Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	2nd October 2018	**Level(s)**	FY, CT, ST
Type of visit	New site	**Hospital**	New Dumfries and Galloway Royal Infirmary
Specialty(s)	Emergency Medicine & Anaesthetics	**Board**	NHS Dumfries and Galloway

Visit panel	
Dr Alan McKenzie	Visit Chair - Associate Postgraduate Dean for Quality
Dr Peter MacDonald	Associate Postgraduate Dean for Quality
Dr Linsey Semple	General Practice Representative
Dr Olive Herlihy	Foundation Representative
Dr Antonia Calogeras	College Representative
Dr Ailie Grzybek	Trainee Associate
John Dearden	Lay Representative
Alex McCulloch	Quality Improvement Manager
In attendance	
Claire Rolfe	Quality Improvement Administrator

Specialty Group Information	
Specialty Group	Emergency Medicine, Anaesthetics and Acute Care Common Stem
Lead Dean/Director	Professor Ronald McVicar
Quality Lead(s)	Dr Mohammad Al-Haddad
Quality Improvement Manager(s)	Kelly More
Unit/Site Information	
Non-medical staff in attendance	3 – including Senior Nurse/Nurse Managers
Trainers in attendance	6

Trainees in attendance	3 – FY2 (Emergency Medicine)	3 – CT (Anaesthetics)	1 – ST (Anaesthetics)
Feedback session: Managers in attendance	Trainers, DME, Chief Executive, Education Centre Manager, Lead Nurses and General Managers.		

Date report approved by Lead Visitor	19/10/2018

1. Principal issues arising from pre-visit review

The purpose of this new site visit was to undertake an early review of the training infrastructure and training experience (as would be expected by the GMC) in this new LEP. As all of the Quality Management Groups within the Scotland deanery were required to visit the new Dumfries and Galloway Royal Infirmary (DGRI), a coordinated approach was adopted in collaboration with the site. This was to ensure disruption to services was kept to a minimum. This visit report is 1 of 4 that have been generated as a result of a 1 day visit to the specialty groupings of Medicine, Emergency Medicine, Anaesthetics, Surgery, Othalamology, Otolaryngology and Trauma and Orthopaedics.

2. Introduction

Dumfries and Galloway Royal Infirmary is the main hospital in Dumfries. The hospital serves both the town of Dumfries and the entire catchment area of South West Scotland, with a population of at least 148,190. The hospital is run by NHS Dumfries and Galloway (also known as Dumfries & Galloway Health Board). It has 344 staffed beds.

In 2012 it was announced that a new 350 bed state of the art hospital costing £200 million would be built at Dumfries By-Pass on the A75 close to the Garroch roundabout. The new hospital opened on 8 December 2017.

3.1 Induction (R1.13)

Emergency Medicine and Anaesthetics Trainers:

Trainees attended the hospital wide site induction. Bespoke departmental inductions were provided for FY2 trainees in Emergency Medicine and for core and higher trainees in Anaesthetics during their first couple of days. This incorporated corporate, occupational health and IT information. Trainees were provided with an induction booklet and given orientation tours of the departments. Induction documentation was also available to trainees on the board intranet site. As the departments were relatively small, trainees who were late in starting their post or who missed the initial induction were provided with catch up 1-2-1 sessions.

All Trainee Cohorts:

All trainees received hospital and departmental induction and felt it to be of a good standard.

Nursing and Non- Medical Staff:

Nursing staff felt the induction the trainees received was comprehensive. The nursing staff covered general housekeeping arrangements during departmental induction and the advanced nurse practitioners worked closely with the trainees to support them through induction and afterwards.

3.2 Formal Teaching (R1.12, 1.16, 1.20)

Emergency Medicine Trainers:

Local departmental teaching was delivered to trainees through weekly 2-hour Thursday morning sessions. There were also Thursday lunchtime Foundation teaching sessions that trainees were released from their clinical commitments to attend. Teaching was free of interruption.

Anaesthetics Trainers:

Trainees were able to attend monthly CPD sessions, journal clubs and monthly morbidity and mortality (m&m) meetings. Trainees were also encouraged to attend the hospital wide teaching sessions. Due to the small nature of the department, 1-2-1 informal teaching happened on a regular basis.

Emergency Medicine FY2 Trainees:

Trainees were able to attend local teaching sessions on a Thursday morning and were able to attend the FY2 regional teaching that was required of their curriculum. There were occasions when the departmental teaching clashed with FY2 teaching and it was felt there could be work done around the scheduling of the teaching to avoid this. Trainees estimated they received 3 hours approx. teaching per week.

Anaesthetics Core and Higher Trainees:

Trainees received 1-2-1 informal teaching daily. Critical care teaching sessions were also available to the trainees to attend through video-conferencing although sometimes the access to this could be limited for trainees if it fell on a Tuesday.

Nursing Staff:

Not covered.

3.3 Study Leave (R3.12)

Emergency Medicine Trainers:

Trainees were released to attend Advanced Life Support (ALS) & Paediatric Advanced Life Support (PALS) courses and immersive simulation training which was planned into their rotas at the beginning of the year. Trainers felt there were no barriers to trainees receiving approved study leave.

Anaesthetics Trainers:

Trainers felt the Anaesthetics rota was flexible enough for trainees to be released for study leave. There were no barriers in supporting study leave.

Emergency Medicine FY2 Trainees:

The trainees had not applied for study leave yet but did not anticipate any barriers to taking any.

Anaesthetics Core and Higher Trainees:

There were no barriers identified by trainees in taking study leave.

3.4 Formal Supervision (R1.21, 2.15, 2.20, 4.1, 4.2, 4.3, 4.4, 4.6)

Emergency Medicine Trainers:

All trainees were allocated both Educational and Clinical Supervisors. All trainers were trained and had time in their job plans to provide supervision for trainees. Trainers received 1 SPA in their contract for Clinical Supervision. The Department holds performance support review meetings every 3 months.

Anaesthetics Trainers:

Trainees in Anaesthetics rotate to Dumfries for a 6-month placement from Glasgow whilst maintaining their educational supervisor in Glasgow, which they have for a year. They are allocated local clinical supervisors for the 6-month period they are in Dumfries. Trainers received 1 SPA in their contract for clinical supervision. Doctors with performance managements issues were discussed amongst trainers, generally before the trainee was due to start their post.

All Trainee Cohorts:

All trainees had been allocated educational supervisors, had met with them and had agreed learning plans in place.

Nursing Staff:

Not covered.

3.5 Adequate Experience (opportunities) (R1.15, 1.19, 5.9)

Emergency Medicine Trainers:

The trainers in the department were all familiar with the curriculum requirements of the trainees that rotate through their department. As the departments were small and there were small numbers of trainees, the trainers felt this provided them with more experience of the curriculums.

Anaesthetics Trainers:

Trainers were aware of the curriculum requirements of their trainees and each supervisor, maintained responsibility for the same sections of the curriculum each year. There were some competences that trainees were unable to gain experience of in Dumfries, but these were generally obtained in other centres before they got there.

All trainee cohorts:

Trainees noted lots of senior presence in both Emergency Medicine and Anaesthetics. There were lots of opportunities for 1-2-1 teaching and trainees felt they received lots of experience that would help them achieve their curricular requirements. The trainees reported a good balance of training verses activity of non-educational benefit.

Nursing Staff:

Not covered**.**

3.6. Adequate Experience (assessment) (R1.18, 5.9, 5.10, 5.11)

Emergency Medicine and Anaesthetics Trainers:

Addressed when discussing opportunities above. There were reported to be good opportunities for supervised learning events (SLEs) and Direct Observation of Proceedures (DOPs) within Emergency Medicine. Anaesthetic trainers stated assessments could be trainee dependent however SLEs were readily completed.

All trainee cohorts:

All trainees were able to complete Workplace Based Assessments (WBAs) and felt them to be fair and consistent.

Nursing Staff:

Nursing staff contributed to the assessment of their trainee colleagues by sending feedback responses for Workplace Based Assessments such as Case Based Discussions (CBDs) and Multi-Source Feedback (MSF).

3.7. Adequate Experience (multi-professional learning) (R1.17)

Emergency Medicine and Anaesthetics Trainers:

Not covered:

All trainee cohorts:

Not covered.

Nursing Staff:

Nursing staff attended the minor ailments teaching that took place on Thursdays, along with their trainee colleagues and find these teaching sessions to be helpful.

3.8. Adequate Experience (quality improvement) (R1.22)

Emergency Medicine and Anaesthetics Trainers:

An annual quality improvement poster competition takes place each year and trainees are encouraged to undertake projects, discussing ideas with their consultant colleagues and showcasing their work in the posters, which they present at monthly meetings.

All Trainee Cohorts:

Trainees reported good opportunities to become involved in audit and quality improvement projects.

3.9. Clinical supervision (day to day) (R1.7, 1.8, 1.9, 1.10, 1.11, 1.12, 2.14, 4.1, 4.6)

Emergency Medicine Trainers:

As it was a small unit it was relatively easy to distinguish between the different grades of the trainees. Consultants wore black scrubs and the trainees wore green scrubs which made them easily identifiable to all members of staff. A coloured badge system was also in place and each cohort of trainee wore a different coloured badge. Trainees at FY2 level are not allowed to seek consent for procedures from patients.

Anaesthetics Trainers:

Trainers introduced themselves to new trainees as they started and new trainees were supported at all times. Trainers noted the coloured badge system in place which helped staff identify which grade a trainee was. Trainees were able to obtain consent from patients for sedation, otherwise they did not seek consent from patients for procedures.

All trainee cohorts:

All trainees had been allocated clinical supervisors and found them to be approachable and accessible. Trainees did not report any instances of having to work beyond their competence or experience.

Nursing Staff:

Nursing staff differentiate between grades of trainees by introducing themselves to new cohorts of trainees when they start. They felt trainees were well supported in the small teams at DGRI and were not aware of instances where they had to cope with problems beyond their competence.

3.10. Feedback to trainees (R1.15, 3.13)

Emergency Medicine and Anaesthetics Trainers:

Feedback was provided to trainees informally on a regular basis through 1-2-1 on the job learning. Feedback was also provided through Workplace Based Assessments.

All Trainee Cohorts:

Trainees regularly received feedback on their clinical decisions and it was generally on a day to day and 1-2-1 basis.

3.11. Feedback from trainees (R1.5, 2.3)

Emergency Medicine and Anaesthetics Trainers:

Trainers obtained anonymised feedback from trainees from evaluations sent out after teaching sessions. They noted the GMC National Training Survey as a source of trainee feedback as well as ARCPs.

All Trainee Cohorts:

An online feedback service was being developed in Emergency Medicine, but the trainees advised they hadn't used it yet. All trainees felt they had opportunities to provide feedback to their trainers and were aware of who to approach.

3.12. Workload/ Rota (1.7, 1.12, 2.19)

Emergency Medicine Trainers:

Trainers advised the Emergency Medicine rota was compliant and teaching was planned into the rota for trainees. Supervision was provided for trainees up until 10.00 pm each day. The workload could be heavy in the out of hours period for trainees and the department had FY2 vacancies which they were currently trying to recruit to.

Anaesthetics Trainers:

Trainers felt the rota was manageable for trainees. There was some flexibility to allow teaching/learning for trainees during the day. In the out of hours period the trainees are supported by the on-call consultant. Trainers advised there were currently known rota gaps from trainees going to the Princess Royal Maternity Unit in Glasgow for Obstetrics experience and locum cover had been recruited to cover these vacancies.

All Trainee Cohorts:

Trainees found their rota to be both manageable during the day and in the out of hours period. They did not describe any rota issues that had contributed to patient safety concerns. The Anaesthetics trainees noted the known rota gaps that are created by trainees going to the Princess Royal Maternity unit in Glasgow for Obstetrics experience and felt this could sometimes be strain on the workload of the team over a 3-month period.

Nursing Staff:

Nursing staff were not aware of any concerns the trainees may have regarding their rotas.

3.13. Handover (R1.14)

Emergency Medicine Trainers:

There were 3 handovers daily in Emergency Medicine, a morning handover which was informal, a formalised post lunchtime handover (2.00pm) which the full multi-disciplinary team attended and the evening handover to the emergency department night team (10.00pm). The lunchtime and evening handovers are consultant led but no written handover is taken due to the nature of how Emergency Medicine works.

Anaesthetics Trainers:

An overnight into day handover took place each morning at 8.30 am and a day to the night team handover took place in the evening at 10.00 pm. Handover was consultant led and recorded in a review book. Trainees were in attendance and participated in handover.

Emergency Medicine FY2 Trainees:

Trainees noted the morning handover to be informal and a full multi-disciplinary team handover at 2.00pm took place each day. There was also an evening handover from the day – night team that took place at 10.00pm.

Anaesthetics Core and Higher Trainees:

Trainees attended a night to day team handover in critical care at 8.30 am. Consultants were present, and a review of the patients recorded on the handover sheet was undertaken. Trainees felt handover was effective in ensuring information was shared.

Nursing Staff:

Nursing staff felt handover was effective and noted the 2.00 pm consultant led handover to be the main MDT handover in Emergency Medicine. Nursing staff confirmed it was structured and effective.

3.14. Educational Resources (R1.19)

Emergency Medicine and Anaesthetics Trainers:

Not covered – addressed by DME in introductory talk at the start of the day. Highlighted very good Educational Resources in the new hospital.

All Trainee Cohorts:

Not covered.

3.15 Support (R2.16, 2.17, 3.2, 3.4, 3.5, 3.10, 3.11, 3.13, 3.16, 5.12)

Emergency Medicine Trainers:

Trainees were able to feedback on their training at end of block meetings and more informally Monday morning weekend debrief meetings. Trainees with performance issues were discussed at a regular departmental meeting of supervisors.

Anaesthetics Trainers:

Trainees were able to feedback on their training informally on a regular basis. The Anaesthetics team would pull together to support trainees with performance issues and the trainee would be provided with close supervision and support. Support was provided for trainees through their educational supervisor, the local director of medical education, the education manager and the performance support unit in the deanery.

All Trainee Cohorts:

All trainees felt support was available for those struggling with the job and they would be happy to approach their educational or clinical Supervisors for support. There were no less than full time trainees in the group and no trainees had returned from a career break.

Nursing Staff:

Nursing staff would raise any concerns they had around the performance of a trainee with their consultant colleagues. None were noted.

3.16 Educational governance (R1.6, 1.19, 2.1, 2.2, 2.4, 2.6, 2.10, 2.11, 2.12, 3.1)

Emergency Medicine and Anaesthetics Trainers:

The DME is an emergency medicine consultant and briefly covered governance in his introductory presentation. Support for trainees in difficulty as outlined above in both Emergency Medicine and Anaesthetics

3.17 Raising concerns (R1.1, 2.7)

Emergency Medicine and Anaesthetics Trainers:

Concerns about patient safety were raised by trainees through the Datix system. Outcomes of Datix were discussed at m&m meetings. Work was underway now to re-programme Datix to provide feedback to trainees on the Datix reports they raised.

All Trainee Cohorts:

Trainees would raise concerns through the Datix system, none present had raised any concerns through the system but expected they would receive feedback on them if they did. Trainees noted m&m meetings as forum where learning from incidents was gained. Trainees felt they could raise any concerns about their training with their consultant colleagues. There did not appear to be a trainee forum in place.

Nursing Staff:

Nursing staff confirmed patient safety concerns were raised through the Datix system and feedback was generally provided through a senior nurse.

3.18 Patient safety (R1.2)

Emergency Medicine and Anaesthetics Trainers:

Not covered.

All Trainee Cohorts:

Trainees had no concerns about the safety of the environment for patients. Patients in Anaesthetics or Emergency Medicine were not boarded out to other wards.

Nursing Staff:

Nursing staff felt the environment at DGRI was safe for patients. They described patient boarding as an irregular occurrence in Emergency Medicine. There were nursing huddles which took place each morning, included trainees.

3.19 Adverse incidents (R1.3)

Emergency Medicine and Anaesthetics Trainers:

Not covered.

All Trainee Cohorts:

Trainees would discuss any adverse incident with their consultant supervisors however none of the trainees had experienced such an incident.

Nursing Staff:

No adverse incidents were noted. Nursing staff confirmed the environment to be open and supportive.

3.20 Duty of candour (R1.4)

Emergency Medicine and Anaesthetics Trainers:

Trainers felt an open and honest culture was in place within the hospital and the consultants themselves tried to lead by example by reflecting on their own practice and discussing learning with the trainees.

All Trainee Cohorts:

Trainees would discuss any incidents where something went wrong with their educational or clinical Supervisor and had no concerns about being supported if they had to do this.

3.21 Culture & undermining (R3.3)

Emergency Medicine and Anaesthetics Trainers:

Trainers felt an open and honest team culture was in place and undermining incidents were felt to be a rare occurrence. Incidents were noted of behaviours that could be considered undermining, but the trainers feel the incidents were resolved at the time on the wards to the satisfaction of all parties. The trainers had used Royal College of Surgeons Human Factors material to address undermining behaviours.

All Trainee Cohorts:

Trainees noted their consultant colleagues to be supportive and approachable. They had not witnessed or been subjected to any undermining or bullying behaviours. If they had any concerns of this nature, they would be happy to raise them with a consultant colleague or educational/clinical Supervisors.

Nursing Staff:

Nursing staff in Emergency Medicine had noted an incident of a personality clash with a locum consultant. This was addressed locally with the permanent consultant team. The nursing team confirmed a team culture was in place to support the trainees.

3.22 Other

4. Summary

Is a revisit required? (please highlight the appropriate statement on the right)	Yes	No	Highly Likely	Highly unlikely
		✓		

The visit team found the training environment within Dumfries and Galloway Royal Infirmary to be of a high standard. There were no requirements identified during this visit.

Positive aspects of the visit:

Emergency Medicine:

- Handover – structured with senior presence
- Induction
- Educational and clinical supervision
- Teaching – formal teaching programme
- Supportive environment
- Multidisciplinary team working – strong ethos
- Good learning opportunities for practical procedures.

Anaesthetics:

- Induction
- Access to study leave
- Clinical Supervision
- 1 to 1 informal teaching for Core Training
- Clinical experience/ learning opportunities
- Study leave

Less positive aspects of the visit:

- Critical care teaching – limited opportunities via VC to Glasgow.
- FY2 regional teaching clashing with local teaching sessions in Emergency Medicine.

5. Areas of Good Practice

Ref	Item	Action
5.1	Handover – structured with senior presence EM	

6. Areas for Improvement

Ref	Item	Action
6.1	Access to the Critical Care training opportunities in Glasgow could be improved.	
6.2	Teaching timetable to be reviewed to avoid clashes with regional teaching for Foundation trainees in Emergency Medicine.	

7. Requirements - Issues to be Addressed – No requirements

8. DME Action Plan – Not required.