Building a Better Health Service

CARE COMPASSION TRUST LEARNING

Lead NCHD Awards

September 2017

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Quality Improvement Division

National Doctors Training & Planning

Contents Page

Introduction to the Lead NCHD Awards

The Lead NCHD initiative represents a 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 although in its infancy the Lead NCHD Initiative is a success story! 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 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 second annual Lead NCHD awards are:

1st Work life, Wellbeing and Efficiency: *Valuing Voices Programme - improving quality through staff engagement*
Dr Mortimer O'Connor, Mercy Hospital Cork)

2nd Medication Good Catch Initiative – A collaborative approach (Dr Louise Hendrick, Temple Street Children's University Hospital)

3rd Beating burn out: being kind (Dr Anna McHugh, Letterkenny General Hospital).

I would like to acknowledge Professor Eilis McGovern, Director, NDTP, Dr Philip Crowley, National Director, Quality Improvement Division (QID) and Dr Julie McCarthy, National Clinical Lead, Clinical Director Programme for their continued support of the Lead NCHD programme and these awards. In addition, I would particularly like to thank Dr Catherine Diskin for her unwavering support and outstanding leadership in her role as National Lead NCHD 2016-2017 and Ms Juanita Guidera, QID Lead Staff Engagement for her guidance and help with the Lead Programme and associated Initiatives.

All entries are included in this booklet organised by hospital. With the permission of Dr Healy, Lead NCHD Cork University Hospital 2015-2016, Improving the NCHD culture in Cork University Hospital - A 10 point plan, is also included as it may be of interest to newly appointed Lead NCHDs.

Thank you,

Louise

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

Work life, Wellbeing and Efficiency: *Valuing Voices Programme - improving quality through staff engagement*

Dr Mortimer O'Connor[1], Ms Fiona Lynch[2], Ms Juanita Guidera[3], Ms Victoria Collins[4], Ms Maureen Flynn[5], Dr Megan Alcock[6], Dr Catherine Diskin[7]

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Introduction

In 2017, in partnership with the Quality Improvement Division (QID), the Mercy University Hospital commenced a programme to test the Valuing Voices Programme as a staff engagement methodology designed to build leadership capacity by training and mentoring four local facilitators to engage staff and enhance teamwork using a combination of staff listening, action planning and Front Line Ownership techniques. NCHDs had an opportunity to share and act on their ideas and suggestions for improvement with the facilitators through a series of listening, action planning and implementation sessions. The focus of the work was to improve NCHD wellbeing.

Methods

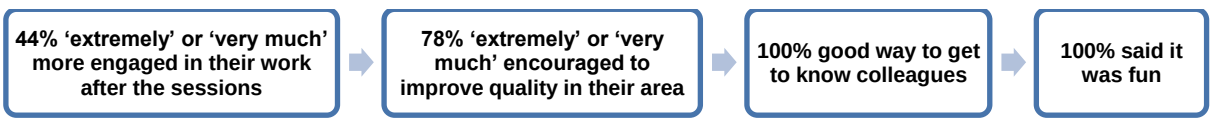
The QID Lead for Staff Engagement trained four facilitators in the methodology and provided mentoring throughout the process. The Lead NCHD (LNCHD) and Medical Manpower Manager (MMM) led the project on site. 20 NCHDs participated in staff listening sessions with the goal of improving NCHD wellbeing. 12 NCHDs participated in an action planning session. The action planning session focused on 4 themes identified at the listening sessions. Using a frontline ownership ethos, LNCHD and MMM coached 12 NCHDs to act on these themes. The executive management team agreed to support and act on the top suggestions for improvement.

Results

The top 4 themes identified at the listening sessions were:

1. Introduction of a handover/ward jobs book
2. Review and improvement of the bleep policy
3. Enhancing the on-call rota and distribution of work on night/weekend call
4. Introduction of additional computers to improve efficiency on the ward

NCHD selected their area of greatest interest to develop and implement the required changes. The facilitators gave direction and mentorship to the groups.



Conclusions

Through frontline ownership using the Valuing Voices Programme the MUH is improving the efficiency of the hospital, the work life of NCHDs and aiding staff wellbeing.

Work life, wellbeing and efficiency

Valuing Voices Programme - improving quality through staff engagement

Mortimer O'Connor[1], Fiona Lynch[2], Juanita Guidera[3], Victoria Collins[4], Maureen Flynn[5], Megan Alcock[6], Catherine Diskin[7]
Mercy University Hospital in collaboration with the Quality Improvement Division, Health Service Executive, Ireland

Aim and objectives

In 2017, in partnership with the Quality Improvement Division (QID), the Mercy University Hospital commenced a programme to test the Valuing Voices Programme as a staff engagement methodology. The programme is designed to build leadership capacity by training and mentoring four local facilitators to engage staff and enhance teamwork using a combination of staff listening, action planning and Front Line Ownership techniques[1,2]. Non Consultant Hospital Doctors (NCHDs) who participate in the programme have an opportunity to share and act on their ideas and suggestions for improvement with the facilitators. The focus of the work is to improve NCHD wellbeing.

Intervention description and methodology

The Mercy University Hospital, volunteered to be the partner site for test of concept of this approach. As part of the initial engagement with the site, the executive management team agreed to support and act on the top suggestions for improvement from staff and the key theme of NCHD wellbeing was agreed.

Following the design of the programme within the Quality Improvement Division using learning from initiatives with a number of sites in 2015 and 2016, the programme commenced in January 2017 using a five step approach.

Step one: Training for facilitators

- Each facilitator participates in a one day training programme, with a follow up practical session for 3 hours in advance of the first listening session

Step two: Facilitating a listening session

- NCHDs identify what's working well and the top priorities for improvement

Step three: Facilitating an action planning session using a front line ownership approach

- NCHDs use critical and creative thinking to develop an action plan based on outputs of the listening session using a world café approach. Participants self select the idea they want to work on from a list developed through the staff listening sessions

Step four: Facilitating implementation sessions using a front line ownership approach

- NCHDs act on the ideas, engaging other stakeholders as required. Frequency of meetings for action planning are determined by local team and need. During this stage, local facilitators receive ongoing mentoring as desired from the QID Lead Staff Engagement and NCHDs are mentored by the Lead NCHD and Medical Manpower Manager

Step Five: Sharing success stories / innovation

- Participants will share outputs with their colleagues to demonstrate that ideas were listened to and acted on.

Figure one: Overview of the programme

The Quality Improvement Division Lead for Staff Engagement trained four facilitators in the Valuing Voices methodology and provided mentoring throughout the process to co-design interventions with facilitators based on local need. The Lead NCHD and Medical Manpower Manager led the project on site through the process outlined above.

20 NCHDs participated in staff listening sessions with the goal of improving NCHD wellbeing. 12 NCHDs participated in the follow up action planning session which focused on the four themes identified at the listening sessions. NCHDs self selected the area of greatest interest to them offering to develop and implement the required changes.

Using a front line ownership ethos, the Lead NCHD and Medical Manpower Manager will coach 12 NCHDs to act on these themes. The QID Lead Staff Engagement will continue to coach the facilitators in the methodology as desired.

The four themes were as follows:

- Introduction of a handover / ward book
- Review and improvement of the bleep policy
- Enhancing the oncall rota and distribution of work on nights and weekend call
- Introduction of additional computers to improve efficiency on the ward

Challenges and supports

Communications in relation to the process was challenging as staff do not have access to a work email address and nature of working hours. Additional time spent outlining the vision at the start of the process and immediately communicating outputs of the listening sessions will help with further implementation. Informal data also indicates that a directive communications style was most effective to encourage participation which contraindicates the approach of inviting and working the willing only. This warrants further study.

Benefits / outcomes

Preliminary findings indicate that the methodology was well received at both the training for facilitators and the staff listening sessions. While 22% of staff were undecided about the benefit of the staff listening session with one person commenting that they were unsure, 100% of facilitators and 78% of NCHDS said they would recommend it to colleagues.

- 44% 'extremely' or 'very much' more engaged in their work after the sessions
- 78% 'extremely' or 'very much' encouraged to improve quality in their area.
- 100% good way to get to know colleagues
- 100% said it was fun

Figure two: Post Staff Listening Session comments from NCHDs on actions they will stop and start doing

What is one thing you will START doing as a result of this work?

"Discussing issues with nurses, maybe we could come up with a more efficient way of communicating together"

"Talk about wellbeing more openly with colleagues"

"Engage more with management to change problems"

"Making my suggestions for improvement known"

"Discuss need for journal club"

What is one thing you will STOP doing as a result of this work?

"Ignoring problems as I'm only temporary"

"Focus on factors uncontrollable"

Conclusion

The findings supports the literature that valuing staff knowledge and expertise impacts engagement[3]. Higher staff engagement levels result in lower patient mortality, reductions in the number of incidents, improved clinical care, improved patient experience, improved staff wellbeing, lower absenteeism rates and improved staff retention[4,5].

As there is existing evidence that where staff are engaged, quality improves[6] it is also expected that this intervention will ultimately result in improvements in service delivery locally and that facilitators will develop further skills to lead future quality improvement projects using this approach.

Pictured above are the Lead NCHD, Medical Manpower Manager and NCHS who participated in action planning sessions

Key learning

1. Commitment to release staff and encourage participation is essential
2. Communication style impacts engagement. NCHDs appreciate clear concise communications
3. Changes cannot be made in isolation. NCHDs now need to engage with others
4. Creating an opportunity for NCHDs to share and act on their ideas will lead to improvements in efficiency and wellbeing based on initial reports.

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Acknowledgements
Special thanks to the staff of Mercy University Hospital who engaged in this process and / or provided cover so that others could attend the session. Full support, leadership and commitment from the management team is critical to the success of the work and in this regard, we wish to thank the Executive Management Team, Mercy University Hospital for their willingness to engage in the process and their commitment to listen to the feedback and action the top suggestions in collaboration with staff.

Thanks especially to Dr. Michael Gerdam and Leah Gitterman for encouraging our use of the Front Line Ownership approach and their ongoing support, encouragement and sharing. Thanks also to Yvonne Delaney and Steve Pitman RCSI for their guidance in relation to measurement. Thanks to Dr. Catherine Diskin, National Lead NCHD for supporting this work. Finally thanks to the project sponsor, Dr. Philip Crowley, National Director Quality Improvement Division for his active encouragement and endorsement of this work.

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Taking the Temperature: Wellbeing of NCHDs at University Limerick Hospital Group (ULHG)

Dr Aisling O'Riordan[1], Dr Michelle Canavan[2]
[1 2]Lead NCHDs ULHG

Objectives

This project looked to assess NCHD morale across the University Limerick Hospital Group (ULHG) and to identify key areas of concern, in order to inform future initiatives aimed at improving NCHDs' experience.

Method

An electronic survey was sent to all NCHDs enrolled with the human resources department of the UHLG with a valid email address. This totalled 370 invited participants. The survey contained 13 questions with a mixture of multiple choice and free text answers to give both quantitative and qualitative information. The survey was open to participants from February 21st 2017 to March 27th 2017.

Results

There were 101 responses to the survey, giving a response rate of 27%. Respondents were asked to rate morale among NCHDs at ULHG with an average of 5/10. On the question of bullying participants cited verbal abuse, obstructive and negative attitudes, and feeling undermined. Factors identified with bullying include stressful work environment, limited staff and pressure to complete tasks.

Participants felt the positive aspects of working at ULHG included camaraderie, supportive colleagues, good case mix, learning opportunities as well. Their suggestions for improving the NCHD experience at UHLG cited a need for increased staffing as a priority, after this they looked for improved efficiency through IT and payroll transparency. They also looked for improved induction, access to leave and improved communication between staff.

Finally, when asked what kind of stress management strategies would help respondents looked for improved IT and leave featured regularly. NCHDs also suggested yoga, mindfulness and sports activities.

Outcomes

These results have been presented to the management of the hospital and to NCHDs. It has directed our work this year as Lead NCHDs and we hope that it will inform the incoming Lead NCHDs in Limerick and elsewhere as to what NCHDs' priorities are.

Taking The Temperature

Wellbeing of NCHDs at UL Hospitals Group (ULHG)

Aisling O'Riordan, Michelle Canavan, Lead NCHDs ULHG

Objectives

For Non-Consultant Hospital Doctors (NCHDs) issues around morale, bullying and access to educational opportunities, impact on their day-to day work as well as their overall sense of job satisfaction and happiness. This project looked to assess NCHD morale across the UL Hospitals Group (ULHG) and to identify key areas of concern, in order to inform future initiatives aimed at improving NCHDs' experience.

Method

An electronic survey was sent to all NCHDs enrolled with the human resources department of the UHLG with a valid email address. This totalled 370 invited participants. The survey contained 13 questions with a mixture of multiple choice and free text answers to give both quantitative and qualitative information. The survey was open to participants from February 21st 2017 to March 27th 2017.

Results

There were 101 responses to the survey, giving a response rate of 27%. The first 4 questions gathered data on the respondents demographics.

Question 5 asked respondents to rate morale among NCHDs at ULHG with an average of 5/10. The results of Question 6 -10 are illustrated in figures 1-5. On the question of bullying (Question 9) participants cited verbal abuse, obstructive and negative attitudes, and feeling undermined. Factors identified with bullying include stressful work environment, limited staff and pressure to complete tasks.

Fig.1 Q6: Do you feel valued as an employee at ULHG?

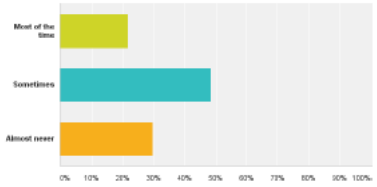


Fig.2 Q7: Would you work at ULHG again next year or recommend working here to another colleague?

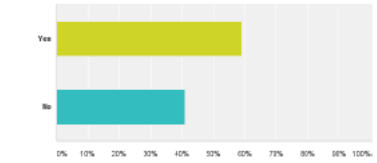


Fig.3 Q8: Do you feel you receive adequate training at UHLG?

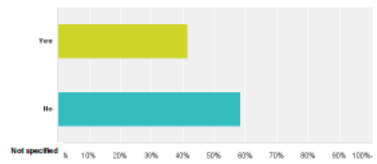


Fig.4 Q9: Have you ever experienced bullying while working at ULHG?

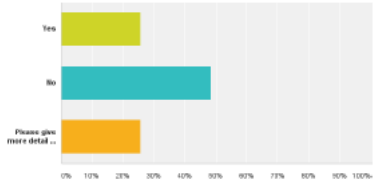
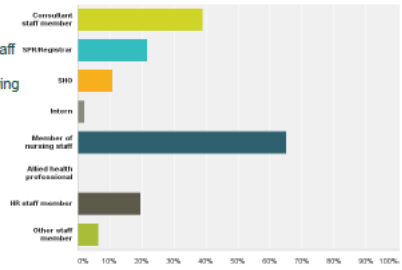


Fig.5 Q10: If you answered yes to question 5 - what staff member(s) were involved in the bullying episode?



Questions 11 asked participants what are the positive aspects of working at UHLG? Recurring themes included camaraderie, supportive colleagues, good case mix, learning opportunities as well as social issues such as competitive rent and free car parking.

"There's a sense of enthusiasm and will to push things forward, to improve and attempt to establish UHL as a center of excellence in the country"

When asked what suggestions do you have for improving the NCHD experience at UHLG? (Question 12) NCHDs cited a need for increased staffing as a priority, after this they looked for improved efficiency through IT and payroll transparency. They also looked for improved induction, access to leave and improved communication between staff.

"First of all, start treating people not on training schemes as humans, with dreams and ambitions too "

Finally question 13 asked what kind of stress management strategies would help. Again staffing, improved IT and leave featured regularly. NCHDs also suggested yoga, mindfulness and sports activities.

"Employ more NCHDs to get the time to implement any sort of stress management time outs! Every team in the hospital is stretched to the end! "

Outcomes

These results have been presented to the management of the hospital and to NCHDs. It has directed our work this year as Lead NCHDs and we hope that it will inform the incoming Lead NCHDs in Limerick and elsewhere as to what NCHDs' priorities are.

This survey inspired a number of projects.

- Dedicated NCHD wellbeing night with guest speakers
- NCHD sports teams
- NCHD involvement in hospital sports and social committee
- Development of e-referral/e-discharge
- Restructured induction.

Acknowledgements

Clinical Directorate of the University Hospital Limerick

NCHD Committee of the UL Hospitals Group

Deirdre King De. Montano General Manager Chief Clinical Director

Quality Improvement Project: Improving Clinical Handover

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Background

Clinical Handover of care is known to be one of the most precarious procedures in modern medicine. Failure in handover is a major preventable cause of adverse events for the patient and this is principally due to human factors of poor communication and systemic error. The HSE has identified the need to improve the quality of clinical handover. This project therefore targets a department-wide, general hospital-wide issue, therefore the importance of which will only increase.

Objectives

To investigate and improve the quality of clinical handover within the department of Obstetrics & Gynaecology at Cavan General Hospital using the plan, do, study, Act (PDSA) cycle.

Plan

• To investigate the current clinical handover practice within the department of Obstetrics & Gynaecology.

• To improve the quality of clinical handover, in order to meet the best practice standards for clinical handover as laid out by the HSE.

• To implement a clinical handover amongst NCHD's, in order to be able to trace accountability.

• To use the clinical handover model to create a 'tool kit' from this project that can be applied to other handovers within other specialties, and across both acute sites within the RCSI hospital group.

Conclusion

There is a strong consensus is that the formal clinical handover face-to-face meeting is maintained, supporting best practice guidance that verbal handover should not be replaced, only supported, by organised systems.

QI Project Reflections

Benefits:

• Greater mutual appreciation and understanding of roles of manager and clinician

• Wider understanding of a common issue across the HSE and opportunity to benchmark against other Hospital groups, and health systems.

Challenges:

• Resources – no time in job plans for project.

• Difficult to bring about behavioural change in a large organisation.

• Lack of information sharing cross-organisation – different departments and individuals unknowingly working on same issues.

QUALITY IMPROVEMENT PROJECT: IMPROVING CLINICAL HANDOVER

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Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

BACKGROUND

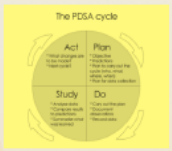
"Handover is the transfer of professional responsibility and accountability for some or all aspects of the care of a patient, or group of patients, to another person or professional group on a temporary or permanent basis"[1] - Irish Medical Council, 2016

Clinical Handover of care is known to be one of the most precarious procedures in modern medicine. Due to a result of the European Working Time Directive (EWTD), there has been an increase in the number of handovers taking place, and therefore has elevated the need for the quality of handover to be improved and regulated.[2]Failure in handover is a major preventable cause of adverse events for the patient and this is principally due to human factors of poor communication and systemic error.[3]

The department of Obstetrics & Gynecology has experienced problems relating to the quality of its handover procedures. The quality of clinical handover needed to be addressed. Moreover, the HSE has identified the need to improve the quality of clinical handover. This project therefore targets a department-wide, general hospital-wide issue, therefore the importance of which will only increase.

OUR AIM

To investigate and improve the quality of clinical handover within the department of Obstetrics & Gynaecology at Cavan General Hospital using the plan, do, study, Act (PDSA) cycle.[4]



PLAN

- To investigate the current clinical handover practice within the department of Obstetrics & Gynaecology.
- To identify areas of weakness in this current clinical practice, using a variety of research methods.
- To improve the quality of clinical handover, in order to meet the best practice standards for clinical handover as laid out by the HSE.
- To implement a clinical handover amongst NCHD's, in order to be able to trace accountability.
- To use the clinical handover model to create a 'tool kit' from this project that can be applied to other handovers within other specialties, and across both acute sites within the RCSI hospital group.

DO

1. Investigation of current clinical handover procedure within department of Obstetrics & Gynaecology at Cavan General Hospital, and identification of issues:
- There is current formal policy for clinical handover
- Uncoordinated time and place for clinical handover - (exception: labour ward handover (registrar-registrar)
- No use of paper record of clinical handover.

2. An NCHD survey of opinions and experiences of current clinical handover procedures, including meeting with the clinical director, prof. Hayes and general manager, . Ray Bonar.

3. Survey of NCHD's working in Cavan General hospital regarding clinical handover, to be carried out again following improvements. Pre-implementation survey carried out.

4. Comprehensive research into best practice, and creation of an formal clinical handover system based on shortcomings of the existing system against best practice.

STUDY

The survey was created in order to query the clinical handover system in department of Obstetrics & Gynaecology against Cavan General hospital Hospital against the key elements identified in best practice documentation, as well as observed and anecdotally reported issues.

PRE IMPLEMENTATION SURVEY (N=7)

•4/7 respondents thought that the current clinical handover arrangements were ineffective.

•3/7 thought a minimum data set for clinical information would be useful.

•4/7 thought the current computer software systems were inadequate.

•3/7 had experiences problems locating patients due to inadequacies of the live bed state, leading to temporarily 'lost patients

POST IMPLEMENTATION SURVEY (N=7)

- 4/7 thought there should be use of both the clinical handover pro forma and the Friday handover meeting.
- 6/7 thought a way of prioritising the jobs on the weekend handover list would be beneficial.
- 5/7 thought a hand-back system would be useful for the returning on call teams.

DOCUMENTATION OF CLINICAL HANDOVER SHEETS

	TOTAL NUMBER	PERCENTAGES
DATE RECORDED	48 DAYS	
TIME RECORDED	29	60.4%
'HANDED-OVER BY' RECORDED	37	77.1%
'HANDED-OVER TO' RECORDED	32	66.7%
PATIENTS DETAILS RECORDED	40	83.3%
CONSULTANT DETAILS RECORDED	40	83.3%
DIAGNOSIS RECORDED	39	81.3%
REASONS FOR HANDOVER RECORDED	39	81.3%
'TASKS TO BE DONE' RECORDED	39	81.3%

CONCLUSIONS

The introduction of the paper pro forma has measurably improved opinion on the quality of clinical handover. There is a strong consensus is that the formal clinical handover face-to-face meeting is maintained, supporting best practice guidance that verbal handover should not be replaced, only supported, by organised systems. A way of prioritising 'tasks to be done' on the clinical handover spreadsheet is required. The use of a simple hand-back system may be useful for the team consultant returning to their patients following the on call shift.

ACT

The conclusions drawn above compel the following actions:

1.Clinical handover 'Tasks to be done' on the paper pro forma require ranking in terms of urgency. This was presented at and accepted by NCHD's at the 'NCHD Forum Meeting'.

2. Completion of all the categories the clinical handover pro forma has been made compulsory.

3. A clinical handover 'Gold Standard' using the ISBAR tool had been created, which includes both use of the paper pro forma and summarises the best practice guidelines. The Gold Standard mandates signing of attendees at the clinical handover meeting being kept by the site practitioner.

4. The on-call sho will wait in the Doctors' room in the morning to give returning teams a quick hand-back on issues arising during the on call shift with their patients. These issues will also be recorded in the archived pro forma.

5. A short teaching session will be given to all new NCHD's regarding safe clinical handover and practice at Cavan General Hospital.

FUTURE RECOMMENDATIONS

1. To possibly roll out an electronic handover in the near future. As there were concerns about length of time taken to fill in paper proforma, there is a computer in the doctors room so it may be feasible to be filled in quickly during the handover.
2. Audit Handover meeting attendance and completion of paper proforma fields.
3. Liaise with IT and senior clinicians and managers concerning up further use & possible up grading of the hospitals IT systems, using results from surveys and literature review.

QUALITY IMPROVEMENT PROJECT REFLECTIONS

BENEFITS

- Greater mutual appreciation and understanding of roles of manager and clinician
- Wider understanding of a common issue across the HSE and opportunity to benchmark against other Hospital groups, and health systems.

CHALLENGES

- Resources – no time in job plans for project.
- Difficult to bring about behavioural change in a large organisation.
- Lack of information sharing cross-organisation – different departments and individuals unknowingly working on same issues.

REFERENCES AVAILABLE ON REQUEST

A Qualitative Exploration of Non-Consultant Hospital Doctor's (NCHD's) Perceptions of Quality Improvement in Ireland

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[2] NCHD, Cavan General Hospital, Ireland
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Background
Health care professionals aim to provide the highest quality of care. To improve patient care, quality Improvement (QI) is considered as an essential component. (Berwick, 2013)

Objectives
The aim of our study was to understand the current experience NCHDs have of QI and how this varies across different specialties and levels of seniority. Secondly it was to identify areas of excellence and the barriers that NCHDs face in QI.

Methodology
A ten question anonymous online questionnaire was distributed to all the NCHDs in a district general hospital in Ireland. The completed questionnaire results remained anonymous. Data was analysed, and all quantitative data and figures presented in this study was derived from the questionnaire.

Results
Majority of the NCHDs had completed zero QI projects, and they were neither satisfied or dissatisfied with their past QI experience. Majority of participants had not received any formal QI training, and over 70% believed that QI training should be made mandatory. Over half of the NCHDs believed that lack of QI knowledge/methodology and lack of time were the main barriers which discouraged them from taking part in QI projects.

Conclusion
NCHDs need to be trained in QI. Without developing this competence, NCHDs are unlikely to create projects which can potentially make a difference to improve patient care. Without providing NCHD's with the tools and time to lead change, they are likely to become demoralised, and will never fully engage with the QI agenda.

Recommendations
1. Protected, bleep-free time should be allocated to all NCHDs in training on a regular basis for QI projects.
2. All clinical supervisors should be trained in QI methodology and their role should expand to include providing advice and support to NCHD's participating in and leading QI projects.
3. The allocation of a Quality Improvement/Audit Facilitator based at Cavan General Hospital.

A Qualitative Exploration of Non-Consultant Hospital Doctor's (NCHD's) Perceptions of Quality Improvement in Ireland

Ahmeda Ali[1] Nazreen Shahrom[2] Gillian Whyte[3]

[1] Lead NCHD, Cavan General Hospital, Ireland [2]Lead NCHD, Cavan General Hospital, Ireland
[3]Quality & Performance Manager, Cavan General Hospital, Ireland

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

ABSTRACT

Background

Health care professionals aim to provide the highest quality of care.

To improve patient care, quality Improvement (QI) is considered as an essential component. (Berwick, 2013)

Objectives

The aim of our study was to understand the current experience NCHD's have of QI and how this varies across different specialties and levels of seniority. Secondly it was to identify areas of excellence and the barriers that NCHD's face in QI.

Methodology

A ten question anonymous online questionnaire was distributed to all the NCHD's in a district general hospital in Ireland. The completed questionnaire results remained anonymous. Data was analysed, and all quantitative data and figures presented in this study was derived from the questionnaire.

Results

Majority of the NCHD's had completed zero QI projects, and they were neither satisfied or dissatisfied with their past QI experience. Majority of participants had not received any formal QI training, and over 70% believed that QI training should be made mandatory. Over half of the NCHD's believed that lack of QI knowledge/methodology and lack of time were the main barriers which discouraged them from taking part in QI projects.

Conclusion

NCHD's need to be trained in QI. Without developing this competence, NCHD's are unlikely to create projects which can potentially make a difference to improve patient care. Without providing NCHD's with the tools and time to lead change, they are likely to become demoralised, and will never fully engage with the QI agenda.

Recommendations

1.Protected, bleep-free time should be allocated to all NCHD's in training on a regular basis for QI projects.

2. All clinical supervisors should be trained in QI methodology and their role should expand to include providing advice and support to NCHD's participating in and leading QI projects.

3. The allocation of a Quality Improvement/Audit Facilitator based at Cavan General Hospital.

OBJECTIVES

The aim of this study to give NCHD's the opportunity to influence local policy of our district general hospital and to lead developments in the future training pathways for QI.

Specifically, we aimed to:

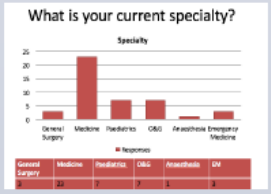
- Understand the current experience of NCHD's have of QI and how this varies across different specialties, and across the levels of seniority.
- Identify the barriers and obstacles that NCHD's face in QI
- Make recommendations that will facilitate NCHD's engagement in QI

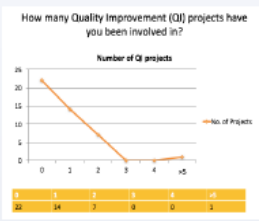
METHODOLOGY

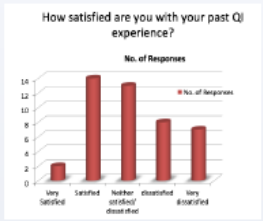
With support from management at Cavan General Hospital, we recruited frontline (training/non-training) NCHD's from different specialties, and stages in their career path to the NCHD Committee Group. An initial literature review ascertained the: current NCHD participation, barriers, and both regional initiatives in QI.

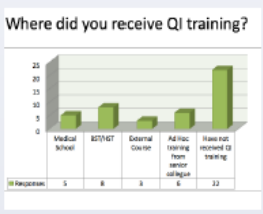
Supported by a regional questionnaire, workshops, focus groups and through email chat we engaged with NCHD's across the district hospital, at Cavan General Hospital on multiple occasions. All quantitative data and figures presented in this presentation are derived from the survey. Focus groups and engagement events were used to solidify emerging themes, explore them in more depth and develop our recommendations.

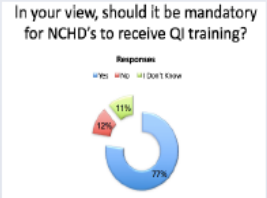
RESULTS

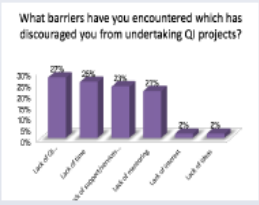


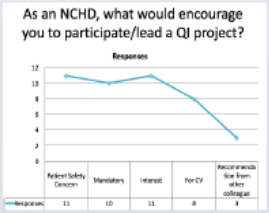












DISCUSSION

Majority of participants work in Department of General Medicine. 61% of participants were at Senior House officer level. Majority of the NCHD's had completed zero QI projects, and they were neither satisfied or dissatisfied with their past QI experience. 75% of NCHD's had not been directed to some skilled based mentoring in the workplace. Majority of participants had not received any formal QI training, and over 70% believed that QI training should be made mandatory. Over half of the NCHD's believed that lack of QI knowledge/methodology and lack of time were the main barriers which discouraged them from taking part in QI projects. A concern for patient safety was the main reason which would encourage NCHD's to partake in a QI project.

CONCLUSION

NCHD's need to be trained in QI. Without developing this competence, NCHD's are unlikely to create projects which can potentially make a difference to improve patient care. Without providing NCHD's with the tools and time to lead change, they are likely to become demoralised, and will never fully engage with the QI agenda.

In conclusion, QI is a vital source to drive the Health Service Executive (HSE) to provide the highest quality of patient care.

RECOMMENDATIONS

1.Protected, bleep-free time should be allocated to all NCHD's in training on a regular basis for QI projects, and provision of a clinical audit facilitator.

2. All clinical supervisors should be trained in QI methodology and their role should expand to include providing advice and support to NCHD's participating in and leading QI projects.

The Long-awaited Transfer of Tasks – How are we Performing?

Dr Ahmeda Ali[1] Dr Daire Sean Gibbons[2] Dr Hammad Khan Danish[2] Dr Nazreen Shahrom[3]
[1]Lead NCHD and GP Trainee, Cavan General Hospital, Ireland
[2]NCHD, Department of Medicine, Cavan General Hospital, Ireland
[3]NCHD, Department of Obstetrics and Gynaecology, Cavan General Hospital, Ireland

Background

The transfer of tasks involves the transfer of intrinsic elements from the medical staff to the nursing staff. Each hospital in Ireland is required to prioritise this matter and to ensure that the necessary tasks are undertaken and implemented.

Aim

The aim of this audit is to evaluate and verify the Transfer of Tasks at Cavan General Hospital.

Standard, indicator and target

The Nursing/Medical Interface section of the Haddington Road Agreement (Appendix 7, Point 4).

Methodology

Data was collected in the Department of Medicine, and Obstetrics & Gynaecology. This was examined over a two week period in 2016. Data recorded included the location of the patient, and the task undertaken by the NCHD/nursing staff. In addition, an anonymous survey of ten nurses working, in the same hospital, was carried out. This survey enquired as to the reasoning behind declining to partake in the transfer of tasks.

Results

The majority of ward based tasks are still being undertaken by the NCHD's. According to the data collected, the main wards of current concern are Medical 1 and Surgical 2. A survey of ten nurses, showed that over 60% of nurses believed that they were not adequately trained to undertake the intrinsic elements of the tasks.

Conclusion

From an organisational point of view, in order to effectively use valuable resources for clinical care, one can argue that the essential concept is that there must be a need to reduce the reliance on NCHD's to undertake ward based tasks. Appropriate designation will consequently lead to fewer delays in patient centred care.

Action plan

Increase the awareness of the HSE guidance document. Presentation to hospital management in order to provide further training for the nature and feasibility of the Transfer of Tasks. Re-audit in 6 months.

TRANSFORMING CULTURE: THE LONG AWAITED 'TRANSFER OF TASKS'

Ahmeda Ali[1] Daire Sean Gibbons[2] Hammad Khan Danish[2] Nazreen Shahrom[3]

[1]Lead NCHD & ICGP Trainee, Cavan General Hospital, Ireland
[2]NCHD, Department of Medicine, Cavan General Hospital, Ireland
[3]NCHD, Department of Obstetrics and Gynaecology, Cavan General Hospital, Ireland

ABSTRACT

BACKGROUND: The transfer of tasks involves the transfer of intrinsic elements from the medical staff to the nursing staff. Each hospital in Ireland is required to prioritise this matter and to ensure that the necessary tasks are undertaken and implemented.

AIMS: The aim of this audit is to evaluate and verify the Transfer of Tasks at Cavan General Hospital.

STANDARD, INDICATOR AND TARGET: The Nursing/Medical Interface section of the Haddington Road Agreement (Appendix 7, Point 4).

METHODOLOGY: Data was collected in the Department of Medicine, and Obstetrics & Gynaecology. This was examined over a two week period in 2016. Data recorded included the location of the patient, and the task undertaken by the NCHD/nursing staff.
In addition, an anonymous survey of ten nurses working, in the same hospital, was carried out. This survey enquired as to the reasoning behind declining to partake in the transfer of tasks.

RESULTS: The majority of ward based tasks are still being undertaken by the NCHD's. According to the data collected, the main wards of current concern are Medical 1 and Surgical 2. A survey of ten nurses, showed that over 60% of nurses believed that they were not adequately trained to undertake the intrinsic elements of the tasks.

CONCLUSION: From an organisational point of view, in order to effectively use valuable resources for clinical care, one can argue that the essential concept is that there must be a need to reduce the reliance on NCHD's to undertake ward based tasks. Appropriate designation will consequently lead to fewer delays in patient centred care.

ACTION PLAN: Increase the awareness of the HSE guidance document. Presentation to hospital management in order to provide further training for the nature and feasibility of the Transfer of Tasks. Re-audit in 6 months.

BACKGROUND

In order to improve the quality of patient centred care, each health care professional within a clinical group should perform tasks they appropriately trained for an vice versa.
One can argue that the concept that there must be a need to reduce the reliance on NCHD's to undertake ward based tasks. From an organisational point of view, that would ultimately mean that there is less time for clinical care. This is a waste of valuable resource.
Appropriate designation will consequently lead to fewer delays in intravenous cannulation, venepuncture and administration of intravenous antibiotics.
Agreement on the transfer of tasks was initially reached under the Haddington Road Agreement in 2013. The parties to the agreement were the IMO, the INMO and SIPTU, as well as health service management.
In February 2016,the Minster for Health had conveyed his approval for the Transfer of Tasks from Non-Consultant Hospital Doctors to Nurses/Midwives under the Nursing /Medical Interface Section of the Haddington Road Agreement (Appendix 7, Point 4). The sanction granted on the basis that implementation will follow the terms of the document "Final Agreement on Transfer of Tasks" under Nursing/Midwifery Interface Section of the Haddington Road Agreement.
According to the Agreement, the following tasks including their intrinsic elements will be transferred from Medical staff to Nursing/Midwifery:

- Intravenous cannulation; including, in the appropriate setting, peripheral cannulation in adults or peripheral cannulation in children which are subject to additional specific protocols and arrangements
- Phlebotomy — currently carried out by NCHD's as distinct from general routine phlebotomy, which is the responsibility of specifically trained and employed phlebotomy staff;
- Intra Venous drug administration — first dose; including in the appropriate setting of Medication management
- Nurse led delegated discharge of patients.

A core principle underpinning the allocation of tasks to either Medical or Nursing/Midwifery employees is that the task is undertaken by the most appropriate employee at the particular time, in the particular location.
These tasks remain the responsibility of each qualified and trained health professional and no individual or group is excluded from this responsibility.
The Transfer of tasks had commenced in January 2016 and implementation in lone with this agreement should have occurred by 30th June 2016.

OBJECTIVES

According to the agreement, each hospital in Ireland is required to prioritise this matter and to ensure that the necessary tasks are undertaken and implemented. The aim of this audit is to evaluate and verify the "Transfer of Tasks" at Cavan General Hospital. Additionally, we aim to assess the current prevalence of adherence of Haddington Road Agreement in term of tasks.

METHODOLOGY

Data was collected from the Department of Medicine and Obstetrics/Gynaecology for a two week period (05/11/2016 till 19/11/2016) at Cavan General Hospital.
It is important to note that the model of CGH, medical patients are admitted in Surgical 1, surgical 2 and surgical 3 (Pre Discharge Unit).Data was collected in an anonymised manner by NCHD's and recorded in the proforma.NCHD's recorded the tasks which they had undertaken – ie. Intravenous cannulation, administration of drugs and phlebotomy.
A total number of 224 tasks were recorded by fourteen different doctors.

RESULTS

Figure 1: Preliminary study – one day snapshot of IV cannulations taken place in Cavan General Hospital

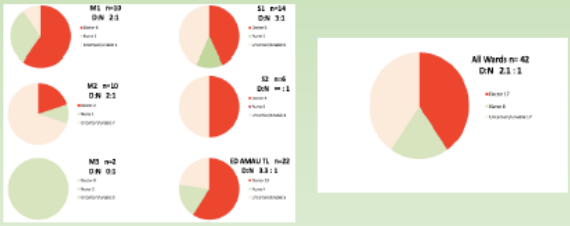


Figure 2: The number of recorded tasks which have been undertaken by NCHD's.

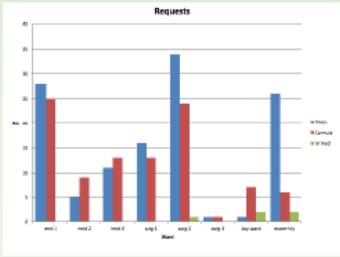


Figure 3: The most common reasons provided by the nursing staff for declining the transfer of tasks:

Reasons
"Not our job"
"We're not trained"
"We are not phlebotomists!"
"We are too busy"
"We have the course done, but we are not allowed to do it"
"Not signed off"
"Not part of the job"
"Not trained – too busy"
"We're not trained"
"We are just too busy!"

CONCLUSIONS

The Irish healthcare system is at a time of fundamental change affecting all stakeholders; providers, clinicians, health plans and patients. Faced with the imperative to deliver high-quality care at a cost effective manner, healthcare leaders are focusing on strategies needed to succeed in a new environment. When implementing new strategies such as the 'Transfer of Tasks', clinicians often find culture is a step or two behind. By aligning strategy, structure and culture, healthcare leaders have an opportunity to systematically develop an organization that can manage the challenge of change and achieve high levels of performance. This will then improve the patient care experience by getting healthcare professionals to work effectively together across all disciplines.

RECOMMEDNDATIONS

1. Prioritisation to implement the Haddington Road Agreement with immediate effect
2. The local management team need to ensure that staff members are communicated with in respect of these developments.
3. To re-discuss the progress at the Local Implementation Group.
4. Evidence of specific confirmation of tasks being undertaken by nurses and that associated benefits are being achieved.
5. To ensure that progress in relation to Transfer of Tasks is being sustained.

Beating burn out: being kind – Occasional Acts of Kindness

Dr Anna McHugh[1], Dr Catherine Diskin[2], Ms Juanita Guidera[3], Dr Lynda Sisson[4]
[1] Lead NCHD Letterkenny General Hospital
[2] National Lead NCHD/NDTP Fellow
[3] QID Lead Staff Engagement
[4] HR Lead Staff Health and Wellbeing and Occupational Health

Background

Aging populations, increasing demands, lack of collegiality and healthcare systems under strain mean physician burn out is becoming a worrying epidemic that poses a real threat to quality care provision for patients. Staff engagement is the opposite to burn out. Engaged, positive, mentally resilient staff have been proven to improve patient care, outcomes and personal job satisfaction.

Question: Can low key daily interventions prevent burn out and boost staff engagement?

Method

In Donegal an "OAK" – Occasional Act of Kindness - initiative was launched in the challenging winter months. NCHD's, Hospital Consultants, GP's and allied health professionals were invited to attend a lunch time session where complimentary refreshments were provided. Colleagues were simply encouraged to sit for even 5 minutes and have a chat. Staff checked in, asked how colleagues were coping and took an interest in each other's lives. The aim was to boost collegiality, overcome bullying in the work place and to encourage occasional acts of kindness to one another when stressed. An online survey adapted from Wilmar Schaufeli's validated staff engagement tool was completed by participants.

Results

Staff engagement scale	Agree/Strongly Agree
Boosts Collegiality and Strengthens relationships at work	97%
Would make me more likely to take the initiative to help a colleague if they were struggling	90%
Boosts my energy at work	80%
Increases my mental resilience at work	83%
Enhances my enthusiasm at work	90%
Helps me persevere, even if things are not going well	87%
Helps me to continue working even for long period of time	63%
Helps to instill a sense of pride in the work place	84%
Boosts overall morale at work	93%

Conclusions

Low key daily interventions can be effective in promoting staff engagement and positively influencing patient care, as one participant fed back "Simple things make a big differences."

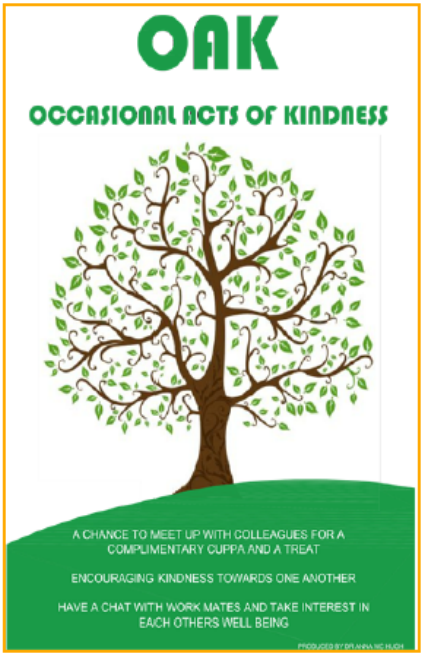
Beating Burn Out – Being Kind

Anna McHugh, Catherine Diskin, Juanita Guidera, Zakiah Amir, Lynda Sisson

Background

There are increasing evidence of burnout among healthcare workers in Ireland from many established causes. It is now a palpable turning point in the healthcare system that health and well-being is no longer a soft or 'fuzzy' issue to be ignored but a real threat to the workforce and to patient safety. Realising its paramount importance; how can we redesign our daily working lives to address burn out?

Workers engagement is the opposite to burn out[1]. Engaged, positive, mentally resilient workers have been proven to improve patient care, outcomes and personal job satisfaction[2, 4]. There is evidence that simple, low-key positive activities[3] such as saying hello, asking someone how they are, stopping and giving someone directions instead of diverting gaze can make all the difference in a highly pressurised environments.



Result

Result from the UWES:

Staff engagement scale	Agree / Strongly Agree
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Would make me more likely to take the initiative to help a colleague if they were struggling	90%
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Boosts overall morale at work	93%

Our Initiative - OAK

OAK was launched in Letterkenny University Hospital in December 2016. All staff of all grades and departments were invited. Refreshments including tea, coffee, treats and baked goods were provided. Colleagues were encouraged to sit for even 5 minutes and have a chat. Staff simply checked in, asked how colleagues were coping and took an active interest in each other's lives. The aim of this initiative was to boost collegiality, overcome bullying in the work place and to encourage acts of kindness to one another in a demanding work atmosphere.

Evaluation Process

Attendance on the day varies from administrative staff, management, academic staff, doctors of all grades, nursing staff, pharmacy and health care technicians. A validated staff engagement, Utrecht Work Engagement Scale (UWES) [1], was adapted to evaluate the intervention. Participants may also leave their own comments in the survey regarding the intervention. Some of the feedbacks which sum up their sentiments were:

"Simple things make big differences"

"Need more focus on this as an integral part of work in the hospital"

"Should definitely be carried forward"

Discussion & Conclusions

Healthcare workers are in a privileged position to hold an important role caring for patients with a duty of care to them. It is acknowledged that our work environment is challenging and we can be made disillusioned with the system. It is important therefore to mobilise in whatever small ways possible to cultivate a safer and more positive system. Our intervention proved that taking an interest in others' and your own well-being has a positive effect on people's attitudes to work and quality patient care. If each workers make a resolution to be helpful, positive and carry out occasional acts of kindness, this could be achieved – a system is the sum of all of its parts.

"Simple things make big differences"

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CRISBAR - Computerized Clinical Handover

Dr Derek O'Keeffe, Dr Ramona McLouglin, Mr Brian Mullins
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[2] Medical Manpower Manager, University Hospital Galway
[3] Clinical Director, University Hospital Galway

Background

Clinical handover is defined as "the transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients to another person or professional group on a temporary or permanent basis". Failure of effective handover is a major preventable cause of patient harm. Handover is usually given attention when things go wrong. After review of hospital procedures, it was realized that like most hospitals in Ireland, there was an informal handover procedure in place. However no formal clinical handover mechanism existed for UHG medical teams to handover to the Medical Registrar on call over the weekend. Therefore this projects objective was to develop a formal clinical handover system for UHG to improve patient care and outcomes.

Methods

In August 2016, I engaged with all stakeholders in the hospital to discuss development of a formal clinical handover system in UHG. Arising from this consultation we instigated a formal face to face paper based weekend patient handover system to improve patient care, which was based on the HSE endorsed internationally recognized ISBAR (Identification, Situation, Background, Assessment, Recommendation) handover protocol. After three months piloting and auditing the participation/feedback of the various medical teams with the formal clinical handover, I met with the hospital physicians group and presented our results. They immediately saw the benefit of the formal ISBAR weekend handover format and encouraged us to develop it further.

Results

A digital handover system (CRISBAR – Computerised Record ISBAR) was developed and implemented in January 2017. We now have a HSE intranet web based computerized ISBAR handover system that allows medical teams to highlight patients for handover to the medical registrar on call. Due to the success and portability of our developed CRISBAR system at UHG, it has now been rolled out across other hospitals in the Saolta group.

CRISBAR - Computerized Clinical Handover

Dr. Derek O'Keeffe, Lead NCHD UHG
Dr. Ramona McLouglin – Clinical Director, UHG, Mr. Brian Mullins – Medical Manpower Manager, UHG

Introduction

Good communication is essential in the provision of good patient care. Clinical handover is defined as "the transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients to another person or professional group on a temporary or permanent basis".

Failure of effective handover is a major preventable cause of patient harm. Handover is usually given attention when things go wrong.

After review of hospital procedures, it was realized that like most hospitals in Ireland, there was an informal handover procedure in place. However no formal clinical handover mechanism existed for UHG medical teams to handover to the Medical Registrar on call over the weekend.

Therefore this projects objective was to develop a formal clinical handover system for UHG to improve patient care and outcomes.

I	Identify- Identify self name, position, location and who you are talking to Identify patient name, age,. sex, location	
S	Situation- State purpose "The reason I am calling is ....."	
	If urgent-say so	eg "This is urgent because the patient is unstable with a BP of 90."
B	Background- Tell the story current problem	
	Relevent history Relevent examination Relevent test results Management	If urgent: Relevent vital signs Current management
A	Assessment- State what you think is going on	
	eg "So the patient is febrile and I cant find a source of infection"	Urgent eg "The patient seems to be deteriorating, I think they may be bleeding"
R	Request- State request	
	eg "I'd like your opinion on the most appropriate test"	eg "I need help urgently, are you able to come?"

Implementation, Tactics and Strategy

In August 2016, we engaged with all stakeholders and key decision makers in the hospital handover system to discuss our vision for a formal clinical handover system in UHG.

Arising from this consultation we instigated a formal face to face paper based weekend patient handover system to improve patient care, which was based on the HSE endorsed internationally recognised ISBAR (Identification, Situation, Background, Assessment, Recommendation) handover protocol.

After three months piloting and auditing the participation/feedback of the various medical teams with the formal clinical handover, we met with the hospital physicians group and presented our results. They immediately saw the benefit of the formal ISBAR weekend handover format and encouraged us to develop it further.

Therefore following further consultation with stakeholders and to further improve communication, audit and patient data integrity a digital handover system (CRISPAR – Computerised Record ISBAR) was developed in November 2016 and implemented in January 2017.

Conclusion

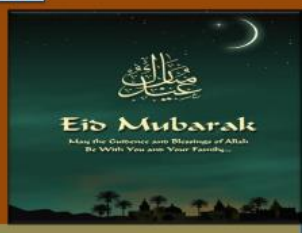
We have now developed a HSE intranet web based computerized ISBAR handover system that allows medical teams to highlight patients for handover to the medical registrar on call.

Due to the success and portability of our developed CRISBAR system at UHG, it has now been rolled out across other hospitals in the Saolta group.

A Day To Remember
"Galway University Hospital Eid Celebration"

Dr Syeda Amna Azim, Lead NCHD (Surgical Directorate, GUH)

Describes the revived Eid celebration



Every year Muslim doctors from around the world come to Ireland, to Galway University Hospital (GUH) for training in their respective fields from India, Pakistan, Egypt, Kuwait, Sudan, UAE, and Saudi Arabia. GUH has always emphasised on providing and supporting pastoral care for all its staff. Every year Muslims celebrate two Eids during the year. First is, **Eid al-Fitr** (عيد الفطر)' festival of breaking of the fast" after observing 30 days fasting in Ramadan. Second is after two months 10 days **Eid al-Adha** عيد الأضحى "Festival of the Sacrifice", also called the "Sacrifice Feast", is the second of two Muslim holidays celebrated worldwide each year, and considered the holier of the two.

Initially back in the days in mid nineties (1996), an event was held by the hospital where all the Muslim doctors gathered in the hospital to celebrate Eid. Current President of Ireland, Mr Michael D Higgins attended previous celebrations. In 2016, Galway University Hospital restored the tradition and celebrated Eid al Adha with staff and their families on Saturday 17th September 2016 on site in the nurse's home cafeteria with the help of Aramark staff and service management organised by the Lead NCHD (Surgical Directorate) Dr. Syeda Amna Azim. This year we celebrated on 2nd July 2017, event was open to all the doctors. The word was spread further and staff from Dublin, Portiuncula, Mayo, Castle bar attended the event with their families. Irish doctors were also part of the celebration namely Prof Gerard O Flaherty, Mr Tom Barry (Consultant Maxillofacial Surgery) with family, National NCHD lead Catherine Diskin, Sharron Dempsey (Women and children NCHD lead), Radiology registrars and the members from the switch board.

The event was attended by local people and more than hundred doctors with their families including consultants and NCHDs associated with various specialities. The venue was decorated, professional henna artists attended along with music "Nasheed" and different activities for children contributed to a wonderful evening. Delicious halal Asian food was enjoyed by all those attending. Social events like this helps to facilitates staff engagement and brings the communities together providing them the platform to integrate with other cultures under one roof. The event was a huge success and compliments from guests included "this Eid we all felt at home away from home". We look forward to more events like this promoting staff engagement.

Lead NCHD Dr Syeda Amna Azim with Dr Saud Bajwa at event in GUH celebrating Eid.

Catherine Diskin National NCHD Lead celebrating "Eid ul Fitr "at Galway University Hospital

The establishment of a Multidisciplinary Research Meeting in the Regional Hospital Mullingar

Dr Doireann Joyce
NCHD Lead and SpR in General Surgery, Regional Hosptial Mullingar, Co. Westmeath

Introduction

The Regional Hospital Mullingar is a Level III facility that delivers healthcare to a diverse group of patients. All age groups are managed in this institution. Services include medicine, surgery, paediatrics, and obstetrics and gynaecology. These departments are supported by allied healthcare professionals including nutrition and dietetics, physiotherapy, speech and language therapy, and occupational therapy. Each of the aforementioned hospital departments carries out research in their area of expertise, however there is little scope for dissemination of this information within the hospital. The aim of this project was to establish a multidisciplinary research meeting in the Regional Hospital Mullingar in order to increase awareness of research studies that have been carried out.

Methods

An application for approval for the running of a research meeting was sought from the General Manager. A 'Call for Abstracts' poster indicating the proposed date for the meeting was displayed in all clinical areas in the hospital. A suitable venue for the meeting was booked and poster display boards were arranged. A meeting chairperson was selected with the purpose of leading the meeting. Judges were chosen for abstract selection and marking of presentations.

Results

A provisional deadline for abstract submission of the 1st of March 2017 was chosen with the meeting scheduled for Friday the 16th of June 2017. In total 22 abstracts were submitted by staff members from a variety of hospital departments including medicine, paediatrics, obstetrics and gynaecology, pharmacy, speech and language therapy and occupational therapy. 8 abstracts were selected for oral presentations and 10 for poster presentations. Prizes were awarded for the top 3 oral presentations and the top 2 poster presentations.

Conclusion

Healthcare professionals are interested in conducting and presenting clinical research. A multidisciplinary research meeting is a viable method of disseminating research that is carried out within the hospital.

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Figure 1 The Regional Hospital Mullingar, Co Westmeath

Aim

The aim of this project was to establish a multidisciplinary research meeting in the Regional Hospital Mullingar in order to increase awareness of research studies that have been carried out and to educate staff on the findings of same.

Methods

An application for approval for the running of a research meeting was sought from the hospital General Manager

A 'Call for Abstracts' poster indicating the proposed date for the meeting was designed, printed and displayed in all clinical areas in the hospital

Sponsorship for the meeting was obtained

A suitable venue for the meeting was booked, poster display boards and catering was arranged

A meeting chairperson was selected from within the hospital with the purpose of leading the meeting. Judges were chosen for abstract selection and marking of presentations on the day of the meeting

Results

The 'Call for Abstracts' poster was designed using Microsoft Powerpoint and contained pertinent information regarding the meeting. My HSE email address was provided for the submission of abstracts. A provisional deadline for abstract submission of the 1st of March 2017 was provided with a the meeting scheduled for Friday the 16th of June 2017.

Figure 2 'Call for Abstracts' poster the was used to advertise the meeting

Hospital Department	Number of abstracts
Medicine	4
Paediatrics	5
Obstetrics and Gynaecology	1
Pharmacy	6
Speech and Language therapy	3
Occupational therapy	2
ICU nursing	1

Table 1 Number of abstracts received from each hospital department

In total 22 abstracts were submitted by staff members from a variety of hospital departments. Table 1 gives a breakdown of the department from which entries were received

8 abstracts were selected for oral presentations and 10 for poster presentations. Prizes were awarded for the top 3 oral presentations and the top 2 poster presentations. The meeting is planned to become an annual event in the hospital calendar.

Dr Doireann Joyce, Dr Mary O'Dea (winner of the 1st prize for oral presentation), Dr Grace Donnelly (Clinical director) and Dr Ron Charles (Meeting Chairperson)

Dr Doireann Joyce, Ms Cora Brennan (CNM 2 and member of judging panel), Mr Des Toomey (Consultant Surgeon and member of judging panel), Dr Ron Charles, Dr Grace Donnelly (member of judging panel) and Dr Michael O'Grady (Consultant Paediatrician and member of judging panel).

Conclusion

Healthcare professionals are interested in conducting and presenting clinical research. A multidisciplinary research meeting is a viable method of disseminating research that is carried out within the hospital.

Establishing a culture of NCHD teaching in Midland Regional Hospital Tullamore

Dr Jimmy Lee[1,], Dr Safras Sattar[2], Ms Nicola Fay[3]
1 Lead NCHD, Midland Regional Hospital Tullamore
2 NCHD Committee Member, Emergency Department, Midland Regional Hospital Tullamore
3 Regional Librarian, Midland Regional Hospital Tullamore

Background

The Research and Education Centre was opened in 2016, and though many hospital staff used this as an opportunity for organizing education sessions, NCHDs did not yet have an established teaching programme. We felt this was an opportunity to establish not only a teaching programme, but a culture of clinical education amongst NCHDs through a weekly teaching programme, delivered largely by Consultants and Specialist Registrars.

Objectives

As there was no previous teaching programme dedicated to NCHDs, it was initially difficult building enthusiasm for such a programme. Particularly amongst trainees, who rotated largely from major centres in Dublin, the culture was one of a "service rotation", where one expected little-to-no educational supports. At times, consultants would cancel last minute, and so a smaller rota of last minute lecturers was required. A push factor away from teaching was its proximity to lunchtime, and this was countered by organizing drug sponsors to bring lunches. Finally, bleeps during teaching were a major disruption for both lecturers and NCHDs, and so establishing protected teaching time in the hospital bleep policy was an integral factor to its success.

Outcomes

For interns, the nationally mandated intern teaching programme was never delivered in Tullamore. This contributed to the "non-teaching" culture for this rotation. A video-link with the Mater Misericordiae University Hospital was established for this, and again, establishing protected bleep-free teaching time was a major factor in its integration.

Finally, the first annual NCHD Award for Excellence in Clinical Education was awarded. This was voted on by any hospital staff or student who felt the efforts of an NCHD to teach others (whether they be fellow doctors, nurses, or students) be recognized. This award was the first of its kind for an NCHD in Tullamore.

The programme was designed to be easily transferrable to the incoming NCHD committee, with a rota of consultants and their contacts. The programme could easily be transferred to other sites, particularly those in similar settings, such as Midland Regional Hospitals Portlaoise and Mullingar.

Establishing a culture of NCHD teaching in Midland Regional Hospital Tullamore

Lee, Jimmy[1, 2], Sattar, Safras[2], Fay, Nicola[3]

1 Lead NCHD, National Doctors Training and Planning, Health Service Executive

2 NCHD Committee Member, Emergency Department, Midland Regional Hospital Tullamore

3 Regional Librarian, Midland Regional Hospital Tullamore

Midlands Regional Hospital Tullamore

Objective

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Growing Pains

As there was no previous teaching programme dedicated to NCHDs, it was initially difficult building enthusiasm for such a programme. Particularly amongst trainees, who rotated largely from major centres in Dublin, the culture was one of a "service rotation", where one expected little-to-no educational supports. At times, consultants would cancel last minute, and so a smaller rota of last minute lecturers was required. A push factor away from teaching was its proximity to lunchtime, and this was countered by organizing drug sponsors to bring lunches. Finally, bleeps during teaching were a major disruption for both lecturers and NCHDs, and so establishing protected teaching time in the hospital bleep policy was an integral factor to its success.

Intern Teaching

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The Patrick J. Murphy Award for Excellence in Clinical Education

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NDTP National Doctors Training & Planning

NCHD wellbeing initiatives boost engagement and can promote NCHD retention

Dr Warren Connolly
Lead NCHD Mater Misericordiae University Hospital

Introduction

Workplace health programmes have been identified by the WHO as one of the 'best buy' options for mental health and wellbeing promotion. From this the HSE has issued the "HSE People Strategy 2015-2018" which is focused on staff wellbeing. Such initiatives have been proven to increase productivity and motivation**, b**ring teams together, build morale and decrease work-related stress**.**

Aim

To provide novel NCHD wellbeing work place initiatives and determine its impact on NCHD engagement, morale, talent retention and absenteeism.

Methods

We carried out two projects simultaneously. Firstly we held NCHD wellbeing seminars which had a focus on life-work balance, leadership and self-care. The second idea was to facilitate a multispecialty break and handover for on call NCHDs. The objective was to improve communication between specialties and to create a team environment on call. We provided food to optimise attendance which was funded by NDTP. Strength of agreement was assessed by the five-point Likert scale.

Results

Forty-nine per cent (54) of 110 eligible NCHDs completed the post intervention questionnaire and 27% (30) the pre intervention questionnaire. Among post-intervention respondents 64% were female, 74% (40) intern, 15% (8) SHO and 11% (6) registrars. The majority of those who engaged with the initiative either "believed" or "strongly believed" it was interesting (100%), improved NCHD communication and handover (92%) and boosted morale (100%). 96%(52) of NCHDs said they were "satisfied" or "very satisfied" with their job post the wellbeing initiative compared to 83%(25) before($p=0.032$). 95% of NCHDs said they would consider the provision of such initiatives when choosing a future employer.

Conclusion

The wellbeing projects have been proven to improve NCHD engagement, and improve job satisfaction. They have also shown potential to improve NCHD retention. This may have important implications for workforce planning for the HSE in a time of large scale NCHD immigration.

NCHD wellbeing initiatives boost engagement and promote NCHD retention

Warren Connolly
Mater Misericordiae University Hospital, Eccles Street, Dublin 7

Introduction

Workplace health programmes have been identified by the WHO as one of the 'best buy' options for mental health and wellbeing promotion. From this the HSE has issued the "HSE People Strategy 2015-2018" which is focused on staff wellbeing. Such initiatives have been proven to increase productivity and motivation, bring teams together, build morale and decreases work-related stress.

Aims

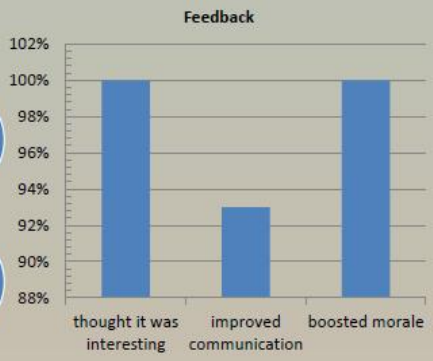
To provide a novel NCHD wellbeing work place initiative and determine its impact on NCHD engagement, morale, talent retention and absenteeism.

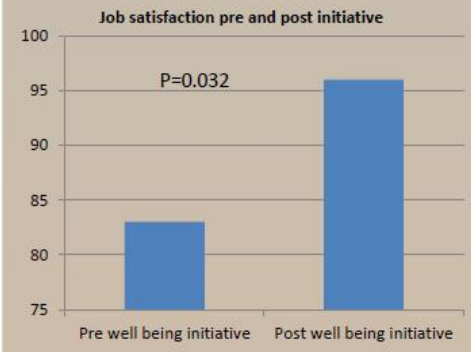
Methods & Materials

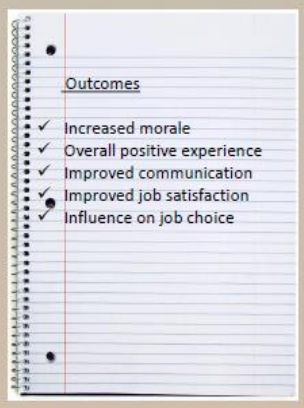
Ideas on how to improve NCHD wellbeing and morale was gathered formally at NCHD committee meetings and via online surveys. We carried out two projects simultaneously. Firstly we held NCHD wellbeing seminars which had a focus on life-work balance, self-care and non-clinical topics. The second idea was to facilitate and nurture a multispecialty break and handover for on call NCHDs. The objective was to improve communication between specialties and between grades and to create a team environment on call. We provided food to optimise attendance which was funded by NDTP. Data was collected pre and post the both initiatives via surveymonkey.com website. Strength of agreement was assessed by the five-point Likert scale.

Results

Topics covered in well being /leadership seminars







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Conclusions

The wellbeing projects have been proven to improve NCHD engagement, and improve job satisfaction. They have also shown potential to improve NCHD retention. This may have important implications for workforce planning and development for the HSE in a time of large scale NCHD immigration.

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- Rajgopal, T. 2010. Mental well-being at the workplace. *Indian Journal of Occupational and Environmental Medicine,* 14**,** 63-65.
- Topp, C. W., Ostergaard, S. D., Sondergaard, S. & Bech, P. 2015. The WHO-5 Well-Being Index: a systematic review of the literature. *Psychother Psychosom,* 84**,** 167-76.

Acknowledgements

Peter Neary
MMUH NCHD committee
HSE NDTP

Implementing Electronic Clinical Handover in a University Teaching Hospital: Physician Attitudes and Clinical Outcomes

Dr JJ Coughlan[1], Dr Thomas M Ross[2], Dr Richard Liston[2]
[1]Lead NCHD University Hospital Kerry, Tralee [2]NCHDs University Hospital Kerry, Tralee

Objectives

The aim of this project was to introduce a reliable, standardised, reproducible method of performing clinical handover regarding inpatients within our medical department. We also sought to assess the attitudes of physicians within our department to medical handover.

Implementation of the initiative including barriers and enablers encountered

BARRIERS	
Staff	User buy-in Lack of auxiliary staff Engagement from senior decision makers
Capital	No funding provided for project
Cultural	New System Increased workload
Infrastructural	No dedicated computer system. Handover required manual input of information Limited to one computer initially Limited engagement from IT staff
ENABLERS	
Staff	Management (Clinical Director, General Manager) Consultants: Agreed at Clinical Governance meeting to fully support pilot
Capital	Cost neutral solution utilised
Cultural	Educational talks given to staff Staff invited to submit proposals for improving system. Promoting 'ownership' of pilot
Infrastructural	Handover template created utilising simple Microsoft Word based system Minimal technical know-how required

Measured outcomes of the initiative including to staff or of resources

Measured Outcomes were pre-specified with results as follows:

- Total number of handovers performed per week: 32 Handovers per week. (6/day)
- Compliance with Mandatory handover of ICU/CCU patients: Average 61% (Range 33%-89%)
- Physician Attitudes to the handover pilot (Assessed via anonymised surveys): Satisfaction with handover improved (24% vs 81%, p=0.000914). Handover was now felt to be a standardised process (33% vs 81%, p=0.007595). Confidence in handover increased (18% vs 81%, p=0.000943) and doctors felt that the process did not increase their workload (36% vs 94%, p=0.000485)

Sustainability of the initiative

Sustainability would be improved by providing auxiliary staff to run the project with NCHD Lead/Consultant/Clinical Director overview as the transient nature of NCHDs is a significant barrier to this.

Potential transfer to other sites

Our system is a simple cost neutral solution which is easily transferrable to other sites and requiring minimal technical know-how or IT support.

Implementing Electronic Clinical Handover in a University Teaching Hospital: Physician Attitudes and Clinical Outcomes

Coughlan JJ, Mross T, Liston R

Background

Clinical Handover is defined as inter-clinician communication occurring at care interfaces. In this study, we analysed the clinical outcomes and physician attitudes associated with the implementation of an electronic clinical handover system in our medical department.

Objective

To create a reliable, standardised, reproducible method of electronically communicating information about patients to other physicians within our department.

Implementation

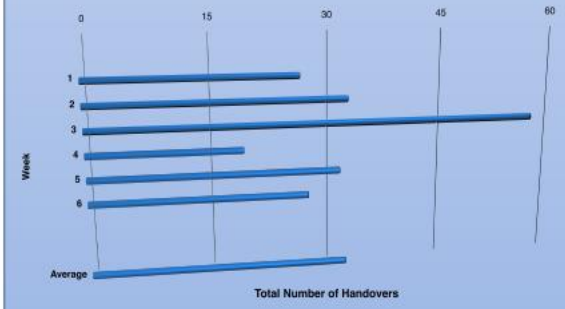
Phase	Action Implemented
1	Electronic Clinical Handover defined as key priority for quality improvement
2	Staff education sessions on the evidence base for clinical handover
3	All staff surveyed on attitudes to handover
4	Electronic Handover templates installed on computers
5	6 week pilot program with staff support and weekly feedback on compliance
6	Repeat survey of staff attitudes post 6 week pilot
7	Electronic Handover of patients continues with monthly audits of compliance

Outcomes

In order to quantify and audit the implementation of our handover, we pre-specified several metrics. These included:

1. Total number of handovers performed per week
2. Compliance with handover of ICU/CCU patients
3. Physician Attitudes (Assessed via anonymous survey)

Total Number of Handovers per week



On average, over 30 electronic handovers were performed each week in our medical department. This translates to roughly 6% of our medical inpatients requiring formal handover each night.

Compliance with handover of ICU/CCU patients

Handover of inpatients in ICU and CCU was mandatory. On average, 61% of ICU/CCU patients were handed over on the electronic handover template during our pilot (Range: 33%-89%)

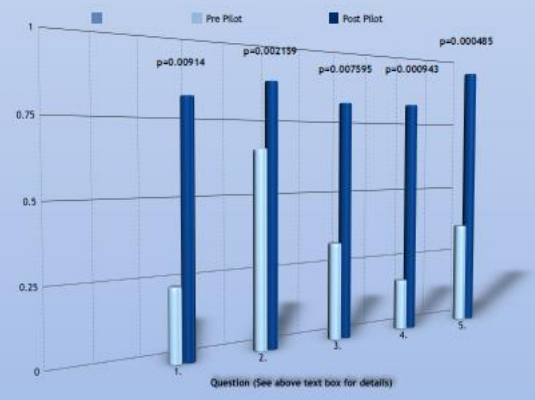
Physician Survey

The bar chart below details the results of surveys carried out before and after our handover pilot. The survey was conducted using a Likert scale and results were expressed as the percentage of doctors agreeing with the statement. The questions included:

1. Are satisfied with the current handover process?
2. Does handover always occur in this hospital?
3. Do you think handover occurs as a standardised process?
4. Are you confident that the tasks you handover will be carried out?
5. Do you think performing electronic handover would/did increase your workload?

The chart below demonstrates the responses to the above questions. Our analysis showed a statistically significant improvement post implementation of the handover pilot.

Physician Attitudes



Conclusions

Electronic Clinical handover is feasible and practical to implement within the Irish healthcare system.

In addition, it was found to be highly attractive to physicians without increasing their workload.

Medication Good Catch Initiative – A collaborative approach

Dr Louise Hendrick[1], Ms Reena Patel[2], Ms Caroline O'Connor[3], Ms Paula Day[4]
[1] Lead NCHD, Temple Street Children's University Hospital
[2] Chief Pharmacist, Temple Street Children's University Hospital
[3] Head of Nursing Development, Temple Street Children's University Hospital
[4] Risk and Legal Services Manager, Temple Street Children's University Hospital

Background

Medication errors and adverse drug reactions are a common cause of patient harm in the hospital setting[1]. Pre-existing medication safety initiatives in Temple Street included the RESPOND reporting system for errors and near misses. The latter includes incidents "that never reached the patient, or that reached the patient but did not cause harm"[2] and are an important way to identify process or systemic failures in order to prevent adverse events. A review of the number of near miss reports suggested possible under-reporting.

Objectives

A collaborative medication safety working group was established and barriers to reporting were explored. Identified barriers included difficulty navigating through RESPOND, with required information often not readily to hand, the time taken to complete reports with a minimum of 8 minutes per case, the assumption that another staff member would complete the report and a lack of feedback on submitted reports.

Methodology

In order to address this, a new paper-based alternative was developed and launched April 2017. The form comprises a simple 'tick the box' design, taking 1-2 minutes to complete with anonymisation and optional signature. Near misses were rebranded as good catches and both the NCHD and Nurse champions promoted communication about the implementation, encouraging staff to report and with a reward approach (with a trophy awarded to the individual reporting the highest number of good catches). This was a cost effective measure with carbon copy booklets on all wards.

Outcomes

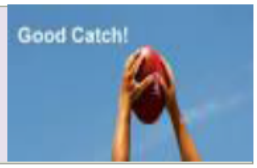
This resulted in a marked increase in good catches from 92 to 467 for March-July 2017 vs 2016. A programme for structured feedback includes a quarterly medication safety newsletter and ward based feedback (currently on 2 wards and due to be extended following successful pilot) on a monthly basis. Additional measures included re-emphasizing the importance of the safety pause and a zero-interruption while dispensing (with nursing wearing special aprons) approach in response to identified good catches.

[1] Kirke C, Tighe P, Colohan G, Harnett B, Creaton G, Delaney T. A Collaborative Study of Medication Safety in Four Irish Hospitals. Irish Pharmacy Journal. February 2007;68-73.
[2] Marella WM. Why worry about near misses? Patient Saf Qual Healthc. 2007;4:22-26.

'Good Catch' Initiative

Promoting reporting of medication safety near misses

L Hendrick, Lead NCHD, R Patel Chief Pharmacist, C O'Connor Head of Nursing Development
Temple Street Children's University Hospital



Background

- Medication safety incidents cover a range of events

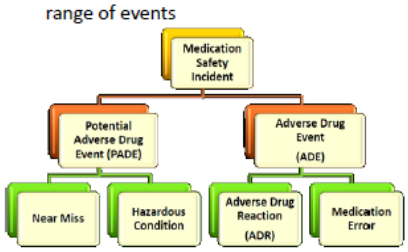


Figure 1 Source: AMNCH Tallaght: Medication Safety Incident Reporting Policy DTC4/2002

- Near misses include incidents "that never reached the patient, or that reached the patient but did not cause harm"
- Near Miss reporting relies on a passive surveillance[1], with underreporting common[2]
- Reports help identify process or systemic failures in order to prevent the occurrence of adverse events

Aim

The aim was to assess barriers to and promote increased reporting of near misses

Barriers identified in Temple Street included:

- Difficulty navigating through RESPOND reporting system, requiring information not readily to hand
- Length of time to complete report: minimum of 8 minutes per case
- Assumption that another staff member would complete the report
- Lack of feedback on submitted reports

These were similar to widely reported perceived barriers[3]:

Top 5 self-perceived barriers to incident reporting for doctors

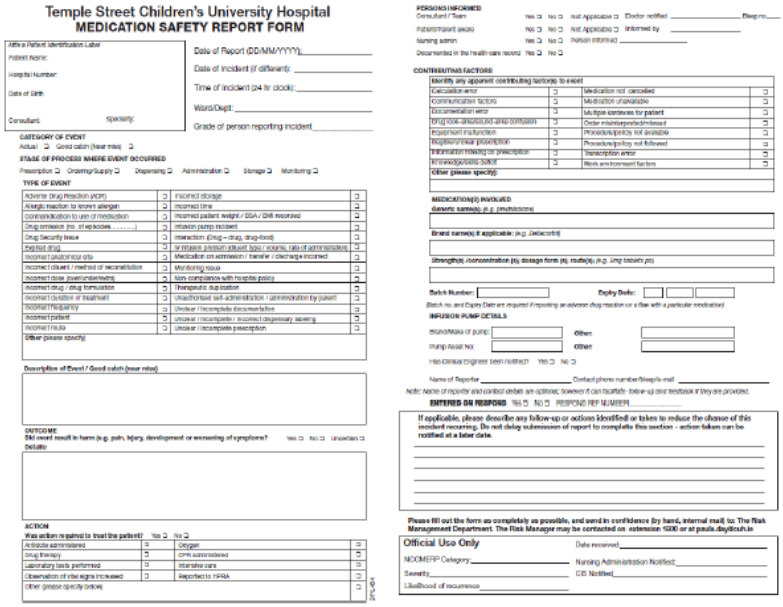
1. No feedback on incident follow-up (57.7%)
2. Form too long; lack of time (54.2%)
3. Incident seemed "trivial" (51.2%)
4. Ward was busy, forgot to report (47.3%)
5. Not sure who is responsible to make report (37.9%)

Initiative

A Medication Safety Working Group was established being a collaboration or the Chief Pharmacist, Lead NCHD, Head of Nursing Development and Ward Sister.
The following measures were taken:

- A paper-based alternative to the RESPOND system was developed and launched April 2017
- Simple 'tick the box' design, 1-2 minutes to complete
- Low cost with carbon copy booklet placed on all wards
- Near misses rebranded as good catches[4]
- Anonymisation of the form with optional signature
- NCHD and Nurse champion with good communication
- Feedback on reporting quarterly with re-education on high risk medications e.g. paracetamol
- Ward based feedback on a monthly basis
- Emphasis on safety pause and no interruptions

Figure 3 Stages of Good Catch Initiative Implementation


Temple Street Children's University Hospital
MEDICATION SAFETY REPORT FORM

Results

- Marked increase in good catch reporting (467 vs 92) for period March-July 2017 vs 2016

Future plans:

- Continued encouragement to report and feedback/re-education on a frequent basis
- Redesign of module to reduce barrier to using online reporting tool
- Consideration for 'high risk medications' card at each rotation date which clips on to ID lanyard
- New Clinical task module proposed and approved by the Lead NCHD and currently in development with link to BNFc and Crumlin formulary and warning box for high risk medications

"A man of genius makes no mistakes. His errors are volitional and are the portals to discovery"
James Joyce

References

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4. Kearns S. Good Catch Program Encourages Reporting Near-Miss Medical Errors. March 25, 2010. http://www.healthleadersmedia.com/quality/good-catch-program-encourages-reporting-near-miss-medical-errors

A programme for NCHD wellbeing

Dr Louise Hendrick[1], Dr Catherine Diskin[2] Dr Adrienne Foran[3]
[1] Lead NCHD, Temple Street Children's University Hospital
[2] National Lead NCHD/NDTP Fellow, Temple Street Children's University Hospital
[3] Clinical Director and Consultant Neonatologist, Temple Street Children's University Hospital

Background

There has been increased focus on physician wellbeing over the past few years, due in part to the association between poor wellbeing and burnout and reduced patient safety[1]. Publication of the RCPI national survey on physician wellbeing in April 2017[2] has provided information on NCHD in Irish Hospitals for the first time. Results identified 80% of doctors reported significant work stress, one third experienced burnout and two-thirds felt they would not discuss mental health problems.

Methodology

Based on the domains of wellbeing and with the support of NDTP and Temple Street Medical Board a series of five workshops were held over five months covering finance (tax accounting and pension management), wellbeing (tai chi, acupressure, and stress-management), interview skills, self-awareness, self-reflection and resilience. This was supported by approval and funding for an upgrade of the doctors' residence and a second paediatric registrar on call shift (from Monday to Friday 5-10pm), two areas identified as issues in an initial survey on NCHD issues (in which all NCHDs considered wellbeing moderately or extremely important). NCHDs were encouraged to practice the principles of resilience, namely sleeping, eating and exercising. Sessions were opened to all staff with HR, occupational health and consultant involvement contributing to an open and supportive environment in which issues were discussed.

Results

Both quantitative and qualitative feedback was obtained with all NCHDs agreeing they had learned practical techniques which they could use at home or work, which would be helpful on an ongoing basis and felt more supported by participating in the sessions. Pre- and post- self-reported stress levels decreased from an average of 7 to 3 following the wellbeing session.

Qualitative feedback included "The talks encouraged us to view challenges from a different perspective and develop new strategies to help in the workplace" and "Even the fact that my employers see this as something important to offer me makes me feel more valued and supported". NCHDs reported they felt better able to manage stress and to talk about issues or difficulties they were facing.

A programme for NCHD wellbeing

Focusing on the non-clinical aspects of NCHD life

L Hendrick, Lead NCHD Temple Street Children's University Hospital

Background

- There has been increased focus on physician wellbeing over the past few years, due in part to the association between poor wellbeing and burnout and reduced patient safety[1]
- Self-management is one of the Irish Medical Council's Domains of Good Professional Practice and doctors are expected to *"have a responsibility to yourself"* however education in this area has been deficient historically
- The first national survey on physician wellbeing was published in April 2017[2] but excluded interns and those not on training schemes, who are often considered vulnerable

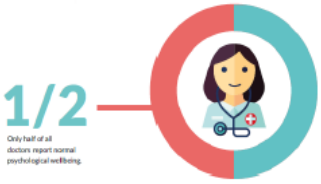
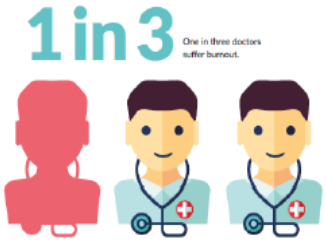


Figure 1 Wellbeing Source RCPI on Wellbeing[2]

Results[2] identified the following:
- 80% of doctors reported significant work stress with effort exceeding rewards gained
- 20% reported that they had enough time for family or personal life due to work commitments
- 80% reporting working while ill or injured.
- 7% had severe or extremely severe levels of depression
- 6% had severe or extremely severe levels of anxiety
- 10% had severe or extremely severe levels of stress



	Consultants	HSTs	BSTs	Total
Burnout	24.4%	38%	38.4%	30.7%

Figure 2 Burnout Source RCPI Report on Wellbeing[2]

Figure 2 Mental Health Source RCPI Report on Wellbeing[2]

Recommendations
- Prioritisation of staff welfare by hospital management, policy makers and the health service
- With the ultimate aim of improving physician and patient safety

Objectives

- The aim was to increase engagement of NCHDs with the principles of wellbeing
- These include self-awareness, self-reflection, financial management, control, connectedness and self-compassion.
- Additionally, the aim was to break away from the 'just get on with it' mentality, to develop practical skills to help with management of the non-clinical aspects of medicine, and make NCHDs aware of supports available

FINANCE – Cusack Garvey Accountants
Personal finance, tax & pensions

WELLBEING – Caring for Caregivers
Stress management & relaxation techniques

WORK – Dr Adrienne Foran
Interview skills & Increased support

AWARENESS – Dr Paddy Barrett
Burnout, managing workload and work-life balance

RESILIENCE – US Navy Seal
Human performance in high-risk operations

- With the support of NDTP and Temple Street Medical Board a series of five workshops were held over five months
- Sessions were interactive and NCHDs were actively encouraged to participate with at least 25% of sessions open to questions and answers, or discussion of any issues NCHDs wished to raise in a supportive environement
- Initially sessions were restricted to NCHDs but were opened to encourage dialogue between NCHDs, Consultants, HR, Occupational Health and other staff
- The programme was supported by improvement in the working environment by way of approval and commencement of upgrade of the residence, and by approval and funding for a permanent 2nd paediatric registrar on call shift to cover high demand Monday to Friday 5-10pm.

Results

Both quantitative and qualitative feedback was obtained with all NCHDs agreeing they had learned practical techniques which they could use at home or work, which would be helpful on an ongoing basis and felt more supported by participating in the sessions.

Qualitative feedback included the following:

"It was a nice change to actually be taught something practical on how to actively deal with stress"

" The resilience talks were very informative and inspiring"

"So much of our day is spent running around, task driven, that it was great to have a chance to stop and reflect"

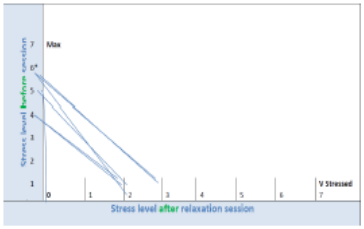
"The talks were interesting, engaging and extremely useful!"

"The talks encouraged us to view challenges from a different perspective and develop new strategies to help in the workplace"

" Really useful practices to take away"

"Even the fact that my employers see this as something important to offer me makes me feel more valued and supported".

All NCHDs reported reduction in stress levels (average from 6/7 before wellbeing session to 2.5/7 after)



NCHDs were encouraged to practice the 'SEE' principles of resilience
- Sleep: adequate sleep, support for overnight registrar to have a nap/break when the 2nd registrar is present
- Eat: healthy eating
- Exercise: having an active lifestyle

Consultants that attended helped contribute to a supportive and open sharing of issues

Increased awareness of support programmes including the employee assistance programme, Practitioner Health Matters, as well as HR and Occupational Health

Involvement of Occupational health with a drop-in session on fatigue, promoting strategic napping and increase awareness of the increased risk of accidents when tired

Continuity planning with
- Occupational Health involvement with a peak performance series currently underway
- Professorial talks with the theme 'things I wish I known at the start of my career" organised for the current year

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2. National Study of Wellbeing o Hospital Doctors in Ireland, Hayes B et al, April 2017 RCPI.
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Improving the NCHD culture
in Cork University Hospital

A 10 point plan

Produced by the CUH NCHD Forum March 2016

Reproduced in this booklet with kind permission from

Dr Liam Healy, Lead NCHD, Cork University Hospital 2015-2016

"It isn't the mountains ahead to climb that wear you out; it's the stone in your shoe"

-Muhammad Ali

Background

On December 2nd 2015, CUH Salary Department announced that due to an administrative error, 224 of 298 NCHDs would not be paid their overtime. A similar event had occurred the year previously in December 2014. That evening, social media was full of suggestions that CUH as an institution did not value its doctors, urging others not to work there again. The issue was swiftly resolved in the days after the non-payment of overtime. It was not, as some believed, a ploy on the part of hospital management to defer payment until the next calendar year. It was simply an administrative error in the salaries section of the hospital. The episode highlighted, however, a latent belief amongst doctors that they were not properly valued by the hospital.

Objective

To examine ways in which the culture in CUH can be improved so that doctors appreciate that they and their training are valued by the hospital.

1. Induction

First impressions last. The CUH induction for new doctors starting in July is a valuable opportunity to properly welcome new doctors. The induction process should take place in the main CUH auditorium, without exception, affording this occasion the importance it deserves. Previous inductions have taken place in smaller, overcrowded rooms because the main lecture theatre was being otherwise used. Coffee and scones should be provided. Each doctor should get an induction pack containing:

a) A history of CUH, how it has evolved, and where it will be in future
b) At outline of the clinical directorate model and the opportunities for NCHDs to participate in hospital life through various committees
c) Preset ID passwords for the various hospital IT systems
d) An ID card, either processed before arrival with a digital passport photo having been submitted, or organised on the induction day
e) Information on salaries, HR etc., including contact details.

There should be brief introductions from the CEO, Clinical Directors and NCHD leads, if available. Each directorate should then hold more specific inductions later that week, e.g. one for anaesthetic SHOs, one for medical registrars, one for paediatric SHOs etc. A social evening should

be planned by the lead NCHDs for the first Thursday of that week, welcoming new doctors to Ireland, to Cork and to CUH.

2. Language

Culture is often conveyed through symbols and language. Both the terms "Non- consultant hospital doctor" and "junior doctor" are pejorative terms. They don't describe one's strengths or accomplishments but instead highlight one's lack of seniority or what one has not yet achieved. CUH should become a pioneer in Irish medicine in deciding to use more positive terms to describe its medical workforce – examples may include "doctors in training", "residents" etc. Perhaps suggestions could be taken from the hospital staff and the three most popular terms put to a hospital vote. CUH should then adopt this term into its vocabulary in relation to all matters arising with its doctors.

3. Identity

Successful organisations create a brand, not just for customers, but so that employees can identify with a collective, e.g. Munster Rugby. Hospitals are ideally placed to tap into this desire people have to be part of a collective. Every doctor realises that current medical practice means that patients are not treated by an individual but by a collection of individuals working in synchrony to provide the best care possible. CUH should issue every doctor with a lanyard, proudly emblazoned with the CUH logo. Lanyards could be colour coded – red for Registrars, Green for SHOs, blue for interns – so that people can identify with their own "tribe" and so that consultants and nurses can spot a doctor's level of experience at a glance. CUH should ensure that doctors have scrubs that are similarly colour coded, with the word "DOCTOR" on the back and the CUH logo featuring proudly on the front.

4. Recognition

CUH currently recognises the "Intern of the Year" which is a very valued custom within the hospital with some illustrious previous winners. There is no recognition as personally valued as the recognition from one's peers. There should also be an "SHO of the Year" and a "Registrar of the Year" within each Directorate, as voted for by the doctors themselves, with the end of year awards ceremony expanded so that all of the hospital attends and recognises the work of people who have excelled.

5. Training Quality Assurance

Almost every post within CUH is a training post. Anecdotally, some posts are invariably better than others. The very act of measuring the quality of those posts would ensure that training providers fulfil their obligations to their juniors that extend beyond mere service provision. Every CUH intern and SHO post should be assessed with an end of year survey, administered and collated by the doctors themselves, with the results published, so that the very good training jobs

can be applauded and the jobs that are not providing high quality training can be improved as needs be.

6. Human Resources and Salaries

Interactions between doctors and administration could be improved upon. Perhaps a website could be established by CUH on its intranet, explaining clearly what a doctor's entitlements are, how salary is calculated, how overtime is calculated, how tax is calculated etc. I suspect that many of the enquiries to CUH salaries and administration relate to the same recurring issues. Perhaps once every month, a representative from the administrative staff could come to the main hospital building at a pre-designated time and answer any questions people have, either collectively or individually.

7. Engaging with Senior Management

At a recent NCHD forum meeting in CUH, the CEO offered in future to speak to Specialist Registrars on various matters in relation to life as a Consultant and the management responsibilities that entails. Specialist Registrars, regardless of whether they are at the start or the end of their training would find it very valuable to have a clearer insight into the Consultant interview process, how clinicians engage with senior management, changes in the structure of hospital governance etc. A short programme of lectures on these topics, given by senior management, would give CUH trainees a considerable advantage in advancing their training towards a consultant post.

8. Task Transfer

A recent, internally published, three year survey of the intern experience in CUH revealed that the single biggest thing that interns would change to improve their training was to reduce the undue reliance on them to undertake ward-based tasks that, from an organisational point of view, would more appropriately be undertaken by colleagues. CUH lags behind the equivalent Dublin teaching hospitals, for example, in insisting that ward based tasks such as ECGs, first dose intravenous medicines, phlebotomy and intravenous cannulation, are solely the responsibility of a doctor. A national plan is underway to ensure that these tasks are distributed more fairly and CUH should ensure that this occurs as soon as is possible.

9. Infrastructure

Many wards in CUH have just two computers per ward, shared by doctors, nurses and therapy staff. There in no non-clinical area in the hospital where doctors can go to do various tasks, from printing an inpatient list, to checking an x-ray result to accessing a paper for journal club. I suggest

doubling the number of computers on each ward, but also ensuring that each ward has an office area for doctors so that they can undertake the vital administrative parts of their job, removed from the hurly burly of ward life. I also suggest a computer room for doctors so that they can access journals and other educational material online in an appropriate environment.

The doctors' Res in CUH is in need of refurbishment. One of the biggest barriers to a nicer Res is a cultural shift required amongst doctors themselves and how they shouldn't mistreat it by leaving it untidy, with foodstuff lying around etc. What is clear is that there is not enough space for personal items such as bags or coats. Similarly a kitchen area where one can simply make a cup of coffee would be a welcome addition.

10. Publishing Recent Wins

The recent disquiet over the overtime issue in December 2015 did not reflect the enormous progress that has been made in CUH in recent years from an NCHD perspective. Put simply, there has never been a better time to be an NCHD in CUH and the recent gains should be made obvious to all:

a) Most of CUH's NCHDs are EWTD compliant. CUH has an EWTD committee with direct involvement with senior management that meets twice a month.
b) There have never been more positions on various hospital committees through which NCHDs can get involved in shaping CUH as an institution.
c) CUH has never had more educational opportunities available from departmental journal clubs, though to departmental Radiology meetings, to SHO teaching, intern teaching and the weekly hospital Grand Rounds.
d) CUH has very high pass rates for MCRP exams with a comprehensive Consultant-led tutorial schedule before each exam and a very high rate of SHOs progressing on to Higher Specialist Training
e) There is a real appetite amongst senior management to involve NCHDs in improving the training opportunities the hospital provides.

Conclusion

Management Consultant Peter Drucker is attributed with the quote "Culture eats strategy for breakfast". What is being increasingly realised in the business world is that creating the right organisational culture is a valuable recruitment tool. The marketplace for recruiting junior doctors used to be local. It is now national and even international - each of the top three Irish graduates from UCC medicine class in 2015 chose to undertake their intern training in Dublin rather than in CUH. Staff retention in medicine is problematic for reasons beyond the remit of CUH. Morale amongst junior doctors is undoubtedly low due to pay cuts and uncertainty over training prospects. Operating within this difficult national environment is a huge challenge for CUH.

An organisation's culture is embodied by the rituals, myths, symbols and stories that make up the organisation's history, its priorities and its vision for the future. CUH should not anchor its ambition for its NCHDs in the low expectation of doctors' working conditions in times past, but should continue to build on its recent advances, driven by senior management, to make its NCHD cohort feel respected and valued. Collectively improving the small aspects of CUH life - the "tiny noticeable things" - will ensure that CUH is a hospital that people will be proud to be a part of.