Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Quality Improvement Division

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

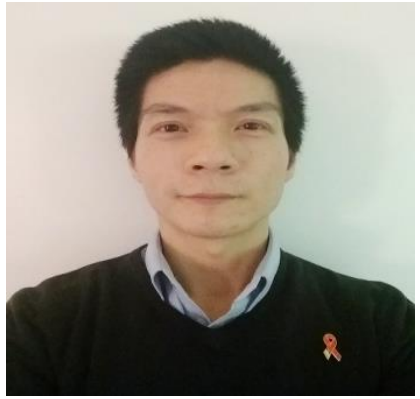
1pm Tuesday November 27th 2018

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:

<u>Computer or dial in:</u>

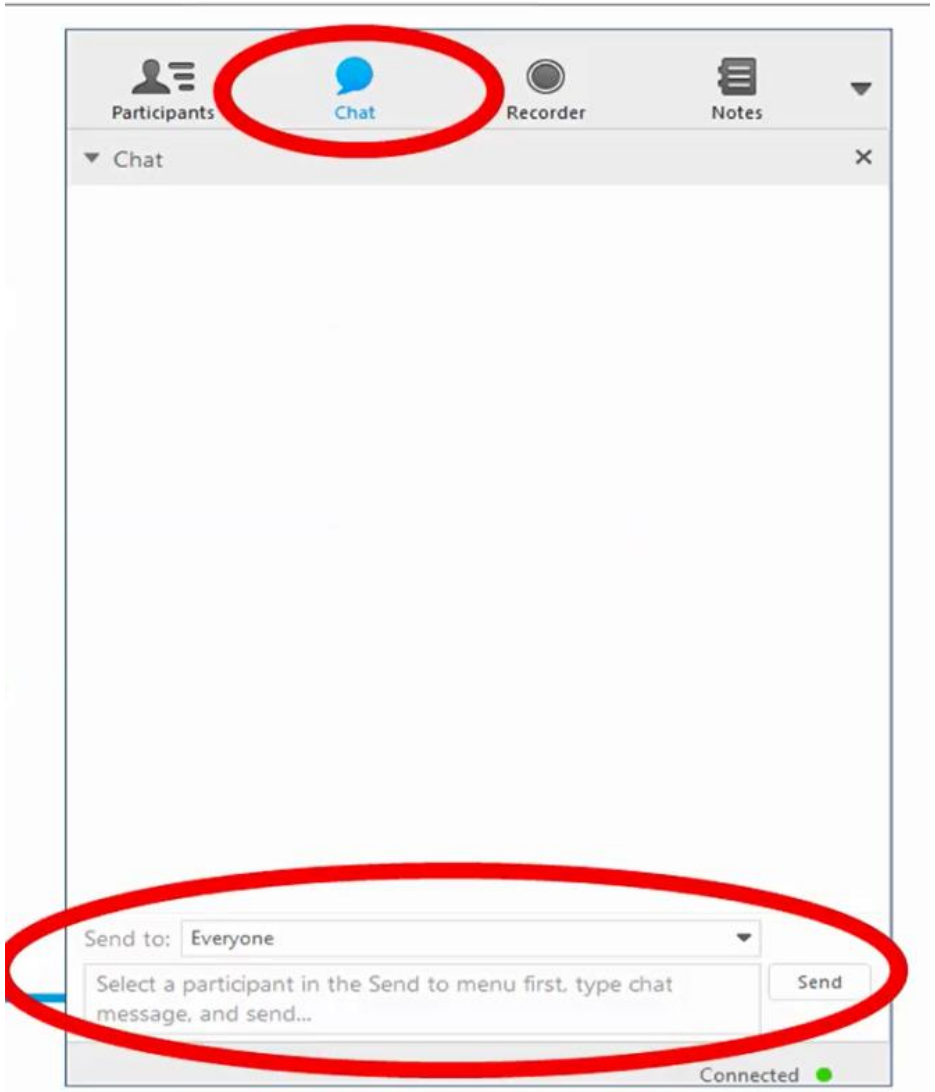
Telephone no: 01-5260058

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

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 disclosure[1]

Patient-related incidents are sometimes unavoidable[2]

Errors or incidents may be being under-reported[3]

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

PlayDecide: Patient Safety

Discuss patient safety issues
Exchange perspectives
Formulate group position

What is PlayDecide: Patient Safety?

“Serious game”

Educational focus
Discussion-based
Interdisciplinary exchange

play decide

INFOTUDE

ecsite
EUROPEAN NETWORK
SCIENCE CENTRES & MUSEUMS

www.playdecide.eu

Co-development process

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.

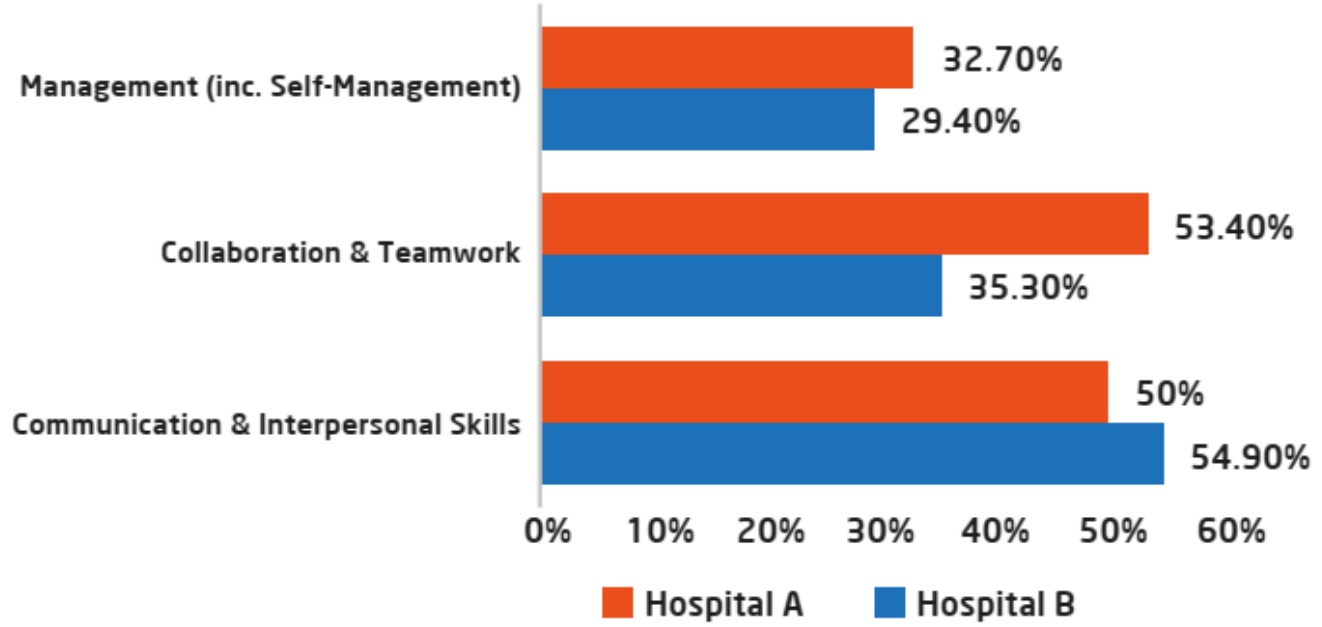
Testing the game

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 safety[1]; safety concerns based on Medical Council's eight domains of professional practice[2]; and semi-structured interviews.

Top 3 contributory factors to incidents identified by junior doctors[3]



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

1) Nembhard 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

How to play

2 Discussion (contd)

How to play

3 Group response formulation

Policy positions for Medical Professionalism in relation to Patient Safety

Positions

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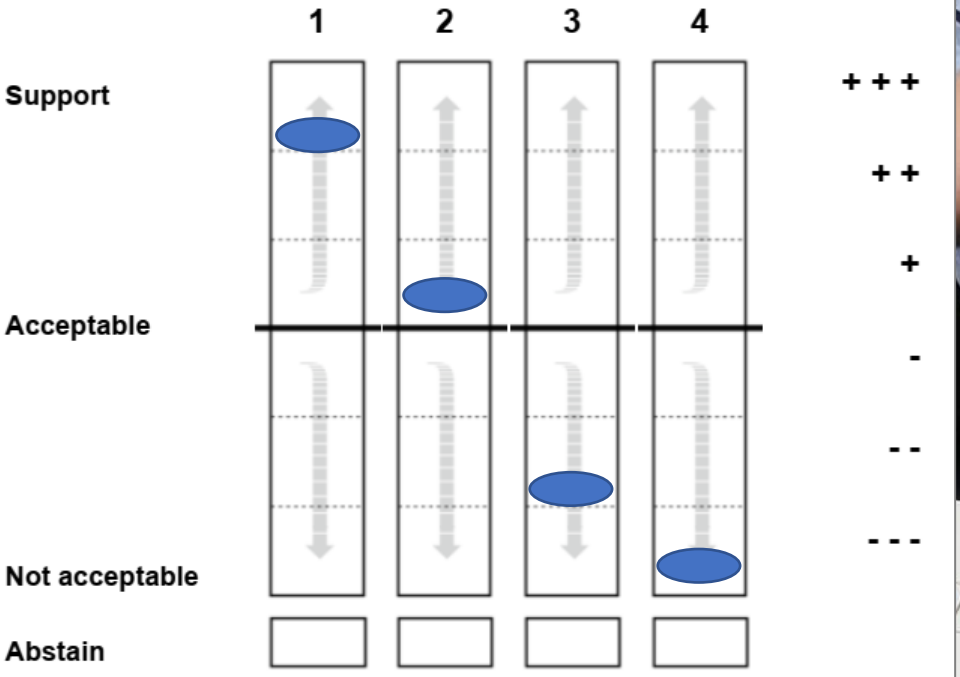
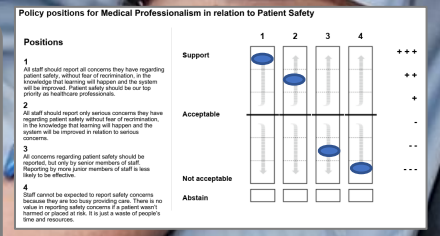
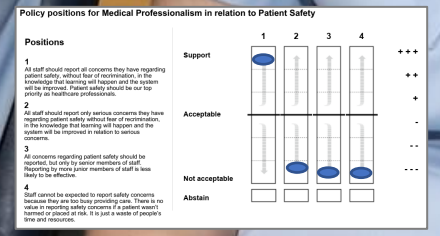


How to play

3 Group response formulation (contd)





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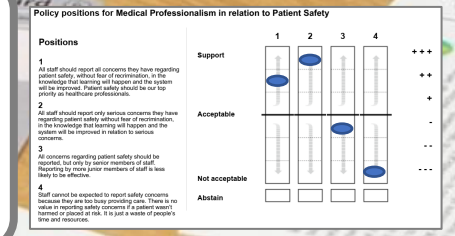
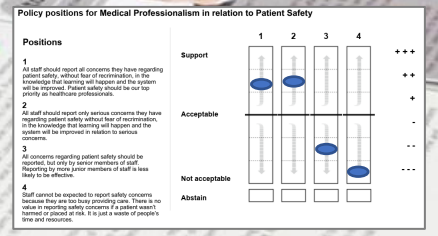




Content update: 2018 edition

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

Benefits of PlayDecide: Patient Safety

Interdisciplinary learning

Engage in open dialogue

Understand MDT perspectives

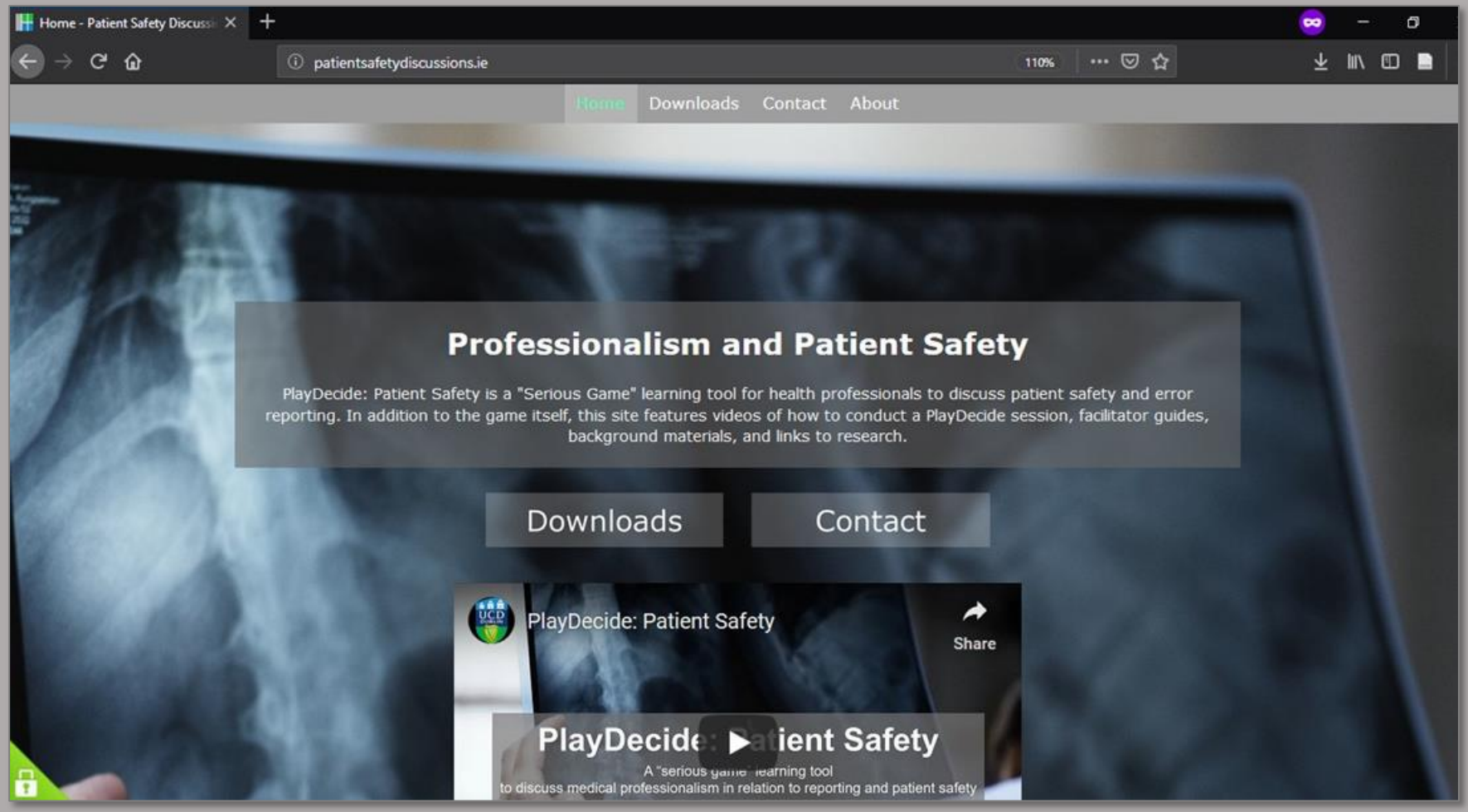
Explore patient safety challenges

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



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play decide

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Health Service Executive

Gníomhaireacht Bainistíochta an Chisteáin Náisiúnta
National Treasury Management Agency

Comhairle na nDochtúirí Leighis
Medical Council

Helpful links

Framework for Improving quality

www.qualityimprovement.ie

Improvement Knowledge and Skills Guide

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

Follow us on Twitter (@QITalktime)

Missed a webinar – Don't worry you can watch recorded webinars on HSEQID QITalktime page

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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