Junior doctors and improving the quality of care for older people in hospital

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ABSTRACT

A number of recent high-profile reports have described sub-optimal care of older people in UK hospitals. Older people already form the bulk of hospital inpatient work and it is recognised that they often experience adverse events as a result of their hospitalisation. This, coupled with an ageing population, means there is great need to improve the quality of care for older hospitalised patients. In this article, we argue that junior doctors can, and should, play a central role in the process of improving the quality of care for older people in hospital. We describe a series of innovative, trainee-led projects that have sought to improve quality of care for hospitalised older people. Lastly, we explore how senior clinicians can support junior colleagues to make meaningful, sustainable change, with specific reference to induction processes, quality-improvement projects and role modelling.

KEYWORDS: Quality improvement, older people, junior doctors

Introduction

The Darzi report in 2008, *High quality of care for all*, placed a new emphasis on quality in the NHS.[1] The subsequent high-profile Francis inquiry[2] and Keogh report[3] demonstrated many severe deficiencies in quality of care, particularly for older people. Much is said about the future challenges facing health services as a consequence of the ageing population, yet older people already constitute the bulk of inpatient admissions – they are, in essence, the 'core business' of the NHS. Preventable adverse events in hospitalised older patients include falls, delirium, pressure ulcers and medication errors[4] – these are common, serious and have huge financial implications for the health service. Quality of care for older people in hospital can therefore be considered a barometer for quality of care for the rest of the NHS.

The Royal College of Physicians' (RCP) publication, *Future Hospital: caring for medical patients*,[5] called on all hospital staff to commit to improving quality of care, and described how hospitals should support their staff to take ownership of this process. In this article, we argue that junior doctors should have a central role in improving the quality of care for older people in hospital. Examples of trainee-led initiatives aiming to improve the standard of care for older people are shared. Lastly, the need for junior doctors to be supported by senior clinicians, if they are to function as agents for change, is explored, with reference to the induction process, quality-improvement projects and role modelling.

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Junior doctors' role in improving quality of care

During their training, junior doctors gain experience of working in a number of different clinical settings. Their regular rotation between departments provides them with a unique perspective on clinical care, especially at ward level, with Francis describing them as 'the eyes and ears' of the NHS.[2] Junior doctors may be less likely to be desensitised to sub-standard care compared with colleagues who have worked in the same environment for more prolonged periods. Conversely, junior doctors may have been exposed to examples of excellent practice and may be able to seed such practice between sites.

Since the Francis report highlighted how, in some cases, junior doctors' concerns about sub standard care were ignored, there has been greater recognition of how junior doctors can, and indeed should, contribute to improving quality. Junior doctors subsequently formed part of the 'rapid response review teams' that evaluated quality within the Keogh report. Similarly, the Care Quality Commission (the NHS regulatory assessor) has also now incorporated junior doctors into their assessment teams. Furthermore, there is increasing recognition that despite their relative lack of seniority, junior doctors have great potential to act as clinical leaders for driving quality improvement (QI). Keogh referred to them as 'potentially our most powerful agents for change' and called on their latent energy to be 'tapped not sapped'.[3]

Examples of trainee-led initiatives

Within geriatric medicine there are a number of examples of trainee-led initiatives aimed at improving quality of care. Most notably, Dr Kate Granger, now an elderly care consultant at Pinderfields Hospital, UK, founded the 'Hello my name is…' project while a trainee (Figure 1).[6] This campaign sought to remind healthcare professionals of the importance of introducing oneself when delivering care. The campaign emphasised that introductions are a key component of making

Fig 1. hello my name is… This logo was designed to remind healthcare professionals of the importance of introducing oneself when delivering care and has since been used on name badges, lanyards and stickers. The logo is available for print and web at http://hellomynameis.org.uk

an essential human connection with a person and that they are critical to developing a therapeutic relationship and building trust. The project has gained the support of over 400,000 NHS professionals, was cited as a key component of compassionate care in the UK government's response to the Mid Staffordshire NHS Foundation Trust Public Inquiry, and has been disseminated globally via social media.

The power of social media to disseminate good practice was also harnessed by Dr Sean Ninan, an elderly care registrar in Yorkshire, UK. Dr Ninan wrote an engaging blog article aimed at junior doctors that described 21 tips for providing older people with better care.[7] This article generated huge interest on social media outlets, such as the micro blogging site Twitter. His blog article was also actively disseminated via British Geriatric Society outlets. Examining the comments section of the blog article reveals a number of posts from geriatricians, some of whom described how the article had been incorporated into their departmental induction for junior doctors who were rotating to work within their elderly care service.

In 2012, a group of geriatric medicine trainees in north-east England established the Association for Elderly Medicine Education (AEME) with the aim of improving the care of older patients through education and engagement of junior doctors. AEME's first educational event, Geriatrics for Juniors (G4J), attracted over 100 junior doctors from across the UK. The popularity of G4J was such that the event now occurs annually and is complemented by a series of satellite, local events, 'G4J Connect', that have ran at a number of sites across the UK. AEME have also developed a series of older person specific e-learning resources – mini geriatric e-learning modules (MiniGEMs).[8] MiniGEMs are video podcasts hosted on YouTube, that offer a concise summary (in less than 7 minutes) of clinical problems commonly encountered by junior doctors caring for older people. MiniGEMs are optimised for mobile learning on smartphones or internet-enabled tablet devices and, as of April 2016, had been reviewed over 23,500 times in 135 countries.

Lastly, trainees at North Cumbria University Hospitals Trust developed a smartphone app ('Confusion: Delirium & Dementia') based on delirium and dementia guidelines, to assist junior doctors with the assessment and management of confused patients. It is recognised that patients with cognitive impairment have higher mortality, longer length of stay and experience more complications. The app contained a mix of information on cognitive assessment methods, interactive sections, medication guidance and example case studies. The trainees who developed the app sought to tap into the ubiquitous nature of smartphones among junior doctors, and worked on the premise that facilitating quick and easy access to information at the bedside would increase the likelihood of junior doctors undertaking a cognitive assessment. The app has been shown to improve cognitive assessment by junior doctors in the acute hospital setting.[9]

The Future Hospital report[5] called for a workforce that is able to meet the needs of patients across the system. To do this, the report cited the need to provide medical education and training that will help doctors develop the knowledge and skills required to care for older patients, particularly those living with frailty and/or dementia. Innovative, trainee-led teaching approaches, harnessing the potential of new technologies such as mobile learning and apps, may help the physicians of tomorrow develop the skills required for high-quality care of the older, hospitalised patient.

How senior clinicians can support junior doctors

Induction

It is important to acknowledge that the duration of junior doctors' rotations within a department is often very short – typically 4 months for foundation doctors or core trainees, and 1 year for specialist trainees. Clinicians supervising junior doctors must therefore strive to ensure that juniors receive a high-quality and focused departmental induction. However, delivering this is challenging, particularly given the pressures of service delivery. Given time constraints, we argue that the induction process needs to be made more efficient and offer a number of suggestions that may help to accomplish this. First, close consideration ought to be given to content – older people form the bulk of inpatient work and thus geriatric medicine principles (such as comprehensive geriatric assessment, multidisciplinary team working, medication review, atypical presentations and discharge planning) should be a central part of any departmental induction. Second, clinicians should look to harness the potential power of technology within the induction process. Orientating junior doctors to geriatric medicine specific e-learning resources that are purpose designed for mobile learning (such as those described above) may be more attractive to trainees and consequently may reduce the time required for face-to-face induction. Third, we suggest that trainees are actively involved in the development of the induction content; trainees may be more readily able to draw on their own recent experiences when developing such resources, thus rendering them more applicable to the day-to-day practice of fellow junior doctors.[8,9]

Quality improvement projects

It is recognised that junior doctor-led QI projects can lead to improvement in both the quality of clinical care and of multidisciplinary working. Consultants need to encourage QI projects specific to the care of older people; for example, in comprehensive geriatric assessment, end-of-life care, cognitive assessment, medication reviews or discharge planning. A balance must be struck, however, between encouraging a junior doctor to explore a project in a given area and simply presenting them with an entirely pre-planned project. Giving a junior doctor a pre-determined project to undertake may in fact be detrimental to their motivation to complete it; not

being involved in the generation of ideas and subsequent project development may result in a junior doctor lacking ownership for the project. The aim should be to support junior doctors not only to develop the skills to look after older patients, but also to develop the ability to make organisational changes to improve quality and safety of care. Given the short duration of junior doctor placements, senior clinicians also have a key role in ensuring sustainability of such projects once a junior has moved to a different placement.

The Health Foundation publication, *Involving junior doctors in quality improvement*, highlights a number of factors that have been identified as catalysts for junior doctor-led QI projects.[10] First, clinicians must lead by example through demonstration of the importance of QI. On a broader level, clinical workplaces must strive to foster an environment that values improvement and supports change, a sentiment that is echoed in the Future Hospital report.[5] Exactly how clinicians go about cultivating this environment in their workplace presents challenges; again, the demands of service delivery mean that often junior doctors have very little time to undertake such projects. We argue that a critical factor is empowering trainees: providing trainees with the tools to undertake QI projects more efficiently is key. The RCP's 'Learning to make a difference' (LTMD) project aimed to support trainees to develop their skills in QI methodology 'at the frontline'. Subsequently, the feasibility and acceptability of junior doctor-led small scale QI projects (within the core medical training programme) drawing on the principles of the LTMD project, was demonstrated.[11] We commend to readers a number of key features that made such projects practicable. First, project completion is far more likely if trainees are encouraged to target focused, small-scale change, rather than undertaking vast, time-consuming data collection for audits. Second, the use of a recognised framework, the plan-do-study-act cycle for example, helps trainees to clearly structure and schedule their projects. Lastly, orientating trainees to a suite of existing online resources that are available to guide and support their QI project, assists trainees and also frees up valuable supervisory time for seniors.

Role modelling

The potential impact a senior clinician can have on a junior doctor in their formative years cannot be underestimated. Physicians must seek to demonstrate to their junior doctors what high-quality care of older people 'looks like', since good practice is contagious and readily absorbed by junior doctors. Health professionals also need to be mindful of the language that is sometimes employed when older patients are discussed; terms such as 'acopia', 'bed blocker' and 'failed discharge' are considered by some to be pejorative terms that can unwittingly become barriers to quality care of older patients. Positive role modelling and proactive mentoring can be a potent driver to a junior doctor exploring a career in a particular specialty. It has been recognised that some junior doctors hold negative perceptions about higher medical training[5] – the need to ensure that internal medicine is valued and attractive to junior doctors was a key component of the Future Hospital report. Physicians need to be mindful of the powerful, potential impact of positive role modelling on career choices, and perhaps even more mindful of the potentially detrimental effect that negative role modelling can have on a junior doctor in their formative years.

Conclusion

The quality of care that hospitals provide to older people ought to be a key priority for the NHS. Now is the time to concentrate on improving basic hospital ward-based care for older people through encouraging, supporting and empowering our junior doctors to become drivers for change. ■

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