

Heat Event 2016 - Poster Presentations

Hull Education and Training

Departmental pleural aspiration and drainage: a quality improvement project

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Introduction

The aim of this project was to evaluate and improve patient safety pre, during and post pleural procedures for pleural effusions¹.

Method

A proforma was created using the British Thoracic Society (BTS) guidelines for pleural procedures. Data was collected for ten patients undergoing pleural aspiration and/or intercostal drain insertion for pleural effusions, both before and after the implementation of the pleural procedure checklist².

Results

One hundred percent of ultrasound findings and mark-ups were documented compared to 70% prior to the checklist being in place. The platelet count and coagulation was recorded in 40% of patients compared to 30% and 10% respectively, prior to the checklist. None of the patients in this project received a patient information leaflet. Pre and post observations were documented in 20% of patients after the implementation of the checklist compared to 0% and 10% of patients pre-checklist.

Discussion

Data highlighted a deficiency in the recording of observations pre and post procedure, coagulation and platelet count and post procedure instructions to nursing staff and patient. In general, an improvement in all areas was seen after the checklist was implemented. The lack of information for the patient could also lead to delays in the presentation of some post procedure complications. Whilst the proforma and checklist are a step in the right direction, further work is required to improve patient safety in pleural procedures. As such we plan to develop a patient information leaflet as well as formally introduce the checklist and proforma in our departmental meeting. This will then be re-audited to ensure we are maintaining good practice.

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- 2.Havelock T, Teoh R, Laws D, Gleeson F. Pleural procedures and thoracic ultrasound: British Thoracic Society pleural disease guidelines 2010. Thorax 2010;65:i61-i76

Cardiothoracic Discharge Medications: Are we doing it right?

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Methods

Immediate Discharge Letters were assessed over the course of 1 week on 2 occasions on ward 27 in Castle Hill Hospital. After the first week of assessment, posters were created and were displayed in all the areas doctors write discharge letters. The posters content stated reasons why medication changes should be documented.

Results

On the first round, there were 16 discharges in the initial week period with 11 males and 5 females. 5 of the procedures were cardiac surgery and 11 were thoracic. There was a 50:50 split of elective and non-elective admissions. On 3 IDLS there was no prescription of medications. 6 patients were prescribed all new medication. The key finding 15 IDLs had no documentation on reason for change in medication and only 1 IDL did have. This was re-audited after the interventions of the posters and it was found that demographics were similar for all IDLs.

Length of Stay (days)	Sex	Diagnosis
1	M	elective cabg - cancelled (MSSA+
11	M	Transfer from Scunthorpe - urgent CABG
2	M	RTA, chest drain insertion
18	M	Transfer from Cardiology, CABG
5	M	Elective bronchoscopy & VATS biopsy
5	F	Elective bronchoscopy & VATS thoracotomy
6	M	Transfer from York - urgent CABG
?	M	Stabbed, pneumothorax resolved
?	M	Sternal wound infection
19	M	Pneumothorax, pleurectomy & bullectomy
2	F	Oesopagoscopy for stricture
8	F	Recurrent pneumothorax, talcum pleuradesis
3	F	Thoracotomy, wedge resection
3	M	VATS wedge resection
9	F	Elective admission for lung biopsy
3	M	Trauma

Discussion

All too often following cardiac surgery, medications are changed and the new doctors on the ward that do discharge summaries fail to write the reasons for the change. This results in GPs calling up asking why medication has been changed or patients potentially wrongly taking medication for long periods of time. This is not just the case in cardiothoracic surgery but also most specialties. The aim of this audit was to assess

documentation surrounding medication changes on Hull and East Yorkshire NHS Trust Immediate Discharge Letter. It was found that in this specialty that there was almost no evidence behind the reason for medication changes being documented. This needs to be addressed for patient safety. Potential options are training for new doctors starting rotations and Lorenzo not allowing the completion of IDLs unless documentation is present.

Doctors and Medicaese

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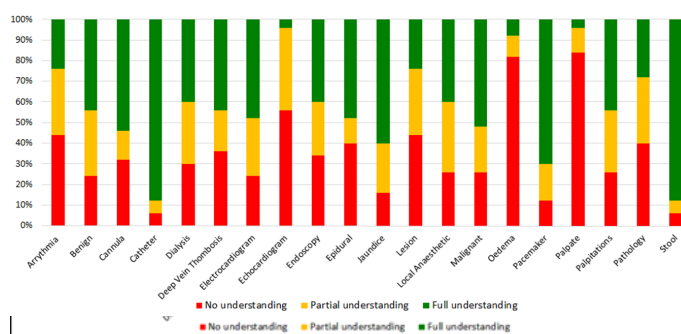
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Introduction

In becoming a doctor medical students are essentially taught a new alien language which may contain as many as 13,000 new expressions and words¹, but if a doctor is to communicate successfully with patients they must also learn to converse by substituting all jargon for understandable lay words. One single technical word or phrase used by a doctor in consultation with a patient may be enough to render an entire conversation meaningless or misunderstood². Doctors often use medical terms almost subconsciously, not appreciating whether patients understand them or not.

Methods

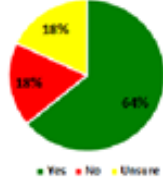
We undertook a survey of 50 randomly selected adult inpatients over 3 weeks at Diana Princess of Wales Hospital, Grimsby. A standard proforma was used for this task and each patient's understanding of 20 words, that the investigators believed to be in common usage, were assessed. The patients were then asked a series of supplemental questions to give their subjective view of doctors' use of jargon terms and general communication abilities.



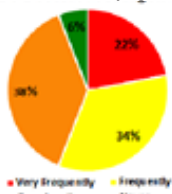
Do Doctors check patients understand what they've said?



Would you ask a doctor to clarify what they mean?



Do Doctors use jargon?



Discussion

These results show that the level of understanding of medical words by patients varies greatly from one

individual to the next, and depends heavily on the specific jargon term used. In particular, it seems that a large proportion of patients have only partial or no understanding of what could be considered as a random sample of relatively simple and commonly expressed medical terms. This is worrying given that a majority said that doctors frequently use these medical terms. Fortunately, even though many patients displayed limited understanding of medical terminology a majority said they would feel empowered to stop a doctor and seek clarification of any jargon they did not comprehend.

Key messages:

- A significant proportion of patients perceive that doctors use medical terminology they do not understand.
- Doctors should take note, and seek to minimise their use of jargon on the presumption that there is a high probability their patients will not understand even commonly used technical medical words.
- Technical medical words do not have to be avoided at all costs so long as a patient's comprehension of any jargon term used is immediately checked by the doctor, and if necessary an understandable lay explanation is given.
- Meanwhile it may be time for all healthcare professionals when explaining complex medical issues to patients to add a second phrase after the obligatory, "Hello, my name is.....",³ a follow up statement along the lines of, "Now, if I say anything at all you do not understand then you must stop me and I will explain what I mean...."

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3. Hello My Name Is... Kate Granger [Online] [Accessed 29/04/2016] Available from: <http://hellomynameis.org.uk/>

FY1-led ward rounds: Can an aide-mémoire help?

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Ward rounds are a fundamental aspect of the care of medical inpatients but surprisingly, how to conduct them is not formally taught¹. The Royal College of Physicians describe medical ward rounds as 'a complex clinical process during which the clinical care of hospital inpatients is reviewed', but they recognise that a number of important aspects are often forgotten². Acknowledging human factors in the busy hospital environment with the use of a checklist may help improve patient safety and the quality of the ward round³.

Methods

In June 2015 we conducted a survey of Foundation Year 1 doctors (FY1s) at North Lincolnshire and Goole NHS Foundation Trust (NLaG), which showed FY1s were frequently leading their own ward rounds but felt unprepared to do this. It also showed that 79% thought an aide-mémoire would be useful, so we implemented an aide-mémoire for the next cohort of FY1s in August 2015. In May 2016 we re-surveyed to assess the effectiveness of the intervention, as below.

Results

Out of the 48 potential NLaG FY1s in 2016, 25 completed the survey. 88% stated they led ward rounds alone ≥ 2 times per week and only 16% felt prepared to do this. After the introduction of an aide-mémoire, 28% felt prepared to lead their own ward rounds and 56% said the credit-card sized aide-mémoire was useful in reminding them of aspects to consider (92% had received an aide-mémoire and 58% kept one with them). 96% of participants said a teaching session discussing aspects to consider on ward rounds should be delivered for the next cohort of FY1s.

Discussion

FY1s in NLaG were regularly conducting ward rounds alone but did not feel prepared for this, but there was a 12% improvement in preparedness after introduction of the aide-mémoire. The sample size limits the external validity of the results, but the good response rate (52%) suggests a successful recruitment process, increasing the internal validity. Given the low cost of the aide-mémoire, we recommend the aide-mémoire is still made available for FY1s to act as prompt to help them deliver thorough and effective ward rounds. A teaching session to support this was very popular among FY1s. However, we recognise that this intervention does not address inevitable time pressures and interruptions and the individuality of each patient and better support and training is still required to help FY1s deliver and lead safe, systematic and thorough ward rounds at NLaG.

Acknowledgements

Many thanks to Dr McNeil who supervised the project and Dr Mysore who reviewed the checklist produced, as well as all the FY1 Doctors in NLaG who participated in the study.

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An exploration of Foundation Year Doctors' experiences in the care of the dying

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Background

Foundation Year Doctors (FYs) provide much of the day-to-day care for dying patients on the wards. It has been estimated that during a doctor's first year of practice, forty of the patients they care for die¹, but studies have shown that they feel under-prepared to care for these patients² and learning needs have been identified³. We aim to explore FYs experiences in order to identify ways in which training and support can be improved, which may then enhance the care delivered to dying patients.

Method

We have conducted a qualitative study using semi-structured interviews and focus groups to find out what experiences FYs have had in care of the dying, what training they have received in this area and how well supported they have been in their role. We aimed to recruit fifty FYs from five sites across North Yorkshire and the East Coast (NYEC) Foundation School through purposive sampling. FYs in Hull, York, Scarborough, Scunthorpe and Grimsby were invited to participate in either a focus group or a telephone interview. All recordings have been transcribed verbatim and thematic analysis is being undertaken. We are using a modified grounded theory approach with the published 'Priorities for Care of the Dying Person'⁴ guidelines as a conceptual framework.

Results

Eight focus groups and twenty-one interviews were conducted, and forty-seven individuals participated (see *Table 1*). Initial analysis has suggested that positive experiences of caring for dying patients were associated with supportive teams, advance planning and respect for patients' wishes. Negative experiences were associated with insufficient senior support and persistence with treatment perceived as futile. Most FYs felt they had been reasonably well prepared for caring for the dying during medical school, but there was a general desire for more experiential learning and training around the physiology of death, communication skills and anticipatory medications. A number of FYs suggested that death was still a taboo subject and that emotional support may be lacking. Regarding the five 'Priorities for Care of the Dying Person'², FYs found recognition of the dying person and discussions with family most challenging. They felt reasonably confident with communication and breaking bad news in general, but found this more challenging when on-call. Many said it was valuable having a nurse or senior colleague present for support when breaking bad news for the first time. FYs felt that patients were generally well cared for but

sometimes there was a lack of clarity in the plan or poor documentation, leading to issues with patient care. They also described a number of examples of conflict between various involved parties.

Table 1 – Demographics of 47 participants who contributed

Demographic factor	Results
Age	Mean=25.7 years (range=23-38 years) Not disclosed=2 participants
Medical school of graduation	Hull York Medical School=14 participants 16 other medical schools=32 participants Not disclosed=1 participant
Grade	FY1=24 participants FY2=23 participants
Gender	Female=27 participants Male=20 participants

Discussion

We have had a strong response rate for a qualitative study and it seems we have reached thematic saturation. As seen in Table 1, we have a good range of participants and although there may be variation in FYs experiences at different Foundation Schools, we hope that by involving FYs from 5 separate hospitals and as graduates from a range of medical schools, we have data that is representative both internally and externally. Overall, our findings show that experiences are variable depending on the hospital, speciality and team members. There are a number of examples of good practice across the Foundation School, and areas for improvement. When thematic analysis is complete, we will produce recommendations for how to improve the experiences of FYs with a view to therefore improving patient care.

Acknowledgements

Many thanks to our supervisors, Dr Gabrielle Finn and Prof Miriam Johnson, and the Postgraduate Medical Education teams on each of the five sites and all of the FYs that have spared the time to participate.

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A national survey on asthma education and discharge planning

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Background

UK is one of the European countries with the highest Asthma prevalence rate and 10% of children get readmitted within a month. Randomised trials suggest that good discharge planning and education can substantially reduce the number of future asthma readmissions. According to Paediatric Asthma Audit Report 2012 and 2013, discharge planning remains the area for improvement.

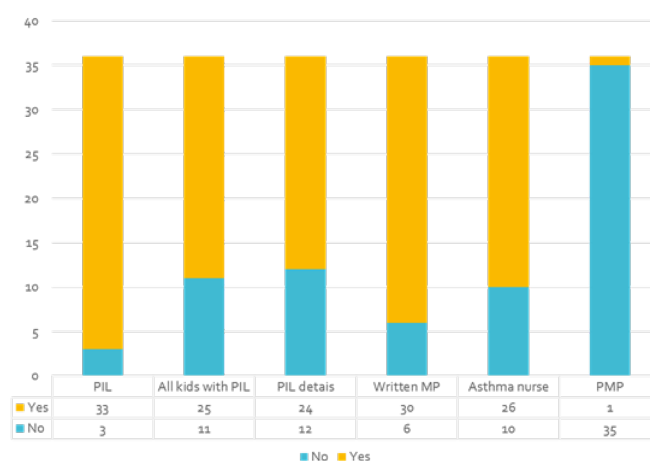
Telephonic Survey Method

There were six simple questions about asthma Patient Information Leaflets (PIL), written discharge planning and the hospital practice.

Results

- 36 responses were collected from different paediatric registrars working in DGHs and level three paediatric hospitals in the UK (Fig 1).
- Three of them were not aware of any asthma PIL (8.3%).
- Four of them denied if children get PIL upon discharge (11%) and seven of them were not sure (19.5%).
- Twelve of them were not aware if PIL says about asthma management at home post discharge (33%).
- Six did not think they give any written management plan (17%).
- Ten of them said there is no asthma nurse in their hospital (28%).

Fig. 1



PIL: Patient Information Leaflet MP: Management Plan PMP: Personalized Management Plan

Almost all the responses about the weaning of salbutamol inhaler after discharge from hospital were different. Only one mentioned about the personalised management plan.

Post discharge salbutamol weaning protocols differ widely:

From 10 puffs 4 hourly on day one to wean gradually to

2 puffs 12 hourly on day seven. To 2 puffs 4 hourly for 2 days only.

Conclusion

We need more awareness about the discharge planning and "Personalized" action plan for children going home after an acute admission.

References

- Asthma UK Press release 13th March 2014
- Paediatric Wheeze /Asthma Audit Report 2012 and 2013 British Thoracic Society Dr Paton
- NICE guidelines 2013

Race against time

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Introduction

Duchenne Muscular Dystrophy (DMD) is the most common type of muscular dystrophy in the UK. About 100 boys are born with the condition each year and about 2500 boys are living with this condition.

Background and approach

DMD is a challenging chronic disease that requires multidisciplinary collaboration of healthcare professionals and individualized treatment approach for the adolescent patients and their families. Receiving a diagnosis of Duchenne muscular dystrophy is a difficult process for any family. They need a lot of support with a very sympathetic and empathetic approach. I had an opportunity to discuss the journey of P family from the occurrence of symptoms to the diagnosis and now facing the complications of the disease process. Their good and not so good experiences.



Conclusion

There are strategies that can be implemented in the clinic that can facilitate the process and guide families toward a positive outcome of coping in spite of the diagnosis. Certain strategies may be particularly important at specific times of crisis, such as at diagnosis or during transitional phases, while others may be

ongoing to meet recurrent or emerging needs.

Acknowledgement

Mr and Mrs P for their consent and providing me with their story and pictures.

Preparing final year medical students to discuss cases with seniors: does practice make perfect?

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Background

Junior Doctors require strong communication skills in order to practice safely and deliver excellent patient care¹. Clinical communication skills have become a core component of the undergraduate medical curriculum in the UK over the past 20 years². However, teaching generally focuses on consultation skills and communication with patients. Inter-professional communication is largely neglected despite the fact that communication failures are the leading cause of inadvertent patient harm³. Doctors must be competent in communication with colleagues including presenting and discussing cases to allow them to handover safely and seek advice from senior colleagues. We wanted to explore final year medical students' confidence regarding communication with colleagues, particularly seniors, and see whether this could be improved by teaching.

Method

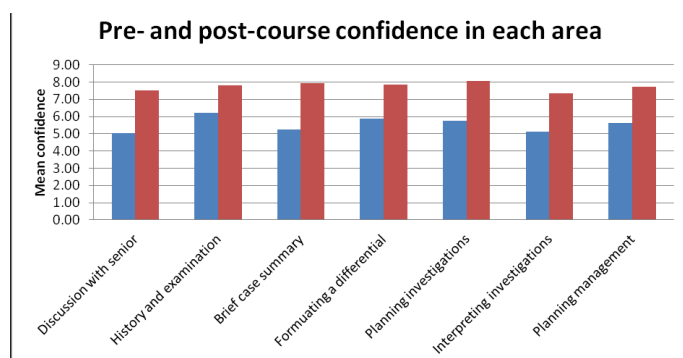
We developed a four week teaching programme for final year HYMS students in Hull and York. This consisted of four two hour sessions. Each session involved students rotating around five 20 minute 'stations' in small groups. Stations were led by Junior Doctors who had prepared a case which they would outline at the start of the session. They would then ask the students to give a brief summary, suggest and justify differential diagnoses and investigations and formulate a management plan. The Junior Doctors would give feedback and suggestions to the students during each station. We used an anonymous online pre- and post-course questionnaire to assess confidence levels before and after the programme. We asked the students to rate their confidence in each skill from '0' (no confidence) to '10' (fully confident). In the post course questionnaire we added open questions to assess the overall quality and value of the teaching, and provided the opportunity for free text comments to collect qualitative feedback on the course.

Results

The programme was run successfully in York but unfortunately this was not possible in Hull due to organisational issues so here we present the results of the York programme only. Out of the 25 students that signed up to the programme, we had an average of 22 attendees per session. Of those signed up, 23 completed the pre-course questionnaire (93%) and 15 completed the post-course questionnaire (60%). Before the course,

mean confidence in all areas was 5.55 out of 10 (SD 1.69). Lowest confidence was in discussion with seniors (5.04, SD 1.79) and highest confidence was in history taking and examination (6.22, SD 1.38). After the course, confidence improved in all areas, from average of 5.5 to 7.75 out of 10 (SD 1.13) (See Figure 1). The largest improvement in confidence was regarding discussing cases with seniors and giving brief clinical summaries. Teaching quality was rated excellent, on average 9 out of 10 (SD 0.96). Eighty seven percent of students either 'agreed' or 'strongly agreed' that the course had helped them prepare for discussing cases with seniors as a Doctor and all respondents (100%) would recommend the course to a colleague. Suggestions for improvement in the free-text comments included more sessions, more neurology, putting students on-the-spot more, giving handouts and increasing standardisation between stations.

Fig. 1



Discussion

As previously mentioned, we hoped to deliver the course on two sites but unfortunately the whole programme was only delivered in York due to organisational issues in Hull. However, there was a good turn-out in York, response rates were good and the findings were very promising. The pre-course questionnaire had a better response rate than the post-course, probably because it was a pre-requisite for attending the teaching and the course finished 1 week prior to finals so students had other priorities when post-course questionnaire was deployed. Our findings demonstrated that students felt most confident with history taking and examination, which they are taught and they can practice independently, but lacked confidence in the areas that involved interaction with colleagues and seniors (discussing differentials, investigations and management plans). The teaching programme provided students with an opportunity to practice these skills and improved confidence in all areas and all students would recommend to a colleague. The organisation was quite challenging as it required the recruitment of 20 junior doctors to deliver the 5 stations. We briefed the tutors to ensure that they understood the structure and purpose of the course but there was still some variation in how the stations were run, as suggested in the free-text comments. In conclusion, the course

clearly helped to improve confidence regarding inter-professional communication, which is essential for delivering safe, high quality patient care¹. Further study is needed to determine whether confidence correlates with competence and whether the teaching programme leads to improvement in skills and care delivered after graduation. We feel there is sufficient evidence to support the value of the teaching programme and we would like to implement the teaching more widely in future years.

Acknowledgements

Many thanks to Prof Loubani who oversaw the project and the HYMS students who participated in the programme and provided valuable feedback.

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