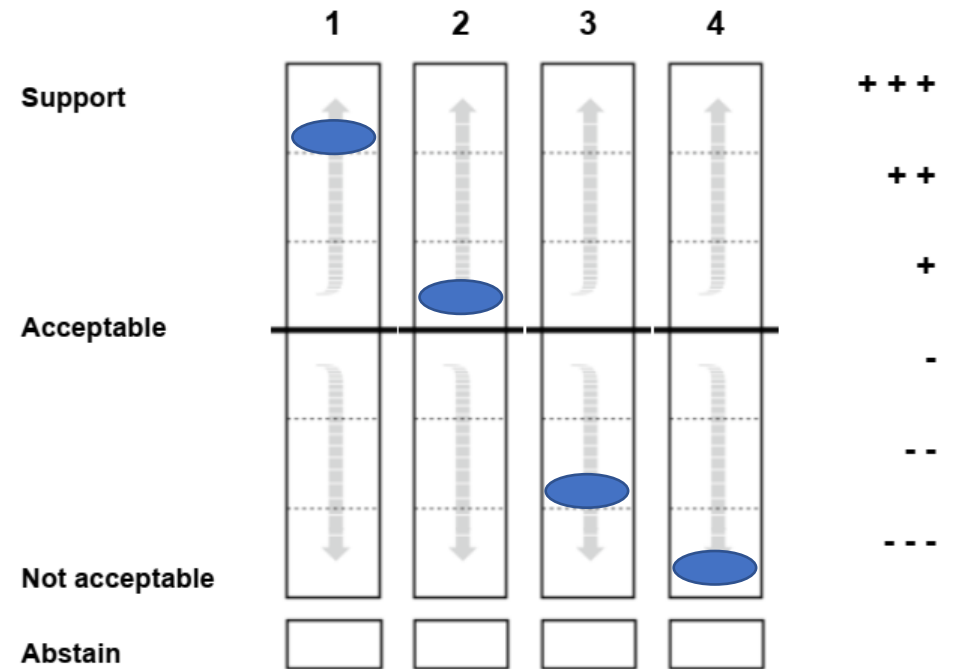
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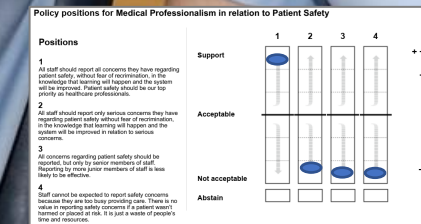
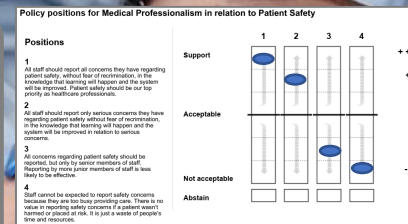
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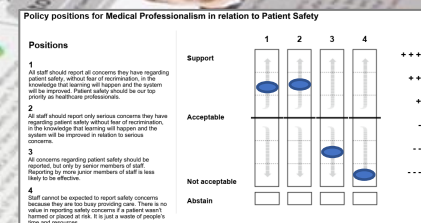
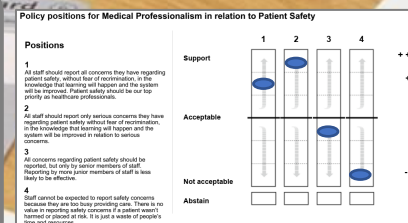
How to play

3 Group response formulation (contd)



1

All staff should report all concerns they have regarding patient safety, without fear of recrimination, in the knowledge that learning will happen and the system will be improved. Patient safety should be our top priority as healthcare professionals.



Content update: 2018 edition


Feedback from other testing groups indicated a desire for the game to be revised to include a wider range of perspectives.

We sought contributions from other stakeholders, and the game has now been revised to include:

- GP
- Management
- Nursing
- Pharmacy
- Physiotherapy
- More patients
- Updates to information and issue cards with recent topics of interest

Story Card 20

Power relationships between team members




Fahad is a basic grade physiotherapist working at a hospital.

During my first week on the orthopaedic ward, I was due to see a patient who had just undergone a knee replacement. The nurse manager told me during handover that the patient should be mobilised to the bathroom during his physiotherapy session. I knew that it was too soon after his surgery to do so, but the nurse manager insisted that the patient was doing unexpectedly well post-op, and his wishes should be respected. I did as I was told, but urged the patient to be cautious and not to get up without my assistance. He ignored my instruction, and subsequently fell while standing up to flush the toilet. He wasn't injured, but I felt that I had been pressured to obey commands of a senior staff member, leading to a situation that could have been very dangerous.

Story Card 15

Different perspectives on reporting



Isaheem is Operations Manager of a specialist clinic.

Several consultants emailed me complaining about reduced levels of administrative support at the clinic. It was causing delays in getting letters typed up to send to patients' GPs, and they noted that this was a risk to patient safety. I contacted the Clinical Nurse Manager (CNM) to ask for specific details of any incidents that had occurred. The CNM informed me that they would often take time from their work schedule to contact the GPs directly, and this helped minimise the risk to patient safety. I'm glad that the clinical staff are willing to make the extra effort to help our patients, but I agree that the situation is not ideal. I need the information on incidents to back up our request for additional staff hours – but when I asked for more specific details, the consultants accused me of wasting time and not addressing the actual problem.

Info Card 26

Finding the baseline to improve patient safety

The Irish National Adverse Events Study (INAES) commenced in 2013 and examined the frequency and nature of adverse events at Irish hospitals, acting as a retrospective baseline of incident rates before HSE established the National Clinical Programmes in 2010. The INAES found that one in eight patients (12.2%) experienced an adverse event in 2009, at an incident rate of 10.3 per 100 admissions.

Issue Card 23

Connecting with patients during mandatory open disclosure

Mandatory open disclosure regulations will ensure that issuing an apology or information to patients cannot be taken as an admission of liability. This should help to build an open culture around patient safety reporting, but who is responsible for making sure that that patients get informed about serious incidents, and how can we make sure that this happens in a timely manner?

Benefits of PlayDecide: Patient Safety



Interdisciplinary learning



Engage in open dialogue



Understand MDT perspectives



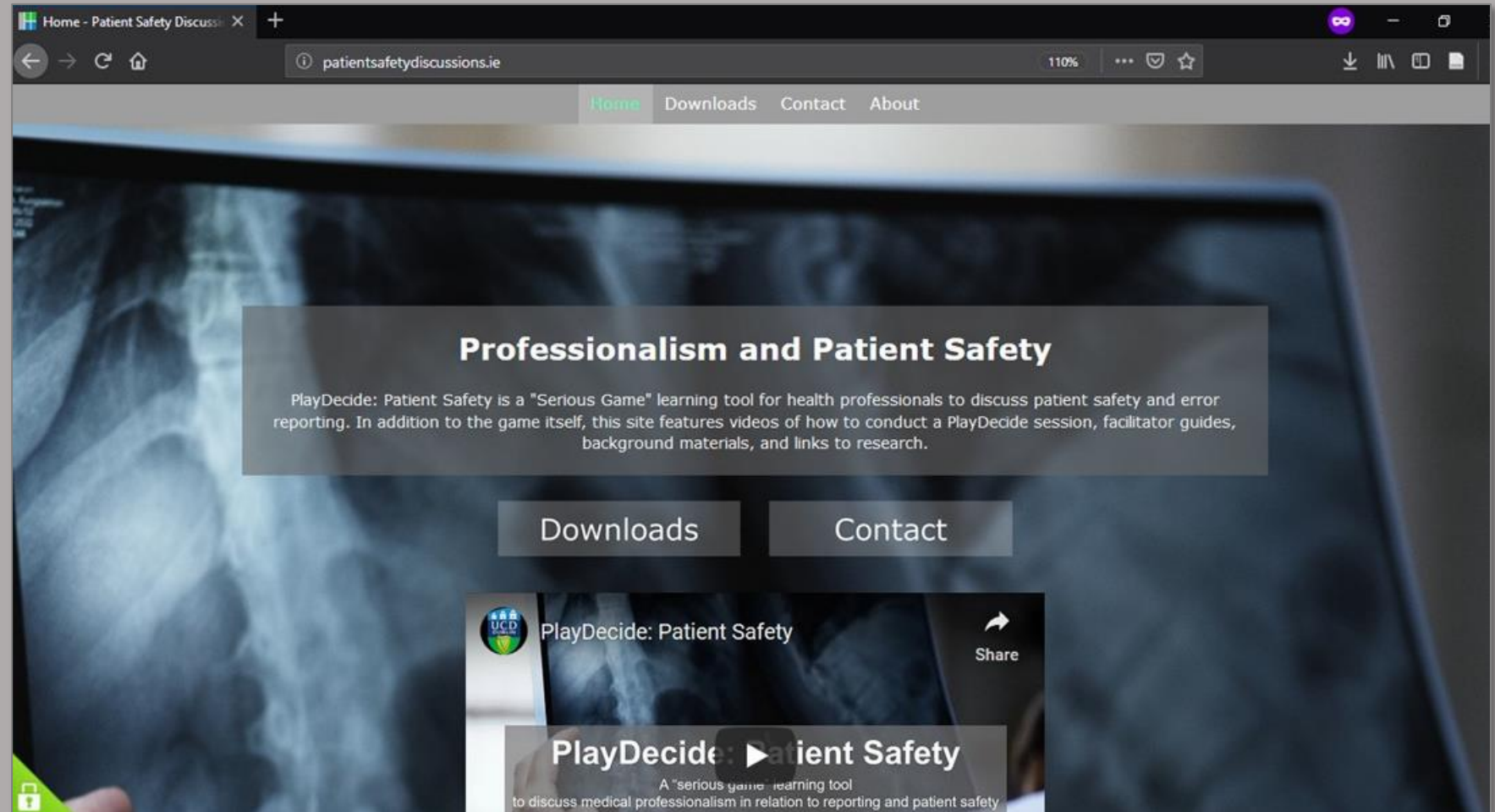
Explore patient safety challenges

Outputs: www.patientsafetydiscussions.ie

2018 MDT edition of
PlayDecide: Patient
Safety

Policy brief on medical
professionalism in
relation to patient
safety

Promotional video
outlining the game





UCD School of Nursing, Midwifery and Health Systems
UCD College of Health and Agricultural Sciences



www.PatientSafetyDiscussions.ie

HealthSystems@ucd.ie

[@UCDHealthSystem](#)

Helpful links

Framework for Improving quality

www.qualityimprovement.ie

Improvement Knowledge
and Skills Guide

<http://www.hse.ie/eng/about/Who/QID/aboutQID/>



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Next Webinar: Tues 11th Dec 1-2pm:

Topic – A guide to HSE QA & I Tool

Speaker: Declan O'Keeffe Acute Hospitals Division HSE

Thank you from all the team @QITalktime

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