

A requirement, a value or a service?

How widening access is framed on medical school webpages



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Introduction

UK governments have set medical schools ambitious widening access (WA) targets to increase student diversity. University webpages are highly influential resources with 92% of prospective students using websites to inform their application decisions. However, little is known about how schools use their webpages to present WA initiatives, or the impressions these presentations may create for potential applicants, policy makers and educators.

Methods

We employed a critical discourse analysis (CDA) approach to examine how UK medical schools discursively frame WA policy enactment on their websites².

Discursive Frames

'Framing' is a powerful rhetorical strategy used to shape the ways an individual or group develop or reorient their perceptions of an issue.³

Frames may be created by: selecting certain information, keywords or themes; the use of evaluative or emotional language; repetition; and categorization.²

These perceptions may be translated into actions: the increase, or withdrawal, of support for an issue or person.³

A CDA approach requires the researcher to: analyse the linguistic features of a text; investigate the factors influencing a text's production and consumption; consider its broader social context⁴; and evaluate its potential impact on audiences.⁵

Research Questions

- How do medical schools discursively frame their approach to WA policy enactment?
- What characterizes these frames?
- Which key messages might these frames communicate to audiences?

References

1. The Student Room, 2016. *The Conversion Report*. Available at: <http://tsrmatters.com/new-student-insights-conversion-report-2016/> [Accessed May 7, 2016].
2. Entman, R.M., 1993. Framing: Toward Clarification of a Fractured Paradigm. *J. Commun.* 43(4), pp.51–58.
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4. Fairclough, N., 1989. *Language and Power*. London: Longman.
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Results

Three discursive frames were identified. These frames utilized different linguistic and discursive strategies to create a distinctive tone and promote a particular presentation of WA.

The Institutional Frame

- Webpages typically presented an enduring system of admissions that accommodated the **'requirement'** of WA.
- This frame adopted a **detached tone**, created through less frequent pronoun use, formal lexical choice and passive voice.
- This frame implied that **WA should be limited to existing systems of selection and recruitment**.

"There are a number of ways in which applicants can have access to the medicine programme at XXX apart from the standard application routes, and there are a number of opportunities to visit the Institution to find out more about University and medicine in particular." (School 3)

The Value-Driven Frame

- WA was presented as a **'value'** to be embedded into admissions and wider medical school practices.
- This frame adopted a **persuasive and emotive tone**: 'we' and 'our' were used frequently to emphasise the school's position and opinion.
- This frame promoted **larger scale integration of WA** throughout the school.

"It is hoped that the collaboration between WP and medical education will allow the [WA outreach] programme to flourish, with the aim of XXX becoming a leader in delivery of WP into medicine and with the School able to boast that "it teaches doctors from the age of 14!" (School 9)

The Service-Oriented Frame

- Webpages presented WA as a **'service'** provided through WA initiatives. Success focussed on the achievement of WA targets.
- This frame's **engaging tone** was created by the use of participant testimonials and the pronoun 'you' to directly address the reader.
- The webpages positioned **WA initiatives as an additional 'product'** provided by schools to address a 'need' in the market.

"Join us for a week to sit in and observe our students in their learning environment... You'll also have the opportunity to visit the research laboratory and try out our specialist IT and e-learning resources." (School 16)

Conclusions

These frames may influence how audiences: judge the attractiveness of the institution; orient their attitudes towards WA; and perceive the 'correct' implementation of WA policy. Medical schools should ensure the impressions promoted on their websites align with those they practice and/or aspire to.



Bedside Chest Ultrasound Training: Progress of delegates who attended a nationally recognised practical training course - Hopes and Challenges

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Ayr Chest Ultrasound Skills for Physicians Course Faculty

INTRODUCTION

Physician-performed-bedside-Chest-Ultrasounds (P-CUS) on patients with pleural effusion (PPE) prior to pleural procedures has become accepted good practice in the UK. Royal College of Radiologists (RCR) training guidelines for Physicians to attain Basic (Level 1) CUS competency (BCUS-C) list both theoretical and practical training requirements, for the trainee to complete, under supervision from a Training Mentor (STM).

Currently, such training opportunities are limited in the UK. Since June 2005, the first author has organised a Basic Thoracic Ultrasound Skills course for Physicians twice a year, (initially in Middlesbrough and, since 2012, in Ayr), aimed at addressing the RCR training requirements.

More than 540 delegates from across the UK and abroad, have attended the 24 courses organised over 12 years. We were interested to learn about their subsequent progress in P-CUS training.



Figure 1: Geographical origin of delegates from the UK to our Course. In addition, delegates from the Republic of Ireland, Netherlands and Singapore have attended. Their data has not been included in this study

METHODS

With ethics committee approval, in November 2011, we invited all the delegates who had attended our course between June 2007 and January 2011 to participate in a web-based questionnaire survey: <http://www.kwiksurveys.com/online-survey.php?surveyID=15EM19e3adac4>

We specifically sought responses to the following questions:

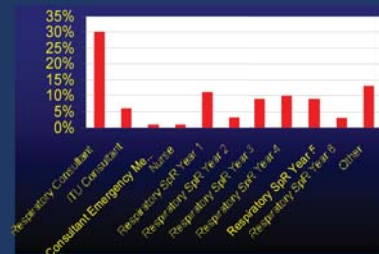
- Whether he/she has attained Basic (Level 1) Chest Ultrasound Skills Competency since attending our course.
- If yes, how long did this take to attain?
- Did they have an identified Chest Ultrasound (CUS) training mentor BEFORE and/or AFTER they attended the course?
- If yes to above, who was their CUS training mentor (radiologist or chest physician)?
- What did each respondent perceive as important hurdles in his / her CUS training pathway?
- What was his/her confidence levels in practicing bedside CUS on patients with pleural and diaphragmatic pathology?
- Whether there was a dedicated Pleural Diseases' clinic in his / her current hospital.

RESULTS

A. RESPONSE RATE FOR THE QUESTIONNAIRE SURVEY

Total number of delegates June 2007 to January 2011	: 216
Number of e-mail invitations sent to partake in the survey	: 207
Number of wrong e-mail addresses (returned undelivered)	: 8
Number of delegates who received the e-mail invitation who were eligible for inclusion	: 198
Number of respondents	: 105
RETURN RATE $(105 \div 198) \times 100$: 53%

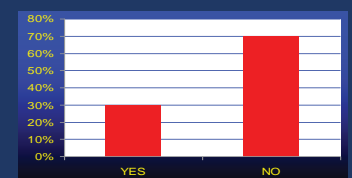
B. GRADE OF THE DELEGATES WHEN THEY ATTENDED



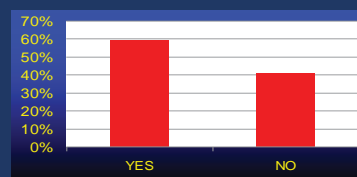
C. GEOGRAPHIC LOCATION OF RESPONDENTS



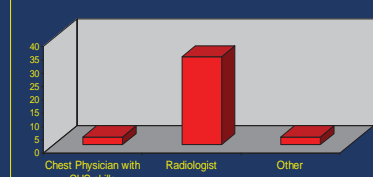
D. WAS A WILLING CUS TRAINING MENTOR IDENTIFIED BEFORE THE COURSE?



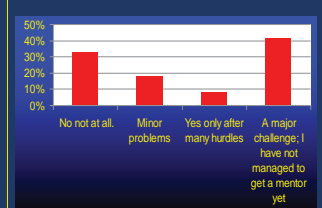
E. WAS A WILLING CUS TRAINING MENTOR IDENTIFIED AFTER THE COURSE?



F. IF YES, TO ABOVE, WHO WAS THE CUS TRAINING MENTOR? (n = 58 (55%))



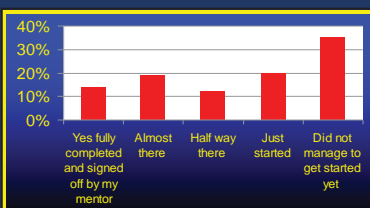
G. WAS IT DIFFICULT TO GET A CUS TRAINING MENTOR?



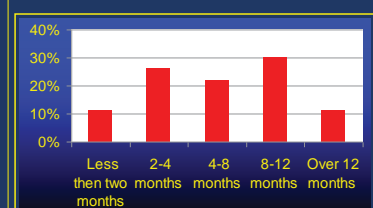
H. SOME EXAMPLES OF PERHAPS RELEVANT COMMENTS

- "Radiologists very keen to be involved"
- "Supportive radiology department"
- "Difficult to get radiology support; they have their trainees"
- "No chest consultant with CUS skills in my centre"
- "Easy to agree in principle; difficult to coordinate training times"
- "Had mentor in previous hospital; None in current posting"
- "Finding time to train amongst other work commitments"
- "Radiologists suspicious and not keen on helping"
- "Awaiting delivery of our ward-based ultrasound machine"

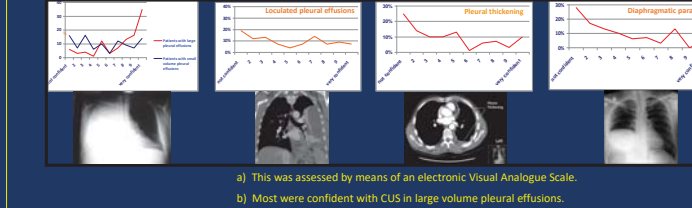
I. LEVEL 1 CUS COMPETENCY ATTAINED?



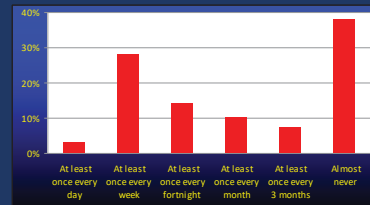
J. IF YES, HOW LONG DID IT TAKE TO ATTAIN LEVEL 1 CUS?



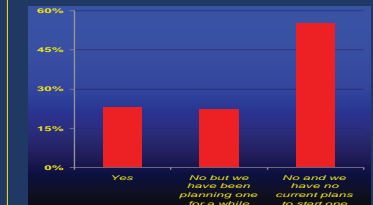
K. HOW CONFIDENT WAS EACH RESPONDENT WITH CUS FOR THE FOLLOWING PLEURAL/DIAPHRAGMATIC PATHOLOGY?



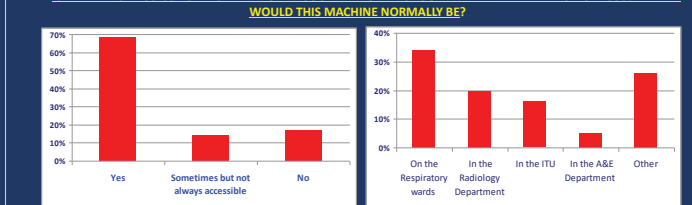
L. FREQUENCY OF INDEPENDANTLY PERFORMED CUS BY EACH RESPONDENT?



M. IS THERE A DEDICATED PLEURAL DISEASES CLINIC?



N. IS THERE EASY ACCESS TO A PORTABLE ULTRASOUND MACHINE SHOULD THERE BE A NEED TO DO A CUS? WHERE WOULD THIS MACHINE NORMALLY BE?



O. SINCE ATTENDING OUR CUS COURSE HOW LONG IS YOUR WAIT FOR A BEDSIDE CUS TEST NOW?



SUMMARY OF THE RESULTS

- 14% of delegates who attended our AYR chest ultrasound course have attained Basic (Level 1) Competency in Chest ultrasound at the time of this survey
- A further 19% 'Almost There' since they came to the CUS course
- Attaining Level I competency appears to take 4-6 months on average when working in units or firms that see 2-4 patients with pleural effusions per week.
- Those CUS trainees working in units with dedicated Pleural Diseases' Clinics appear to attain Level 1 competency sooner.
- Difficulty accessing an ultrasound machine (32%) and a Training Mentor (41%) remain major hurdles.

CONCLUSIONS

While patient safety advantages of P-CUS are accepted, major hurdles remain in the path of physicians aspiring for Basic Chest Ultrasound (Level 1) Skills.

We believe our results are applicable and representative of all participants who attend the several other chest ultrasound courses now available across the UK

Attending a Chest Ultrasound course, as required by the RCR CUS training guidelines, does not mean there will be a hurdle-free seamless transition to Level I competency in Chest Ultrasound Skills

The hurdle we have identified need to be overcome to assist the learning process of trainees in bed side chest ultrasound skills

Collaborative multi-speciality efforts to address these could improve opportunities for more of the delegates attending CUS theory/practical courses around the UK to complete basic chest ultrasound training requirements and Attain Level 1 Competency.

Dealing with Death and Dying as a Junior Doctor

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Aim

- We hypothesised that current medical undergraduate training provides limited guidance for doctors managing dying patients, notably personal coping skills.
- Our aim was to develop a teaching session for final year students to target this gap in the curriculum.

Method

- We conducted an anonymised survey of Foundation Year 2 doctors to understand their personal experiences and teaching experience on managing dying patients.
- Using this data, we developed a 45-minute teaching session titled *'Dealing with Death and Dying as a Junior Doctor.'*
- Main sections included: anticipatory prescribing, communicating with relatives, verifying death and personal coping techniques.
- Teaching sessions were delivered to final year medical students at the University of Edinburgh (n=119) over six large group sessions. Student feedback was then completed via an anonymous online portal.

Sample of Slides from Undergraduate Teaching Session

What's Missing?

How to actually deal with death and dying as an FY1!

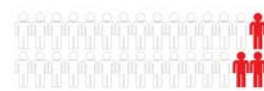
- How YOU may be involved in a patient's death
- Anticipatory prescribing
 - Communicating with grieving relatives
 - Verifying death
 - Cardiac arrests

How a patient's death may affect YOU

Why are we teaching you about death?

On a standard 30 bedded ward:

- 3 patients won't survive this admission



Communicating with Relatives

'SPIKES'

- Setting up the interview
- Assessing their Perception
- Obtaining their Invitation
- Giving Knowledge and information
- Being Empathetic
- Summarising

FY2s in NHS Lothian

- "Talking with team: proper debrief"
- "Ask seniors why etc."
- "Drink tea"
- "Discuss with friends"
- "Taking time out to relax before continuing"
- "Discuss with colleagues"
- "Sensible"
- "You break"
- "Talking to someone at home who is not a doctor"
- "Immediate and delayed debriefing"
- "Talking with friends/colleagues"
- "Reflect in portfolio"
- "Discussions with colleagues and personal reflection"
- "Cry a bit"

Adam Kay

"My coping strategies were almost non-existent. I'd love to say it was 'gallows humour' but that was the most superficial of release valves. I ignored, and didn't discuss things at all. What I did do that worked was play the piano, which took me away to a different place, and distracted me from real life."

I'd advise students that there aren't any medals for bravery, and there's no place for machismo. Even surgeons are allowed to cry. We're all human."

Outline of the session

Why is this relevant for all juniors? Because statistically, 1 in 10 inpatients will die on their current admission.

Using the SPIKES framework, we give our 'top tips' for communicating with relatives.

We present the advice and coping strategies of FY2s in Lothian.

We present the advice of writer and former doctor.

Results

- Data on FY2 Doctors revealed only two thirds (67.6%) had been educated on how to verify patient death and less than one third (25.6%) educated on personal coping skills following patient death.
- Prior to the teaching session, over half of students reported feeling apprehensive about caring for dying patients.
- Following the session, all students rated the session positively and over 70% described it as 'excellent'.
- Feedback comments (*on the right*) highlighted the importance of this topic and that it was not covered in the curriculum.

Student Feedback Comments

'Very genuine, real and relevant.'

'Really refreshingly open, honest and practical look at dealing with death and dying- a topic that whilst looming over all of us like a dark cloud has never been properly addressed before.'

'Frank conversation from someone our age and grade.'

'Hugely relevant.. But often brushed over.'

'Honest and open discussion.'

'A really useful talk which has filled a major gap in the curriculum.'

Conclusions

- Dealing with death is an important aspect of a junior doctors clinical role, yet many have limited education on managing this (practically and emotionally).
- We have successfully developed a teaching session targeting this gap in the medical curriculum, with overwhelmingly positive feedback.

Reference: Clark D, Armstrong M, Allan A, Graham F, Carnon A, Isles C. Imminence of death among hospital inpatients: a prevalence cohort study. *Palliative Medicine* 2014; 28(6):474-9.

Thanks: Dr Olayinka Ogundipe (Consultant Physician in Medicine of the Elderly and Honorary Clinical Senior Lecturer, NHS Lothian), Dr Kim Steel (Consultant Physician in Palliative Care Medicine, NHS Fife) and Mr Adam Kay (Writer).

A Pilot Study Assessing the Effectiveness of Peer Assisted Learning to Undergraduate Medical Education

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Aim

Peer-Assisted Learning (PAL) has been greatly utilised in the context of medical education, with numerous initiatives seeking to aid students during exam periods. Although PAL has been positively received by many students as a means of supporting their learning, there is a lack of objective evidence which demonstrates benefit of PAL. Performance in a series of Multiple Choice Question (MCQ) tests was measured in a group of students attending revision lectures created and delivered by fellow senior students. PAL resulted in an increase in performance, thereby validating it as a means of educating students for revision purposes.

Methods

Two presentations were created by senior medical students on the subjects of 'Endocrinology' and 'Hepatology'. Twelve relevant MCQs were then formulated and checked for accuracy. Junior medical students were recruited via advertisement on various social media platforms. We ran two cycles of this study in the interest of expanding our sample size. A total of 95 students attended our 'pre-lecture' tests (figure 3). Following the completion of the revision sessions, we asked attendees to complete a 'post-lecture' assessment, of which there were 49 respondents. results were then tabulated using SPSS. The data were analysed in view of two parameters: The average score achieved by each student in both papers across both sessions, and the overall performance of all students for each question.

Outcomes/Results

In comparing the relevant average scores, a paired sample t-test was utilized. In the first session, average score increased from 7.7 to 11.2 ($p=0.001$). In the second session, there was an increase in the average score from 7.8 to 8.8 ($p=0.04$). Both of these are shown in figure 1. We also discovered an increase in performance for 9 out of 12 questions in the test ($p=0.02$), with notable improvement in questions on Liver Function Tests and Endocrine Physiology (Figure 2). The data therefore demonstrate statistically significant and objective benefit to PAL in the revision process.

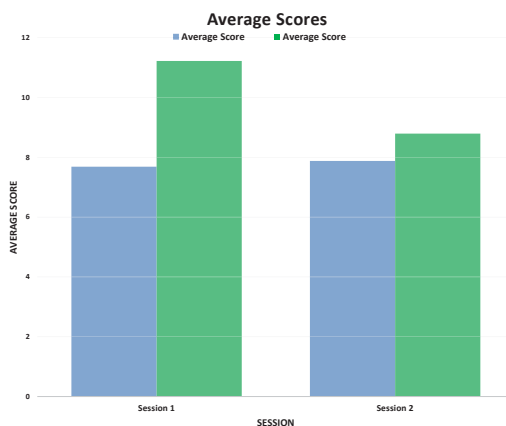


Figure 1: Average Scores for Each Session

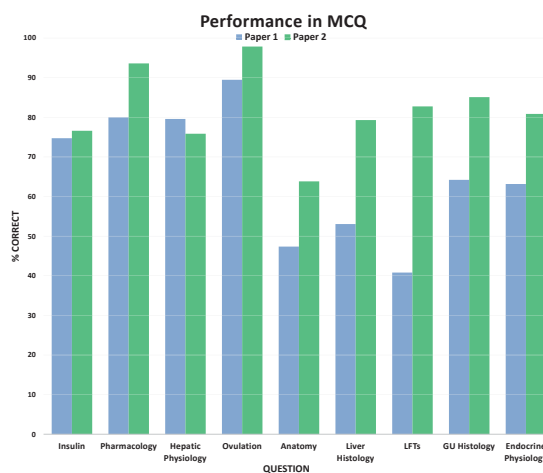


Figure 2: Overall Performance by Question

	Session 1	Session 2	Total by paper
Paper 1 (Pre-lecture)	46	49	95
Paper 2 (Post-lecture)	18	31	49
Total by session	64	80	144

Figure 3: Sample Size per Session

Conclusions

In this study we showed benefit to PAL for medical students in their pre-clinical years. The improvement in performance suggests that PAL may have a role to play in the provision of medical education. Further evidence is required with a larger sample size and wider range of topics. We would also extend this study to students learning content for the first time in order to alleviate any confounding factors such as previous revision or learning by repetition.

Contact

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References

1. Peer-assisted learning (PAL) in undergraduate medical education: An overview, *Z Evid Fortbild Qual Gesundheitswes.* 2017 Apr;121:74-81.
2. An assessment of student satisfaction with peer teaching of clinical communication skills, *BMC Med Educ.* 2014; 14: 217.

#SaynoSHO in University Hospital Ayr

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Dr Derek McLaughlan, Assistant Director of Medical Education,
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Introduction

As part of 'Modernising Medical Careers' the term Senior House Officer (SHO) was made obsolete in 2007.¹ However, it is still used to refer to a wide range of doctors with variable experience making it difficult for nurses to know the best person to contact in different situations. In August 2017, trainees were provided with coloured badges, corresponding to their training grade, with the aim to improve understanding of staff nurses.

Methods

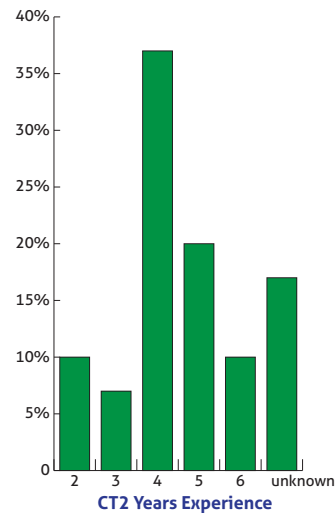
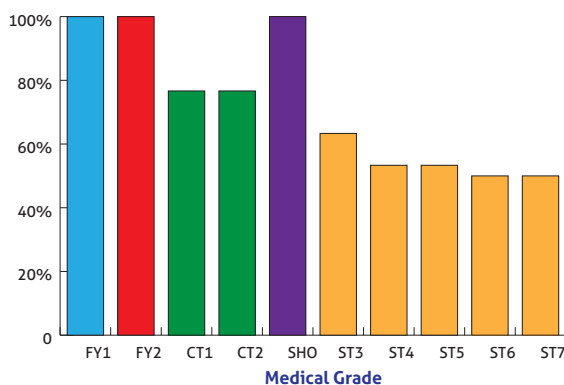
We compiled a questionnaire to assess understanding of medical grades and knowledge of the colour-coded name badges among 30 nursing staff (band 5+) across medical & surgical wards. We asked who they would contact in a range of clinical scenarios. Next we re-launched the concept by distributing corresponding coloured lanyards, provided education using a modified poster, then re-assessed the understanding of 19 nursing staff across medical & surgical wards.



Results

All respondents (n=30) had heard of the terms SHO and FY1/FY2. 77% recognised CT1/CT2. Recognition reduced for ST grades.

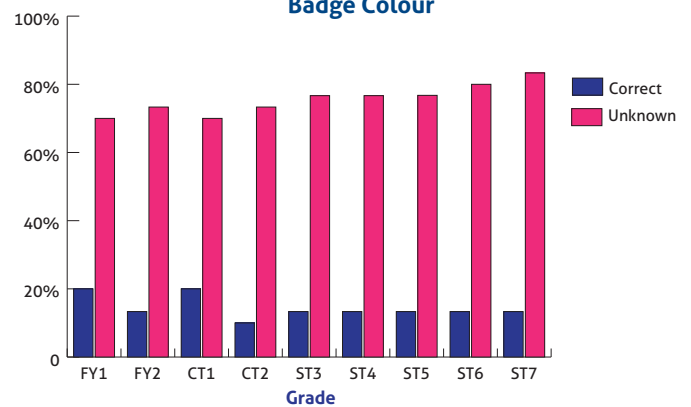
Recognising Doctors Titles



Only 7% (n=2) correctly identified the numbers of years experience of a CT2 as 3 years. 17% (n=5) marked 'unknown' and over 65% (n=20) thought they had more experience.

20% (n=6) correctly identified FY1 and CT1 badge colour but for all other grades, the correct response was less.

Badge Colour



After the education session and introduction of the coloured lanyards, 63% (n=12) nurses stated that it was easier to know the grade of doctors. 89% (n=17) stated that this will have a positive impact on their knowledge of who to contact and 84% (n=16) stated that they now had a better understanding of medical grades.

Conclusion

The introduction of name badges made little difference to the ability of nursing staff to identify the grade of a doctor. Indeed, the general consensus was that staff were unaware that the doctors had coloured badges. The majority of nurses stated that an improved understanding of the training system would make them feel more confident and that the introduction of coloured lanyards and associated education sessions successfully achieved this. In the future, we aim to include an introduction to medical grades at trust induction for new nurses.

References

1. House of Commons, Health Committee, 'Modernising Medical Careers', Third report of session 2007-2008, Volume 1, 24 April 2008.

Assessment of patient safety culture in an adult oncology department in Saudi Arabia



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¹ Centre for Healthcare Education Research and Innovation, Aberdeen, UK

² Department of Human Resources & Organisational Behaviour, University of Greenwich, London, UK

Background & Aim

Medication errors are a significant cause of mortality and morbidity in hospitalized patients¹. Research shows that the death rate from medication errors is increasing globally^{2,3}. Professional communication is known to be major contributor to medication error⁴. However, studies looking at medication errors in the Middle Eastern (Gulf) countries are relatively few in number, and of poor quality⁵. Additionally, those studies which have been carried out in this context focus either on scrutinising poor systems or lack of knowledge as the main factors underpinning error, and/or pilot interventions to decrease error. In contrast, and drawing on the wider literature, the purpose of our study was to evaluate patient safety culture across different healthcare professionals related to medication errors from different countries of origin working in an adult oncology department in a Saudi Arabia.

Methods

This was a cross-sectional survey of 130 healthcare staff (doctors, pharmacists, nurses) working in an adult oncology department in Saudi Arabia. We used the Hospital Survey of Patient Safety Culture (HSOPSC)⁶ to examine perceptions of safety culture during the month of February 2017. Data were analysed using SPSS v24 for descriptive statistical analysis, calculating composite positivity, and running t-test, ANOVA test, and linear regression to identify factors influencing the patient safety culture.

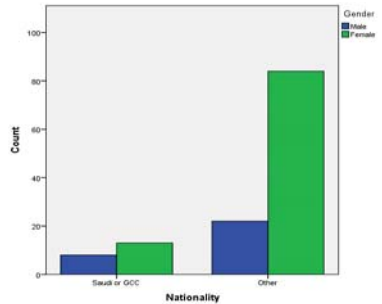
Results

127 of 130 questionnaires were returned, yielding a response rate of 97.7%. Eight out of the twelve HSOPSC composites were considered as areas for improvement (percent positivity < 50%). Significantly different mean scores were observed across the three professional groups in all twelve HSOPSC composites. Doctors tended to rate patient safety culture significantly more positively than nurses or pharmacists. Nurses scored significantly lower than pharmacists in the majority of HSOPSC composites. No significant differences in patient safety culture composite scores were observed between Saudi/Gulf Cooperation Council (GCC) and non-Saudi/GCC groups. Regression analysis showed that frequency of reported events is predicted by feedback and communication about errors, and teamwork across units, while perception of patient safety is associated with respondents' profession and teamwork across units.

We report our preliminary survey findings here. We collected 127 completed surveys. The proportions of those responding from different professional groups are presented in Table 1.

Table 1	Profession	Frequency	Percent
	Physicians	21	16.2
	Pharmacists	18	13.8
	Nurses	88	67.7
Total		127	97.7
Missing		3	2.3
Total		130	100

Of 127 responses, 67.7% were from nurses, 13.8% from pharmacists and 16.2% from doctors. Three respondents did not state their professional group. 23.1% of respondents were male, 74.6% female. The majority of staff were from groups other than (Saudi or GCC/ Other).



Analysis of the HSOPSC identified eight of the 12 safety dimensions with low positivity (less than 50%); supervisor/manager expectation & actions promoting patient safety, management support for patient safety, overall perception of patient safety, communication openness, teamwork across units, staffing, handoffs, and non-punitive response to error (with the following percentage of positivity 27.7%, 27.8%, 49.02%, 17.3%, 6.1%, 27.6%, 14.15% and 11.3% respectively).

HSOPSC dimensions with highest positivity were teamwork within unit (69.3%), organizational learning-continues improvement (65.3%), feedback & communication about error (56.1%) and frequency of events reported (62.4%).

Patient Safety Culture Composite	Medical Doctors	Pharmacists	Nurses
	Mean (SD)	Mean (SD)	Mean (SD)
Teamwork within unit	3.92 (0.38)	4.01 (0.53)	3.69 (0.60)
Supervisor/Manager expectations & actions promoting patient safety	2.64 (0.54)	3.41 (0.74)	2.48 (0.50)
Organizational learning – continuous improvement	3.61 (0.51)	3.83 (0.46)	3.53 (0.42)
Management support for patient safety	3.28 (0.58)	3.29 (0.72)	2.33 (0.55)
Overall perception of patient safety	3.53 (0.53)	2.87 (0.53)	3.29 (0.48)
Feedback and communications about error	3.68 (0.71)	3.42 (0.62)	3.40 (0.57)
Communication openness	3.44 (0.66)	2.81 (0.52)	2.03 (0.72)
Frequency of events reported	3.46 (0.75)	3.14 (0.74)	3.77 (0.97)
Teamwork across hospital units	2.63 (0.61)	2.11 (0.43)	2.29 (0.46)
Staffing	2.50 (0.60)	3.02 (0.47)	2.68 (0.50)
Hospital handoffs & transitions	2.72 (0.88)	2.59 (0.67)	2.19 (0.66)
Non-punitive response to errors	2.95 (0.80)	2.44 (0.75)	2.06 (0.60)

Conclusion

This study is the first empirical study of patient safety culture in an oncology setting in Saudi Arabia. The preliminary data helps our understanding of how communication relates to medication error in a complex, multi-professional clinical setting. It highlights specific issues, most obviously, in communication openness, staffing, handoffs, and non-punitive response to error. On a positive note, quality improvement and reporting systems were rated highly. This study brings into question the assumption that all healthcare professionals have a shared understanding of patient safety.

We urge healthcare leaders and policy makers to look at patient safety culture at this granular level in their contexts, and use this information to develop strategies and training to improve patient safety culture.

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COME HERE. GO ANYWHERE

What are the perceptions of final-year medical students' preparedness to conduct and participate in ward rounds upon graduation? A literature review

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Background

Ward rounds are an integral feature of medical practice and are critical in providing safe clinical care (RCP/RCN, 2012). Participating in ward rounds as a junior doctor entails a complex interplay of clinical and non-clinical skills in a time pressured format. These individual domains have been suggested as areas of practice undergraduate students are lacking in preparedness for upon graduation (Brennan et al., 2010).

Aim

In order to establish the evidence around undergraduate preparedness for ward rounds, a narrative literature review was undertaken.

Methods

A search was developed to address the question: What are the perceptions of final-year medical students' preparedness to conduct and participate in ward rounds upon graduation? The following base terms were used: preparedness for practice, medical students, and ward round. Medline (via Ovid search interface) and Web of Science Core Collection databases were searched over a three-week period in October 2017 adhering to Best Evidence Medical Education principles in search construction. Additionally, the GMC's website was hand searched.

Results/Discussion

Following screening of titles and abstracts eight papers were identified as being relevant. It became apparent heterogeneous terms are used to describe the notion of 'preparedness'. The focus of studies was typically towards individual aspects of ward rounds (for example prescribing, multidisciplinary teamworking). Consistent deficits were identified in junior doctors' confidence in undertaking these components. There is some evidence to support the use of simulated ward rounds in increasing the confidence of final year medical students.

Conclusion

The perceptions of undergraduate students' preparedness to conduct and participate in ward rounds upon graduation from medical school is inadequately explored in current education research. Knowledge of these perspectives will allow learning opportunities during student assistantships (and indeed, the rest of undergraduate training) to be better informed. Based on the findings of this literature review a research protocol is currently being developed to contribute to the evidence base.

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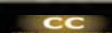
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Wellcome Library, London. Wellcome Images
images@wellcome.ac.uk <http://wellcomeimages.org>

Colour Coding of Lanyards



to denote grade and experience of doctors

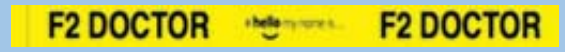
A M Carragher, L Parks, L Loughrey.

Northern Ireland Foundation School NIMDTA

Introduction: Identification of doctors in clinical settings is more difficult since the traditional white coat disappeared from wards in the United Kingdom. Other healthcare professionals wear coloured and readily identifiable uniforms with their role specified clearly. Patients and the public find it increasingly difficult to identify doctors and define their expertise and grade.

Promoting Excellence R1.10 requires 'that organisations must have a reliable way of identifying learners at different stages of education and training, and equally they must make sure all staff members take account of this so that learners are not expected to work beyond their competence'.

In August 2014 all Foundation doctors in Northern Ireland were introduced to the 'hello my name is..' campaign started by Dr Kate Granger and branded coloured lanyards were distributed. In July 2015 permission was sought from Dr Granger to utilise her logo on coloured lanyards to distinguish F1 and F2 doctors. These grey and yellow lanyards were distributed to all Foundation doctors.



In Judo skills, ability and competence are assessed before awarding the next ascending grade of coloured belt. Appropriate colours for all medical training grades was agreed with both the medical school and the Foundation School. For specialty grades the hues of blues, allow blue to signify post Foundation doctors and yet distinguish separately those in core, specialty and GP training. In keep with the black belt in Judo, black lanyards with Senior Doctor written on them have been distributed to the recognised trainers of Foundation doctors.

Queens University Belfast Medical School distributed their maroon /red coloured lanyards in August 2016 to their medical students. Recognition of the expertise and grade of doctors is important for all healthcare staff. It is also important for patients and members of the public who visit and attend clinical settings for treatment and care. This may be critical in some instances for patient safety.

'following the media publicity of the campaign, wearing a lanyard with this logo has caused a significant number of patients to comment on how enthused they are by this initiative, ... it also has made me more mindful of introducing myself clearly to all patients'.





Will 'a good catch' increase learning from 'near misses' ?



A M Carragher L Parks K O'Boyle M King
Northern Ireland Foundation School NIMDTA

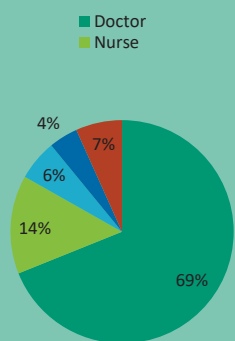


INTRODUCTION: Attitudes to reporting 'near misses' were examined with Foundation doctors in 2007 and repeated in 2017 using a questionnaire. Other international medical centres¹ have changed the term used and have shown increased levels of reporting of "unplanned events that did not result in injury; illness or damage but have the potential to do so."

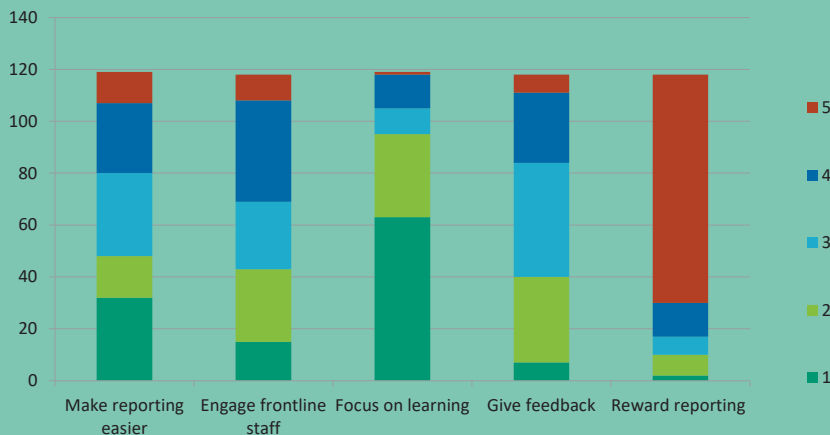
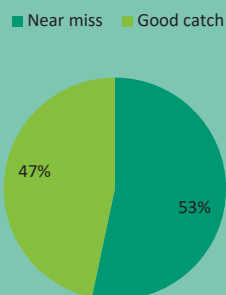
METHODS: A new term 'a good catch'² was introduced to determine if this would boost reporting. Using a paper based survey 120 healthcare professionals were asked to preference the two terms 'near miss' and 'a good catch' and to rank the importance (on a scale of 1 to 5) of five NPSA actions to improve patient safety reporting³

RESULTS: A greater preference for 'near miss' terminology is evident but doctors as a group preferred the newer term 'a good catch'. Analysis of the ranking showed more importance placed on learning and making reporting easier and little regard for a reward based reporting system.

Healthcare Role



Preferred Definition



CONCLUSION: Traditional terminology remains embedded however there is scope to improve the reporting of incidents which do not result in harm. The introduction of new terminology elsewhere has increased reporting levels by a more positive attitude towards reporting. A focus on learning derived from the incidents and easier reporting systems will further improve patient safety.

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Images taken by Dr Lorraine Parks

Driving educational change through an ultrasound teaching fellowship

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Scottish Medical Education Conference, 26-27th April 2018



Background

Ultrasound (US) is now used across a wide spectrum of disciplines¹

- Improved safety profile of US-guided procedures
- More challenging patient population
- Advances in sonographic technology

At our institution a single decommissioned US machine was dedicated for teaching: teaching was therefore limited and inconsistent.

This fellowship was established to align personal educational objectives with a vision to urgently meet this need.

Methods

- Establishment of a year-long fellowship with dedicated time for teaching.
- Collaboration with stakeholders (industry/university/clinical staff) to source US equipment.
- Undergraduate curriculum development to include US teaching.
- Small group practical tutorials were developed:
 - ❖ Basic US principles taught in a large group setting.
 - ❖ Practical experience of sonography in small groups (max 10), using live models (peers) with direct observation/feedback.
- Provision of US educational materials for anatomy demonstrators.
- Development of mastery learning post graduate courses using US (PICC line insertion, airway US).

Discussion

- 214 students/doctors received sonography teaching, over 22 sessions.
- Thematic analysis of formal feedback demonstrated:
 - ❖ Candidates were receptive to this teaching. In particular, students valued the practical, hands-on nature of US tutorials and felt the subject matter was interesting and helpful.
 - ❖ Negative factors included the student:tutor ratio and time available for individual practice.
- Retention of knowledge was confirmed at four months.
- Based on feedback, smaller groups will be trialed allowing more "time on probe".
- The ongoing capability to deliver high quality US teaching has been assured by the purchasing of six new US machines, as a direct result of this work.

Conclusions

Establishment of an US teaching fellowship has been successful in championing the importance of US education and expanding local undergraduate and postgraduate US teaching capability and delivery.

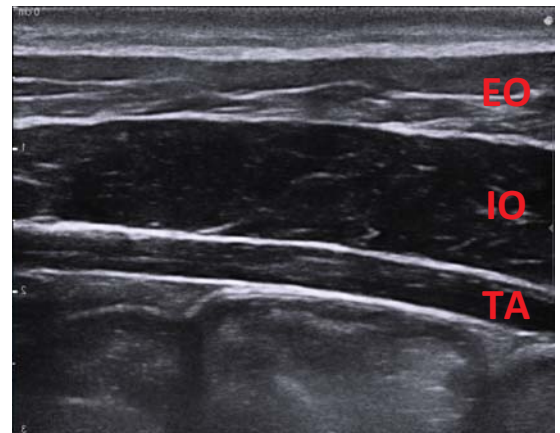


Figure 1. Sonoanatomy of the anterior abdominal wall



Figure 2. Sonographic identification of the cricothyroid membrane



Figure 3. One of six wireless US probes purchased from Ballater Medical

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Learning from Excellence in the ICU

Assessing Awareness and Effectiveness

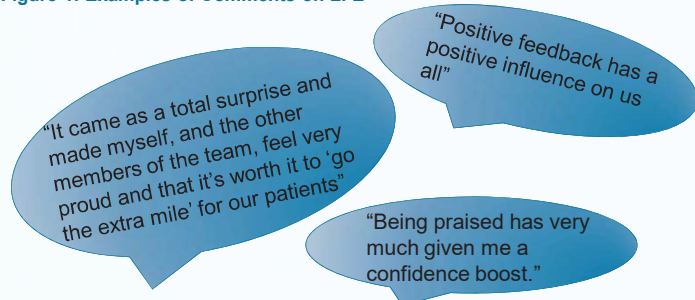
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Background

Strategies to improve patient safety often focus on analysis of error in healthcare, leading to an emphasis on adverse events and consequences. The interplay of patients, carers and technology is more complex than ever and providing simple and achievable solutions to address errors is not always possible. An unwanted side effect of focusing on error is a detrimental effect on staff morale. One way to balance this negativity is to study what goes well in healthcare and why. Learning from Excellence¹ (LFE) was developed by Dr Adrian Plunkett et al as a means of identifying, capturing and learning from episodes of peer reported excellence. In a time of increasing focus on trainee burnout, this also provides an opportunity to improve staff morale.

Figure 1: Examples of Comments on LFE



Aim

LFE was introduced in the Intensive Care Unit (ICU) at Aberdeen Royal Infirmary (ARI) in December 2016. Staff members can report examples of excellent practice using a simple online form which utilises existing incident reporting software. Our aim was to assess the awareness of the scheme in our ICU and its impact so far.

Methods

An online survey was sent to our multiprofessional group of report recipients. Questions focused upon awareness of LFE and its impact on morale and clinical practice. The LFE team also analysed the reports in order to categorise them and ascertain any potential changes to practice which could be implemented.

What topics did reports relate to?

- Team work
- “Being nice”
- Quality care
- Supporting others
- Education and training
- Organisation and management
- End of life care

Results

45 recipients were surveyed, 30 (67%) responded.

Figure 2: Awareness

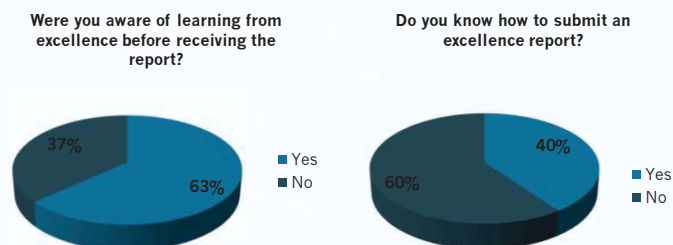
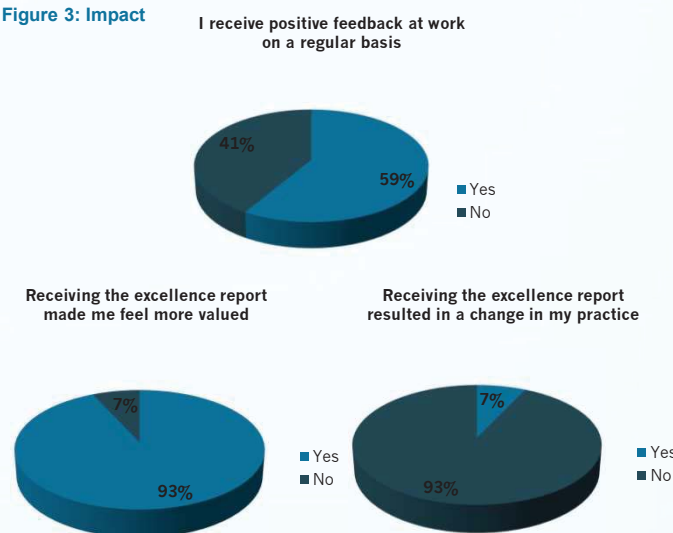


Figure 3: Impact



Conclusions

Although our work has shown an ongoing lack of awareness of LFE in our department, it has highlighted the positive impact on staff morale. In the context of increasing demand on the health service, there has been a recent focus on the issue of stress in doctors. With a 2017 RCOA survey finding 85% of anaesthetists to be at risk of burnout², this is a prominent issue. Our recipients commented on the reports' effect on their confidence and self-esteem, as well as the usefulness of having examples of unsolicited positive feedback for e-portfolios and revalidation. Studies have shown that nurturing positivity in healthcare staff is linked to improved resilience and better patient experience^{3,4}. The reports have highlighted things we are doing well, such as end of life care and education, and suggestions as to how we can improve simulation-based training have come about as a result. It is hoped that as we work locally to increase awareness of LFE that there will be more reports submitted and therefore greater opportunity to learn from excellent practice.

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The Intersection Between Early and Developing Professional Identities in First Year Medical Students

Ilesha Ewart



“I have to see things the way people who work there see things, all the health care professionals, the nurses, the doctors, all of them... I have to adjust to it and I have to accept that I will be, hopefully, I will be a part of this team.”

Introduction

Students do not enter medical school as blank slates¹. They are a mixing pot of continually developing identities formed throughout childhood from internal and external influences. Experiences, societal views and the media all contribute to identity formation and the preconceptions of identities, including that of a doctor².

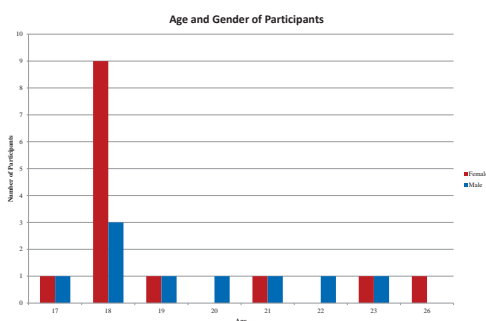
When preconceptions clash with the realities of medical school it can result in tensions that challenge the formation of a professional identity. Professional identities lead to improved career prospects, increased wellbeing in medical students and doctors, and ultimately good patient care³⁻⁵. Therefore, it is essential to fully understand the impact of preconceptions and associated tensions upon the formation of a professional identity.

Methods

All 1st year medical students in 2013 were invited to participate. 14 males and 9 females (Figure 1) self-selected to take part in this qualitative study underpinned by a constructivist epistemology.

Data was collected via individual audio diaries, recorded following four of the first clinical hospital-based placements over a 3 month period.

Diaries were transcribed verbatim and 3 participants chosen for initial analysis using an inductive, thematic approach. A framework was developed and used to interpret the remaining data using template analysis⁶.



Results

Template analysis revealed 3 themes: a good doctor (Figure 2), staff interactions (Figure 3) and a good patient (Figure 4).



Figure 2: Emergent themes and recurrent phrases used by participants describing a good doctor

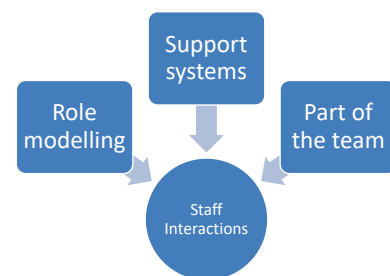


Figure 3: Subthemes comprising the overarching theme of staff interactions with participants



Figure 4: Recurring phrases used by participants describing a good patient and relevant subthemes.

Conclusion

This study revealed preconceptions associated with becoming a doctor, working life and associated tensions. Moreover, this study identified preconceptions held about patients, patients who are ‘good’ and tensions occurring when students encounter those who contradict this notion.

Awareness of such preconceptions and potential tensions may enable educators to support the students formation of a professional identity throughout medical school.

Acknowledgements

Many thanks to Miss Eve Stubbing and Prof. Jennifer Cleland for their help and support throughout this project.

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COME HERE. GO ANYWHERE

Aim

Under the Equality Act 2010¹ the University has a general duty to eliminate discrimination, to promote diversity and to encourage good relations between the diversity strand (protected characteristics). The GMC has identified four priorities for work on equality, diversity and inclusion up to 2020².

As LGBT (Lesbian, Gay Bisexual, Transgender) Youth Scotland champions within Dundee's UG Medical School, the authors wished to collect information around the attitudes to and experiences of gender-identity and sexuality diversity of our MBChB students.

We also wanted to compare with results of a similar survey run in 2011.

Methods

The 2011 questionnaire was modified to reflect changes to the University structure and guidance from the Equality Network re. nomenclature relating to gender identity and sexuality.

Ethical approval was received from UoD, and submitting the questionnaire assumed consent.

All MBChB students were invited by email to complete the online anonymous questionnaire during February 2018 (LGBT+ history month). 1 reminder was sent out on Purple Friday (LGBT+ awareness day).

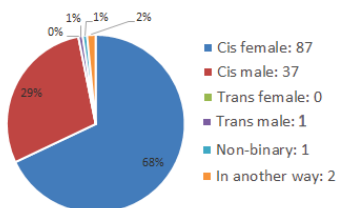
Analysis was via Excel, and free-text was coded using thematic analysis.

Results

Response rate

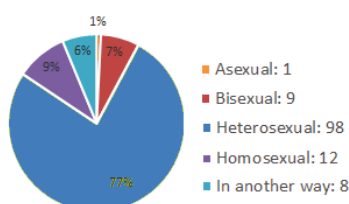
There was a 15% (n=128) response rate which was fairly evenly distributed across the years.

How would you describe your gender?



Both 'in another way' said they would not use cis, something also highlighted by 3 who had selected a cis option (2 cis female and 1 cis male)

How would you describe your sexuality?



References

- Equality Act 2010 available at <https://www.gov.uk/guidance/equality-act-2010-guidance>
- GMC (2018) *Equality, diversity and inclusion* available at <https://www.gmc-uk.org/about/how-we-work/equality-and-diversity>
- HEA (2016) *Equality and diversity in learning and teaching in higher education* available at <https://www.heacademy.ac.uk/knowledge-hub/embedding-equality-and-diversity-curriculum-0>

Significantly more students identifying as LGB+ would be worried if some or all of their contacts knew of their sexuality.

	Heterosexual			LGB+		
	Yes	Some	No	Yes	Some	No
Own doctor(s)	0%	1%	99%	10%	20%	70%
Employers	0%	2%	98%	23%	43%	33%
Family	0%	1%	99%	27%	30%	43%
Fellow students	0%	2%	98%	10%	40%	50%
Flat mates	0%	1%	99%	7%	11%	82%
Friends	0%	1%	99%	7%	21%	72%
Lecturers	0%	2%	98%	23%	37%	40%
Neighbours	0%	3%	97%	7%	45%	48%
Supervisor	0%	1%	99%	20%	43%	37%
Work colleagues	0%	2%	98%	13%	53%	33%

Although some heterosexual and LGB+ would like to be involved in the University LGBT+ group, half of LGB+ said they would be worried to attend in person.

	Heterosexual	LGB+
Equality for LGBT+ people benefits the University	84%	93%
Equality for LGBT+ people benefits LGBT+ people	94%	97%
Equality for LGBT+ people benefits non-LGBT+ people	66%	87%
I would worry about attending an LGBT+ network event in person	21%	50%
I would like to be involved in the LGBT+ group	24%	30%
I feel alienated by University practice in relation to LGBT+ issues	8%	10%

Students were more than twice as likely to have suffered harassment due to their sexuality. LGB+ students were twice as likely to have observed / experienced bullying due to LGBT+ identity.

	Heterosexual	LGB+
I have suffered harassment due to my sexuality	9%	23%
My sexuality has hindered my job / studies	0%	10%
Have you observed / experienced homo / bi / transphobia while at the University?	26%	50%

The majority of detailed cases were about language used, rudeness and homophobic jokes.

2nd year
Heterosexual
Cis-female
Lecturer/students making homophobic jokes / derogatory comments

Some students talked about offensive behavior of others during and after LGBT+ sessions.

During an LGBT+ lecture, a few students walked out in protest against the subject
4th year
cis-female
heterosexual

Current initiatives mentioned included non-gendered toilets, the LGBT charter, LGBT month events, safe spaces for discussion, and inclusion in the curriculum³. However, one student was less positive.

4th year
Cis-male
Pansexual
The undergraduate medical school office dresses up in purple and nothing changes.

Priorities for future work included decreasing stigma, educate lecturers / professionals, and continuing inclusion in curriculum. Most were positive in their outlook, though one 4th year heterosexual cis-female student commented
I find it a danger to normalise LGBT

Comparison with 2011 survey

The 2011 survey received only 12 replies (6 male 6 female), none of whom identified as heterosexual. Only one identified any current initiatives (an external speaker talking about the blood ban) and none made any suggestions for future initiatives regarding LGBT+ issues.

Similar patterns of concern over sexual and gender identity were shown, but with such small numbers we have not presented them as percentages. A high majority thought LGBT+ networks within the University benefitted both LGBT+ and non-LGBT+ people. Only one thought networks should only be open to LGBT+ community.

The question relating to observing homo/transphobic behaviours was not asked in 2011 as we had hoped to follow this up in focus groups. As no-one had volunteered for these in 2011 we amended the 2018 questionnaire.

Discussion

The increase in response rate for 2018 over 2011 may reflect the introduction of the LGBT+ charter in the medical school with highly visible champions; more awareness and acceptance in society generally; and promotion of LGBT+ History Month including Purple Friday. However, taking part in these events without an obvious link to action may result in a negative attitude to such events.

Harassment due to sexuality is much higher in LGB+ students than heterosexual students. This may also explain their heightened awareness of homo / bi / transphobic episodes. It is important we sensitise all students and staff to these unacceptable behaviours and the potential effect they have on the LGBT+ community. This is important not only to them as students, but also as future health professionals.

Two respondents identified as transgendered / non-gender binary. Sharing their views in this poster would risk deanonymising them. These views are being taken into account by the Medical School. We also recommend a study across medical schools to explore further attitudes and experiences.

Of particular interest was the students who voiced objection to being labelled cis. This was an addition to the 2018 survey, and shows the power of a label. By giving students only the options of cis, trans, non-binary or 'other' we were encouraging cis students to experience labelling in the same way the trans community are labelled.

Take-home points

- There is still homo and transphobic behaviour from students, lecturers and hospital staff.
- Many LGBT+ students are still not happy with certain contacts knowing their sexuality.
- Pursuing an LGBT+ charter and having champions appears to raise awareness of issues.
- Events such as Purple Friday can be viewed as empty gestures if not linked to other actions.
- Replacing female / male with cis female / cis male can provide a good reflective learning activity.

Evaluation of Patient Safety Culture in a Secondary Care Setting in Kuwait



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Background & Aim

Creating positive patient safety culture is considered essential to improve patient safety outcomes^{1,2}. Yet, achieving this can be challenging as attitudes towards patient safety and the nature and prevalence of adverse events differ by country^{3,4}. To standardize and support the provision of safe healthcare services⁵, the Ministry of Health (MOH) in Kuwait has embraced a number of patient safety and quality improvement initiatives, Yet changing organisational culture is not an easy task^{6,7}. This study aimed to conduct the first evaluation of patient safety culture in a secondary care setting in Kuwait

Methods

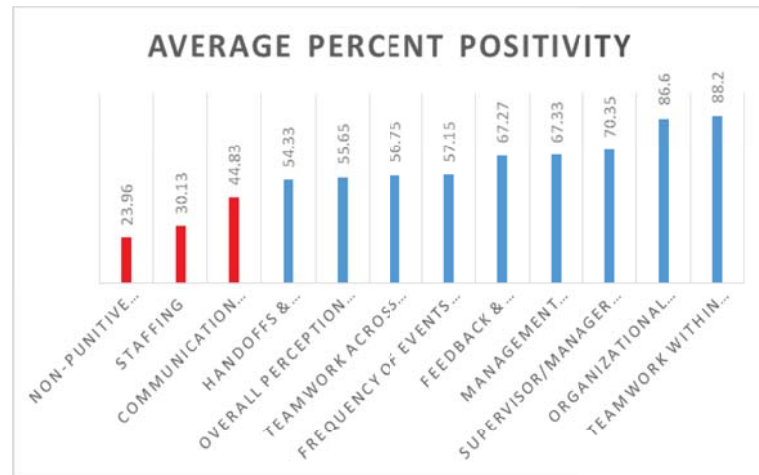
This was a cross-sectional questionnaire study carried in a medical department of a general hospital in Kuwait using the Hospital Survey on Patient Safety Culture (HSPSC). Multiple linear regression analysis were conducted to identify patient safety culture predictors. Both ANOVA and Kruskal Wallis test were used to assess the differences between total scores and scores achieved in each dimension by the different country of origin groups.

Results

One thousand and eight completed questionnaires were received, yielding a response rate of 75.2%. Three dimensions of patient safety culture were found to be priority areas for improvement: non - punitive response to errors, staffing, and communication openness. Teamwork within units and organizational learning and continuous improvement were identified to be areas of strength. Statistical analysis showed that respondents from Kuwait/ Gulf State countries have less positive perceptions of patient safety culture compared to Asian respondents. Regression analysis showed that respondents' countries of origin, professions, age and attendance at patient safety courses / lectures are significantly associated with perceptions of patient safety culture.

Respondents Characteristics

Profession	N = 1007	%
Physician	73	7.2
Nurse	606	60.1
Pharmacist	20	2
Technician (e.g. EKG, Lab, Radiology)	225	22.3
Physical, Occupational, or Speech Therapist	8	0.8
Dietician	12	1.2
File clerk /Unit assistant/ /office work	12	1.2
Administration/Management	11	1.1
Other	40	4
Country of origin	N = 1008	%
Kuwaiti/ Gulf States	167	16.6
Arabian	155	15.4
Asian	661	65.6
European/ American	0	0
Other	25	2.5



Conclusion

It is important to consider professional sub-cultures within organisations whenever a patient safety culture evaluation is carried out. This study showed that patient safety is perceived differently among different countries of origin and professional groups in a medical secondary care setting. Therefore, investing in initiatives and practices (e.g., training, policy setting, and leadership support...etc.) that improve the overall perception of patient safety and frequency of events reported is essential for improving the safety of health care delivery.

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COME HERE. GO ANYWHERE

The Professional Compliance Analysis Tool (PCAT)

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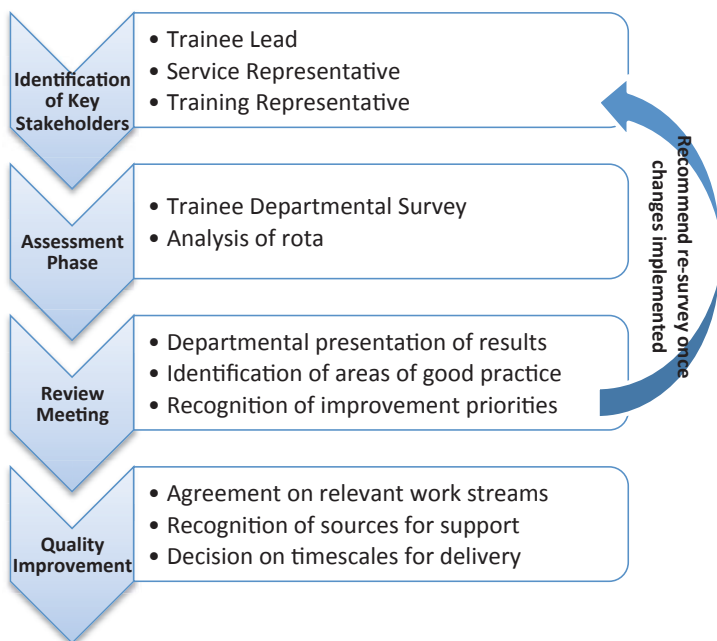
Introduction

PCAT aims to help create working environments conducive to high-quality patient care, effective training and staff wellbeing. It achieves this by engaging trainees, departments and wider stakeholders in quality improvement conversations, exploring issues around working patterns beyond simply the number of hours worked.

Method

Following stakeholder engagement, doctors working on a rota are surveyed on areas related to training, service delivery and health and wellbeing. This data is combined with an analysis of the rota's structure to generate a report for presentation to the department, with the aims of recognising areas of success and identifying and agreeing areas of potential improvement. To date, this has largely been facilitated by Scottish Clinical Leadership Fellows (SCLFs) working within Scottish Government, although delivery of PCAT is increasingly being administered locally in departments and Health Boards.

The PCAT Process



Format of report produced

	FY 1	Registrar
Adequacy of medical staff		
Handover incorporated into rota template		Results presented back in a 'Red-Amber-Green' (RAG) system, which helps to visually emphasise the areas which require prioritisation
Changeover incorporated into rota template		
Induction -Organisation		
Induction -Department		
Workload intensity -Day time		Qualitative data is presented as anonymised free text in addition to the RAG data
Workload intensity -Out of hours		
Escalation policy in place		
Policy effective?		

Results

PCAT has been successfully implemented in Scotland across many specialties and geographical locations. The RCoA has committed to undertaking PCAT in every anaesthetic department in Scotland by July 2018. RCSEd have also endorsed the tool. NHS Grampian and NHS Highland have adopted PCAT at Health Board level and there has been by-request uptake in various specialties across other territorial Boards. Qualitative data shows that PCAT has resulted in meaningful improvements to rotas and working environments in the areas where it has been used. Initial analysis of quantitative data, assessing serial GMC survey results, also suggests a trend towards improvement, although further data is awaited.

Conclusion

PCAT is a novel QI tool that has successfully improved the working lives of many doctors across Scotland. It is anticipated that further adoption of PCAT by Health Boards and Colleges will accelerate its delivery. This, supported by robust quantitative data obtained from GMC surveys, will confirm PCAT's important role in improving the working lives of doctors in training across Scotland.



Helping a nursery develop evidence-based illness policy for children - opportunities and challenges.

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1-Introduction

Background

- Preschool children consume an estimated 13.4 million GP consultations per year.^{1,2}
- Suboptimal nursery illness policy can lead to unnecessary GP referrals through uncertainty or poor management of minor ailments resulting in exacerbation of disease/disease spread.
- With GP's stretched to their limit it is important to reduce the number of unnecessary GP referrals.³
- Currently, nursery's construct their own illness policy with limited guidance from local NHS boards and some direction from their local authority.

Aim

- To assess and address inadequacies in a local nursery's illness policy.

2- Methods: Analysing Current Guidance

- Initially the current guidance given to local nursery's by NHS Lothian was analysed.⁴
- This was found to be at a level inaccessible to nursery nurses, being excessively jargonised and overdetailed with an example page shown in **Figure 1**.
- It was a concern that this inaccessible format would be off-putting for staff who would instead choose to employ word of mouth rules in a non-evidence based manner.
- This was confirmed by staff who had limited confidence in their current policy and typically made decisions based on word of mouth rules or based on internet searches.

Fig. 1

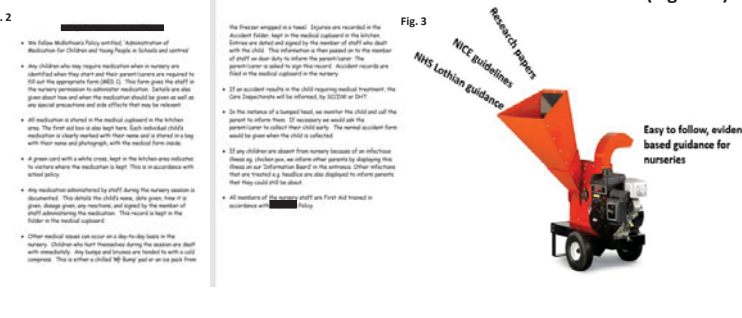
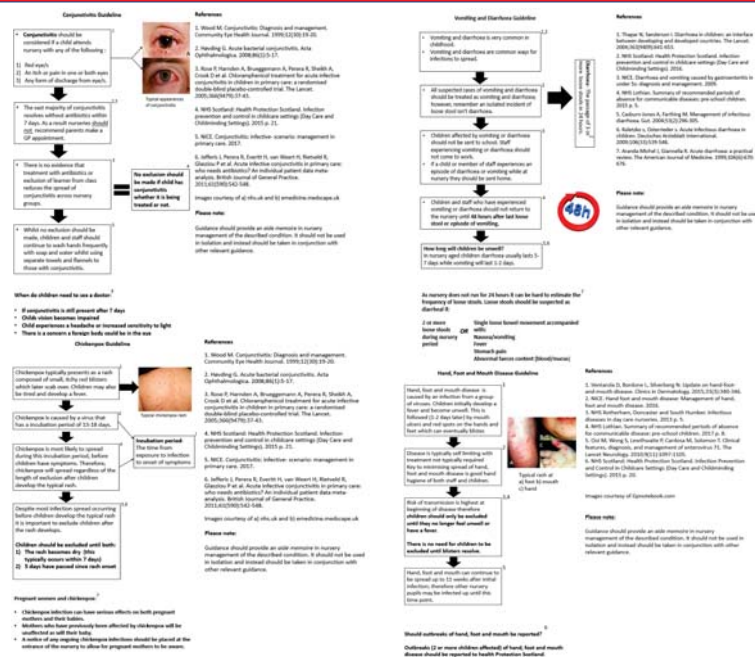
Disease/Condition	Typical Incubation Period	Route of Infection	Risk of person to person spread	Recommended Period of Absence	Action
Scarlet fever	1-3 days	Direct contact with respiratory secretions. Contact with patients or carriers.	High risk of transmission unless adequately treated.	Until clinically recovered and 24 hours after start of treatment.	Antibiotics are recommended for affected children.
Strep throat (Group A Streptococci)	1-3 days	Direct contact with respiratory secretions. Contact with patients or carriers.	High risk of transmission unless adequately treated.	Until clinically recovered and 24 hours after start of treatment.	Antibiotics are recommended for affected children.
Staphylococcus aureus infection	Variable and variable	Contact with patients with purulent lesions.	High for certain groups of patients, and if special considerations for	None	HPT will only follow up cases of PVA, staph.

2- Methods: Addressing Inadequacies

Methods

- Figure 2** shows the illness policy of a local nursery involved in this project. It is limited, with the direct management of diseases unaddressed.
- When senior staff were asked why they had not incorporated the Lothian guidance into their policy one member of staff explained she would not 'know where to start'.
- Staff felt that guidance would more accessible in a format that was similar to both a fact-sheet and a flowchart.
- Staff described greatest requirement for further guidance in managing chickenpox, diarrhoea and vomiting, hand, foot and mouth disease and conjunctivitis.
- To generate such guidance content from NHS Lothian, NICE and other evidence based medicine articles were incorporated in a format accessible to staff (**Figure 3**).

3- Results: New Guidance



4- Conclusions

- Current NHS Lothian guidance is inaccessible to nursery nurses.
- Nursery nurses did not incorporate NHS Lothian guidance into their illness policy due to this inaccessible format.
- Senior nursery staff were not confident in their current illness policy.
- Staff felt the best format for further guidance would be a fact-sheet, flowchart hybrid.
- Staff were happy with the easy to follow guidance created by synthesising NHS Lothian guidance, NICE guidelines and other research papers.
- Staff felt this new format was more accessible than current tabular guidance.

5- Discussion

- Pitching of guidance at a level that is only understood by a healthcare professional is inappropriate.
- With work done with one local nursery showing that this inaccessible guidance leads to substandard illness policy, it could be hypothesised that this is indicative of an issue with nursery's on a wider scale.
- Inadequate nursery policy leads to GP referral. With GP's stretched to their limit and with preschool children having the highest crude consultation rate when excluding those >65 years it is important to minimise the number of appointments made for minor illnesses.¹
- Issues highlighted in this project regarding poor guidance resulting in poor policy could be addressed in future work via three routes:

- Through issuing of additional more accessible guidance.
- Through input from healthcare professionals on a one-to-one or nursery group basis.
- By issuing all local nursery's with one uniform centrally generated illness policy.

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