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1. ABSTRACT

The project was designed with the aim of identifying the induction' needs of trainee medical staff at Stockport's Stepping Hill and Blackpool's Victoria Hospitals, and on a wider scale developing a 'Gold Standard' for the induction of trainees across the North West Region.

Over a twelve-month period, trainees, their colleagues and patients, have been consulted via discussions and survey questionnaires; trainees have been observed in their daily work; changes to existing induction' programmes have been trialled; induction practices at other Trusts have been considered; and recommendations in published literature, reviewed.

As a result, it has been possible to identify the written and verbal information necessary to deliver to trainees at their induction, and define the specific requirements of the departmental programme.

2. PROJECT OUTLINE

The Improving Junior Doctors' Induction Initiative was a joint venture between Stockport's Stepping Hill (SH) and Blackpool Victoria (BV) Hospitals, over a twelve month period. Staffing consisted of one full-time Project Manager, who was based in the Training & Development Department at Stepping Hill.

The process of induction at the two Trusts is largely different, as is the content of the programmes (see appendix 1 for the August 2000 Day 1 Induction' Programmes, as an example). The differences between the two are not unusual, as Trusts both across the North West Region and elsewhere, each have their own individual format for the induction of trainee medical staff. This variation highlights the need for the identification and subsequent sharing of best practice between induction providers, so greater standardisation and quality in the inductions received by all trainees can be enabled. This is partly the reason why the need for this project arose.

Other motives for the project's initiation, include SH and BV's recognition that increasing demands on trainees to provide a high quality of patient' care, necessitated a review of the induction' practices necessary to equip them with the knowledge and skills required to do this effectively at a post's start. Problems with the standard of practice demonstrated by trainees in such as documentation, communication, and clinical skills, as well as their apparent lack of understanding of their own roles and responsibilities (including in relation to those of nursing staff), all needed rectifying. Furthermore, the lack of consistent dissemination of guidelines and other relevant Trust information to trainees, suggested an evaluation of trainees' induction needs was becoming imperative.

Consequently, the Organisation & Development Manager at SH and the Postgraduate Education Centre Manager at BV, proposed a project which it was hoped would provide a review of the induction practices at the two Trusts, including the verbal and written information presented as part of them. It was Intended from this review, to be able to produce recommendations for an induction package which would achieve more effective retention of material by trainees, and hence result in better working practices and patient' care. Subsequently, this would consolidate the Clinical Governance process at both Trusts, by improving the interactions between trainees, the hospital' systems and multidisciplinary teams.

3. LITERATURE REVIEW

There are a limited number of studies on the provision of induction programmes for trainee medical staff. This lack of research-based evidence is possibly one reason for the diversity that can be seen between Trusts. However the published research that does exist, provides useful guidance and demonstrates a need for the widespread review of induction practices.

One such study is that conducted by Gale et al (1992), who reviewed the induction of Pre-Registration House Officers (PRHOs or HOs) at Lewisham Hospital, where more brief and interactive methods contradict more traditional models of delivering induction. Induction takes place as a full day on the 31st of July (for which those attending are paid) prior to the uptake of post, guaranteeing a bleep-free day and thorough handover from their predecessor. The induction programme includes participating in small discussions led by outgoing PRHOs on 'being a house officer' in the Trust, plus talks on death; breaking bad news; and counselling, monitoring and support. In February, induction consists merely of the above group discussion and talks, over an hour and a half total duration. Individuals starting their first HO post in February are encouraged to themselves arrange to shadow their predecessor prior to start, as time for a handover is not possible.

This relatively minimalist approach is continued in Gale et al's suggestion that 'small and slim' handbooks which are easily transported in the pocket, should be provided, as it has been found at Lewisham as elsewhere, that,

"...large handbooks tend to be seldom used and easily misplaced ... the handbook must remain small and short if it is to be used."

Both Lewisham's own concise handbook and programme have been found to work well and are considered to be wholly sufficient by trainees. Furthermore, it has been proved that at one month following induction, Lewisham' trainees are able to remember the induction' information they received, much better than those in receipt of a more traditional programme and material elsewhere. However, Gale et al conclude that whilst a 'user friendly' Trust induction is strongly preferable, they also,

"... urge recognition that further induction to individual firms and their practices will be needed."

Thus recognising the importance of good local provisions to accompany the main Trust programme.

Ward & Stanley (1999) also conducted a review of the induction of trainee doctors, leading them to support Gale et al in advocating,

"Flexible, timely programmes, supported by comprehensive written information....."

They reviewed the induction needs of 64 Senior House Officers (SHOs) in five hospitals in Anglia via a semi-structured interview, and came to highlight the need for flexibility due to the variety of needs of individual trainees. They acknowledged the fact that those who miss induction due to starting out of time with the main rotations thus need 'comprehensive written advice' to be available, as do trainees who are from overseas and others with particular circumstances. They recognise the value of consulting the opinions of trainee grade medics in the evaluation and development of their induction programmes, which many Trusts fail to do, but also advise against allowing trainees' views to significantly impact upon induction-provisions unless substantiated by the views of more senior staff. This is because in reality,

"... some topics may be vital to provide, despite trainees attaching less value to them."

Ward & Stanley demonstrate the importance of evaluating the departmental and main hospital' inductions in distinct separation from one another. Results from the 64 interviews they conducted, showed that information on for instance 'ordering tests / investigations', 'cardiopulmonary resuscitation', 'study leave', 'educational timetables / events', and 'bleeps / switchboard', were to be considered by most to be of 'real value' in a hospital induction programme aimed at SHOs. In comparison, such as information on 'health and safety', 'bereavement / breaking bad news', 'laundry/white coats', 'independent/pastoral advice', and a 'Chief Executive's welcome', were reported by over half of interviewees to be of 'little value' in a hospital programme. Similar was found in the case of both 'health and safety' and the 'Chief Executives Welcome' in the Stockport / Blackpool Project.

In comparison, Ward & Stanley found that SHOs expressed 'discussing the post with the outgoing trainee' and 'shadowing a trainer or trainee' either 'before, or on starting' to be of the greatest value to them as regards an induction into the department. Topics such as 'the departments' expectations of you', 'on-call / rota / shift / cover arrangements', 'timetable of service commitments', 'departmental protocols', and again 'tests available and how to order them' and 'useful telephone numbers / bleeps', were viewed by most SHOs to be of 'much' use in a departmental induction at the start of post. Overall, 65% of those in receipt of local programmes were 'satisfied' or 'very satisfied' with the experience, and 75% of those who were not provided with a departmental induction would have actually liked one. This reiterates the vital importance of providing a good departmental, alongside hospital, induction programme, and again supports the similar findings of the Stockport / Blackpool project as regards the information most greatly appreciated by trainees.

Williams & Cheung (1998) considered the views of senior house officers and registrars, in relation to the need for 'induction training, career counselling, and performance review' in three hospitals. As regards induction training, views were collected via a 13-item postal survey questionnaire, which was distributed twice across a 6-year interval. 73 responses (46 from SHOs and 27 from registrars) were received in the first round, and 118 (85 from SHOs and 33 from registrars) in the second 6 years later. However, whilst an expected difference in respondents' results across specialties appeared, no significant dissimilarities in the perceived needs of the two grades were identified. Over the 6-year period, induction needs proved to change little, with both rounds of results demonstrating a,

“... notable preference for specialty-based rather than hospital-wide, induction training.”

It was found that the information generally welcomed by SHOs, included that relating to 'career prospects', 'research opportunities', 'postgraduate activities', 'clinical policies' and 'admission and bed policies'. However, whilst both rounds of respondents viewed communication matters as generally important, neither wanted to receive more information on it at induction. Similarly, material on, 'patient discharge policies', 'key management personnel', 'diagnostic encoding procedure', or 'medical audit procedures' were not given priority as induction topics, even though in reality there is a genuine need for a good level of knowledge in these areas. This therefore supports Ward & Stanley's previous point, that there is a discrepancy between trainees' actual needs and wants, leading Williams & Cheung conclude that,

“The rejection by many junior doctors of induction training in communication, discharge policies and encoding procedures does not reflect the known problems in these areas, and suggests that attitudes, as well as knowledge and skills, need to be addressed in order to achieve improvements.”

They suggest that the needs and attitudes of trainees therefore need to be met at a much earlier stage in their careers, specifically by way of their undergraduate learning. The Stockport / Blackpool project similarly found greater collaboration to be needed between undergraduate and postgraduate trainers.

To look at the recommendations for the induction of trainee medical staff from organised bodies, a report entitled 'A Good Start' by the Standing Committee on Postgraduate Medical and Dental Education (SCOPME) (1993) recommends that,

"An induction programme will be most effective if it is designed and carried out according to the principles of adult learning."

These principles include making learning a relevant and active experience, and illustrating why the knowledge it provides is needed and will make trainees' working lives easier. SCOPME state that trainees should be consulted on the 'content and style' of induction, and be able to monitor and receive feedback on the progress they make in developing their capacities for medical practice as a result of the induction process. The programme should aim to 'lower stress and build confidence', be uninterrupted, available at the start of all new appointments, and include a process of evaluation.

SCOPME suggest the organisation of an induction programme be keenly attended to, as given the limited time usually available for induction, poor organisation leads to an overload of potentially irrelevant information and little being achieved. Both oral and written methods of presentation have their advantages and disadvantages, and need to be considered carefully. For example, whilst short talks have the benefit of enabling staff participation in the delivery of information, and ensure trainee's exposure to important messages that could otherwise go unread if presented on paper, they also lack interaction, give generic as oppose to individual information and have been found to do 'little to reduce stress'. Oral communication by way of small group work and handovers also has its disadvantages, but at least is more individualistic and participative. Written material on the other hand is observed to quickly date, can be expensive, too large and difficult to digest and easily stored away to never be opened. However, it is also readily available as a resource to those missing an induction programme, and provides detailed information needed for reference. Therefore the organisation or delivery of induction is as important as the information it provides.

SCOPME identify special induction provisions to be needed by those in specialist training, doctors who have qualified abroad, locums, those with disabilities, part-time trainees, and those 'returning to work after a long absence' (the latter two categories relating largely to female trainees and the care of their children). These individuals' induction programmes, should like those of all other trainees,

"... form part of a planned, continuing and systematic educational programme."

Particularly overseas trainees and those who have been out of post for an extensive period, should not be expected to be sufficiently adjusted after a single day's induction, and the Clinical Tutor / Educational Supervisors should identify and ensure the meeting of individuals' induction needs. These special cases are often overlooked by Trusts when developing programmes for induction, as well as largely by researchers.

A later report also by SCOPME (1997) looked at 'Multiprofessional working and learning' and discusses how working as part of a diverse team has benefits for the patient but is sometimes difficult for the professions involved. Thus, it is important that trainee doctors have a good understanding of colleagues' roles and how they can complement their own role, which is how involving other professions in their induction can help. According to SCOPME, the 'key concepts in multiprofessional working and learning' include,

"...placing a high value on the inherent strengths of the individual professions...members of one profession having respect for the others... ensuring real communication between professionals...[and] working to one objective of the education and training of all health professionals."

This can only be accomplished if the value of non-medics is demonstrated by Trusts, one way of which, would be through their full and significant inclusion in the induction process.

The General Medical Council (GMC) have published a range of documents which relate to the induction of trainee medical staff. In 'The New Doctor' (1997) a number of

recommendations for the content of PRHO' induction are set out, detailing recommendations for shadowing, those starting their first post in February as oppose to August, a range of topics which talks should cover, and the content of handbooks amongst other things. 'The Early Years' (1998) makes recommendations for the induction of SHOs. These mainly relate to provisions for delivering information on education and training, and again the content of talks and handbooks. As expected, more emphasis is placed on familiarisation with the Trust and specialty's individual practices in the case of SHOs, as oppose to general clinical practices in the case of PRHOs.

The GMC' document 'Good Medical Practice' (1998) positively promotes the involvement of doctors in each other's induction and training. It addresses doctors, stating,

"The GMC encourages you ... to contribute to the education and training of other doctors, medical students and colleagues."

It talks about many of the topics which the Stockport / Blackpool project's 'Gold Standard' subsequently recommends for induction, such as accepting gifts, documentation, clinical audit, patient' communication, and working as part of a team. Many of the issues relating to teamwork occur in more detail later in the later GMC document, 'Teamworking in Medicine' (2000). This comments that effective teamwork only arises from understanding each others roles and responsibilities, respecting each other and their professions, and sharing the same values for providing good patient' care. As such, it supports the 'Gold Standard's' recommendation for including non-medics in the induction process. The GMC says,

"Inter-professional collaboration, which encourages professionals and those in training to learn with, from, and about one another, can encourage respect for the contribution each profession has to make to patient care."

In the Department of Health's document, 'Working Together' (1999), the NHS Taskforce on Staff Involvement states that,

"By April 2000 each local employer [should] have reviewed their induction arrangements and agreed specific improvements with local staff, including junior doctors."

The taskforce found evidence that the establishment of 'two-way communication', via surveying staff on their needs as employees, provides them with a feeling of control over their work. As a result this lowers levels of stress in an organisation and leads to better 'attitudes, behaviour and performance' from staff, a conclusion which can be seen to positively affirm the Stockport / Blackpool project's consultations with trainees and their colleagues. The NHS Plan (2000) reinforces this with the statement that,

"...every member of staff in the NHS is entitled to belong to an organisation which can prove that it is investing in their training and development..."

The NHS Plan's reforms include improving medical education and trainees' working conditions, as well reducing the strain on staff by increasing the number of Consultants and general practitioners by 2004. The recognition by the NHS of the need for a review of the ways in which trainees receive induction, education, and training, maintains the argument that research into best practice is a valuable and useful resource which all should utilise.

In conclusion therefore, it would seem that the limited research on the provision of induction for trainee medical staff is congruous. It appears to be generally agreed that no single induction programme could meet the needs of all trainees, and that a thorough departmental programme is the closest provision realistically available to be in anyway tailored towards this variety of needs. The research demonstrates the value of consulting with trainees in the development of induction, but that it is necessary to temper findings with the knowledge and opinions that come only from the greater experience of others. Trainees are more likely to be open to induction' information and perceive it as more useful when the content is kept to a reasonable quantity and is what they deem to be relevant, both in terms of written and verbally delivered information. Hence reinforcing the need for 'two-way communication' with trainees, as regards the content of their induction programmes.

Whilst induction at most Trusts contains some of the aforementioned 'ingredients', it seems that the majority do not possess the complete recipe for a wholly successful programme for trainee medical staff. SCOPME, the GMC, Department of Health and NHS, all appear acutely aware of the need for change in induction processes. So it is to the evidence-based research that they and others provide, along with opinions and experiences of their own trainees, that Trusts need to look for guidance in developing and effectively directing their induction' resources.

4. SCOPE & AIMS OF THE PROJECT

The initial purpose of this project was to improve trainees' experience of induction at Stepping Hill and Blackpool Victoria Hospitals, thus facilitating their effective integration into the systems in operation at each, and subsequently resulting in more efficient delivery of patient care in the early stages of a training post. Practically, the project has aimed to identify potential amendments to the existing induction programmes at both Trusts, trial changes linked to these, and from the outcome of those trials then make recommendations for permanent reforms to the induction processes at each Trust. The intended benefit to trainees being that there should be a reduction in the amount of verbal and written information they receive during induction, which is unnecessary or irrelevant at the immediate start of a new post. The project's ultimate aim has been to produce a 'Gold Standard' document on the induction of trainee medical staff. This has been developed based upon the above trials, alongside consultation with all involved in induction at Stockport and Blackpool, observation of newly inducted trainees in their daily work, consideration of induction programmes at Trusts across the North West Region, and published literature on best practice in the induction of medical trainees.

The project has been limited in several ways, including mainly:

- By only two inductions taking place during its twelve month period.
- Time and staffing constraints meant that induction programmes across the region were unable to be more comprehensively considered via visits to individual Trusts. Similarly, discussions on the topic of trainee medics' induction could only be entered into with a limited sample of staff, with it being necessary to target others via a survey questionnaire method. Observations of trainees were restricted owing to their time-consuming nature, as was the collection of 'Patient Stories'.
- There was difficulty in gaining information from medics, owing to the pressures on their time and in some cases their unco-operation due to a resistance to change.
- Difficulties were posed by the project base being outside of the two Postgraduate Education Centres involved.
- The involvement of two Trusts, as oppose to one in the project, caused complications. To a significant extent many limitations were posed by the geographical distance between the two Trusts, making it difficult for the Project Manager to obtain information from, and implement changes at Blackpool Victoria whilst being based in Stockport. Also the dissimilarity in induction processes between Stockport and Blackpool has posed problems in exercising standardisation during the course of the project.

5. PROCEDURE

IDENTIFICATION OF BEST PRACTICE IN INDUCTION

- Relevant published literature was reviewed.
- General Medical Council, Royal College and North West Deanery recommendations were researched.
- All Postgraduate Education Centres in the North West Region were contacted for details of their induction practices / programmes.
- All Directorates at SH and BV were contacted for details of their induction practices / programmes.

CONSULTATION WITH TRAINEES

- Questionnaires were administered to trainees prior to the August 2000 induction at both SH and BV (see appendices 2). Administration at both Trusts was via Postgraduate Education Centre meetings and the delivery of a copy to every trainee through the internal post. Unfortunately, the response rate was extremely poor and so no valid conclusions could thus be made.
- Induction evaluation sheets were distributed at the August 2000 induction at SH (see appendix 3), a summary of the findings from which are in appendix 4. Due to the annual leave of BV staff shortly before the August induction however, it was not possible to gain information on BV's final programme and therefore design a suitable evaluation sheet in sufficient time for induction there.
- Questionnaires were distributed 4-6 weeks following the August 2000 induction (see appendix 5) via the same methods as the pre-August questionnaire, as well as via Clinical Audit meetings at Stepping Hill. A summary of the results gained from those completed by trainees at SH can be found in appendix 6.
- However, as results were again found to be inadequate at BV, conclusions could not be made from the post-August induction questionnaire there, and so a discussion was held with a group of PRHOs as an alternative method of collecting information. A summary of this can be found in appendix 7.
- Observations of trainees were conducted at both Trusts, and appendix 9 should be referred to for a summary of the key points identified from these. 8 trainees of varying grade across a range of specialties were observed for a period of between 2 and 4 hours each, over the course of June 2000.

CONSULTATION WITH OTHERS

- A staff questionnaire was distributed to an extensive range of staff via internal post at both SH and BV (see appendix 9). These included Directors, Consultants, Managers, nursing staff and many others. A joint summary of the results for the two Trusts can be found in appendix 10.
- 1-to-1 and group discussions were held with the following staff:
At SH: Clinical Audit, Clinical Directors, Clinical Risk Manager, Clinical Support Services, Health & Safety Officer, Medical Director, Medical and Surgical and Trauma & Orthopaedic

Sisters, Medical Staffing Officer, Postgraduate Clinical Tutor, Surgical Nurse Practitioners, Telephone Manager, Undergraduate Tutor.

At BV: Clinical Leaders, Medical Staffing Officer, Pharmacy, Postgraduate Centre Manager. (See appendix 11 for a brief joint summary of the key points resulting from these discussions).

- ‘Patients’ Stories’ about their experiences (particularly of trainee doctors) whilst in hospital at Stepping Hill, were collected from 20 patients following Ethics Committee approval and the design of a ‘Patient Information Sheet’ (in size 16 font in case of patients’ visual impairment) (appendix 12) and Consent Form (appendix 13). Ward Sisters’ help was sought in identifying patients suitable to participate. Criteria for suitability was that they were to be sufficiently well, have been in the hospital for at least 3 days, and were expected to remain for a minimum of a further 2 weekdays (to give the Project Manager time to speak to them). Ward Sisters as persons impartial to the project, were also asked to approach suitable patients with ‘Information Sheets’ and invite them to participate, so as to avoid any obligation being felt if approached by the Project manager. A summary of the key points raised in these stories is located in appendix 14.

N.B. It was chosen to refer to trainees specifically as ‘Junior Doctors’ when speaking to patients, to avoid assumption by the layperson that a ‘trainee’ was unqualified to treat them.

TRIALLED CHANGES TO INDUCTION (At SH only)

Departmental programme:

- Prior to the August 2000 induction, an A5 booklet containing basic ‘Guidelines for the Directorate / Departmental Induction of Junior Doctors’ was produced (see appendix 15 for an A4 version), in an attempt to create some standardisation across directorates / departments at some level. This was devised based upon best practice identified from the programmes already in use in individual directorates at SH and BV, in addition to other information gathered by the project by that time. Whilst distributed at SH, this was not used at BV where there were already guidelines in place.

- Separate lunches were held for each directorate in the Postgraduate Education Centre at the end of Day 2, to which directorates were asked to invite a range of staff to enable trainees to informally meet members of the multidisciplinary team.

Hospital programme:

- Due to the fact that changes to the Postgraduate Centre’s “Junior Doctors’ Handbook” were unable to be trialled, as copies for the year’s duration of the project had been arranged prior to the project’s start, a “Junior Doctors’ Induction Supplement” was alternatively produced to trial information. From the identification of possible gaps in the written information distributed at induction, sections were produced on services / facilities in the local area; telephones & bleeps; documentation; and guidance on seeking support in response to either your own, or a colleagues’ problem, which may either arise from, or affect, your work. In addition there were sections on computer services (including an application for a computer login ID) and car parking (including an application form for a Trust discounted parking permit). The supplement was produced as an A5-size document and presented in a small ring binder, of which an A4 version can be found in appendix 16.

- Laminated wall charts of useful telephone numbers / bleeps were produced for each ward in collaboration with the Telephone Manager (see appendix 17), along with a pocket-size laminated card for each trainee. The cards had generally useful telephone numbers / bleeps on one side, & those specific to the trainee’s particular directorate on the other. One example of these can be found in appendix 18, but please note that cards were in fact reproduced a lot smaller than shown (approximately 10cm x 10cm in reality).

- There was the introduction of a talk from the Trust's Solicitor, which is usually received only by those in the Medical Directorate through the local induction programme. This was in an attempt to highlight medico-legal issues as early as possible in trainees' work with the Trust, as had been highlighted as necessary through 1-to-1 discussions with such as the Trust's Litigation & Complaints' Officer.
- Slight additions to the content of talks by Pharmacy and Microbiology were made, relating to issues around documentation and safe practice, which had also been deemed as areas in need of greater attention via staff' discussions.
- A social buffet was held in the Doctors' Mess at the end of Day 1, to which all new and out-going trainees were invited to informally meet and share experiences with one another, along with all Consultants responsible for trainees.
- A 'quiz' was distributed with a prize of music vouchers offered. Questions appertained to the range of written material received through induction, and were intended to encourage trainees to actually pick-up, search through, and realise what information was in their possession. (See appendix 19).

6. SUMMARY OF RESULTS

In addition to recommended attention to the 'Gold Standard' document produced (see appendix 20), specific recommendations are made below for the two Trusts involved in the 'Improving Junior Doctors' induction Initiative'.

6.1 RECOMMENDATIONS FOR THE IMPROVEMENT OF INDUCTION AT STEPPING HILL

Hospital programme

- Brief small group IT tutorials for those new to the Trust and therefore unfamiliar with the computer system, are recommended as favourable to the current talk which is delivered accompanied by an overhead presentation.
- The Trust Solicitor should continue to talk to trainees at induction, covering documentation and other issues relevant to practising safely within the Trust.
- As much information as possible regarding telephones / bleeps and useful numbers should be provided, as these were found to be very useful to trainees.
- The educational and personal support available within the Trust, and how to access it (including when on nights or on-call), needs to be further stressed at induction. This is so that all trainees are clearly aware / reminded of sources of support at each new post's start, when support is most likely to be needed.
- Currently in August, HOs experience repetition of the Postgraduate Clinical Tutor's talk, by receiving it on both their own induction day and the second day attended by all grades. It is thus recommended to maximise use of the time available, that HOs instead receive another talk of benefit to them during one of the Postgraduate Clinical Tutor's sessions.
- For HOs in their first post, it would be beneficial to provide a session either in the main hospital programme or departmentally, on the brief basics of completing the various forms they are to be faced with from day one e.g. discharge summaries, death certification etc. They should also be provided with an opportunity to enter into a discussion on their 'roles and responsibilities as a HO', including what they are 'allowed' to do as a HO, how 'to do' a ward round, and what happens when they are on-call and so on. HOs often appear anxious regarding these aspects of the job, and so this would alleviate that. Meeting with nursing staff to explain and clarify extended nurses' roles and the roles of nurse practitioners, would also be of great benefit to new HO's.
- An additional social event should to made be a part of the induction programme in some form, to enable new trainees to meet existing and outgoing post-holders as well as members of their multidisciplinary team, and to do so in an informal way.

Departmental programme

- There needs to be greater communication and monitoring across directorates in the Trust, to ensure all trainees receive a similar basic content and overall standard of local induction, regardless of where they are placed. The 'Guidelines for the Directorate / Departmental Induction of Junior Doctors' in appendix 15, should be used as a minimum measure.

- To avoid overlaps and / or omissions in the information received by trainees through the induction process overall, there needs to be better co-ordination between those organising the hospital and departmental induction programmes, in respect of the programmes' content.
- Consideration should be given to providing directorates with a specific timetabled slot, either during or following-on from the hospital programme. This would ensure that at least those trainees starting in line with the main rotation periods, would receive local information as early as possible.
- Where the outgoing post holder either has insufficient time to provide a good handover or they are not available to deliver this, another appropriate team-member should be appointed to the task (e.g another medic or a senior member of the nursing staff). In this case, the incoming trainee should be given the opportunity to contact the out-going postholder prior to their departure, by provision of a contact telephone or bleep number. The handover should in all cases include explanations of peculiarities of that particular multidisciplinary team e.g. extended nursing roles and what these mean in terms of both the trainee's post and the functioning of the team as a whole.
- There should be a move towards the greater involvement of nursing staff in the induction of trainees. Many nurses are willing to more formally share the wealth of their knowledge and skills, which trainees often appear to utilise as a valuable resource. The help and advice nurses informally provide to trainees is felt to be generally unacknowledged at present, and as such leads to it being resisted by a proportion of medics. Nurses' experience should especially be utilised much more fully at a local induction level.

Written induction material

- Trainee doctors frequently fail to be aware of the content of information received via induction at SH. Thus they (especially HOs who are usually free before their first post) should where possible receive more of the written induction material ('Junior Doctor Handbook' etc.) prior to starting in their new job. This would allow them time to read and use the information to prepare for the post, so there would be familiarity with the material available for reference from the very start. Alongside this, the provision of a local contact to answer any queries raised from this material or generally, should be made available prior to arrival on the job.
- Consideration needs to be given to incorporating into the 'Junior Doctor Handbook' or elsewhere in the induction information distributed by the Postgraduate Centre, the information provided during the period of the project via the 'Junior Doctor Induction Supplement'. For example, application forms for a parking permit and computer login, information on sources of support in the Trust, and guidance on good documentation practices, would be particularly beneficial.
- Furthermore, consideration should be given to providing the 'Junior Doctor Handbook' in a different format, as suggested below:
 1. Produce a smaller Handbook that only contains information of immediate use to a trainee carrying it in their work, and to provide a separate publication containing the material needed for only occasional or less urgent reference, which could be kept to one side.
 2. Alternatively, produce the Handbook in a format in which sections could easily be removed or added. This would enable trainees to individually select the information that they consider of particular use to them in their work (according to their experience etc.), and carry this alone after removing sections they choose to keep to one side for only occasional reference. This would also enable the more detailed information needed by

such as PRHOs and overseas' trainees, to be added as sections to the handbooks of only those to whom it appertained.

- General information as regards training records, Individual Performance Reviews, appraisals, educational supervision etc. needs to be provided to trainees either as part of the Handbook or as a separate item.
- Consideration should be given to providing trainees with more of the information given to other staff new to the Trust, for example back care advice &/or manual handling training. Also, a Trust 'Staff Handbook' should be given, as it cannot be assumed that trainees do not need the information other staff receive via this on such as childcare, paternity / maternity leave, changing personal details and NHS benefits.

Other factors

- If it has not been possible earlier, it should be ensured that trainees are informed of basic details of their post at the main hospital induction (preferably at its start). Such as their department, wards, and the Consultant to whom they are to be attached, are all vital to be provided, otherwise trainees have been observed to remain anxious about these details throughout the induction programme and at a loss as to where to go at its close.
- It is recommended that the hospital induction programme where possible, attempts to focus more on providing help to trainees with the practical aspects of beginning a new job. For example the provision of application forms for staff car parking permits and IT logins mentioned earlier, were found to be very welcome by trainees.
- Formal provisions for the induction of those starting outside of the August and February induction programmes need to be made at either hospital or departmental level. It should be ensured that these trainees receive all written material distributed in the August / February programmes, as well as a condensed induction programme in some form.
- The induction needs of those on the General Practice Vocational Training Scheme (GPVTS) requires more attention. This is especially pertinent in the case of SHOs, who it is assumed are generally in need of less guidance in a new post due to their grade. However, as the organisation of the GP training scheme means that a trainee can take up a post at SHO level without having worked in a particular directorate before, both the Trust and members of the multidisciplinary team, need to appreciate their potential need for extra initial support.

6.2 RECOMMENDATIONS FOR THE IMPROVEMENT OF INDUCTION AT BLACKPOOL VICTORIA

N.B. These are recommendations for the induction of PRHOs only, as other trainee grades were unable to be consulted sufficiently to enable valid recommendations as regards their induction to be made.

PRHO June shadowing induction programme

- Trainees feel that what they learn as part of this programme, is difficult to remember several weeks later at the start of their post in August. Therefore, it may be of benefit to hold a very brief 'refresher session' at their start in post, covering some of the most key information the June programme provides them with.
- An explanation is needed as to the value of this period of induction to PRHOs, in relation to how the experience will equip them with useful knowledge and skills regardless of where their first post may turn out to be. Otherwise, as some PRHOs at BV reported, shadowing is felt to be of little use when done at a time prior to receiving results from final exams. Some individuals felt that whilst their post at Blackpool was unconfirmed, shadowing was perceived to be a potential 'waste of time' and hence those trainees failed to actively learn from it.
- It is recommended that the CAST workshop also be provided at a later point than as part of the shadowing programme, or an update session be held very early in August, as again PRHOs would prefer this to be fresher in their memories at the start of post.

PRHO Day 1 August induction

- Consideration should be given as to whether information on Clinical Governance could be provided later, as PRHOs do not value it as a Day 1 topic.
- A time for brief formal introductions to the multidisciplinary team is recommended in this programme, as PRHOs report not being remembered by colleagues from their time shadowing in June.
- A session to clarify / reaffirm the PRHO's role, responsibilities, and when it would be appropriate to refer to a senior, should be considered for Day 1.
- More information on the prescribing of antibiotics appears to be needed from the very start of placements.

Written material

- The provision of a booklet specifically containing written protocols would be of great benefit to HOs in addition to the 'Medical Staff Handbook for Junior Doctors', particularly if produced in a very portable form.
- To improve HOs' use of written induction material, their attention needs to be drawn more towards its content (especially of the above Handbook), and the benefits of reading / referring to it highlighted. At present as at Stockport, trainees of all grade at BV, appear often unaware of the content of the written information in their possession.

6.3 A 'GOLD STANDARD' FOR INDUCTION

A separate document of the above title can be found in Appendix 20.

The 'Gold Standard' has been compiled as part of the project, in response to the need for greater quality and standardisation across the inductions provided for trainee medical staff in the North West Region. It brings together results from the project's own trialled changes to induction' programmes and material; its consultations with trainees, hospital staff and patients; and the observations made of trainees.

Consideration has been given to recommendations made by the University of Manchester's Department of Postgraduate Medicine & Dentistry, the General medical Council and other relevant bodies, as well as published research literature. Furthermore, best practice in the induction' programmes of Trusts throughout the region was identified and used, via details provided to the project by Trusts themselves.

The document sets out recommendations for 'essential ' and 'desirable' induction criteria, relating to both hospital and departmental / directorate programmes, along with its accompanying written material. It contains sections on 'the delivery of induction', 'educational matters', 'policies / procedures / guidelines', 'personal needs', and 'recommendations specific to the departmental / directorate induction'.

7. ANALYSIS & DISCUSSION

The focus of this project has been to improve the quality of patient care through improvement of the induction of trainee medical staff. A good induction establishes proficient levels of competency and importantly impacts upon the confidence of trainees. This subsequently reflects upon the treatment provided to patients in those trainees' care.

The results of the project are intended to provide those responsible for the provision of induction programmes, with guidance based on identified best practice. It has brought together various elements of research, recommendations and existing practice, to form suggested methods of working that can be implemented into both hospital and departmental induction' processes. It considers not only the views and expressed needs of trainee grades, but also the opinions of their colleagues, and experiences of the patients whom they treat. Practical aspects affecting induction, such as time constraints and limited resources have also been heeded.

The original plan for the project encountered problems, resulting in divergence in ways as follows:

- It had been the intention that trainees would provide information on their experiences and views through participation in individual interviews with the Project Manager, and that locum cover would be employed during their absence for these. It however transpired very early on in the project that reluctance was expected from Consultants as regards the release of trainees from duties for this task, and that employing locum cover would not be a practical solution. Thus questionnaires were instead designed and distributed at various points in the project timetable, as an alternative but possibly less effective method of obtaining information from trainees.
- Trialled changes to the 'Junior Doctors Handbook' at Stockport were unable to take place, as the production of copies for the year's duration of the project had been arranged prior to the Project Manager's uptake in post. As a result, the 'Junior Doctors Induction Supplement' was produced to contain some of the information which the project would have ideally trialled as changes to part of the Handbook.
- Generally, fulfilment of the project's aims was limited at Blackpool by difficulties in the gathering of information and implementation of change there. As previously mentioned, this was largely due to the geographical distance between Blackpool and the Project Manager's Stockport' base. This created numerous obstacles in terms of the profile of the project and communication with staff at Blackpool Victoria Hospital.
- The lack of co-operation from key staff, whilst not directly changing the project plan, has made it necessary to alter the methods by which certain aspects were addressed in order for the project's aims to be fulfilled. These staff included trainees, who were not only difficult to access, but extremely difficult to extract opinions, views and experiences from.

Despite this divergence from the original plan, all of the project's aims have been fulfilled, and it is hoped that the results will make a positive difference to the induction' training of trainee doctors and the care they provide to patients.

8. SUMMARY & CONCLUSIONS

The project concludes that inductions vary widely across departments and Trusts, and that whilst many demonstrate good standards, not all inductions score highly in all areas. There is a need for greater standardisation in the induction process, so that trainees regardless of their grade, department or Trust, can expect to receive a satisfactory level of induction at the start of each new post. There is also the necessity for increased attention to be paid to the needs of those trainees who start out of rotation, belong to the General Practice Vocational Training Scheme, are from overseas, have disabilities or other particular needs.

Overall, each directorate or Trust needs to employ methods of delivery of induction which suit and work best for them and their trainees, whilst also compliment other provisions that are made (such as a Consolidation period, and the contents of an on-going training programme). They need to cover educational matters, policies / procedures / guidelines and personal needs, as best they can within the restraints dictated by time, finance and other resources.

Trainees need to be consulted on their induction' experiences and needs, but their views affirmed by those of more experienced or senior persons before they are allowed to impact significantly upon the induction' process. Written information should to be succinct and relevant, and include that provided to all other Trust' employees. Talks should be delivered only by individual's with whom early direct contact would be of immediate benefit to trainees. Trust and departmental / directorate' programmes need to be co-ordinated, so as to both avoid repetition and enable information to be presented in whichever programme it is most suitable. Importantly, sufficient time should be devoted to local induction and its value not underestimated, with as many members of the multidisciplinary team as possible involved and trainees being given time to ask their own questions on preferably an individual or small group basis at some point.

The results from the project are to be used by Stepping Hill and Blackpool Victoria Hospitals to further improve their individual induction' processes, as well as be taken forward by the North Western Deanery's Department of Postgraduate Medical and Dental Education, to improve the standard of trainees' induction across the region.

Owing to the wealth of issues which have arisen in relation to the on-going training and support needs of trainees during the course of the 'Junior Doctors Induction Initiative', a subsequent project has been established to consider these. This will again run for a twelve-month period supported by the North West Deanery's 'Blending Service With Training' Initiative, from the same base at Stepping Hill Hospital, but will involve Stockport NHS Trust alone.

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GLOSSARY OF TERMS / KEY TO ABBREVIATIONS

Advanced Life Saving (ALS) Course

A course undertaken by trainee medical staff and others. It provides training in emergency procedures in which the basic life support efforts of cardiopulmonary resuscitation are increased by establishment of such as an intravenous fluid line, possible defibrillation, drug administration, control of cardiac rhythms, and use of ventilation equipment.

Cardiopulmonary Resuscitation (CPR)

A basic emergency procedure for life support, consisting of artificial respiration and manual external cardiac massage. It is used in cases of cardiac arrest to establish effective circulation and ventilation in order to prevent irreversible cerebral damage resulting from oxygen deprivation.

Blackpool Victoria Hospital (BV)

British National Formulary (BNF)

This is a reference book for doctors and pharmacists, containing information about all aspects of medicines, such as their uses, doses, side-effects, contra-indications and interactions, as well as the dosage forms available and costs. It also provides information about writing prescriptions and aspects of labelling requirements for medicines and offers guidance on prescribing in a variety of areas.

Community Practice Nurse (CPN)

A nurse working within community settings, to conduct preventative, curative, and rehabilitative practice.

Departmental / directorate / local induction programme

The programme of induction which takes place within the specialty in which a trainee doctor is to work. It covers information that is only applicable to trainees within that specialty specifically.

General Medical Council (GMC)

The General Medical Council protects the public by setting standards for professional practice, overseeing medical education, keeping a register of qualified doctors and taking action when a doctor's fitness to practise is in doubt.

General Practitioner Vocational Training Scheme (GPVTS)

A programme of vocational training consisting of 'prescribed experience' which provides doctors in the UK with the skills, knowledge and competencies necessary to work in general practice and meet the needs of NHS patients. It has a minimum duration of 3 years (or equivalent), during which at least 1 year must be spent as a HO in a hospital post and 1 year as a Registrar in general practice.

Hospital induction programme

The programme of induction which in the case of trainee medical staff usually takes place in the hospital's Postgraduate Education Centre or equivalent. It covers information that is generally applicable to all trainee, regardless of the specialty in which they are employed to work.

Methicillin-Resistant Staphylococcus Aureus (MRSA)

An antibiotic-resistant bacterium that is prevalent in hospitals amongst vulnerable and debilitated patients, causing symptoms such as wound and skin infections, urinary tract infections, pneumonia and 'blood poisoning'.

Overseas Clinical Examination (OSCE)**Pre-Registration House Officer (PRHO or HO)**

A person with a medical degree who is in their first year of postgraduate training. They are employed by a hospital to provide services to patients whilst receiving training. The year can take the form of 6 months in medicine and 6 months in surgery, or 4 months in medicine, 4 in surgery, and 4 in another specialty.

Senior House Officer (SHO)

A trainee doctor who has completed their term as a PRHO.

Specialist Registrar (SpReg)

A trainee doctor who has completed their term as an SHO.

Stepping Hill Hospital (SH)**The Standing Committee on Postgraduate Medical and Dental Education (SCOPME)**

This was set up in August 1988 and was concerned with postgraduate and continuing medical and dental education in England. However, as the result of a ministerial decision, SCOPME was disbanded at the end of March 1999. Its aims included to advise the Secretary of State on the delivery of postgraduate and continuing medical and dental education, and to identify problems and develop solutions in consultation with relevant parties.

APPENDICES

**STOCKPORT POSTGRADUATE MEDICAL EDUCATION CENTRE,
STEPPING HILL HOSPITAL**

PRE-REGISTRATION HOUSE OFFICER INDUCTION PROGRAMME

Tuesday 1st August 2000

8.30 am	Registration & Coffee
8.45 am	Welcome & Introduction Dr I K Mecrow, Postgraduate Clinical Tutor
9.00 am	Skills Laboratory Workshop <ul style="list-style-type: none">•blood gases•venepuncture•cannulation•male catheterisation
11.00 am	Coffee
11.15 am	Introduction to Clinical Services offered by Pathology <ul style="list-style-type: none">•blood transfusion•microbiology•biochemistry•histopathology•haematology•cytology•immunology•introduction to staff•how specimens are processed•important issues regarding requests and bottles•infection control
12.30 pm	Lunch
1.15 pm	Visit to the Wards
2.45 pm	Coffee
3.00 pm	Resuscitation Workshop (this workshop is for those House Officers who did not attend the Consolidation Period Resuscitation Course)
5.00 pm	Close

**STOCKPORT POSTGRADUATE MEDICAL EDUCATION CENTRE,
STEPPING HILL HOSPITAL**

INDUCTION PROGRAMME FOR NEW MEDICAL STAFF

Wednesday 2nd August 2000

8.30 am	Coffee & Registration
9.00 am	Dr C Burke, Chief Executive, Stockport NHS Trust
9.05 am	Welcome / Introduction by Dr Ian Mecrow, Postgraduate Clinical Tutor
9.25 am	Dr S Remington, Medical Director
9.35 am	Dr M Taylor, Consultant Microbiologist
9.45 am	Mrs M Beecroft, Pharmacist
9.55am	Dr D Menzies, Consultant in Occupational Health Medicine
10.05 am	Dr S Mehta, Consultant Radiologist
10.15 am	Ms C Sparkes, Clinical Risk Manager
10.25 am	Mrs J Jorgensen, Senior Bed Manager
10.35 am	Coffee break
10.55 am	Mrs S Hope, IT Services Manager - Data security Mr G Tonks, Pathology Laboratory Manager - Pathology Results
Service	
11.05 am	Dr R Gill, Local Medical Committee Representative
11.20 am	Mr Dave Hartle, Fire Officer
11.30 am	Mrs M Arnold, Personnel Officer
11.40 am	George Davies & Co, Trust Solicitors
12.30 pm	Departmental Lunches in Pinewood House

HEALTH PROFESSIONALS' EDUCATION CENTRE, BLACKPOOL VICTORIA HOSPITAL

PRHO DAY 1 INDUCTION

1st August 2000

8.30 am	Welcome Breakfast	The MDU Rep will be in attendance together with the Bayer Rep
9.00 am	The PRHO Year Appraisal mentoring	Dr P Isaacs, Clinical Tutor
	Log Books & RITA Forms	Mrs Hilary Booth, Education Centre Manager
9.40 am Manager	Library Services	Mr John Rule, Library Services
10.00 am	Resuscitation Training Information	Mrs G Noblett, Resus Training Officer
10.30 am	Coffee	
10.45 am	Consent & Treating Patients Against their Wishes	Dr R Gulati, Consultant, Care of the Elderly
	Good Notekeeping	As above
11.40 am	Complaints	Mrs A Grainger, Complaints Manager
12.10 pm	Death Certification Meet Coroner's Staff	Dr K S Vasudev, Consultant Histopathologist
12.45 pm	Lunch. The new House Officers will be joined by junior doctors' rep's. Payroll staff will be present. Security photographs.	
1.45pm	Common Prescribing Errors	N Walters, Senior Pharmacist
2.30 pm	Clinical Governance	Mrs R Anderson, Clinical Risk Manager
3.30 pm	What your Consultant will expect from you; What you can expect from him / her. & How good Hos deliver good pre & post operative care to surgical patients.	Mr M Lambert, Consultant Surgeon
4.30 pm	Close	

**HEALTH PROFESSIONALS' EDUCATION CENTRE, BLACKPOOL VICTORIA
HOSPITAL**

PROGRAMME FOR THE GENERIC DAY 1 INDUCTION OF SHOs & SpRs

2nd August 2000

9.00 am	To your Directorates for your Induction Programmes	
4.00 pm	Return to the Education Centre	
	Welcome	Dr P E T Isaacs, Clinical Tutor
	Study Leave	Mrs Hilary Booth, Education Centre Manager
	How to get the best from the Education Centre Library	Mr John Rule, Library Services Manager
4.45 pm	Medical Staffing Issues	Mrs Sylvia Watson, Medical Staffing Officer
5.00 pm	Payroll	
5.15 pm	Resuscitation Training Info	Mrs G Noblett, RSO
5.30 pm	Fire Regulations	

**PRE-AUGUST 2000 INDUCTION' QUESTIONNAIRE FOR ALL TRAINEE GRADES
(STEPPING HILL & BLACKPOOL VICTORIA)**



Improving Junior Doctor Induction Questionnaire



Stockport's Stepping Hill & Blackpool Victoria Hospitals have been successful in together gaining funds under the "Blending Service with Training" initiative provided by the Postgraduate Deanery, which are being used to run an **"IMPROVING JUNIOR DOCTORS' INDUCTION INITIATIVE"**.

As part of the project we are looking to consider trainee doctors' experiences of induction, so that at the start of placements:

- 1.) *You are provided with only the most useful and necessary information.*
- 2.) *Your integration into hospital systems can be smoother & more effective.*

**So please take the time to complete this questionnaire
thoroughly, as what you tell us will be vital to the project.**

(It should take approximately 20 minutes)



FOR MORE INFORMATION CONTACT: Catherine Smith, Project Manager
Via the Health Professionals' Centre, Blackpool Victoria (ext. 3566)
or the Training Department, Stepping Hill Hospital, Stockport (0161-419-5738)

Grade _____

Directorate _____ / Department _____

Date began work at this hospital _____

Length of time at others hospitals previously _____

Firstly, could you briefly tell me about any induction you have received in relation to your training, prior to the induction received here in FEBRUARY?

(E.g. *When & where did you receive them?*

What did they comprise of?

How long did they last?)

SECTION A: GENERAL HOSPITAL INDUCTION

(N.B. This is what you received through the EDUCATION CENTRE as opposed to in **your individual directorate / department**, which you will be asked about later)

- 1) Could you tell me WHAT you found particularly useful in the Induction you received here in FEBRUARY through the Education Centre?

WHY?

- 2) WHAT do you think was lacking in that induction process i.e. HOW do you feel it could have been improved?

WHY?

- 3) How would you rate the length of time spent on your induction in February in the EducationCentre?

More than sufficient

Sufficient

Insufficient

4) What did you think of the Information Pack given to you by the Education Centre as part of your induction?

(a) Was it too big ? Too small? Just the right size?

WHY?

(b) WHAT was and wasn't useful in it?

WHY?

(c) Was there anything you think would have been useful to have included in it, that wasn't there?

WHY?

(d) What percentage of it would you say you have actually used or read to date? ____%

What percentage of it would you say you use each day whilst on duty? ____%

& WHEN / WHY did you last use it?

(e) Overall, how would you rate the Information Pack from the Education Centre?

Excellent? Good? Adequate? Poor? Inadequate? Other?

SECTION B: DIRECTORATE/DEPARTMENT INDUCTION

- 5) Could you tell me WHAT you found particularly useful in the induction you received here in FEBRUARY through your directorate / department?

WHY?

- 6) WHAT do you think was lacking in that induction process i.e. HOW do you feel it could have been improved?

WHY?

- 7) How would you rate the length of time spent on your induction in February in your directorate / department?

More than sufficient

Sufficient

Insufficient

- 8) Were you given an information pack by your
directorate? - *See the questions below*
department? - *See the questions below*
neither? - *Proceed to question 9*

- (a) Was it too big? Too small? Just the right size?

WHY?

(b) WHAT was and wasn't useful in it?

WHY?

(c) Was there anything you think would have been useful to have included in it, that wasn't there?

WHY?

(d) What percentage of it would you say you have actually read or used to date? ____%

What percentage of it would you say you use each day whilst on duty? ____%

& WHEN / WHY did you last use it?

(e) Overall, how would you rate your Directorate / Departmental Induction Pack?

Excellent? Good? Adequate? Poor? Inadequate? Other?

SECTION C: FURTHER QUESTIONS

9) Would you have welcomed receiving more information prior to induction (i.e. before the start of your post)?

No

Yes - WHAT information in particular?

WHY?

10) If you think back to February and the initial stages of your current placement, how well would you say you had been equipped for immediate work with patients in this hospital, by:

(a) the main EDUCATION CENTRE induction?

As well as was possible	Quite Well	To an acceptable level	Not too well	Not well at all	Other
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WHY?

(b) the DIRECTORATE / DEPARTMENTAL induction?

As well as was possible	Quite Well	To an acceptable level	Not too well	Not well at all	Other
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WHY?

11) HOW did you feel overall about starting work after the induction period?
(please tick more than one box if necessary)

Confident

Anxious

Indifferent

Other - *Please describe*

WHY?

- 12)** Since your induction period, WHAT has been your biggest problem in
- delivering patient care
 - or - education and training
 - or - both?

- 13)** Was there anything more which could have been added in the following areas, which would have made you more confident?

(a) Skills training - Which areas?

(b) Knowledge - What?

(c) Experience - What?

Thankyou for completing this questionnaire.

“JUNIOR DOCTORS’ INDUCTION” EVALUATION SHEET (STEPPING HILL)

Medical Education Centre - Tuesday 1st August, 2000

As we are currently trying to improve the induction received by trainee doctors at Stepping Hill, we would be grateful if you could provide us with feedback on today.

Grade _____

Directorate _____ / Department _____

Please rate the usefulness of the following on a scale of 1 to 5, where:

1 = Not at all useful

2 = Of some limited use

3 = Quite useful

4 = Very useful

5 = Extremely useful

1 2 3 4 5

A. Talk by Dr. Ian Mecrow, Postgraduate Clinical Tutor

Which aspects were particularly useful or not? WHY?

1 2 3 4 5

B. Skills Laboratory Workshop overall

Which aspects were particularly useful or not? WHY?

1 2 3 4 5

C. Introduction to Clinical Services offered by Pathology

Which aspects were particularly useful or not? WHY?

1 2 3 4 5

D. Visit to the wards

Which aspects were particularly useful or not? WHY?

1 2 3 4 5

E. WRITTEN INFORMATION RECEIVED overall

What of the written information do you think you will find the most useful? WHY?

F. What parts of the day have been most useful to you? WHY?

G. What would you have liked to have seen done differently? WHY?

H. How prepared for beginning work here do you now feel? Please rate on a scale of 1 to 10, where 1 = Not at all ready and 10 = Completely prepared.

1 2 3 4 5 6 7 8 9 10

WHY?

“JUNIOR DOCTORS’ INDUCTION” EVALUATION SHEET (STEPPING HILL)

Medical Education Centre - Wednesday 2nd August, 2000

As we are currently trying to improve the induction received by trainee doctors at Stepping Hill, we would be grateful if you could provide us with feedback on today.

Grade _____

Directorate _____ / Department _____

Please rate the usefulness of the following on a scale of 1 to 5, where:

1 = Not at all useful

2 = Of some limited use

3 = Quite useful

4 = Very useful

5 = Extremely useful

1 2 3 4 5

A. Talks by:

Dr. Chris Burke, Chief Executive

Dr. Ian Mecrow, Postgraduate Clinical Tutor

Dr. Shirley Remington, Medical Director

Dr. M. Taylor, Consultant Microbiologist

Michelle Beecroft, Pharmacist

Dr. Donald Menzies, Consultant in Occupational Health

Dr. S. Mehta, Consultant Radiologist

Carole Sparks, Clinical Risk Manager

J. Jorgensen, Senior Bed Manager

G. Tonks, Pathology Laboratory Manager

Dr. R. Gill, Local Medical Committee Representative

Dave Hartle, Fire Officer

Margaret Arnold, Personnel Officer

Julie Hesketh, Trust Solicitors

1 2 3 4 5

B. WRITTEN INFORMATION RECEIVED overall

What of the written information do you think you will find the most useful? WHY?

C. What parts of the day have been most useful to you? WHY?

D. What would you have liked to have seen done differently? WHY?

E. How prepared for beginning work here do you now feel? Please rate on a scale of 1 to 10, where 1 = Not at all ready and 10 = Completely prepared.

1 2 3 4 5 6 7 8 9 10

WHY?

YES NO

F. Did you attend the house officers' buffet last night?

If yes: **1 2 3 4 5**

How useful did you find it as a team building activity?

Comments:

1 2 3 4 5

How useful have you found it in providing you with a support network, with which to start your new post?

Comments:

“JUNIOR DOCTOR’S INDUCTION” EVALUATION (STEPPING HILL)
- SUMMARY OF RESULTS

DAY 1 - HO's:

Total responses = 15

Specialty:

General Surgery	= 5
Urology	= 2
General Medicine	= 1
Cardiology	= 3
Diabetes & Endocrinology	= 2
Care of the Elderly	= 1
GPVTS	= 1



RESPONDENTS WERE ASKED TO, "Please rate the usefulness of the following on a scale of 1 to 5, where:

- 1 = Not at all useful
- 2 = Of some limited use
- 3 = Quite useful
- 4 = Very useful
- 5 = Extremely useful"

RESULTING AVERAGE RATING OF:

<u>A.</u> Talk by Dr. Ian Mecrow, Postgraduate Clinical Tutor	= 3.4
<u>B.</u> Skills Laboratory Workshop overall	= 4.1
<u>C.</u> Introduction to Clinical Services offered by Pathology	= 3.5
<u>D.</u> Visit to the wards	= 3.9
<u>E.</u> Written information received overall	= 3.5



RESPONDENTS WERE ASKED AS REGARDS THE ITEMS RATED, "Which aspects were particularly useful or not?"

ANSWERS TO:

A. Talk by Dr. Ian Mecrow, Postgraduate Clinical Tutor

(the numbers shown in brackets represent the rate each respondent gave this item)

(3) "Explanation about Clinical / Educational Supervisors."

(3) "Educational contract."

(4) "RITA / Meeting with supervisors."

(3) "Useful to answer questions, otherwise short."

(3) "Repeated on next day."

B. Skills Laboratory Workshop overall

(the numbers shown in brackets represent the rate each respondent gave this item)

(4) "All very good."

(4) "All - good revision after holidays."

(4) "Good to have opportunity to refresh before starting work."

(4) "Central line - less useful - quite overwhelming on first day. Other stations - very useful."

(3) "Venepuncture / cannulation."

(4) "I don't think we need to be taught venepuncture at this stage."

(5) "More venflon practice."

(5) "Some useful tips given."

(5) "Just a good overall recap with some good hints to make procedures easier."

(2) "Have done most things before - would have been more useful in Consolidation."

C. Introduction to Clinical Services offered by Pathology

(the numbers shown in brackets represent the rate each respondent gave this item)

(4) "Now we know what happens to all those bottles!"

(4) "Would not otherwise see labs + staff were friendly."

(5) "Nice to know when people are available to talk to and services available."

(4) "Useful to see around department. All tips they gave were also useful."

(3) "Information about cross-matching, amounts of blood required in a tube, specific tests performed in Stockport."

(4) "Information about out-of-hours services."

(3) "Useful - opening times, services available etc. Not - tour of all pathology labs."

(3) "Useful to know set up. Bit too much on what is done."

(2) "Some aspects i.e. which machines do which job, totally useless!"

D. Visit to the wards

(the numbers shown in brackets represent the rate each respondent gave this item)

(3) "Got to know patients."

(4) "I got to find out about the patients under my care."

(5) "Good to have patient hand-over."

(5) "Knowing my patients and how to continue to care for them."

(4) "Good revision - knew ward already but no harm going back!"

(5) "Did ward round as HO left."

(2) "HO had very little time to tell me about his patients. - There was no written hand-over."

(-) "Didn't have - HO away. But met with Nurse Practitioner and spoke to other

- HO's, which was useful."
- (3) "Talking to pre-existing HO. Unfortunately I was unable to shadow the current HO - he was on nights."
 - (2) "No - HO on holiday. Already spent 3 weeks on ward in June."
 - (5) "Possibly need longer."
 - (5) "This is the first time I have been to Stepping Hill Hospital."

E. Written information received overall

(the numbers shown in brackets represent the rate each respondent gave this item)

- (4) "Good to have written, as information overload!"
- (3) "Colour of blood tubes."
- (4) "Handbook - good to have all information in one place."
- (4) "Junior Doctors' Handbook."
- (5) "Junior Doctors' Booklet."
- (2) "Not informed in advance. Accommodation poorly organised."

THE FOLLOWING QUESTIONS WERE ALSO ASKED, AND RESPONSES GAINED:



F. What parts of the day have been most useful to you? WHY?

- "All good."
- "Clinical skills."
- "Skills."
- "Skills lab., talking to HO's and Path. Lab."
- "Skills workshop."
- "Life support + skills workshop. All of it really!"
- "Resuscitation - very good teaching session."
- "Resus. Workshop."
- "Practical."
- "Speaking to the previous HO's."
- "On wards."



G. What would you have liked to have seen done differently? WHY?

- "None."
- "More information in advance."
- "Explain how to use bleep, how to bleep someone, how to make referrals, common problems on call etc."
- "Tell us exactly how to do on call and ward round, and tips by HO - one give a talk."
- "I am sorry that I did not attend the morning session, I couldn't help it."



H. How prepared for beginning work here do you now feel? Please rate on a scale of 1 to 10, where 1 = Not at all ready and 10 = Completely prepared.

RESULTING AVERAGE = 5

WHY?:

(the numbers shown in brackets represent the rate each respondent gave this item)

- (2) "Scared!"
- (5) "Still apprehensive, as I was before, but that is to be expected and today was very useful but obviously cannot tell you everything. I can think of nothing, though, that could be done in addition to what was done."
- (4) "The long break although necessary, has left my brain blank of medical knowledge."
- (4) "Long break before starting."
- (5) "I would like more information about my actual job - and its structure."
- (7) "Never been a doctor before!"
- (8) "Consolidation."
- (5) "Consolidation - brilliant."

DAY 2 - All trainee grades:**Total responses = 42****Specialty:**

General Surgery	= 5
Ophthalmology	= 2
Urology	= 3
General Medicine	= 2
Cardiology	= 3
Diabetes & Endocrinology	= 2
Care of the Elderly	= 2
Anaesthetics	= 7
Paediatrics	= 1
Psychiatry	= 2
Old Age Psychiatry	= 1
Trauma & Orthopaedics	= 2
Orthopaedics	= 1
A & E	= 3
GPVTS	= 5
Not given	= 1

Grade:

HO	= 15
SHO	= 22
SHO Clinical Fellow	= 1
SSHO	= 2
SpReg	= 2



RESPONDENTS WERE ASKED TO, "Please rate the usefulness of the following on a scale of 1 to 5, where:

- 1 = Not at all useful
- 2 = Of some limited use
- 3 = Quite useful
- 4 = Very useful
- 5 = Extremely useful"

AVERAGE RATING OF:**A. Talks by:**

	HO	SHO	SSHO	SpReg	Overall
Chief Executive	3.1	3.4	2	2	3.2
Postgraduate Clinical Tutor	3.7	4.6	3.5	3	4
Medical Director	3.4	4	3.5	3	3.6
Consultant Microbiologist	3.9	4.4	3.5	3	4
Pharmacist	4.1	4.1	3.5	3	3.9
Consultant in Occupational Health	3.2	4	4.5	3	3.6
Consultant Radiologist	3.5	4.2	4	3	3.8
Clinical Risk Manager	3.3	3.3	3	3	3.2
Senior Bed Manager	3.7	4.1	4	3	3.8
Pathology Laboratory Manager	3.7	3.7	4	4	3.7
Local Medical Committee Rep.	4.5	4.6	4	4	4.4
Fire Officer	4.3	4.4	4	3.5	4.1
Personnel Officer	3.4	3.3	4	2	3.2
Trust Solicitors	3.9	4	5	2.5	3.8

B.

	HO	SHO	SSHO	SpReg	Overall
Written information received overall	4.1	3.5	4	3.5	3.7

THE FOLLOWING QUESTIONS WERE ALSO ASKED, AND RESPONSES GAINED:

B. "What of the written information do you think you will find the most useful?
WHY?" (the numbers shown in brackets represent the rate each respondent gave this item)

HO's

- (3) "That relevant to clinical work."
- (5) "Info. from microbiology on prescribing etc."
- (4) "Pharmacy info."
- (-) "Pharmacy - important."
- (4) "Pharmacy. Telephone numbers. Path. Lab. Information."
- (-) "Antibiotics."
- (5) "Antibiotic guidelines, phone numbers. All information that is going to be useful early on and which is now easily available."
- (5) "Junior Doctors' Booklet."
- (4) "Booklet - pocket size - so can go in white coat. - Concise."
- (-) "Not read yet. Probably useful to have."
- (-) "Not read yet. Useful usually to have written information."

SHO's

- (-) "All."
- (4) "Plenty of information and contacts."
- (3) "Pharmacy info."
- (-) "Antibiotics."
- (-) "Antibiotic guidelines."
- (4) "Antibiotics policy."
- (3) "Junior Dr.'s Handbook. Details of facilities available."
- (4) "Handbook - useful phone numbers."
- (5) "Phone number list."
- (-) "I don't know as I haven't read it yet. Numbers of wards etc. + intranet info. Car parking."
- (-) "Haven't read it yet."
- (3) "I suspect most of it will remain in a pile somewhere (it usually does)."

SSHO's

- (5) "Handbook - very handy."
- (3) "Phone no.'s."

SpReg's

- (4) "Junior Doctors' Handbook - concise reference to most topics."



C. "Which parts of the day have been most useful to you? WHY?"

HO's

"Information about the Trust."

"Talks which told us about practical aspects of starting work. E.g. what services available at what time etc."

"Useful to meet everyone. Most talks were useful to some degree but particularly those such as pharmacy, radiology, microbiology, and the bed manager."

"Pharmacist. Medico-legal."

"Negligence."

"Local Medical Committee Representative was excellently presented."

"Local Medical Committee Rep. and Fire Officer."

"The interesting and relevant ones. The only item I had a problem with is the computer lecture - I think it should have been small groups, step-by-step in front of a computer."

SHO's

"All."

"All."

"First and second half. Important information."

"More practical aspects - Intranet demo. etc."

"IT."

"Computer. Drug prescribing."

"Bed Manager information."

"Get to know people."

"Meeting staff and info. provided on contacts for further information or problems."

"Postgrad. Stuff. But I can't really say I'd learnt a lot about how to get study leave sorted out."

SSHO's

"Almost everything."

SpReg's

"Most of it quite useful."



D. "What would you liked to have seen done differently? WHY?"

HO's

"Nothing."

"Nothing."

"Nothing."

"Very useful. But a lot of information already given to HO's the day before."

"Computer thing - 1 speaker better than 2, 'cos very confusing. A handout and small group tuition would be better. Also by doing consolidation, already know the basic gist of the system, which is self-explanatory."

"Less medico-legal emphasis."

"Instructions from Trust's Solicitors very long-winded."

"Is a lot to take in on one morning but I realise the time constraints and it is better than missing out talks. Also, refreshments always appreciated! The Solicitor's talk was perhaps a bit long."

SHO's

"Nothing."

"Nothing."

"Lots of repetition in different talks."

"There's a lot of stuff which could have been condensed! A lack of dynamism in most presentations."

"Dr. Remington - very negative. Bed Manager - confusing info. - how about a handout for individual specialties i.e. how many admissions per day for psychiatry. What if there is no bed when patient is seen in A & E etc.?"

"Solicitor's talk was good but inappropriate timing."

"Sorting out car parking / personnel / bleeps at same time. Hospital map in information pack."

SSHO's

"Nothing."

SpReg's

"More information on leisure facilities (we all need a healthy break to do the work better!)"



E. "How prepared for beginning work here do you now feel? Please rate on a scale of 1 to 10, where 1 = Not at all ready and 10 = Completely prepared.

	HO	SHO	SSHO	SpReg	Overall
Resulting average	5.7	6.6	7	7	6.3

WHY?:

(the numbers shown in brackets represent the rate each respondent gave this item)

HO's

(7) "Never been a doctor before!"

(5) "Consolidation."

(8) "Consolidation Period prepared us well, having already worked with them. Good having various departments speak to us on practical aspects e.g. requesting investigations."

(6) "Good Consolidation Period + HO induction."

(5) "As apprehensive as I was before but as ready as I'll ever be! The course was useful and there was nothing else that could be included that I could think of."

(7) "Not sure what on call duties are."

(8) "Feel that have been given a lot of useful info. To make the transition to starting work easier."

(5) "Still - the type of work and organisation of the ward is difficult to imagine. - I have not met any of my Consultants."

(5) "I was just being informed yesterday that I had got the job here."

SHO's

- (4) "I haven't had a rota yet + potentially am on call this evening. Still don't know about bed policy and whether I am likely to get GP calls at night or what to do with A & E referrals. Haven't had Psychiatry induction yet, hopefully this will answer more things."
- (6) "There's no substitute for getting onto the ward."
- (8) "Worked here before."
- (9) "Have already worked in the trust and in the specialty."

SSHO's

No comments

SpReg

- (7) "Enough information, although still a lot to be explored."



F. "Did you attend the HO's buffet last night?"

'Yes' = 12 (N.B. This means 12 of those at day 2 of induction attended the buffet, and not that this was the total number attending the buffet.)

Those answering 'Yes' were then asked,

"How useful did you find it as a team building activity?" (using the scale of 1 to 5)

RESULTING AVERAGE = 3.2

COMMENTS:

(the numbers shown in brackets represent the rate each respondent gave this item)

HO's

- (3) "It was good to meet other HO's."
- (5) "Nice to share concerns etc. prior to starting and to talk to some people already in post."
- (2) "Our main team building took part during consolidation period in the clinical skills period. The two new members of the group have been included by invitation to pub and chatting to yesterday."
- (3) "We all know each other pretty well already, but it's always useful when free food is available!"
- (1) "HO's already knew each other and not many SHO's turned up."
- (4) "Not many SHO's there."
- (3) "Pub better."

SHO's

- (3) "Had great potential - good idea but turnout very poor. No senior staff present at all."

SSHO's & SpReg's

No comments

& "How useful have you found it in providing you with a support network with which to start your new post?" (Using the scale of 1 to 5)

RESULTING AVERAGE = 3.3

COMMENTS:

(the numbers shown in brackets represent the rate each respondent gave this item)

HO's

(3) "Again the Consolidation Period was more instrumental in achieving this, but certainly spending time together is a very useful way to start these jobs as we all need the support."







(3) "Quite a lot of overlap with HO induction."

SHO's, SSHO's & SpReg's










No comments

RECOMMENDATIONS ARISING FROM THE EVALUATION OF INDUCTION

FOR HO's:

-  Possible minor review of content of Skills Laboratory Workshop.
-  Where the existing HO is unavailable during the 'ward visit', all HOs to receive patient hand over from an appropriate other, and sufficient time to be dedicated to this by staff in all cases.
-  Practical job aspects to be focused upon where possible, including by those providing talks.
-  More information on posts about to be undertaken, to be provided in advance.
-  Information to be provided on: How to use the bleep system, how to make referrals, what doing a ward round entails, what to expect from duties on call, & how to deal with common problems arising. (Possibly to be included in a talk from an existing HO.)
-  Less repetition of content received on day 2 with other grades of trainee medical staff.

FOR ALL TRAINEES:

-  Practical introduction to the hospital's computer system, in the form of small group demonstrations accompanied by a handout.
-  Continue strong emphasis on introductions to key individuals & departments via induction.
-  More concise information from Solicitor's talk.
-  Less repetition across the content of speakers' talks.
-  More dynamism in presentations.
-  More direction to where information on topics can be found in the written material given. Some information requested, was already in the literature e.g. map of hospital & bed policy.
-  Handout from Bed Mgr., to include anticipated daily admission numbers per Specialty etc.
-  Rota for at least the initial few days to be provided prior to trainee's first day.
-  More clarification for those on the GPVTS scheme on how their work is arranged e.g. are they likely to get GP calls at night?

POST-AUGUST 2000 INDUCTION QUESTIONNAIRE (STEPPING HILL)

QUESTIONNAIRE FOR ALL TRAINEE GRADES

"IMPROVING JUNIOR DOCTORS' INDUCTION INITIATIVE"

As you will be aware from your induction in August, the above is taking place at this Trust, as part of the Postgraduate Deanery's 'Blending Service With Training' Initiative.

Most of you completed Evaluation Sheets at the end of induction, but hadn't had time to either read the written material given to you as part of the programme, or use any of it as part of your new post. *Therefore we would be grateful if you would take a few minutes to complete the following. ALL ANSWERS WILL BE TREATED CONFIDENTIALLY.*

GRADE _____

DEPARTMENT _____
/DIRECTORATE _____

In answering here, please consider how often you have actually used each item *(please tick)*:

ITEM	Not at all useful	Of some limited use	Quite useful	Very useful	Extremely useful
JUNIOR DOCTORS' HANDBOOK					
INDUCTION SUPPLEMENT (<i>black ring binder</i>)					
Pharmacy - 'Pharmacy News'					
- Microbiology Guidelines					
- Managing Pain Guide					
- Local Prescribing Guidelines					
Needlestick Injury Information Card					
IT information - Data Security					
- Guidelines for using e-mail					
Phone No. Card (<i>received with bleep</i>) & Tel. Wall Charts on the wards					
Handouts FROM OWN DIRECTORATE					
TO BE ANSWERED BY HO's ONLY: Skills' Lab. Handouts					
Pathology - 'Path News'					
- Handouts from lab. Tour					

WE WOULD PARTICULARLY LIKE TO KNOW MORE ABOUT YOUR USE OF THE JUNIOR DR. HANDBOOK & INDUCTION SUPPLEMENT.

1. JUNIOR DOCTOR HANDBOOK

(a) Approximately how often have you referred to this since starting in post?

NEVER ONCE/TWICE A FEW TIMES QUITE A LOT REGULARLY

ANY COMMENTS:

(b) Having referred to it, did you find the answer you were looking for?

NEVER RARELY SOMETIMES MOSTLY ALWAYS

ANY COMMENTS:

(c) Which sections do you feel are the most valuable for it to contain? (Please tick)

(d) Which sections do you feel could be omitted? (Please mark with a cross)

	✓ x		✓ x
Accommodation		Local Information	
Bed Management Policy		MacMillan Nurse	
Cardiac Arrest Team		Mortuary Services	
Car Parking		Notifiable Diseases	
Catering		Occupational Health	
Clinical Audit Dept.		Occupational Therapy	
Clinical Risk Management		Pathology Lab. Guide	
Coroner's Office		Payroll Dept.	
Counselling		Personnel Department	
Death of a patient		Postgrad Medical Education Centre	
Diabetes Advice		Postgrad Med. & Dentistry Dept.	
Doctors' Mess		Professions Allied to Medicine	
ECG Dept.		Resuscitation Training Dept.	
Education & Training		Security	
Endoscopy / Bronchoscopy		Sickness reporting	
Fire Department		Specialty Tutors	
Health & Safety		Stockport & Local Services	
Hospital sites' locations		Study leave	
Leave arrangements		Telephone System	
Library			

(e) Is there any other information which you feel the Handbook would benefit from containing, which is not included at present?

TYPE OF INFORMATION	WHY?
_____	⇔ _____
_____	⇔ _____
_____	⇔ _____
_____	⇔ _____
_____	⇔ _____
_____	⇔ _____

2. INDUCTION SUPPLEMENT

(a) Approximately how often have you referred to this since starting in post?

NEVER ONCE/TWICE A FEW TIMES QUITE A LOT REGULARLY

ANY COMMENTS:

(b) Having referred to it, did you find the answer you were looking for?

NEVER RARELY SOMETIMES MOSTLY ALWAYS

ANY COMMENTS:

(c) Which sections do you feel were most valuable for it to contain? (Please tick)

(d) Which sections do you feel could be omitted? (Please mark with a cross)

✓✗

Local Information Directory

Telephones & Bleeps

Documentation

Computer Services

-Including application form for login ID

Staff Problems

Car Parking

-Including application form for parking permit

(e) Is there any other information which you feel the Supplement would benefit from containing, which is not included at present?

TYPE OF INFORMATION	WHY?
_____	⇒ _____
_____	⇒ _____
_____	⇒ _____
_____	⇒ _____
_____	⇒ _____
_____	⇒ _____

ADDITIONALLY:

During the last few weeks since you started in post, how useful have you found the following induction events to have been? *(please tick)*:

EVENT	Not at all useful	Of some limited use	Quite useful	Very useful	Extremely useful
A. THE DIRECTORATE LUNCH - As a team building activity					
- In providing a support network, with which to start your new post?					
ATTENDEES TO ANSWER ONLY:					
B. THE TUESDAY EVENING BUFFET - As a team building activity					
- In providing a support network, with which to start your new post?					

ANY COMMENTS?

ON-GOING TRAINING NEEDS

There are aspects of induction which you may feel it more appropriate to have been conveyed to you at a later date.

There are also probably many things over the last few weeks, which you wish you had been prepared better for by training.

*WITH THIS IN MIND, PLEASE LOOK AT THE
FOLLOWING QUESTIONS:*

1.) Please give examples of skills, knowledge & responsibilities expected of you since beginning in August, which you have felt insufficiently prepared to practice:

e.g.i _____

e.g.ii _____

e.g.iii _____

e.g.iv _____

e.g.v _____

2.) In what ways have you been in need of support so far, practically, mentally and emotionally? Did you manage to obtain this support & if so, from whom?

3.) As you are aware, at present trainee medical staff are given large quantities of information to process at the start of placements. We feel this would be better used if it were to be delivered closer to the times at which you actually employ it in patient care.

With this in mind, what training would you have welcomed at which points over the last few weeks?

WEEK 1: Training event(s) _____

WEEK 2: Training event(s) _____

WEEK 3: Training event(s) _____

WEEK 4: Training event(s) _____

WEEK 5: Training event(s) _____

WEEK 6: Training event(s) _____

WEEK 7: Training event(s) _____

WEEK 8: Training event(s) _____

WEEK 9: Training event(s) _____

WEEK 10: Training event(s) _____

4.) Have there been any times when you have felt confused over either your own role & responsibilities, or those of other members of the multidisciplinary team?

No

Yes When? _____

Thank you for completing this questionnaire.

POST-AUGUST 2000 INDUCTION' QUESTIONNAIRE (BLACKPOOL VICTORIA)

QUESTIONNAIRE FOR HOUSE OFFICERS

Dear House Officer,

As you may already be aware, Stockport's Stepping Hill & Blackpool Victoria Hospitals have been successful in together gaining funds under the "Blending Service with Training" initiative provided by the Postgraduate Deanery, which are being used to run an **"IMPROVING JUNIOR DOCTORS' INDUCTION INITIATIVE"**.

As part of the project we are looking to consider your experience of, and opinion on induction. This will hopefully make things easier for trainees in the future, so that at the start of placements:

- 1.) *You are provided with only the most useful and necessary information.*
- 2.) *Your integration into hospital systems can be smoother and more effective.*

So please take a few minutes to complete this questionnaire,
as your response is vital to the project.

If you would like anymore information on the project, I can be contacted on 0161-419-5738.

Many thanks,

Catherine Smith
Project Manager.

Directorate _____ / Department _____

SHADOWING INDUCTION: Since starting in post, please rate how useful the following aspects of the Consolidation Programme you attended, have proved to be: (please tick)

DATE	TOPIC / EVENT	Not at all useful	Of some limited use	Quite useful	Very useful	Extremely useful
Tues 30th May	Rotas, Holidays					
	Fire Lecture					
	Health & Safety					
	Resuscitation Questionnaire					
	Lunch with Junior Dr. Rep's					
	BMA Rep, & Mess President					
Fri 2nd June	Tutorial - Fracture Interpretation					
Tues 6 th June	Visit to the Pathology Lab.					
Weds 7th June	Mini ALS Course					
Fri 9th June	Tutorial - Critical Appraisal Skills					
	CAST Workshop					
Tues 13th June	Visit to Radiology Dept.					
Thurs 15th June	Visit to the Hospice					
	Aspects of Pain					
	Nausea & Vomiting					
	Breaking Bad News					
	Terminal Restlessness					
Fri 16th June	Tutorial - Chest X-Rays					
Fri 23rd June	Haemorrhage					

DAY 1 AUGUST INDUCTION: Since starting in post, please rate how useful the following aspects of the Induction you attended on the 1st August, have proved to be: *(please tick)*

TOPIC / EVENT	SPEAKER	Not at all useful	Of some ltd use	Quite useful	Very useful	Extremely useful
The PRHO Year Appraisal Mentoring	Dr. Peter Isaacs, Clinical Tutor					
Log Books & RITA Forms	Hilary Booth, Ed'n Centre Mgr					
Library Services	John Rule, Library Mgr					
Resus. Information Training	Mrs. G. Noblett, Resuscitation Officer					
Consent & Treating Patients Against Their Wishes	Dr. R. Gulati, Cons., Elderly					
Good Notekeeping	Dr. R. Gulati, Cons., Elderly					
Complaints	Mrs. A. Grainger, Complaints Mgr					
Death Certification / Meet the Coroner's Staff	Dr. Vasudev, Cons. Histopathologist					
Meeting Junior Dr. Reps at LUNCH	-----					
Meeting payroll at LUNCH	-----					
Taking security photos at LUNCH	-----					
Common Prescribing Errors	N. Walters, Senior Pharmacist					
Clinical Governance	Rose Anderson, Clinical Risk Mgr					
What your Consultant will expect from you: What you can expect from them	Mr. M. Lambert, Consultant Surgeon					
How HO's deliver good pre & post operative care to surgical patients	Mr. M. Lambert, Consultant Surgeon					

WRITTEN MATERIAL: Since starting in post, please rate how useful the following material received through both the Consolidation & Induction Programmes, have proved to be. In answering, please consider how often you have actually used each item: *(please tick)*

ITEM	Not at all useful	Of some limited use	Quite useful	Very useful	Extremely useful
Junior Doctors' Handbook					
MDU publications					
The New Doctor' GMC booklet <i>(orange)</i>					
Library handout					
Radiology booklet <i>(red)</i>					

WE'D PARTICULARLY LIKE TO KNOW MORE ABOUT YOUR USE OF THE JUNIOR DOCTOR HANDBOOK.

1) Approximately how often have you referred to it since starting in post?

NEVER ONCE/TWICE A FEW TIMES QUITE A LOT
REGULARLY

ANY COMMENTS:

2) Having referred to it, did you find the answer you were looking for?

NEVER RARELY SOMETIMES MOSTLY ALWAYS

ANY COMMENTS:

- 3) Which sections do you feel are the most valuable for it to contain? (Please tick)
 4) Which sections do you feel could be omitted? (Please mark with a cross)

✓✗	✓✗
Admissions Policy	Library Site Map
Appraisal	Notifiable Diseases
Car Parking	Pathology
Catering	Pharmaceutical Services
Chaperoning	Policies & Procedures
Complaints	Security
Death of a Patient	Social Activities
Directorate' Staff & Services	Theatre Dress Code
Duty Rota	Training Record
Educational Supervision	Trust information
Health Professionals' Centre	Useful 'Phone No.'s
Health & Safety	Wards & Dept's
Leave	Other _____

- 5) Is there any other information which you feel the Handbook would benefit from containing, which is not included at present?

TYPE OF INFORMATION	WHY?
_____ ⇨	_____
_____ ⇨	_____
_____ ⇨	_____
_____ ⇨	_____
_____ ⇨	_____

Thank you for completing this questionnaire.

POST-AUGUST 2000 INDUCTION' QUESTIONNAIRE (BLACKPOOL VICTORIA)
QUESTIONNAIRE FOR SENIOR HOUSE OFFICERS & SPECIALIST REGISTRARS

Dear SHO / SpR,

As you may already be aware, Stockport's Stepping Hill & Blackpool Victoria Hospitals have been successful in together gaining funds under the "Blending Service with Training" initiative provided by the Postgraduate Deanery, which are being used to run an **"IMPROVING JUNIOR DOCTORS' INDUCTION INITIATIVE"**.

As part of the project we are looking to consider your experience of, and opinion on induction. This will hopefully make things easier for trainees in the future, so that at the start of placements:

- 1.) *You are provided with only the most useful and necessary information.*
- 2.) *Your integration into hospital systems can be smoother and more effective.*

So please take a few minutes to complete this questionnaire,
as your response is vital to the project.

If you would like anymore information on the project, I can be contacted on 0161-419-5738.

Many thanks,

Catherine Smith
Project Manager.

Directorate _____ / Department _____

DAY 1 AUGUST INDUCTION:

Since starting in post, please rate how useful the following aspects of the Induction you attended on the 1st August, have proved to be: *(please tick)*

TOPIC / EVENT	SPEAKER	Not at all useful	Of some limited use	Quite useful	Very Useful	Extremely useful
Welcome	Dr. Peter Isaacs, Clinical Tutor					
Study Leave	Hilary Booth, Education Centre Manager					
Education Centre Library	John Rule, Library Services Manager					
Medical Staffing Issues	Sylvia Watson, Medical Staffing Officer					
Payroll	Carole Copeland, Deputy Payroll Manager					
Resus. Information Training	Mrs. G. Noblett, Resuscitation Training Officer					
Fire Regulations	Deputy Fire Officer					

WE'D PARTICULARLY LIKE TO KNOW MORE ABOUT YOUR SEPARATE DIRECTORATE INDUCTION.

TOPIC / EVENT	SPEAKER	Not at all useful	Of some limited use	Quite useful	Very useful	Extremely useful
Separate Directorate Induction						

1)

What was most useful about it?

WHY?

_____	⇒	_____
_____	⇒	_____
_____	⇒	_____
_____	⇒	_____
_____	⇒	_____

2)

What do you think could have been done better / it was lacking?

WHY?

_____	⇒	_____
_____	⇒	_____
_____	⇒	_____
_____	⇒	_____
_____	⇒	_____

WRITTEN MATERIAL:

Since starting in post, please rate how useful the following material received through both the Consolidation & Induction Programmes, have proved to be. In answering, please consider how often you have actually referred to / used each item: (please tick)

ITEM	Not at all useful	Of some limited use	Quite useful	Very useful	Extremely useful
Junior Doctors' Handbook					
MDU publications					
The Early Years' GMC booklet (<i>green</i>)					
Library handout					
Radiology booklet (<i>red</i>)					

WE'D PARTICULARLY LIKE TO KNOW MORE ABOUT YOUR USE OF THE JUNIOR DOCTOR HANDBOOK.

1) Approximately how often have you referred to it since starting in post?

NEVER ONCE/TWICE A FEW TIMES QUITE A LOT
REGULARLY

ANY COMMENTS:

2) Having referred to it, did you find the answer you were looking for?

NEVER RARELY SOMETIMES MOSTLY ALWAYS

ANY COMMENTS:

3) Which sections do you feel are the most valuable for it to contain? (Please tick)

4) Which sections do you feel could be omitted? (Please mark with a cross)

Admissions Policy	✓✗	Library Site Map	✓✗
Appraisal		Notifiable Diseases	
Car Parking		Pathology	
Catering		Pharmaceutical Services	
Chaperoning		Policies & Procedures	
Complaints		Security	
Death of a Patient		Social Activities	
Directorate' Staff & Services		Theatre Dress Code	
Duty Rota		Training Record	
Educational Supervision		Trust information	
Health Professionals' Centre		Useful 'Phone No.'s	
Health & Safety		Wards & Dept's	
Leave		Other _ _ _ _ _	

5) Is there any other information which you feel the Handbook would benefit from containing, which is not included at present?

TYPE OF INFORMATION		WHY?
_____	⇔	_____
_____	⇔	_____
_____	⇔	_____
_____	⇔	_____

Thank you for completing this questionnaire.

POST-AUGUST 2000' INDUCTION QUESTIONNAIRE (STEPPING HILL)

SUMMARY OF RESULTS

8 weeks following the induction of trainee doctors on 1st August 2000, the 53 who attended were invited to complete questionnaires (see appendix 1) via several Departmental Clinical Meetings in the Trust's Postgraduate Education Centre. Of **31 attending and accepting questionnaires** at these meetings, **13 returned** them with the following results:

Respondents' Specialty:

General Surgery	1
Orthopaedics	1
General Medicine	2
Chest Clinic	1
Endocrinology	1
Gastroenterology	1
Rheumatology / Rehabilitation	2
Care of the Elderly	4

Respondents' Grade:

PRHO	5
SHO	6
SpR	2

INDUCTION WRITTEN MATERIAL:

The table below illustrates how useful respondents considered the written material provided at induction to be. Responses from **PRHO's** are shown in red, **SHO's** in blue and **SpR's** in green.

ITEM	Not at all useful	Of some limited use	Quite useful	Very useful	Extremely useful	NO ANSWER GIVEN
JUNIOR DOCTORS' HANDBOOK		****	***	****		**
INDUCTION SUPPLEMENT (black ring binder)		***			*	*****
Pharmacy - 'Pharmacy News'	**	***	***			*****
- Microbiology Guidelines			***	**	*	***
- Managing Pain Guide	*		***	**		*****
- Local Prescribing Guidelines		*	*****	*		*****
Needlestick Injury Hotline Information Card	**	***	**	**		***
IT information - Data Security	*****	*			*	*****
- Guidelines for use of e-mail	****	***		*		*****
Phone No. Card (received with bleep) & Tel. Wall Charts on wards.	**	***		*	**	*****
Handouts FROM OWN DIRECTORATE		*****	*			*****
TO BE ANSWERED BY HO's ONLY: Skills' Lab. Handouts			**	**	*	
Pathology - 'Path News'		****	*	*		
- Handouts from Lab. Tour		**	**	**		

N.B. One **SpR** provided no responses here, as s/he had 'never seen' any of this material. The second **SpR** did not provide a response to 3 items here, because they had not received them either. One **SHO** who only responded to the Junior Doctors' Handbook and Microbiology Guidelines, noted that this was because they were the only items seen. Another **SHO** had only received these plus a Phone No. Card, and a 3rd **SHO** had not seen any IT or telephone number items. This is obviously a problem, particularly if the individual is new to the Trust.

- It can be seen from this table that all grades found the Microbiology, Managing Pain and Local Prescribing Guidelines to have been of the greatest use to them, alongside the Junior Doctor's Handbook. For **HO's** the handouts from the Skills Laboratory and Pathology Laboratory Tour' Handouts, were also valued. **SHO's** appreciated the Needlestick Injury

N.B. PRHO's = Red, SHO's = Blue, SpR's = Green

Information Card, which their own or others' experience has possibly taught them to appreciate by this stage in their work, and SpR's the IT information. Thus it seems that the lower the grade of trainee, the more they find written material of practical use in clinical work to be the most beneficial, and as clinical experience is developed, information on areas of work which are further detached from directly clinical aspects are welcomed.

1. The Junior Doctor Handbook specifically:

(a) When asked "Approximately how often have you referred to this since starting in post?" these responses were gained:

Frequency:	NEVER	ONCE/TWICE	A FEW TIMES	QUITE A LOT	REGULARLY	NO ANSWER
No. of juniors:	***	*****	*	**	*	

(b) When asked "Having referred to it, did you find the answer you were looking for?" these responses were gained:

Frequency:	NEVER	RARELY	SOMETIMES	MOSTLY	ALWAYS	NO ANSWER
No. of juniors:		*	***	*****		***

HO's:

► Of the 2 having used the Handbook 'once/ twice', both found the answer they were looking for 'sometimes'. One commented, "Very good as a phone directory. Out of date re: shops and services. Warfarin chart not filled out properly."

► Of the 2 referring to it 'quite a lot', 1 also only found their answer 'mostly', and the other 'sometimes'. The latter made the comment that, "List of useful no.'s is very good. Warfarin dosager needs information about dosing after starting Warfarin i.e. 5 days after beginning it."

► The 1 who used it 'regularly', again found what they were looking for 'mostly'. They commented, "Very useful, especially the part on Warfarin."

► This shows that PRHO's refer to the Handbook more frequently than other grades and that the telephone and Warfarin pages of the Handbook are particularly well used by them.

SHO's:

► The 2 SHO's who said they had 'never' used the Handbook, therefore did not answer the second question.

► Of the 3 who had referred to it 'once/twice', one 'rarely' found answers, 1 only 'sometimes' and 1 'mostly'.

► The SHO who had used it for reference 'a few times' also 'mostly' found it answered their questions.

► Therefore the Handbook is still of use at SHO level.

N.B. PRHO's = Red, SHO's = Blue, SpR's = Green

SpR's:

- ▶ 1 had 'never' used the Handbook and so therefore could not comment on how often they had found what they were looking for.
- ▶ The other SpR had referred to it 'once/twice' and 'mostly' found answers.
- ▶ This shows that even at SpR level the Handbook is referred to, but unfortunately no other conclusions can be formed here on its use from the response of only one SpR.

(c) & (d) Respondents were asked "Which sections do you feel are the most valuable for it to contain?" and "Which sections do you feel could be omitted?", to be indicated by a tick or cross respectively, at the side of each of the following Junior Dr.'s' Handbook sections:

SECTION	✓	✗	SECTION	✓	✗
Accommodation	****	**	Local Information	****	*
Bed Management Policy	****	*	MacMillan Nurse	****	
Cardiac Arrest Team	*****		Mortuary Services	***	*
Car Parking	**	***	Notifiable Diseases	****	
Catering	****	*	Occupational Health	***	*
Clinical Audit Dept.	***	***	Occupational Therapy	****	
Clinical Risk Management	***	**	Pathology Lab. Guide	***	*
Coroner's Office	****		Payroll Dept.	**	**
Counselling	***	**	Personnel Dept.	***	
Death of a patient	****		Postgrad. Medical Ed Centre	****	
Diabetes Advice	****		Postgrad. Med. & Dent. Dept.	*	***
Doctors' Mess	****	*	Professions Allied to Med.	**	**
ECG Dept.	****		Resuscitation Training Dept.	****	
Education & Training	****		Security	***	*
Endoscopy / Bronchoscopy	****		Sickness reporting	**	**
Fire Dept.	****		Specialty Tutors	****	
Health & Safety	****	*	Stockport & Local Services	*	**
Hospital sites' locations	****	*	Study leave	****	
Leave arrangements	*****		Telephone System	*****	
Library	*****				

N.B. 3 HO's, 3 SHO's and 1 SpR provided no response here.

N.B. PRHO's = Red, SHO's = Blue, SpR's = Green

‣ Overall, the sections felt most valuable in the Handbook, were Cardiac Arrest Team, Coroner's Office, Death of a Patient, Diabetes Advice, ECG Dept., Education & Training, Endoscopy / Bronchoscopy, Fire Dept., Leave Arrangements, Library and the Tel. System.

‣ Respondents most indicated that the sections on Car Parking, Clinical Audit and the Postgraduate Medicine & Dentistry Department should be omitted.

‣ The grade of respondents did not appear to effect responses to sections.

(e) Respondents were asked, "Is there any other information which you feel the Handbook would benefit from containing, which is not included at present?"

3 HO's stated:

‣ "Include pain relief etc. guidelines to minimise the amount of different pieces of paper you have to carry and eventually lose."

‣ "Small booklets relating to specifics of directorates would be better - with the medical bits of the handbook and telephone directory. The remains of the Junior Doctors' Handbook could just be used as an additional Handbook if individual doctors feel it appropriate to need to order a takeaway in all the spare time we get!"

‣ "Warfarin dosage, because there are no charts on the wards."

2. The Induction Supplement specifically:

(a) When asked "Approximately how often have you referred to this since starting in post?" these responses were gained:

Frequency:	NEVER	ONCE/TWICE	A FEW TIMES	QUITE A LOT	REGULARLY	NO ANSWER
No. of juniors:	★★★★★	★★★	★★			

(b) When asked "Having referred to it, did you find the answer you were looking for?" these responses were gained:

Frequency:	NEVER	RARELY	SOMETIMES	MOSTLY	ALWAYS	NO ANSWER
No. of juniors:			★★★	*		★★★★★

HO's:

‣ 2 HO's had 'never' referred to the Induction Supplement, and therefore provided no response to the second question.

‣ The 2 who had referred to it 'once/twice', had both found what they were looking for 'sometimes'.

‣ 1 had referred to it 'a few times', and also found their answer 'sometimes'.

N.B. PRHO's = Red, SHO's = Blue, SpR's = Green

SHO's:

- ▶ 4 SHO's had never referred to the Induction Supplement, and thus left the next question unanswered.
- ▶ 1 had used it 'once/twice' and 'sometimes' found an answer.
- ▶ 1 had used it 'a few times' and 'mostly' found the answer they required.

SpR's:

- ▶ Neither had ever used this item.
- ▶ Overall the Induction Supplement has probably been less-well used than the Handbook, as it was designed to be an item for occasional reference use and thus to be kept for example at home or in a locker, rather than carried around on a daily basis.

(c) & (d) Respondents were asked "Which sections do you feel are the most valuable for it to contain?" and "Which sections do you feel could be omitted?", to be indicated by a tick or cross respectively, at the side of each of the following Junior Dr.'s' Handbook sections:

SECTION	✓	✗	SECTION	✓	✗
Local Information Directory	***	***	Documentation	***	**
Telephones & Bleeps	*****	**	Staff Problems	***	***
Computer Services	***	**	Car Parking	*****	*
- Inc. application for login ID	***	***	-Inc. application for permit	*****	*

N.B. 1 HO, 1 SHO and 2 SpR's provided no response here.

- ▶ It would appear that again information on Telephones & Bleeps is valued highly by trainee doctors. Notably, the information on Car Parking and the provision of an application form for a staff parking permit was found to be a valuable part of the Induction supplement, but not of the Junior Doctors Handbook. This suggests that parking is possibly felt to be an inappropriate subject for the latter, &/or as is likely, it is preferable to be given an actual permit application form than told where to acquire one from, as the Handbook instructs.

(e) Respondents were asked, "Is there any other information which you feel the Handbook would benefit from containing, which is not included at present?"

1 HO's stated:

- ▶ "References to protocols would be good in the Supplement binder."

N.B. PRHO's = Red, SHO's = Blue, SpR's = Green

ADDITIONAL INDUCTION EVENTS

At the end of Day 1 (PRHO) induction, a buffet was provided in the Doctors' Mess, to which all grades of new, existing and out-going medics were invited. At the end of Day 2 (all trainees) induction separate lunches were provided for each Directorate in the Postgraduate Education Centre, at which attendance was determined by the Directorates themselves.

Respondents were asked, "During the last few weeks since you started in post, how useful have you found the following induction events to have been?"

EVENT	Not at all Useful	Of some Limited Use	Quite Useful	Very useful	Extremely Useful
A. THE DIRECTORATE LUNCH - As a team building activity	*		***	****	*
- In providing a support network, with which to start your new post?	*	*	***	**	*
ATTENDEES TO ANSWER ONLY: B. THE TUESDAY EVENING BUFFET - As a team building activity		*		**	*
- In providing a support network, with which to start your new post?	*		*	*	*

► 1 HO did not answer the question on 'the Tuesday Evening Buffet' and so is assumed not to have attended.

► 2 SHO's, and 1 SpR stated that they attended neither event, as is presumed to be the case of the remaining respondents. 1 of the SHO's also said that their Directorate 'didn't get a lunch', when in fact all did. One problem was that trainees were beginning to be bleeped during this time, possibly explaining why this individual was unaware of the lunch.

► Most seem to have found both events useful in both team building and providing a support network, the SHO's the Directorate Lunch especially.

► When invited to make comments about these events, only one person responded. This was a PRHO who felt, "It would have been more useful to meet the medics properly in teams, rather than over lunch."

CONCLUSIONS:

- ▶ There needs to be closer monitor of the distribution of written induction material, to ensure that all grades both attending and missing the main August and February inductions, receive all material which would be of potential benefit to them.
- ▶ Some sections of the Junior Doctors' Handbook need to be reviewed, along with consideration given to incorporating some aspects of the Supplement into this, as oppose to producing it as a separate item.
- ▶ Continuation of the 'Additional Events' would appear to be worthwhile, especially the Directorate Lunches. Work would possibly be needed to improve attendance at anything similar to the Evening Buffet.

POST-AUGUST 2000' INDUCTION (BLACKPOOL VICTORIA)

SUMMARY OF RESULTS FROM A DISCUSSION WITH PRHOs

A discussion held as part of a PRHO Meeting at Blackpool Victoria, resulted in the following points being raised about induction by those attending:

- The shadowing undertaken by HO's in June was very useful but would have been better at a time closer to the start of the uptake of post. This is because trainees feel they do not actively attempt learning at a time when they do not know if they have passed their final exams, and therefore whether they will finally work at Blackpool and use the experience being gained via shadowing. Also, what had been learnt during shadowing had been largely forgotten by the beginning of August when their jobs started.
- The 'mini ALS' course received in June was very useful.
- It was felt that the CAST workshop in June was inappropriately timed and would be better placed at a later date.
- Clinical Governance was inappropriately placed on the day 1 induction in August, as the trainees had too many other things of greater priority to themselves in their early work, to give consideration to this. It was felt that they would attend to it better if addressed with it later.
- HO's would prefer to meet with their teams on day 1 of their post as oppose to receiving talks, as they felt they had been forgotten since shadowing on the wards and were starting with their team members from afresh.
- Protocols for basic diagnoses and treatment would be extremely welcome, especially when working at night when not as many colleagues are around to ask advice. They would help the HO's to respond to patients' needs more quickly.
- More guidance was reportedly needed on when to refer to a senior medic for assistance, as HO's were often met with bewilderment at their need for help when ringing their SHO etc. Protocols were again mentioned, as the HO's felt they would reassure them that after following such, they would be referring to a senior appropriately.
- More guidance on the prescribing of antibiotics is needed, as HO's are repeatedly being contacted by pharmacy because they have prescribed them wrongly.
- They would like an early explanation of what their jobs exactly entail e.g. what are they expected to do on wards and how do they do it? Without this, they feel as though they are acting like medical students in the very beginning, which effects their confidence.
- Many had not looked at the Junior Doctors' Handbook, and one was even unsure as to whether he had one, as he couldn't recall what it was. It appeared that the Handbook had generally not been used very much.
- The HO's were disappointed that the Handbook did not contain protocols, although also felt that a protocol booklet separate to the Handbook would be best, to enable it to be carried without the Handbook information. They felt it unnecessary to have the names of Consultants in the Handbook.

OBSERVATIONS OF TRAINEES (STEPPING HILL & BLACKPOOL VICTORIA)

- A SUMMARY OF RESULTS

This is a summary of the observation of work conducted by 8 individual trainees of varying grades and specialty, over a period of 2-4 hours each, as conducted in June 2000. It should be noted that not every point applies globally to trainees, wards, departments or both hospitals involved in the project.

Through observations, difficulties in the daily work of trainee medical staff were highlighted and classified as follows:

ORGANISATIONAL SKILLS / ATTITUDE

- One HO found he didn't have a tourniquet upon arrival at the bedside of a patient whose blood he was to take. He asked a shadowing medical student if he had one, and when he didn't either, the two of them then spent several minutes looking around the ward whilst the patient sat waiting and getting increasingly anxious about the blood test. By the time a tourniquet was eventually located, the patient had left his bed to go to the hospital shop.
- Other HOs forgot sterile wipes when attending patients in need of injections.
- When a nurse enquired as to the whereabouts of a set of keys last used by a trainee, she was informed by him that they'd 'probably' been left in the (medical?) cabinet door.
- A medical student who was shadowing a HO on a quarantined ward, following direct contact with patients, failed to wash his hands before proceeding to another ward. This fact was not realised until the other ward was about to be entered, and the student had touched numerous doors over the several minutes of his journey there.
- A HO informed another HO and medical student as to the next patient the three of them were to see, & directed them to the side room where the patient supposedly was. However, when he joined them a few minutes later, he found the patient they were examining to be the wrong one.
- Trainees were bleeped by their wards, after leaving without completing discharge summaries.
- One trainee reported enjoying 'delegating' to nurses.
- Trainees were seen arriving late on wards first thing in the morning, and them and others complaining of feeling hung-over etc.

ORIENTATION

- Trainees had difficulty in locating blood forms, as well as remembering which colour of form was needed for which procedure etc.
- Most trainees appeared to locate patients' notes with ease. There was however occasional

difficulty if someone else had had or had got them, resulting in the trainee spending a long time going backwards and forwards checking trolleys and offices for them and asking colleagues.

- Trainees sometimes had problems finding the cardex.
- There were problems locating items in the stores / medical prep. rooms. Nurses when asked for help, were able to locate things immediately.
- Nurses had to be asked where the blood gas syringes were kept on a particular ward.

PATIENT' NOTES

- Notes often fell to pieces in the trainees' hands. They were not attached together properly or in any real order, and having to go through them haphazardly to find information wasted a lot of time. Trainees who had worked in other hospitals previously, commented that this was a problem which appeared specific to Stepping Hill.
- Notes being read (but not written the trainee under observation) were seen to have been written in blue ink on occasion.
- Trainees were sometimes asked to clarify the instructions they had written for a patient's treatment, as nurses were unable to read their handwriting.

COMMUNICATION - with staff

- Nurses were often seen reminding trainees of tasks remaining to be done whilst on the ward.
- Trainees appeared good at communicating with nurses as to what they had done whilst they had been on the ward and conveying instructions for later treatment. However, this did appear to be mostly where nursing staff were going to save the trainee time returning the ward to do carry out duties themselves!
- Some HO grades were unsure about knowing when it would be appropriate to consult with their Registrar, and did not do so without first gaining reassurance from colleagues.
- One HO had failed to communicate with their SHO as to whether it had been arranged for a patient to undergo a procedure, resulting in uncertainty as to whether the patient could eat lunch or not. It subsequently emerged that nursing staff had already made enquiries to the Endoscopy Unit themselves earlier in the day, and that the patient had eaten breakfast anyway. As the HO had not even asked the patient himself whether he'd eaten, he was unaware of this.
- Several times trainees went to see a patient, only to find they had been discharged or transferred to another hospital without them knowing.
- HOs frequently attempted to carry out a task (e.g. write-up a patient's notes) only to find that it had already been done by their SHO or other colleague, without it being communicated.
- On occasion, trainees spent large amounts of time trying to locate such as a patient's x-rays, only to be told by a nurse that they had been sent elsewhere to be looked at.

COMMUNICATION - with patients

- Trainees appear good at explaining to patients what they are doing to them and why, and whether it will hurt etc. Also plans for patients' treatment, what will be done later in the day / week, and when they can go home etc. were well covered.
- However, whilst some trainees talk to patients with great empathy and understanding and display a good 'bedside manner', others are very unemotive and could easily appear detached and unfeeling to patients.

CONTACTING OTHERS

- Trainees frequently consulted colleagues for extension numbers, especially when on wards where numbers were not displayed on the wall.
- One HO had difficulty in knowing how to contact a Consultant in another department. He had to be advised by another HO to contact the Consultant's secretary via the switchboard.
- There was difficulty in knowing how to contact doctors at other hospitals. Trainees are unsure as whether to go through their own or the other hospital's switchboard, and whether they need to contact the doctor's secretary in order to get them bleeped.

MEDICATION

- Trainees (especially HOs) report finding it difficult to do discharge summaries and prescriptions for patients of whom they have no knowledge. They are aware that the pharmacy will check the prescription, but also that the discharge summary is the only information regarding a patient's treatment in hospital that their GP will receive. Therefore some HOs find it preferable that an SHO at least checks the summary, in case of omissions.
- Lack of confidence / competence in deciding on the dosages of drugs can be a problem. Trainees looked to others (other trainees especially) for reassurance that the amount being given was correct.
- A pharmacist came to inform a HO of a patient's dosage that had been wrongly prescribed by himself. The HO then required extensive guidance from the pharmacist as to what the patient should actually need, before he was able to correct it.
- Some trainees do not have a BNF handbook to help them prescribe, apparently due to the fact that there were not enough when they were distributed.
- Trainees who wear a white coat tend to carry at least their BNF in the pocket, but not their Junior Doctor Handbook. Those who don't carry a BNF, then appear to keep one / know where there is one to hand.

COMPUTER SYSTEMS

- One trainee felt more computerisation would reduce the time taken-up by form-filling.
- Some feel it would be helpful to have such as drug charts on the intranet to use.

- There is a wariness of the intranet, as information on it has been known to be wrong and subsequently removed. Such as dose charts were found confusing, as if header notes are missed because they are not in the field of the screen, it would be easy to use the wrong chart and administer an incorrect dose.

- There are problems with the hospital' computer system, as the login for each ward is different and thus difficult for trainees to remember when working on several wards.

'TEAM' ISSUES

- Trainees appear to fail to know their team very well, even 2-3 months into a placement. An example of this is a HO who remembered that he should have rang Occupational Health to inform them of the pregnancy of one of his team, but didn't even know her name before asking colleagues for "the name of that woman who's pregnant".

- Trainees can be very intimidated by their Consultants and find them extremely unapproachable. The level of comfort / discomfort at their presence appears to largely effect the learning experience, depending on how easy a trainee finds it to ask a Consultant questions.

- When in a particular specialist unit at Stepping Hill, the HO being observed obviously lacked confidence within his team, commenting "I try to stay out of the way round here, as they're all a bit high-powered". He then kept quiet whilst conducting rounds with the SPReg and allowing the SPReg to deal with patients.

OTHER ISSUES

- Trainees report needing to clearly know what they have to do and what is expected of them, particularly when they first start in post.

- Trainees reported that there was a problem with accessing information / help when working nights or on-call, thus making them less efficient.

- Trainees need to be made aware of administrative / documentation issues from the start e.g. that diagnosis sheets with blue corners are for medical patients etc.

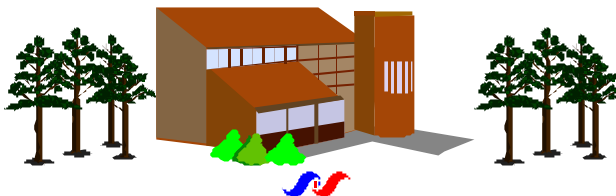
- HOs are often expected to be competent in e.g. taking blood gases at the start of their hospital work, which they may have only had experience in performing on a couple of occasions as a student, or even not at all.

- Trainees commonly needed to ask nurses who to refer patients to. In the case of a stroke the rehabilitation nurse was pointed out, who a SPReg then remembered as "some stroke woman I once met".

- Some trainees mentioned disappointment at there being only limited places on the ALS course, depriving them of the opportunity to attend. They feel in need of more CPR training.

- One trainee found his Junior Doctor Handbook sat on a desk on a ward. He hadn't attended the induction or collected his induction pack, which had thus been sent to his department months back but never even been opened.

STAFF QUESTIONNAIRE (STEPPING HILL)



STOCKPORT ACUTE SERVICES NHS TRUST

Education Centre, Pinewood House, Stepping Hill Hospital, Poplar Grove, Stockport, SK2
7JE

Telephone: 0161 419 4956 Fax: 0161 419 4694

27 January 2000

Dear Colleague

Stockport, along with Blackpool Victoria Hospital, was successful in gaining monies under the "Blending Service with Training" initiative provided by the Postgraduate Deans department.

This money will enable us to employ a project manager to develop our junior doctor induction processes and to find more effective ways of integrating juniors into our hospital and clinical systems to continually improve patient treatment and care.

The results of the project will be shared with Trusts both nationally and regionally.

To start this important project off, could you please answer the two questions overleaf and send your responses, along with any other comments you wish to make, to me at Pinewood House Education Centre.

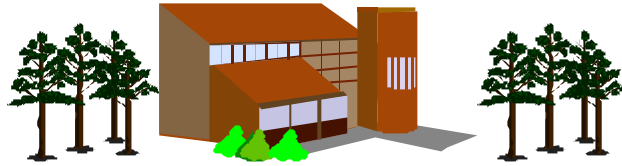
Your responses, along with patients accounts of their treatment and junior doctors experiences will be analysed by the project manager who we hope may start in March.

Thanking you in advance for your co-operation.

Best wishes,

Linda H Espey





Junior Doctor Project Analysis

- 1 From your experience what helps with integrating junior doctors into the everyday working of the hospital or clinic?**

If possible please give examples

- 2 From your experience what hinders junior doctors becoming an effective member of the clinical team sooner?**

If possible please give examples

Name
Contact Number

Department

STAFF QUESTIONNAIRE (BLACKPOOL VICTORIA)



&



Training & Development Services, Pinewood House,
Stepping Hill Hospital, Poplar Grove, Stockport. SK2 - 7JE.
Tel: (0161) 419 5802 Fax: (0161) 419 4694

10th May, 2000
5738

Direct Line: (0161) 419

Dear Colleague,

Stockport's Stepping Hill Hospital and Blackpool Victoria have been successful in together gaining funds under the "Blending Service with Training" initiative provided by the Postgraduate Deanery. These funds are being used to run an "Improving Junior Doctors' Induction Initiative" over a twelve month period, which began in March.

The aim is to find more effective ways of integrating juniors into the hospital and clinical systems to continually improve patient treatment and care, and the results of the project will be shared with Trusts both regionally and nationally.

As part of the project we are looking to consider junior doctors' experiences, and also the experiences of other staff of working with them. I would therefore be grateful if you could answer the two questions overleaf and send your responses along with any other comments you wish to make, **via internal post to myself at Blackpool's Health Professionals Centre**. A prompt reply if possible, would be greatly appreciated.

Please do not hesitate to contact me via the Health Professionals Centre at Blackpool or on the above direct line at Stockport, if you would like to know anything more about the project.

Thanking you in advance for your co-operation.

Yours Faithfully,

Catherine Smith
Project Manager

Improving Junior Doctors' Induction Initiative

- 1 From your experience, what helps with integrating junior doctors into the everyday working of the hospital or clinic?**

If possible, please give examples.

- 2 From your experience, what hinders juniors becoming an effective member of the clinical team sooner?**

If possible, please give examples.

**Name
Contact Number**

Department

SUMMARY OF RESULTS OF STAFF QUESTIONNAIRE (STEPPING HILL & BLACKPOOL VICTORIA)

The following is a summary of the main comments highlighted in the results of the questionnaire distributed to a range of staff within Stockport and Blackpool NHS Trusts, whom have contact with trainee doctors.

A summary of responses to the question:

“From your experience, what helps with integrating junior doctors into the everyday working of the hospital or clinic? If possible, please give examples.”

- Good supervision
 - trainees not being left alone as HOs or very new
 - sufficient time being directed towards trainees, by all relevant staff
- Good communication
 - trainees being told exactly when and where they are to work, & thus being provided with a written timetable
 - being told exactly what is expected of them
 - explaining to them why they are requesting a test, x-ray etc., to enable them to communicate effectively with other departments on this
- Good induction
 - which takes place as early as possible
 - is at least one day long, and when trainees are not working
 - is properly structured
 - consists of a well co-ordinated programme, covering both hospital and departmental practices
 - is tailored to the trainee and conducted by the individual Consultant at a local level
 - explains duties and responsibilities (i.e. clarifies the trainee's role) and the expected benefits of training in that post
 - has more focus on practical aspects to begin with, rather than is an immediate bombardment of clinical information e.g. especially resuscitation, control of infection etc.
 - includes risk assessment / management
 - involves nursing staff - sisters, midwives, such as bereavement support nurses etc.
- Attitudes
 - a keenness / willingness to teach / supervise on the part of SHO's, Registrars and Consultants alike
 - a willingness to learn and accept advice from staff other than the Consultant
 - trainees' acceptance that they cannot possibly know everything and thus the ability to ask for help when it is needed
 - a willingness for trainees to help each other out when one has an unusually large workload and another an unusually small
 - an interest in the Specialty, as oppose to seeing certain placements merely as a 6 month 'chore'

- Good protocols
 - in writing
 - regularly updated
 - kept brief
- Prompt inclusion of the trainee in the departmental team
 - informal introductions to all
 - knowledge of roles of all members of the department, especially for PRHOs
 - awareness of the functions of other areas within their working environment (i.e. other clinics within the main clinic)
 - uninterrupted time at very beginning, to informally ask anything they need to know
 - time with the Consultant on their first morning, to sort everything out
 - good support and tolerance from all the team, including non-clinical members eg. administrative / clerical staff
 - participation in audits
- Support
 - being provided with a focal point or person to which they have access at all times & feel comfortable with, to enable them to access help / advice whenever it is needed i.e. an approachable mentor
 - having access to a support network / 'buddy system', similar to that which exists in nursing
 - regular meetings between the trainee, Clinical Director and Directorate Manager
- Information on, and introductions to, other directorates / local hospitals / services / hospital systems they need to use outside of their own department, including through
 - the intranet / internet
 - ward links etc.
 - visits to other departments (e.g. Day Hospital, A&E, x-ray, clinics, theatres, wards, switchboard location, medical staffing, pain team, palliative care, respiratory nurses), which would provide useful knowledge and help when making referrals and providing cover
 - being made aware of, and attending, meetings and training sessions in other departments, to enable trainees to learn about and discuss a wider range of clinical matters
 - the provision of a ready prepared list of important contact numbers likely to be needed whilst in a particular department
- Prior to arrival
 - receiving introductory information to be read prior to uptake of the post, and it being presented in a more precise and clear format than the present handbook
 - all baseline information to be covered
 - a contact person be provided, who can be approached with queries prior to the start
 - a session in the department to meet staff & ask questions etc., possibly incorporated with a 'hand over' from their predecessor (and the opportunity to shadow them etc.).
 - for HOs, time out with professionals in other disciplines (e.g. physiotherapists) to provide an understanding of related health professions, facilitate the making of more appropriate referrals, and teach the value of reading other disciplines' contributions to medical notes
 - for HOs, time on the wards as a care assistant, to provide them with a good basic awareness of patient' needs and work on a ward
- Occupational Health
 - knowledge of the services on offer from the department
 - an understanding of the necessity to attend a health check prior to employment (as failing to do this has the consequence of delaying their start in post)
 - understanding the necessity to return health status questionnaires as and when requested

- Training
 - which is regular, brief and bleep-free
 - in coping strategies
 - in dealing with people
 - in assertiveness
 - in referral procedures and how to complete referral forms correctly and appropriately
 - in all aspects which would provide a steady grounding in everyday problems
 - which includes ample 'hands on' experience with patients
 - which includes Individual Performance Reviews
- Standardised office systems across departments, for ease of location of forms needed by trainee dr.'s e.g. keeping certain files in a set order & / or place on all wards, or producing an office inventory that stating where things are kept etc. Also, good information on which forms are needed for what, in the first place.
- A sense of being valued, through
 - the way they are treated by other staff
 - decent living accommodation & work facilities (consulting rooms etc.)

A summary of responses to the question:

"From your experience, what hinders junior doctors becoming an effective member of the clinical team sooner?"

- Confusion over roles and their boundaries
 - not knowing what is expected of themselves
 - not understanding the roles of other professionals with whom they work daily
 - a lack of understanding of the extended role of the nurse, which since being introduced has appeared to hinder trainees' integration into the team
 - not understanding what paperwork and administration is their own responsibility and what the ward clerk can offer support with
 - failure to understand how to operate as part of a multi-disciplinary team
- Relationships with / support from the team
 - having no organised way to meet team members - trainees often simply come across them accidentally or late in their attachment
 - lack of support from senior colleagues
 - pressure / lack of empathy from Consultants who don't understand that the trainees are usually very new and very young
 - a lack of team support on the whole
 - the need for an approachable senior supervisor (who isn't necessarily a person to whom they are answerable)
 - not knowing how to relate to other grades of staff, both above and below themselves
 - wrong / poor 'attitudes' of both trainees and other staff, towards each other
 - unwillingness of trainees to accept advice from others
 - the reluctance of trainees to ask for advice (which is probably due to the fact that they are often made to feel 'stupid' by staff across the whole range)
 - the lack of communication between trainees, and other staff and senior management
 - not being made to feel useful
 - not being given enough of their own responsibility
 - needing more support to be available for those working nights and on-call
 - a lack of awareness of CPN's (Community Practice Nurses) and others with whom they do not have daily contact. As a result, the trainee dr. often does not know how to contact them, or when it would be appropriate to do so.

- Patient' care
 - trainees need to realise that whilst they are part of a team, there is more to caring for patients than the short time spent with them on a ward round
 - trainees forget that patients are individuals with differing thoughts, values and beliefs
 - there can be a communication barrier due to the small time spent with patients
 - it can be difficult to act in a patient's best interests when they are hardly known to the dr.
 - there needs to be an increased awareness of the patient as a person as a whole, rather than carrying-out 'piece-meal procedures'
 - trainees often fail to attempt to identify problems themselves, until they are specifically asked to do so
 - there is a lack of continuity if working with emergency patients
 - an unwillingness to get involved in the management of patients
 - the fact that trainees are not involved in discharge planning enough
- Trying to adopt a 'distance learning' approach
- The lack of Individual Performance Reviews
- Poor / lack of knowledge and experience from insufficient basic training
 - in protocols e.g. colorectal and breast follow-ups
 - in treatments e.g. chemotherapy and radiotherapy
 - in clinical procedures e.g. sigmoidoscopy and fine-needle aspirations, for which they need supervision
 - in the appropriateness of sample taking and requests for tests
 - in infection control (meaning that 20% of patients develop an infection whilst in hospital)
 - in the NHS as a whole
 - the need for appropriate information and clear guidelines to be provided throughout the 'network' of staff
 - the excessive pressures of time and the ever increasing demand from all services to impact upon trainee doctors' through their training
- Lack of clinical supervision
- Lack of confidence
- Clothing
 - not adhering to protective clothing policies
 - not knowing how to obtain white coats or have them laundered
- Workload
 - which is excessive
 - which means trainees are too busy and thus stressed
 - trainees need to do more work, more often
- Insufficient time and people to simultaneously induct numerous trainees, often resulting in:
 - an overall poor induction
 - trainees having to saturate too much information in a limited period of time
 - trainees failing to read important documents distributed, due to the volume
 - insufficient orientation to the ward, due to too much of the induction time away from departmental / clinical areas
 - departments either flooding trainees with information, or giving them none and 'leaving them to their own devices'
 - delays in effective functioning
 - sensitisation to an anxious and unconfident pattern of working
 - OSCE's (Over Seas Clinical Examinations) being a problem

- Too short a period in Specialties e.g. one week in clinic, one on night duty, then one back on the ward
- Difficulty in getting used to the different routine practices in each department
- Reduced hours and the consequent cross over and partial shifts, resulting in:
 - an exacerbated lack of a sense of belonging / feelings of isolation, meaning that early personal contact with the team is particularly important
 - the breakdown of the team-type approach
 - trainee dr.'s often being off-duty when the Consultant is doing his rounds
- Not having the physical time and space to sort out their own work and study time
- Frequent absence for study leave, post-call etc.
- Personal issues with specific juniors (*means personal issues which j'r. dr.'s have themselves, or between the j'r. dr. & other staff?*)
- Not attending MDT's
- Before arrival, not knowing what to expect.

SUMMARY OF DISCUSSIONS WITH STAFF (STEPPING HILL)

Below is a summary of the key points raised from the most poignant discussions held with staff at Stepping Hill Hospital.

CLINICAL AUDIT

- All trainees need a better understanding of the documents they are required to use, so as to encourage them to attempt their completion, as well as to improve it. Many trainees, including those who write significant amounts on forms, lack the ability to identify and provide the actual clinical information needed. Thus, good information on documentation is needed at induction.
- An explanation is needed regarding use of the Integrated Care Pathways documents that are used within the Trust, plus the importance and value of their use.
- The higher grades of trainee doctor need information to improve their competency in the management of pain, especially in how to measure and evaluate pain, and in the use of basic drugs in its management.
- Supervisors need to be given more of a structure for the knowledge trainees need to possess right from the start of a post, and thus what is needed at induction.
- Induction methods that are appreciated and responded to by trainees, need to be found. Their attendance at induction and especially on-going training events is poor, even when mandatory. This suggests that they should be asked if a greater tendency towards the ward-based delivery of information, would be preferred to classroom-based.

CLINICAL DIRECTORS

- It would be better to give trainee doctors a shorter induction and concentrate on providing them with good on-going training, partly because staffing is very limited during the periods they are away receiving induction.
- Consent, form-filling, and 'dealing with bad news' all need to be addressed to a greater level, as all are significant issues.
- It is vital that specialty issues are well attended to.
- Current aspects of induction and on-going training for HOs, would be better dealt with in the final year of medical school, such as resuscitation.

CLINICAL SUPPORT SERVICES DIRECTORATE STAFF

- Basic 'people skills' need to feature at induction i.e. the importance of introducing oneself to patients, wearing an identification badge, shutting the door to give privacy when working in clinics etc.
- A visit to the Outpatients' Department would be useful for all trainee doctors.
- Due to the substantial number of complaints made by patients about the lack of confidentiality, the importance of this should be mentioned at induction.

- More use should be made of the intranet, in relation to induction and accessing the associated available written material.

- PRHO's and all medical trainees new to the trust, should either at induction or as soon as possible after the uptake of post, be equipped with a basic knowledge of the therapy services available in the trust. This should include 'what each does', the equipment they have, and when and how to refer patients to them. Without this information, trainees have been known to offer services to patients, which do not exist.

- All medical staff need to have their level of disability awareness improved. Issues around discrimination, the Human Rights' Act and communicating with the disabled need raising.

HEALTH & SAFETY

•Risk Management

- Consultant's think it is not their problem, and that clinical issues are their only concern. Different attitudes have to be built-in to doctors' thinking right from the start.
- Doctors need to have a more holistic view of delivering the care package, so that the safety aspects of such as leaving equipment around (to be tripped over, slipped on, prick people etc.) whilst delivering clinical care, are taken into account.

•Controls' Assurance

- This is now including clinical measures, so awareness needs raising that care is not only under the Clinical Governance Agenda now.

LITIGATION & COMPLAINTS

N.B. These issues relate to all grades of doctor, and not problems encountered solely in relation to trainees.

- Because it is now the Trust and not the individual who is sued when legal proceedings take place, doctors appear to be of the mentality that they will / do not need to take responsibility for their own actions. However, disciplinary if not legal action can still be taken against them individually. Nurses have a code of responsibility - so should doctors. Trainees should have this explained at induction.

- A local Solicitor has always spoken to trainees in the Medical Directorate's induction, and is found to be listened to more than hospital personnel.

- The Medical Director of the Trust has monthly meetings with trainees, does an induction and gives information regarding clinical risk, clinical governance, and what they have to comply with etc.

•Record keeping

- Illegible handwriting is a major problem.
- Doctors each use their own version of short-hand for words for which there are not recognised forms in existence (such as there are for recording blood-pressure etc.).
- Writing in blue ink needs discouraging more, as it does not photocopy well when information is collected for litigation purposes.
- Consciousness is needed of the fact that if something is not written in a patient's notes, then legally it is considered not to have been done. Doctors need to be trained to constantly bear in mind 'what if' they were to have to prove what they have done later.
- Trainees need to always sign and print their name, as oppose to merely putting e.g. 'HO' and their bleep number. If after they have left a post, a case comes to light, then it is difficult to trace who that 'HO' was, especially if it is years on and the memories' of other staff cannot be relied upon.

- It is rare that doctors put the year in a date, which can be crucial. The time also is frequently omitted, yet is information which can make an enormous difference in a litigation case.
- Possibly the sheets which doctors record on need changing, as nurses' ones are more structured (with headed columns etc.) and always result in nurses completing progress and record sheets very well, complete with their name, the date etc. Alternatively, it could be that their training addresses this better than does that of trainees.
- Doctors have been known to put the decimal point in the wrong place or write 'grams' instead of 'micrograms', leading to overdoses occurring. Other simple mistakes have led to patients been given the wrong blood.

•Communication

- The lack of communication between doctors and nurses causes frequent clinical problems, and thus subsequently, litigation cases.
- The lack of communication between medical staff and patients and their relatives, leads to enormous misunderstandings due to simple explanations not being given. Numerous complaints have arisen from the ignorance of patients and their families, caused by medical staff failing to offer information and clarification of what is being done / not done and why. E.g. an elderly gentleman was placed in front of a fan as he had a high temperature. He later developed pneumonia and died, leaving his distressed wife irreversibly convinced that the hospital had caused him to 'catch cold' and killed him.

MEDICAL DIRECTOR

- It is necessary to address induction' needs specifically from the perspectives of a trainee's grade and specialty.
- Manual Handling training is needed at a very early stage.
- Skills that support clinic practice should be focused upon e.g. risk management.
- The support available to trainee medical staff from Consultants, the Clinical Tutor, Postgraduate Tutor, the Postgraduate Deanery and senior Trust personnel, needs to be greatly emphasised at induction. Whilst a significant amount of support is available, its lack of use suggests that trainees are either unclear as to where to find it, or view seeking / accepting support as a weakness.

MEDICAL DIRECTORATE' SISTERS' MEETING

- Take home medication
 - Trainees need to arrange it sooner before patients go home.
- Medication whilst on the ward
 - Trainees need to anticipate when a patient's medication is going to run out.
- Prescriptions
 - Need to be legible
 - Trainees need to check that they are actually giving the correct dose and sort of medication.
- General communication with other staff needs to improve.
 - Trainees need to understand that they can't simply go on a ward, do their work, and then leave without feeding-back to others etc.
- Punctuality when arriving in the morning is a big problem.

- General documentation skills

- Record keeping could be improved
- Dates, times, names etc. need to be recorded more
- Printing their writing would help others to be able to read their notes properly.

- Routines

- Trainees often leave their work incomplete when they go home, meaning on-call doctors have to be bleeped to complete routine tasks which should have been done earlier e.g. simply remembering that patients need to be medicated before the trainee leaves.

- Ward inductions are needed as part of the local / departmental induction.

- Ward clerks are there as an available resource to help trainees locate forms, tell them which to use etc. However, trainees fail to utilise the clerk's knowledge.

- Extended roles taken on by some nurses causes confusion

- Trainees assume that e.g. cannulation is the job of all nurses.

- Referrals

- Trainees do not know who to refer to, or who is appropriate for which sort of problems e.g. physiotherapy.

- Trainees' assessment

- Trainees don't always realise that the Sister will be part of the team assessing them at the end of their 6 month placement. It is felt that if they were made more aware of this, then they may act more carefully on the wards when the Consultant is absent (not 'skive' etc.).

- Housekeeping

- Nurses are not there to tidy and clean-up after trainees, as they seem to think. There are instances where nurses have found such as sharps and other contaminated items left lying around by trainees. (Again, this is usually in the absence of the Consultant.)

- Informed consent

- There is a lack of awareness amongst trainees of the need for informed consent, as well as the fact that it must be properly informed consent, involving a full explanation on procedures etc.

MEDICAL STAFFING OFFICER

- Timing of induction

- The conditions need to be right to enable attendance i.e. induction must take place outside of rostered hours, be bleep-free, and SHO's must not have been on-call the night before.
- The Dean states inductions must take place on the 1st day of employment.

- Medical Staffing

- The department has never been asked what they feel is relevant to the overall induction package.
- They get a 15 minute slot at induction to cover ID badges, contracts, some rotas, where bleep / keys / accommodation can be obtained etc.

- Occupational Health

- Trainees need to realise that if they return their medical questionnaire and relevant vaccination documents etc., then unless they are called-in by Occupational Health, they do not always need to be seen.

- Trainees have to complete a new questionnaire at the beginning of each 6 month placement, even if they are staying within the Trust. This is to update their records, as well as because when they change Specialty there may be different requirements e.g. for in theatre. However, trainees fail to recognise the importance of this.

- Directorates

- Some have asked what they need to cover in the induction they provide, and have been told all the basics e.g. A/L etc., but no specific guidelines are usually given out.
- Many of the issues trainees enquire about are actually directorate ones.
- In the past, Urology have only provided their directorate handbook via the intranet. However, as it takes a few days for new staff to obtain a user ID etc. from computer services, they do not have immediate access to this information.
- Trainees from directorates which provide good inductions, are very rarely seen by the Medical Staffing department.

- Missed inductions

- Those who are working etc. over the induction period and therefore are unable to attend, are not significantly more of a problem to Medical Staffing than those who do attend. This highlights the lack of use of the present induction package.

- SHO's

- Do not need the induction as much as the HO's, but still need to receive mandatory sessions, such as on health & safety. They complain at having heard such before in other Trusts, but if they are new to this one then there will be different issues which they need to be aware of.

- Trainees' induction in comparison to that of other staff

- Other staff who's jobs involve minimal or even no lifting, receive back care information, whereas trainees do not.
- There is other general information in the Staff Handbook, which may be useful to trainees, but which is not included in theirs.

- Junior Doctor Handbook / extra information needed

- There could be two versions of the handbook, one for trainees new to the Trust and a smaller one for those already familiar with many aspects of the Trust and its workings.
- Useful information for newer trainees could include where the nearest bank is, how to get into town from the hospital, where the nearest GP and dentist are to register with. Even experienced staff need this information if they are new to the area.
- Overseas doctors need to know immediately how to join a bank, as well as be informed that a National Insurance number is needed and how to obtain one, plus given the forms to obtain a tax code, to enable them to get paid.

- CPR

- Competency and teaching needs to be much sooner than occurs at present. This is hindered by trainees failing to provide their portfolio of certificates before / when they start, meaning the Resuscitation Training Officer has to chase them individually. However, it is difficult to get trainees to provide even information which will enable them to be paid, so obtaining other literature is even harder.

PHYSIOTHERAPY MANAGER

- A talk is needed from physiotherapy at induction. HO's need to know what physiotherapists actually do and when to refer to them, so they are able to more appropriately refer to the Physiotherapy Department.

- Trainee medical staff do not appear to follow the criteria for referrals provided in their 'Junior Doctors Handbook', especially in relation to emergency respiratory conditions out of hours where a Senior Registrar is required to refer. The need to use their Handbook should be emphasised at induction.

- Trainees need to be told to communicate with physiotherapists more, especially in relation to discharge arrangements. Their improved attendance at multidisciplinary ward meetings should be encouraged, as this would help with the problem of communication.

- Doctors' improved understanding of physiotherapy services would consequently improve the knowledge and actions of nurses, as nurses also seem ill-informed in relation to physiotherapy and appear to therefore take direction from doctors in this.

PROFESSIONAL DEVELOPMENT SPECIALIST

- Trainees should receive training in manual handling as soon as is possible at their start in the Trust.

- Specialty specific manual handling training within the directorate would be of the most benefit.

- The relevance of manual handling issues to doctors needs to be stressed, as they appear to not appreciate these and thus are reluctant to receive training.

RESUSCITATION OFFICER

- It is crucial that resuscitation training is received as soon as possible in a trainee's post.

- All junior medical staff could receive this within a day if groups ran continuously throughout it, and / or several trainers were to run a number of groups concurrently.

SURGICAL NURSE PRACTITIONERS

- HOs need a mentor / coach who can guide them in how to work in a hospital, and act in an advisory capacity in the way that Ward Sisters once did.

- Trainees appear to feel threatened by Nurse Practitioners, as they confuse the trainees own role in the team. Thus a clear explanation around Nurse Practitioners is needed at induction.

- Trainees often fail to take on their own responsibilities, and see how those responsibilities have to be expected to change with each new post.

- The role of the Consultant also continually changes, according to the competency of each trainee s/he gets.

- As trainees fail to recognise the value of Nurse Practitioners, they also fail to take advice from them and / or co-operate with their requests. This can lead to problems in the team's work and thus effect Nurse Practitioners' relationships with Consultants and Anaesthetists etc.

- The 6-monthly rotation pattern can lead to a lack of loyalty from trainees and effect their relationships with patients. They see themselves as being able to have a fresh start every 6

months and thus wrongly assume this makes them unable to acquire a bad reputation by poor work.

- Trainees can have difficulty in being able to prioritise their workload and plan their time. This can cause problems when for example an xray is needed, and the trainee hasn't thought to plan ahead and accommodate for the fact that this cannot be done immediately.
- Communication skills vary widely in trainees. Uncertainty in their work can be conveyed to patients via difficulty in explaining procedures which they themselves do not understand.
- Orientation to the department can be difficult, especially when trainees are reluctant to ask questions and be helped. Each surgical ward is of a different layout, but trainees appear to cope well with this and settle after a few weeks.

TRAUMA & ORTHOPAEDIC (T & O) SISTERS' MEETING

•Infection control

- Trainees are 'abysmal' at this, though Consultants are even worse.

•Medication

- The importance of paperwork and the recording of drugs and their administration is not appreciated, nor is the care needed to be taken in handling them in general. Trainees have been seen to leave drugs lying around, as well as to keep them out at one side 'to use up later' etc. Sisters report often following trainees around when they are dealing with drugs, as they do not trust them to handle them safely.

•Communication

- Patient communication is mostly good.
- Trainees need to more frequently inform colleagues as to when they will be arriving on / returning to a ward, to prevent the need for trainees to be 'hassled' (bleeped etc.) by nurses who are concerned that their absence means duties will be left unfilled.

•Practical skills

- These are generally better than they used to be
- The vacutainer system is a problem, as trainees are only taught how to use a syringe and needle not this.

•Extended roles of the nurse

- Trainees ignore the fact that even if there are nurses present who are able to cannulate, perform ECG's, do male catheterisation etc., then it is still the doctor's responsibility to make sure that it gets done.

•Prioritising

- This is poor, as trainees seem unable to identify priorities on a ward e.g. making sure that discharge summaries are written early enough.

•General documentation skills

- This varies between trainees, and tends to be better with the fewer patients (and therefore time) one has.

- Trainees tend to have little difficulty locating items on wards, as there are only 3 wards in the directorate, all of which have the same layout (as oppose to trainees in medicine who could be working on upto 7-10).

- Trainees work better than they used to some time back, possibly due to working fewer hours and thus not being as tired, as well as seem less hierarchical and more approachable.

- Medical cover

- During the induction of HOs this needs to be arranged to be done by their SHOs
- When any trainees want to spend time in theatre, cover needs to be better organised, as it is difficult to find someone to do discharges etc. in their absence.

- Trainees need to understand that what is put in the 'Job Book' for them, is only there because it is absolutely necessary. All other options will have been tried, and the doctor will be being given work because the nurses could not manage it e.g. where collapsed veins cause problems etc. There is an awareness that the least experienced person on the ward is therefore sometimes asked to do the most difficult jobs, but they need the experience, and if it is beyond them then it is their responsibility to sort it out via such as calling on their SHO.

- Support from seniors

- The competency of a HO can depend upon how good the support in decision-making etc. is from their SHO, as well as the competency of that SHO themselves
- The helpfulness and attitude towards the HO of a SHO, can depend upon the SHOs own experiences of seniors
- HOs can be ignored by SHOs, and have been known to be given 'a really hard time' when they have rung an on-call Registrar about something that really is beyond their capabilities as that stage.

- There is a meeting of the trauma team every morning, and so trainees have regular access to information from others.

- Accessing other departments

- Trainees seem generally ok when dealing such as physiotherapy and OT, as they have regular contact with them from the directorate
- There is confusion as to which channels to go through to request procedures such as a CT Scan i.e. trainees are unsure of whether they have to go through a Consultant or if they can provide the authorising signatures themselves etc.

UNDERGRADUATE TUTOR

- Whilst support is always available, it is not always used until an extreme incident occurs, and then sometimes not even then. Trainees need to learn to access it more frequently and at an earlier stage in a problem. Therefore information on this at induction would be most beneficial.

- Links between undergraduate and postgraduate education and training need to be developed, so there is less distance between the two. Working together on induction and training issues would allow some postgraduate' training' needs to be met earlier, and a smoother transition between undergraduate and postgraduate lives to be experienced.

WARD SISTER

- As part of the local induction, training requirements specific to individual GP trainees on rotation should be identified. It is often forgotten that as these trainees rotate through general practice in addition to medicine and surgery, SHOs can lack the knowledge and skills that other colleagues at the same stage in training already possess. This leads to unrealistic expectations of them and places them under enormous stress.

- Thus GPVTS trainees in particular, appear to need practical and emotional support at the start of placements. This support is often gained from sympathetic nursing staff, which should be recognised.
- GP trainees and all new HO's, should receive induction training in basics such as on-call arrangements and how to organise them, what ward and clinic work entails, and where each trainee should be and when.
- HOs / GP trainees should receive an early explanation of those tasks both performed in nurses' extended roles, and also possibly required from trainees at any time. Alongside this, trainees' expectations that all wards will / will not require the same duties of them, should be challenged.

SUMMARY OF DISCUSSIONS WITH STAFF (BLACKPOOL VICTORIA)

Below is a summary of the key points raised from the most poignant discussions held with staff at Blackpool Victoria Hospital.

CLINICAL LEADERS0

- Nurses get much more information and support in their training than doctors.
- Trainees need to be integrated and introduced to the team and department better. There needs to be a more formal introduction where trainees are made to understand their boundaries. Often the team won't even know a trainee's name, because they don't introduce themselves when arriving upon a ward.
- Nurses tend to be the ones who support trainees, because often Consultants do not do so very well and more senior trainees can be unhelpful and even ignorant towards junior colleagues. Nurses support is however an informal and unacknowledged arrangement, and due to the fact that medics are used to being trained by other medics, many trainees resent receiving instruction from nurses and feel belittled by it.
- Trainees have far too limited knowledge of clinical areas when they start work in them.
- Dress codes need to be monitored more. For example female trainees have been known to attend work wearing such as cropped tops, and few wear white coats, of which many are more grey in colour. The BMA had a good booklet on this.
- Attendance at training that follows on from induction is a problem. T & O provide sessions on bereavement support, but these are very poorly attended by trainees. Such therefore deters people from working to organise training sessions for trainees. A local mechanism is needed to enforce attendance at even mandatory sessions e.g. it needs to be the case that training will not be validated without evidence of attendance.
- Trainees need to be able to perform basic procedures safely. Their competence in such as dealing with drips needs to be assessed prior to being responsible for them.
- Trainees have a very poor interface with the public in some instances. The way they speak to patients and their relatives often conveys a bad attitude, and would not be tolerated in nursing staff. They especially need to improve how they introduce themselves (as well as be encouraged to do so in the first place), answer the telephone, and break bad news, as well as in some cases need greater confidence in speaking to people in general. Improving communication skills would considerably reduce the rising number of complaints on this issue and the distress that it causes. The problem is exacerbated by supervisors, who see displays of arrogance towards the public as appropriate.
- Trainee doctors should be 'policed' more by their seniors in the way in which nurses are.
- Trainees and doctors as a whole, generally do not adhere to standards (of note-taking etc.). Nurses are much better at this, resulting in there being more complaints made about medics than nursing staff.
- Doctors spend much less time with the patient than do nurses, meaning they often overlook wider issues associated with a patient's clinical condition. When a doctor does take time to listen / talk to a patient, they are view extremely positively, irregardless of their

clinical competence. Hence it takes much less time and effort for patients to perceive themselves as receiving good care from doctors, than it does in the case of nurses.

- Trainees need to realise that they are part of a team, and that what they do / don't do effects other people's work.
- Some trainees appear to think that control of infection issues do not really apply to them, no matter what is said.
- Trainees can think that if they have not had to do something in another department or hospital on prior placements, then they do not have to in their current job.
- Senior nursing staff need to be more involved in trainees' inductions, and the Senior Sister should speak to them herself.
- Trainees need more information on other departments and professionals.
- Trainees vary widely, with some being very good, but bad ones causing chaos.

PHARMACY

- Trainee medical staff need to have had better education before they arrive as HOs.
- Doctors need to be trained in such as aseptic and other techniques, as nurses are.
- Safer systems for working in general, should be taught and emphasised to trainee medical staff. This is especially pertinent as regards the administration of intravenous drugs, as pharmacy are unable to detect and rectify mistakes before they are made, as they are able to do with prescriptions.
- More drug guidelines are needed, as trainees often make enquiries with the pharmacy that are inappropriate.
- Trainee medics should be treated as new pharmacists are, which is that they are assumed and treated to be completely naïve, whether they are or not. That way, all vital information is delivered and those who are too unassertive or proud to ask questions, receive all possible answers.
- A better 'mind set' is needed, so trainees routinely consult their BNF.
- The problems that arise from trainees' handling of medication, often relate to the time-pressures they experience.
- There should be regular refresher sessions delivered to trainees at mid-points in their placements.

PATIENT' STORIES INFORMATION SHEET (STEPPING HILL)



PROJECT MANAGER: Catherine Smith
Training Department, Pinewood House, Stepping Hill Hospital.

DIRECT LINE: (0161) 419 5738

PATIENT INFORMATION SHEET

Improving Junior Doctors' Induction Project

We would like you to take part in a project that is trying to improve the way in which Junior Doctors are introduced into their work in hospitals.

We all know how difficult it is when starting a new job and we don't know where anything is or who's who, and in the case of doctors this is particularly difficult as they are in such a position of responsibility. In addition to this, they have to change jobs every 6 months as part of their training!

Therefore **this project is aimed at finding ways of improving the information which Junior Doctors receive at the beginning of each new job.** This will hopefully amongst other things:

- 1) make life easier for the Junior Doctors
- 2) make life easier for the staff with whom they work
- 3) improve patient care.

HOW YOU CAN HELP!

As part of the project, we are looking at the experiences which both staff and patients have with Junior Doctors.

This means that we'd like you to share stories with us about your stay here in the hospital so far, and your experiences with the Junior Doctors. We'd like to talk about everything, whether it is good or bad. This would simply involve an informal chat with the Project Manager, at your convenience. Everything discussed would be kept completely confidential, and your name will not be used in any way.

You have absolutely no obligation to do this, and can change your mind about taking part at any time. If you decide that you would prefer not to be involved, this will not effect the manner in which you are treated by hospital staff in any way.

WHAT NEXT?

You will be asked what you have decided IN THE NEXT COUPLE OF DAYS. If you say you would like to help with the study, then the Project Manager will come and make arrangements to speak to you.

Should you like any more information, or have any concerns about taking part, please do not hesitate to contact Catherine Smith (the Project Manager) at the above address and telephone number.

PATIENT' STORIES CONSENT FORM (STEPPING HILL)



PATIENT CONSENT FORM
Improving Junior Doctors' Induction Project

1. Please read this form carefully.
2. If there is anything that you don't understand about the information sheet or you wish to ask any questions, please speak to the investigator.
3. Please check that all the information on the form is correct. If it is and you understand the explanation then sign the form below.

Please tick

YES I have been given a written explanation of the study (i.e. an information sheet) by the investigator, and have been given the opportunity to ask questions.

YES I have had enough time to think about the study and to talk to relatives and friends about it if I wanted, and have not been pressurised into taking part.

YES I understand the decision is up to me and that I can change my mind without it affecting how I am treated in this hospital in any way.

YES I have been assured that all information collected in the study will be kept confidential and that none of my personal details will be shown in its write-up.

Patient's Signature:.....

Date:...../...../.....

Investigator's signature:.....

Date:...../...../.....

A SUMMARY OF THE RESULTS OF PATIENT STORIES (STEPPING HILL)

Below is a summary of conclusions formed from points raised by patients from a variety of wards, who were invited to share their 'stories' "about their stay in hospital so far, and particularly about their experiences with junior doctors".



PATIENT' SATISFACTION WITH THE LEVEL OF CARE

- The majority of patients said that they 'couldn't really complain' about their experience in hospital.
- Patients were generally confident in the competency of all staff.
- Generally there was confidence in the trainee doctors' abilities, and in approaching them with questions about conditions and treatments. Patients commented that whilst the trainees looked young, they seemed competent. Patients believed that trainees wouldn't be allowed to treat them if they "didn't know what they were doing". Most felt the "amount of training they have obviously already had" was enough to be able to trust in them.
- One patient who usually received private treatment, but had been admitted to Stepping Hill in an emergency, was so impressed by the staff that he had requested not to be transferred into private care for his recovery. He had found the nurses very informative and to 'know what they are doing', and the trainees to be 'reassuring'.
- An incident whereby a confused gentleman was noticed by other patients to have gone missing during a staff' handover and later found outside of the hospital by security, disconcerted patients on that ward. They felt this demonstrated a unexpected lack of attention by staff, which thus could also apply to the care being received by patients, which as laypersons they would be unaware of.
- Patients were generally very understanding of trainees. One man reported that a trainee had struggled for an hour and a half with faulty equipment to take an ECG during an angina attack, until a nurse brought another machine from A&E. Whilst he himself had become 'distracted and panicked' by this, he also had 'felt for' the trainee who had persevered and remained calm despite his frustrations and being beeped throughout.
- One patient observed the majority of trainees seen over his several weeks on a range of wards, to appear unprepared when attending patients. They seemed unaware of histories documented in patient' notes when speaking to them, and unable to answer patients' questions on their conditions. He did not expect them as trainees to be experts, but felt it reasonable to expect them to prepare by either consulting a textbook or another for advice on things they were unsure of, before seeing patients. He described them as ".....trying to

look all important and grown-up with their stethoscopes, yet acting as if they were trying to brag after not doing their homework.....".

COMMUNICATION

- Overall, patients seemed satisfied with the amount of information provided by doctors and staff in general, and found it easy to approach them with questions. They said they had been kept well informed on their conditions, had everything explained to them and had any questions answered.

- There can be problems understanding overseas' doctors who have strong accents, with one patient saying that he had needed a Sister present to 'translate'.

- The elderly and others with hearing difficulties sometimes have to repeatedly request doctors to speak up, as well as have difficulty lip-reading due to the doctor's unclear speech.

- Patient can feel as though 'the older doctors' speak condescendingly towards them on occasion.

- Patients were frustrated by being repeatedly asked the same questions by different people in each department they saw. They could not understand why those treating them were not communicating this information to one another.

- One patient had observed there to be a good relationship between trainees and their seniors, and that all got on very well, noticing that even when mistakes were made, errors were explained "in a nice way and no-one made to be embarrassed". He felt this demonstrated good communication between the team treating him, and thus gave him faith that there was effective communication as regards his own treatment.

- Trainees were said by one gentleman who had received 'bad news', to have delivered it in 'a very nice manner'.

- Patients said that just being told that something was going to hurt and that the doctor or nurse was sorry, made a big difference.

- A couple of minutes of conversation and a bit of joviality, appeared to extensively contribute towards patients viewing staff and their hospital experience positively, particularly when from a doctor. 'Social niceties' made them feel that staff were really interested in them as a person, created a nicer atmosphere and put them at ease. They viewed this as a personal touch, and said it made them feel as if they were not just another face in a bed, and was especially appreciated knowing how busy everyone is.

- However, it needs to be judged when friendliness is appropriate, as a small number of patients feel this behaviour is unnecessary and find it intrusive coming from someone they simply want treatment from and may only ever see once.

- A number of male patients' particularly favoured a Consultant who offered a handshake upon arrival, always asked how the patient was, sat close, and 'really listened' to what the patient had to say. In addition, he frequently looked at his team to check they were also attending to what was said. This led the patients to positively perceive, and have great confidence in, the treatment provided by this Consultant.

- As patients tend to understand the pressures on staff's time, numerous report that being informed of delays in their treatment and explanations as to why, are greatly welcomed. They are generally prepared to be tolerant of the situation as long as they do not feel forgotten and / or are left anxiously waiting for such as an investigation without information. In one incident, a trainee had taken blood and promised to return to the worried patient with the results later that day. However, she never returned and the patient had to wait to receive the results from the Consultant the following morning. The patient felt 'let down' by the trainee, and said that a simple message of explanation had the trainee been too busy, would have sufficed.

- Staff who are very busy can be perceived as abrupt, making it difficult for patients to assert themselves and inform staff that they are hurting them or ask them questions. In other instances, busyness can be read as a suggestion by staff to patients that "I know what I'm doing, and you don't".

NURSING STAFF

- Nurses were generally reported to be very helpful and tolerant of patients perceived by others to be 'difficult'. Patients appreciated the extent of nurses' workload and were reluctant to attribute blame to them for any problems that arose.

- Nurses were perceived to be more supportive towards the patients than doctors, partly due to the fact that nurses spend more time with them.

- One patient had previously stayed a ward where senior nursing staff smoked and so condoned patients doing so in the toilets. These toilets were also found to be very 'filthy' and unpleasant during an outbreak of gastroenteritis on the ward, and staff's standard's of hygiene generally very poor, leading to him catching MRSA. After complaining, previously friendly nurses to suddenly become 'cold' whilst did not 'mistreat' him, only provided the basic care he needed in the absence of any conversation. Consequently, when re-admitted at a later date, he confided in his Consultant that he was concerned at returning to those staff, who suggested in confidence that he had been labelled an 'awkward patient' and was unwelcome on the ward anyway.

- Patients considered some nursing staff to have become unaware of the small things appreciated by ill people. For example, on one ward, patients felt they were not given an early morning drink as nurses considered it a task that they were able to ignore and thus allow to alleviate their workload. However, this was something which patients really valued. This can maybe similarly applied to doctors, who fail to comprehend the minor factors which patients perceive as contributing to their quality of care.

- Patients sometimes consider they are made to feel guilty for choosing to stay in hospital due to worry about their condition, when given the option to either stay or temporarily go home by the Consultant. Patients have felt 'pressurised' to leave by nurses who have not understood their concerns.

- Patients can be made to feel as if they are putting staff to too much trouble. One lady said that she tried to avoid having an evening drink, as she felt she was bothering the nurses if she requested the bed pan during the night. This made her relatives very angry, as both having a drink and needing the toilet were basic needs, which staff didn't even notice her to be going without.

IDENTIFICATION OF STAFF

- Patients rarely knew trainees' names, as after any initial introduction they were subsequently forgotten and patients complained that name badges were not worn to remind them.

- Patients had difficulty differentiating between all types and grades of staff, as even if a name was given, an explanation as to the individual's job title (i.e. doctor or nurse, trainee or Consultant etc.) was rarely provided. Again the name badge was frequently absent to show this. One lady said she had anxiously 'hoped' that a man administering her medication that morning was a doctor, but hadn't liked to ask for fear of insulting him. Other patients found it difficult to know who to direct questions to, when unable to differentiate between for example an auxiliary and a more qualified nurse.

- Few patients spoken to, were aware of who were the trainee medical staff treating them. Those able to identify trainees, tended to assume they were doctors only from the fact that they weren't wearing a uniform, and distinguished them from Consultants because they were 'the young ones'.

- Some patients found it difficult to comprehend the number of people treating them. The inconsistency of faces and lack of introductions, wearing of name badges etc., led to confusion about who had administered which part of their treatment and contributed to patient' anxiety.

GUIDELINES FOR THE DIRECTORATE / DEPARTMENTAL INDUCTION OF JUNIOR DOCTORS

INTRODUCTION

Stepping Hill has been working in conjunction with Blackpool Victoria Hospital, to run an **"Improving Junior Doctors' Induction Initiative"** over a twelve month period (March 1999 - March 2000). This has been led by a Project Manager based in the Training Department in Pinewood House at Stepping Hill, using funds provided by the **Postgraduate Deanery**, under the **"Blending Service With Training"** initiative.

One of the project's aims has been to find more effective ways of integrating trainee doctors into the hospital and clinical systems, to continually improve patient care. Results of the project are of both regional and national benefit to Trusts.

The views of numerous members of staff, patients and trainees, along with observations of trainees in their work and consideration of recognised best practice, has led to a number of conclusions. One of which is that **there needs to be greater standardisation in the quality and content of induction received by trainees across the different directorates / departments.**

Consequently, we have sought to produce some basic guidelines which it is hoped you will consider implementing, if you do not do so already. There is an awareness that some departments will already cover these thoroughly, and others will provide alternative information which is necessary to their specialty in the time available, but it is asked that all give these guidelines consideration in the interest of standardisation.

IF YOU WOULD LIKE ANYMORE INFORMATION OR HELP, THEN DO NOT HESITATE TO CONTACT THE PROJECT MANAGER: CATHERINE SMITH ON EXTENSION 5738.

PROGRAMME GUIDELINES

N.B.

A) These are general guidelines only, and are to be used to form a basis for induction only. All other additional information / activities contributing to induction which are appropriate to the directorate / department, should still be implemented.

B) Remember that the induction' needs of the individual vary according to their grade and experience, and so flexibility around these guidelines is necessary.

C) Owing to widespread suggestions that nursing staff should play a greater part in the induction process, especially the Senior Sister, it should be considered whether she should facilitate most of the following:

- 1) Trainees should be formally introduced to the team as soon as possible.
- 2) They should be provided with some understanding of the roles of team members.
- 3) What their own role and responsibilities are within the multidisciplinary team, should be made clear i.e. what is expected of them.
- 4) They should be made aware of whom is senior to themselves.
- 5) Explanations should be given, of generally appropriate sources of advice and support in various likely situations, as well as when on-call or night duty.
- 6) Trainees should have time with the Consultant as early as possible, to discuss the benefits of the placement, as well as raise any other matters that they may like to discuss.
- 7) Ensure each trainee has a copy of their rota.
- 8) A tour of the department, wards etc., to familiarise individuals with the geography of their new working environment, as well as where various equipment, paperwork etc. are kept, would be beneficial.
- 9) Information on the 'login' for computers expected to be used on each ward is needed, as well as any other security codes for doors etc.
- 10) It may be useful to brief trainees on other departments with which there is frequent contact. This could include the departments' roles, how to contact them, key personnel (to which introductions could also be made) etc.
- 11) Local policies and protocols should be discussed.
- 12) Provisions for refreshments, staff rooms, and the secure storage of personal belongings should be covered.

SUGGESTIONS FOR WRITTEN INFORMATION

- General information on the directorate/department e.g. its main functions, wards and clinics, size etc.
- Information on the organisation of staff within the directorate/department, preferably in chart form.
- Local policies, protocols and/or guidelines.
- Clinical information particularly of use in the directorate/department.
- Rota / staff timetables / meeting times etc.
- Arrangements for leave, which are specific to the department, + applications forms.
- Useful telephone numbers.
- Another other information considered useful to have for reference.

“JUNIOR DOCTORS’ INDUCTION SUPPLEMENT” (STEPPING HILL)

INTRODUCTION

This supplement has been produced in response to the findings of a project entitled "Improving Junior Doctors' Induction Initiative". This is funded by the Postgraduate Deanery for a twelve month period, under their "Blending Service with Training Initiative".

One of the projects' aims is to improve the information you receive at induction, so that only what is most useful and necessary is delivered. Over the coming weeks and months you will be asked for feedback on your experiences, and your co-operation would be greatly appreciated.

For any queries regarding the information in this supplement, or for further information on the project, please contact:

Catherine Smith, Training & Development, Pinewood House.

Ext: 5738

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Telephones & Bleeps

Documentation

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Local Information Directory - Stepping Hill Hospital

N.B.

- All Tel No.'s begin 0161, unless otherwise stated in brackets.
- 'Buxton Rd.' & 'London Rd.' are parts of the A6 close to the hospital.
- These websites will allow you to access local maps, to enable you to locate the services listed:
<http://www.ordsvy.gov.uk>
<http://www.multimap.com>

PLEASE NOTE THAT ALL CONTACTS GIVEN ARE FOR INFORMATION ONLY. THIS DOES NOT IMPLY THAT THE TRUST IS RECOMMENDING ANY OF THE GIVEN SERVICES IN ANY WAY.



NHS Direct: 0845-4647

<http://www.nhsdirect.nhs.uk/>

GP's: Dr. Lightowler, 11 Dorchester Rd., Hazel Grove. 439-5445
Beech House Medical Practice, Beech Ave, Hazel Grove. 483-3335/6222
Dr. J.S. Mortimer, 24 Commercial Rd., Hazel Grove. 487-1200
Dr. Wilkes, 257 Dialstone Lane, Great Moor. 483-3175

Chemists: Co-op Healthcare (in store), 114 London Rd, Hazel G. 456-3260
Haven Pharmacy, 221 London Rd., Hazel Grove. 483-3314
Johnson Arundel Ltd., 61 Arundel Ave., Hazel Grove. 483-8729
MW Fan Pharmacy, 348 Buxton Rd., Great Moor. 483-3516
Marstons Pharmacy, 267 London Rd., Hazel Grove. 483-6555
Perry Vernon Ltd., 349 Buxton Rd., Stockport. 483-3016

Dentists: M. D. Clyne, 128 Mile End Lane, Stockport. 483-2823
Mattison, Eaton & Burke, 265 London Rd., Hazel Grove. 483-2099
J. Paik, 214 Buxton Rd., Stockport. 483-3408
A. Popat, Corra Lim, 316b Buxton Rd., Stockport. 483-2816
Dr. Stoggall, 212 Shaw Heath (behind Stock't rail station), Stockp't. 429-8851

Opticians: N. C. Evans, 155 London Rd., Hazel Grove. 483-5102
Giggs & Binns Ltd., 127 London Rd., Hazel Grove. 419-9534
D. Harries, 313 London Rd., Hazel Grove. 483-8073



Banks: Midland, 279 London Rd., Hazel Grove. 911-6900
Nat West, 180 London Rd., Hazel Grove. 456-0050
Royal Bank of Scotland, 205 London Rd., Hazel Grove. 456-0700
Lloyds TSB, 140-144 London Rd., Hazel Grove. 483-9521
(Numerous other banks can be found in Stockport).

Post Offices: Co-op (within superstore), London Rd., Hazel Grove.
Great Moor Post Office, 350 Buxton Rd., Stockport. 483-2031
Post Office Counters' Customer Help Line. (0345)-223344



Computer Services: PC City 446-1122

Currys, 1a Peel Centre, Great Portwood St. (Jn.27, M60), Stock't. 476-6649

Dixons, 66-68 Merseyway (town central), Stockport. 480-1611

PC World, Peel Centre, Great Portwood St. (Jn.27, M60), Stock't. 477-4422



Transport: The nearest railway station is Woodsmoor. This is an approximate 10 minute walk from the hospital's rear gate (between the Outpatients' B building & psychiatry), from which it is sign-posted. It is on the Buxton-Manchester line and serves Stockport.

Information on bus services to and from Stepping Hill, can be obtained from leaflet racks just inside the hospital's main entrance.

GMPTE (for Gtr. Manchester bus & train information) 228-7811

<http://gmpte.gov.uk/travelin/bus/stockpoa.htm>

Cheshire bus information line (01625)-534850

Derbyshire bus enquiries (01332)-292200

National Express Coaches (0990)-808080

<http://nationalexpress.co.uk/>

National Rail Enquiries (0345)-484950

<http://www.rail.co.uk/ukrail/planner/planner.htm>

Cycling Project North West (cycling information & advice) 745-9099

Manchester city centre car parking information 234-4023/4043

Blueline private hire taxis, 43 London Rd., Hazel Grove. 483-1100

Metro Taxis, 6 Stockport Rd., Cheadle Heath. 480-2901/480-8000

Poynton private hire taxis, 97A Macclesfield Rd., Hazel G. (1625)-859977

Z Cars private hire taxis, 63 Southwood Rd., Woodsmoor. 487-4007



Supermarkets: Asda, Warren St. (town central), Stockport. 429-9599

Co-op, London Rd., Hazel Grove.

Gateway, 239-245 London Rd., Hazel Grove. 483-4894

Kwik Save plc, Commercial Rd., Hazel Grove. 483-4926

Spar, 77 Arundel Ave. Hazel Grove. 483-4847

Tesco, 4 Adern Walk (this is town central), Stockport. 910-9500

Takeaways: Doyal Indian Takeaway, 2 Buxton Rd., Hazel G. 483-5948

Foo Shing, 321 London Rd., Hazel Grove. 483-8305

The Grove Fish Inn, 199 London Rd., Hazel Grove. 483-5512

Hazel Grove Balti, 271 London Rd., Hazel Grove. 483-3735/3742

Hung Fai, 8 Dorchester Parade, Hazel Grove. 439-8198

The New Dynasty, 5 The Boulevard, Hazel Grove. 483-0476

Pizza Company, 73 London Rd., Hazel Grove. 456-7781

Silver Sea Chippy, 51 London Rd., Hazel Grove. 483-6753

Shukri Tandoori Takeaway, 177 London Rd., Hazel Grove. 419-9191

Southern Fried Chicken, 64-66 London Rd., Hazel Grove. 483-5455



Leisure facilities: Superbowl, Grand Central Sq, Stockp't. 476-6624

Altrincham Ice Rink, Devonshire Rd., Altrincham. 926-8316

Blockbuster Videos, 315 Buxton Rd., Great Moor. 483-3722

Opera House, Quay St., Manchester. 834-1787 (Staff discounts available)

Palace Theatre, Oxford St., Manch'r. 242-2523 (Staff discounts available)

Virgin Cinema, Grand Central, Wellington Rd. South, Stockport. 476-5996

The hospital's Health Promotion Dept. has details of local Health Clubs & Leisure Centres, at which staff are able to benefit from reduced rates. They can be contacted on 456-2679.



Seeing the sights!

Stockport Tourist Information 474-4444 <http://www.stockport.co.uk/>

Glossop Tourist Information (01457)-855920

Macclesfield Tourist Information (01625)-504114

Etherow Country Park, B6106, off A626, Compstall. 427-6937

Lyme Hall & Park, A6, Disley. (01663)-762023

Granada Studios Tour 832-4999

Museum of Hatting, Hempshaw Lane, Offerton, Stockport. 474-4460

Silk Museum, Heritage Centre, Roe Street, Macclesfield. (01625)-613210

Tour the Peak District, Manchester, Chester, Blackpool.....

<http://www.cressbrook.co.uk/> (info on the Peak District & National Park)

<http://www.dclally.demon.co.uk/> (info on cycling in the Peak District)

<http://www.manchesteronline.co.uk/>

<http://www.thisischeshire.co.uk/>



TELEPHONES & BLEEPS

See also pages 1-11 & 144-145 of your Junior Doctors' Handbook

Department	Ring	Department	Ring
A&E	4110/4111	Ward A10 (Medical)	5769/5258
CCU	5959/5229	Ward A11 (Medical)	5221/5920
Drs Mess	5268	Ward A12 (Medical)	5220/5921
Drs TV Room	5154	Ward A14 (Medical)	5926/5217
ECG	5077	Ward A15 (Medical)	5216/5928
EEG	5076	Ward B2 (Medical)	5932/5934
Haematology	5614	Ward B3 (Medical)	5233/5936
ICU	4237	Ward B4 (Medical)	5242/5938
Main Reception (Porters)	5019	Ward B5 (Surgical)	5256/5940
Medical Staffing	5020	Ward B6 (Surgical)	5259/5942
Pathology- Reception	5626	Ward C2 (Surgical)	5239/5946
- Bio Chemistry	5627	Ward C3 (Surgical)	5234/5947
- Blood Bank	5612	Ward C4 (Medical)	5243/5950
Pharmacy- Dispensary	5652	Ward C5 (Urology)	5952/5257
- Drug info.	4957	Ward C6 (Urology)	5260/5953
Psychiatry	5723	Ward D1 (T & O)	4019/4282
Staff Restaurant	5081	Ward D2 (T & O)	4074/4022
Switchboard	100	Ward D3 (T & O)	4021/4241
Ward A3 (Medical)	5906/5904	X Ray A	4162/3
Ward A4 (Surgical)	5938/5236	X Ray B	5591
Ward A5 / SSSU (Anaesthetics)	5911/5255		

Using the Hospital Bleep System

- STEP 1:** Dial 8 → You will hear *"This is the multitone paging system, please enter user number"*
- STEP 2:** Dial bleep no. → You will hear *"Please enter four digit message"*
- STEP 3:** Dial your extension no. → You will hear *"Your paging request is accepted"*
- STEP 4:** Hang-up and wait for your call

Virtual Bleeping

If your bleep goes off and the message is 0001 or 0002 etc., then this means that there is an external call for you on the corresponding line. Dial ## and the last digit and you will be connected to your call.

Other Useful Information

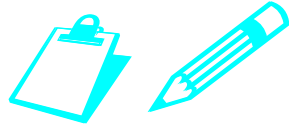
- * Bleep batteries are available from the hospital switch on an exchange basis.
- * Faulty bleeps must be returned to switchboard immediately for repair or exchange.
- * Private calls are permitted but will be charged by invoice or salary reduction. You must go through switchboard to make these calls.
- * Any changes to on-call rota MUST be reported to switchboard as soon as possible.
Any failure to do so will be reported to the appropriate consultant.



HELPLINES:

Alcoholics Anonymous	<u>Tel:</u> 0345-679555
*BMA Stress Counselling Service for Dr.s	<u>Tel:</u> 0645-200169 (24 hours/365 days)
CAB	<u>Tel:</u> 480-3264
Cruse Bereavement Line	<u>Tel:</u> 0181-332-7227
(Drugs) Turning Point	<u>Tel:</u> 0171-702-2300
Lesbian & Gay Switchboard	<u>Tel:</u> 0171-837-7324 (24 hours)
*National Counselling Service for Sick Dr.'s	<u>Tel:</u> 0171-935-5982 (9.30-4.30/Mon-Fri)
National Debtline	<u>Tel:</u> 0645-500511
Rape Crisis Centre	<u>Tel:</u> 0171-837-1600
Relate	<u>Tel:</u> 477-9235
SAMARITANS	<u>Tel:</u> 480-2222
Smokers' Quitline	<u>Tel:</u> 0171-487-3000

*See the Junior Doctors' Handbook (page 41) for more details of these services



DOCUMENTATION

DOCUMENTATION

Do write **legibly**, print if necessary

Only write in **black**

Careful, detailed, full notes should always be made

Unrecognised forms of **abbreviations** should never be used

Medication should always be checked - type of **drug**, **dosage**, position of **decimal points & units**

Every time your name is requested, **sign and print** it in addition to stating your **designation & bleep**

Never write a **date** without its **year**, as it is needed where patients have a long case history

Times must always be recorded, so other staff know when a patient was last checked, medicated etc.

Additions to notes should be **separately** dated, timed & signed, and never inserted into existing ones

The recording of **digits** should always be in the form of **clear numbers**, or else **written in words**

If **errors** are made, **cross them through** and date, time & sign. Never use correction fluid.

Only write references to '**left**' and '**right**' in **full**

Notes should never include **personal comments** about patients, or details of complaints

FROM A LITIGATION PERSPECTIVE

- If you didn't write it down, then legally you didn't do it!
- If you didn't record the time and date, then you can't prove that you did something at the right time!
- Even if a case arises where the trust has to take responsibility for your actions, then YOU can still have disciplinary action taken against you.
- Blue ink and other colours of ink fades and does not copy well in time, which causes difficulties
when cases are being put together in relation to complaints.



COMPUTER RESOURCES

OBTAINING ACCESS

BEFORE YOU CAN USE THE TRUST'S COMPUTER SYSTEM, YOU WILL NEED TO OBTAIN A USER ID AND PASSWORD. To do this, you need to complete a 'User Information' form (enquire with 5497) and return it to IT Services in Beech House.

EDUCATION CENTRE

There is a Computer Room situated across from the Library on the 1st floor of Pinewood House, enabling access to word-processing & the internet. This opens during library hours (Mon-Thurs:8.30-5, Fri:8.30-4.30), but is sometimes unavailable due to training courses.

MINI LEARNING RESOURCES

These are available to all members of staff, and also allow computer access to library databases, word-processing and the internet. They are intended to serve as an additional resource to the Library and Computer Room in Pinewood House, as it is often difficult for people to access these during working hours.

You will need to see your Directorate Manager for booking arrangements.

Training sessions can be booked in Pinewood Library on 4690.

The following departments have 'mini learning resources':

ANAESTHETICS	-the Juniors' Room
CLINICAL AUDIT	
MATERNITY	- on the 1 st floor
MEDICINE	
PAEDIATRICS	- Conference Room, Treehouse
PATHOLOGY	- in the Pathology Library
PHARMACY	- Office Dispensary
PHYSIOTHERAPY	
PSYCHIATRY	- Psychiatry Library
SURGERY	- off A10 corridor

INTRANET

The Trust's intranet service is available from every workstation, and includes information on the Clinical Directorates, Information Services, Education, Internet Access, Health & Safety, the Telephone Directory, and also holds the Web Results Service.

TRUST POLICIES

The Trust has strict guidelines on security, data protection, the use of email and the internet, computer misuse etc., all of which can be obtained in full from 5499. Stringent monitoring of staff's use of resources is conducted, and **ABUSE OF THE SYSTEM WILL RESULT IN DISCIPLINARY ACTION.**

Therefore, for example,

- Do not leave your workstation logged on when unattended (as this leaves it open to abuse from others, under your name)
- Do not use workstations for playing games or personal use
- Do not make copies of software (other than backups) as this is illegal
- Use email and the internet appropriately, and report anything which you receive and consider to be inappropriate.

COMPUTER HELPDESK

Telephone 5497 for help with any difficulties you may have in using the hospital's computer systems.



STAFF PROBLEMS

PROBLEMS WITH OTHER STAFF

QUESTION:

Where do I go if I myself have a problem, or notice that a colleague has?

ANSWER:

Staff problems should always try to be resolved as locally as possible, but if the problem fails to be resolved by those at this level, then here is the suggested route to take. Do not be afraid to go right through 'to the top' if necessary, as your problems will always be welcomed and listened to.

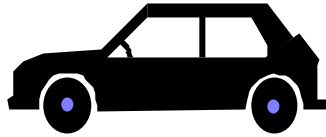
**1. Educational Supervisor
or Consultant**



**2. Clinical Tutor
or Clinical Director**



**3. Medical Director
or Chief Executive**



CAR PARKING

For further details on Car Parking - see your Junior Doctors' Handbook (page 34)

To obtain further copies of the application form for a staff discounted permit, contact:
Barbara Street, Car Park Co-Ordinator: 5032 (Mon-Fri:10-12.30)
Or go to the General Office (on the left, inside the main entrance)

TELEPHONE NUMBER WALL CHARTS (STEPPING HILL)



A & E	4110/4111
Anaesthetics	5046
Bed Manager	5687/4144(bleep1047)
Cardiology	5036
CCU	5959/5229
Chapel	5889
Chest Clinic	5060/5061
Computer Services	5497
EAU	4985/4677
ECG	5077
EEG	5076
Endoscopy	5240
Estates (Maintenance requests)	5396
Gastroscopy Unit	5262
General Office	5646
GUM Clinic	4444
Health & Safety	5469
ICU	4237

Medical Records	5039
Maternity Reception	5279
Mortuary	4388
Occupational Health	5491/4952
Occupational Therapy	5799/5270/5024
Ophthalmology	5878
Outpatients A	4090/4091
Outpatients B	5387/5388
Pathology	5626
Pharmacy	5652/5654
Physiotherapy	4060
Porters	5019
Postgraduate Centre	4684/4685
Psychiatry	5723
Security	5155
Security (nights)	5274
Speech & Language Therapy	5897
Staff Restaurant	5081
Tree House	2000
Urology	5698
X Ray A	4162/4163
X Ray B	5591

WARDS

A1 (Rheumatology)	4123
A3 (Medical)	5906/5904
A4 (Surgical)	5938/5236
A5 / SSSU (Anaes.)	5911/5255
A10 (Medical)	5769/5258
A11 (Medical)	5221/5920
A12 (Medical)	5220/5921
A14 (Medical)	5926/5217
A15 (Medical)	5216/5928
B2 (Medical)	5932/5934
B3 (Medical)	5233/5936
B4 (Medical)	5242/5938
B5 (Surgical)	5256/5940
B6 (Surgical)	5259/5942
C2 (Surgical)	5239/5946
C3 (Surgical)	5234/5947
C4 (Medical)	5243/5950
C5 (Urology)	5952/5257
C6 (Urology)	5260/5953
D1 (T &O)	4019/4282
D2 (T & O)	4074/4022

D3 (T & O)	4021/4241
P1 (Over 65 assessment)	5747
P2 (Over 65 assessment)	5750
P3 (Acute under 65's)	5752
P4 (Acute under 65's)	5754
Ashley (Elderly)	4382/4384
Bronte (Elderly)	4391
Hillside (Day Care Centre)	5795
Meadows (ESMI)	419-6000
Acorn (Medical)	2157/2158
Brambles (Medical)	2155/2156
Mulberry (Day Cases)	2153/2154

CONSULTANTS

A&E:

Mr. Gray	4100
Mr. Southworth	4107
Secretary	4101

ANAESTHETICS:

All	5869
FAX	5045

CHILD & FAMILY GUIDANCE:

All	810
-----	-----

DENTAL SURGEONS:

Mr. Bode	4272
Mr. Thompson	4260
Mr. Tuffin	4272

DERMATOLOGY:

Dr. Ashworth	4782
Dr. O'Driscoll	5476
FAX	5185

ENT:

Mr. Kay	4035
Miss. Ramamurthy	4035

Mr. Rose 4038

FAX 4006

ELDERLY MEDICINE:

Dr. Catania 4329

Dr. Cheadle 4353

Dr. Datta-Chaudhuri 4355

Dr. Duckett 4351

Dr. Nankhonya 4364

FAX 4356

GENITO-URINARY:

Dr. Chatterjee 4448

MEDICINE:

Dr. Ahluwalia 5640

Dr. Archer 5071

Dr. Cryer 5477

Dr. Das 5867

Dr. Hale 5095

Dr. Lewis 5478

Dr. Martin 5471

Dr. Talbot 5840

Dr. Simpson 5070

FAX 4944

OBSTETRICS & GYNAECOLOGY:

Dr. Candelier 5571

Dr. Depares 5540

Dr. Eyong 5543

Dr. McFarlane 5541

Dr. Nuttall 5542

Colposcopy Secretary 5571

FAX 5531

ONCOLOGY:

Dr. Deakin 4263

At Christies 446 3000/3356

Dr. Wilkinson 4975

At Christies 446 3000/3742

FAX 483 8576

OPHTHALMOLOGY:

Mr. Brown 4269

Mr. Hercules 4094

Mr. Morgan 4270

Mr. Moriarty 4095

FAX 483 8576

ORTHOPAEDICS:

Mr. Bamford 4047

OTHER HOSPITALS

Alexandra	6125
Buxton Cottage	6126
Blackburn	6407
Booth Hall	6409
Bolton General	6410
Bury General	6413
Cavendish	6415
Cheadle Royal	6127
Christie	6128
Hope	6426
Liverpool Royal	6430
Macclesfield	6487
Manchester Royal	6132
North Manchester	6133
Preston Royal	6455
St. Ann's Hospice	6134
Salford Royal	6426
Tameside	6461
Trafford	6417
Withington	6320
Wythenshawe	6140

EXAMPLE OF POCKET-SIZE TELEPHONE NUMBERS CARD (STEPPING HILL)

SIDE 1: Generally useful numbers

Department	Ring	Department	Ring
A&E	4110/4111	Ward A10 (Medical)	5769/5258
CCU	5959/5229	Ward A11 (Medical)	5221/5920
Drs Mess	5268	Ward A12 (Medical)	5220/5921
Drs TV Room	5154	Ward A14 (Medical)	5926/5217
ECG	5077	Ward A15 (Medical)	5216/5928
EEG	5076	Ward B2 (Medical)	5932/5934
Haematology	5614	Ward B3 (Medical)	5233/5936
ICU	4237	Ward B4 (Medical)	5242/5938
Main Reception (Porters)	5019	Ward B5 (Surgical)	5256/5940
Medical Staffing	5020	Ward B6 (Surgical)	5259/5942
Pathology- Reception	5626	Ward C2 (Surgical)	5239/5946
- Bio Chemistry	5627	Ward C3 (Surgical)	5234/5947
- Blood Bank	5612	Ward C4 (Medical)	5243/5950
Pharmacy- Dispensary	5652	Ward C5 (Urology)	5952/5257
- Drug info.	4957	Ward C6 (Urology)	5260/5953
Psychiatric Reception	5723	Ward D1 (T& O)	4019/4282
Staff Restaurant	5081	Ward D2 (T & O)	4074/4022
Switchboard	100	Ward D3 (T & O)	4021/4241
Ward A3 (Medical)	5906/5904	X Ray A	4162/3
Ward A4 (Surgical)	5938/5236	X Ray B	5591
Ward A5 / SSSU (Anaesthetics)	5911/5255		

SIDE 2: Directorate-specific useful telephone numbers

MEDICINE			
CCU:		GUM CLINIC:	
-Nurses Station	5959/5229	-Nursing Station	4444
CHEST CLINIC:		-Male Reception	4450
-Reception	5060/5061	-Female Reception	4451
-Consulting Room 1	5067	CONSULTANTS:	
-Consulting Room 2	5067	Dr. Ahluwalia (Gastro)	5640
EAU:		Dr. Archer (Chest cl.)	5071
-Patient Enquiries	4985/4697	Dr. Cryer (Diabetes)	5477
-Office	4677	Dr. Das (Gastro)	5867
ECG:		Dr. Hale (Diabetes)	5095
-Reception/Enquiries	5077	Dr. Lewis (Cardiology)	5478
-In patient ECG	5674	Dr. Martin(Cardiology)	5471
EMERGENCY ADM.		Dr. Talbot (Medicine)	5840
-Patient Enquiries	985/4697	Dr.Simpson (Medicine)	5070

Using the Hospital Bleep System: DIAL 8 & FOLLOW THE INSTRUCTIONS GIVEN

Receiving external bleeps (Virtual Bleeping) If you receive the message 0001 or 0002 etc., then there is an external call for you on the corresponding line. Dial ## and the last digit to be connected to your call.

Other Useful Information:

- * Bleep batteries are available from the hospital switch on an exchange basis.
- * Faulty bleeps must be returned to switchboard immediately for repair or exchange.
- * Private calls are permitted via switchboard, but will be charged by invoice or salary reduction.
- * Switch MUST be informed of on-call rota changes. Failure to do so will be reported to your Consultant.

JUNIOR DOCTOR INDUCTION' QUIZ (STEPPING HILL)



Win £50 of HMV Vouchers!

Simply answer the following ten questions to be entered into the prize draw!!! **All the answers can be found in either the 'Junior Doctor Handbook' or 'Induction Supplement', you received at induction.**

Please return your entry by Wednesday 16th August, 2000 to:
Catherine Smith, either by internal post to the Training Department, Pinewood House,
OR leave at Pinewood House reception for her.

1. What is the name of the Postgraduate Centre Manager?
2. What time does the Education Centre' Library open until on a Friday?
3. Which two people must sign your annual leave form?
4. What is the telephone number of The BMA Stress Counselling Service for Doctors?
5. Where are Death Certificates and Cremation forms to be completed?
6. What is the name of the Consultant to whom cases of notifiable disease are to reported?
7. What is the name of the GP who has a surgery at Magda House, 257 Dialstone Lane, Great Moor?
8. Complete this sentence as regards documentation:
"Unrecognised forms of _____ should never be used."
9. To where do you return the 'User Information' form, to obtain a User ID and Password for the Trusts' computer system?
10. As regards 'Staff Problems', who is it suggested you turn to at the first level?

P.T.O FOR ANSWER SHEET!

ANSWERS:

Name_____ Department_____

Extension / Bleep_____

ANSWERS:

1

2

3

4

5

6

7

8

9

10

DOCUMENT: A 'GOLD STANDARD' FOR INDUCTION



Training & Development Services, Pinewood House,
Stepping Hill Hospital, Poplar Grove, Stockport. SK2 - 7JE.
Tel: (0161) 419 5802 Fax: (0161) 419 4694

**IMPROVING JUNIOR DOCTORS'
INDUCTION INITIATIVE
A 'Gold Standard' for induction**

Catherine Smith

March 2001

Supported by the North West Deanery /
Department of Postgraduate Medical and Dental Education
Under the Blending Service with Training Initiative

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1. INTRODUCTION

This 'Gold Standard for Induction' has been compiled from the results of a twelve month project entitled the 'Improving Junior Doctors Induction Initiative', which has been supported by the North West Deanery's 'Blending Service With Training' Initiative. The document is in response to the need for greater quality and standardisation across the inductions provided for trainee medical staff in the region. It brings together the results gained from the project's own trialled changes to induction' programmes and written material; consultation with trainees, a range of hospital staff and patients; observations of trainees; and research into best practice in induction.

Consideration has been given to recommendations made by the University of Manchester's Department of Postgraduate Medicine and Dentistry, the General Medical Council and other relevant bodies, as well as published literature. Furthermore, the practices of Trusts throughout the North West Region have been observed and best practice across the region attended to in the development of this document.

The document is generic, in being of use irregardless of the grade or specialty of trainee to which it is to be applied. However, there are examples in section 7, of ways in which Trusts can use the document to tailor induction programmes to the particular needs of specific groups.

It is recommended that items contained within sections 2-5 of this document be applied to the hospital / departmental induction of trainee medical staff, as is deemed relevant by the practices in operation at each individual Trust and as far as is possible within the constraints of time and resources available. Those items in section 6 however, are for specific inclusion in the departmental rather than hospital induction programme.

2. THE DELIVERY OF INDUCTION

ESSENTIAL

- All trainees are freed from work commitments during induction.
- Handbooks and other written material are kept relevant and concise, as well as where possible are distributed to trainees prior to the uptake of post, accompanied by details of a contact person should any general questions arise from its reading.
- A wide range of staff are to be involved in the delivery of induction, to facilitate familiarity with those with whom trainees are generally expected to have significant contact.
- Other staff who are largely relevant to trainees but who do not feature in the induction process, should at least be formally introduced to them.
- A formal handover from an appropriate team member is essential. For a PRHO starting their first job in August, this should preferably be the outgoing post-holder. For all grades starting at all times of year, where the outgoing post-holder is to be unavailable for handover, their contact details should be provided and a telephone conversation encouraged as a minimum measure.
- PRHOs should be able to spend a period shadowing existing house officers in both medicine and surgery prior to their start, and all trainees should be provided with the opportunity to informally contact the outgoing postholder by telephone prior to their own uptake in that post.
- Special provisions should be made for trainees who miss the main induction days provided, as well as those on the General Practice Vocational Training Scheme and trainees from overseas or with disabilities.
- There must be an on-going programme of induction, following-on from that provided on the first day(s) of post.

DESIRABLE

- Consideration is to be given to providing trainees with a Trust 'Staff Handbook' (or the Trust's equivalent information pack) in addition to a 'Junior Doctor / Trainee Medical Staff Handbook', as it cannot be assumed that trainees do not need the information which other hospital staff receive. For example, information on childcare, maternity / paternity leave, change of personal details etc. is not usually included in trainees' information.
- Consideration is given to providing information via induction fairs, poster presentations, videos, or group discussions, in addition to / as oppose to via talks and written documents.
- The involvement of nursing staff and the use of their knowledge is encouraged, as is utilisation of their experience of working alongside trainees.
- A tour of the department & / or hospital is provided for those unfamiliar with either.
- A social activity is desirable, as this allows PRHOs and others new to the Trust to informally meet and consequently team-build and forge support networks from arrival.

3. EDUCATIONAL MATTERS

ESSENTIAL

- The Postgraduate Clinical Tutor should be introduced to all new trainees.
- Trainees should meet with their Educational Supervisor.
- The Royal College of Physicians and Associate Tutors should be discussed.
- Details of on-going training programmes should be given.
- All trainees should be made aware of regional study days.
- Research opportunities should be highlighted.
- Appraisal / Individual Performance Review / assessments should be discussed, both to provide explanation of such to PRHOs in their first post and to reinforce the importance of these to other grades.
- Arrangements for maintaining resuscitation skills should be discussed, along with possible consequences of failing to maintain competency in this, again to reinforce its importance.
- Sources of educational and personal support and how to access them should be identified for those new to the Trust.

DESIRABLE

- Information on IT facilities should be provided for those new to the Trust, including access to such and how to obtain passwords etc.
- Information on library facilities should be provided for those new to the Trust.

4. POLICIES / PROCEDURES / GUIDELINES

It is recommended to ensure that all grades of trainee medical staff are familiar with the individual Trust or specialty's policies / procedures / guidelines. A minimum list is detailed below.

ESSENTIAL

Policies on:

- Bed management.
- Harassment.
- Health & Safety at work.
- Telephones & Bleeps.

Procedures for:

- Contacting others (both internal and external to the hospital).
- Dealing with a cardiac arrest.
- Dealing with death.
- Discharging patients from hospital.
- Needlestick injuries.
- Notifiable disease.
- Obtaining results within and outside of normal hours.
- Requesting investigations.

Guidelines on:

- Documentation.
- Infection control.
- Manual handling.
- Medico-legal issues.
- Obtaining informed consent.
- Prescribing and handling medication.

- Treating common conditions.
- Using chaperones.

DESIRABLE**Policies on:**

- Accepting gifts from patients.
- Dealing with complaints.
- Major incidents.

5. PERSONAL NEEDS

It is recommended either information & / or the relevant contacts are provided as regards the items below.

ESSENTIAL

- Accommodation.
- Catering provisions.
- Contracts of employment / Conditions of service.
- Doctors' Mess.
- Duties of a doctor.
- ID badge - obtaining one and the importance of wearing it.
- Induction timetable.
- Maps of the hospital site(s).
- Medical Defence Union' membership / NHS indemnity.
- Occupational health services.
- Personal safety.
- Rotas.
- Salary / payroll information.
- Security.
- Staff structure / "Who's who?" in the Trust and department.

DESIRABLE

- Careers' advice - accessing it.
- Car parking (and staff parking permits if applicable).
- Leave arrangements and related forms.
- Local services' information (including GP's and dentists to register with).
- White coat arrangements.

6. RECOMMENDATIONS SPECIFIC TO DEPARTMENTAL / DIRECTORATE INDUCTION

These recommendations represent the minimum required to be delivered through the local induction programme specifically, and do not include recommendations from previous pages that Trusts may choose to also incorporate into this programme. Other issues relevant to the specific department should additionally be targeted, as should the induction' needs of each individual according to their grade and experience etc. Variation and flexibility of local programmes is thus necessary.

Owing to widespread suggestion that nursing staff should play a greater part in the induction process, it is suggested that consideration be given to Senior Sisters facilitating most of the following.

THE PROGRAMME ESSENTIAL

- Trainees should be formally introduced to members of the team as soon as possible, including the Secretary of the Consultant to whom they are to be attached.
- Trainees should be made aware of whom is senior to themselves.
- Trainees should have time with the consultant as early as possible, to discuss the benefits of the placement as well as to raise any other matters.
- Local policies / protocols / guidelines should be discussed.
- Where necessary, trainees' own role and responsibilities alongside those of other members of the multidisciplinary team (particularly those of nurses with extended roles) should be clarified. (PRHOs, and SHOs belonging to the GPVTS who have not worked in the directorate previously, would particularly benefit from this.)
- The rota should be explained on arrival.

DESIRABLE

- Explanations should be provided of generally appropriate sources of advice and support whilst working in the department, including when on-call or night duty.
- It would be beneficial for those unfamiliar with the department and its wards to be provided with a tour of their new working environment, as well as to have highlighted the location of various equipment, paperwork etc.
- Information on the 'login' for computers expected to be used on each ward is needed, as well as any security codes for doors etc.
- It may be useful to brief especially PRHOs and others new to the Trust, on other departments with which there will be frequent contact. This should include those departments' services, how to contact them, key personnel (to which introductions could also be made) etc.

- Provisions for refreshments, staff rooms, and the secure storage of personal belongings should be covered.
- Where a post is filled sufficiently in advance of its start, trainees should be provided with the telephone number of their Consultants' Secretary, in case of enquiry.

WRITTEN INFORMATION ESSENTIAL

- The provision of local policies / protocols / guidelines is vital.
- Clinical information of particular use in the individual directorate / department should be provided.
- General information on the directorate / department e.g. its main functions, wards and clinics etc. can be extremely useful.
- Rota / staff timetables / meeting times etc. should be distributed.
- Telephone numbers of particular use to members of that department should be given.

DESIRABLE

- 'Leave' arrangements specific to the department should be explained and application / record forms provided.
- Information on the organisation of staff within the directorate / department, preferably in chart form.
- Any other information considered useful to have for reference.

7. EXAMPLE INDUCTION PROGRAMMES

Based on the information contained in the previous pages, below are 3 examples of potential ways in which hospital programmes could incorporate the essential criteria given, when tailoring programmes to particular groups of trainees.

EXAMPLE 1: A HOSPITAL INDUCTION FOR PRE-REGISTRATION HOUSE OFFICERS IN AUGUST / THEIR FIRST POST

This example presumes that at least one full day is available for the induction of PRHOs in August.

PRIOR TO INDUCTION PRHOs HAVE:

- Received their 'Junior Doctors Handbook' or equivalent, plus as much other available written induction material as possible, along with contact name(s) and number(s) for general enquiries relating to this information.
- Have participated in a period of shadowing.
- If the outgoing postholder has not been shadowed, then there has at least been the opportunity to contact them by telephone for a discussion of the post.
- Details have been provided of the Consultant to whom each PRHO is to be attached, along with their specialty and wards to be covered. The name and contact number of the Consultant's Secretary for enquiries, as well as the name and bleep number of their SHO in preparation for their first day, have also been given.
- The rota for at least the first few days in post has been supplied.
- There has been the opportunity to acquire identity badges if living locally.
- Accommodation arrangements have been confirmed.

THE INDUCTION PROGRAMME:

- **8.30am** Arrival, registration, distribution of remaining written information etc.
- **9.00am** Welcome and talk from the Postgraduate Clinical Tutor & Centre Manager, including information on:
 - the Royal College of Physicians and Associate Tutors
 - appraisals, individual performance reviews, assessments etc.
 - details of on-going training programmes and regional study days
 - research opportunities within the Trust

• **9.15am** Interactive small group discussions according to directorate, with an outgoing PRHO (or SHO / suitable other if necessary), including coverage of:

- the duties of a PRHO
- what it is like to be a PRHO at this hospital
- 'helpful tips' from their own experience as a PRHO

• **10.00am** Interactive small group discussions according to directorate, with a member of nursing staff, including coverage of on:

- the nurse's role and responsibilities in relation to those of the PRHO, particularly those of nurses with extended roles, nurse practitioners etc.
- how PRHOs can benefit from the knowledge and experience of their nursing colleagues
- the importance of communication and collaboration between the medical and nursing professions.

• **10.20am** Personnel / Medical Staffing to give a brief talk on general issues such as contracts, pay and leave arrangements, and inform trainees that they will be available for individual enquiries on a stand over lunch (see 1pm).

• **10.30am** Refreshments

• **10.45am** A talk from the pharmacy, including information on:

- general prescribing guidelines
- documentation in relation to medication
- good use of the BNF
- safe handling and administration of medication
- use of the pharmacy for reference and advice

• **11.00am** Training session from the Resuscitation Officer, accompanied by information on:

- arrangements for, and importance of maintaining resuscitation skills
- an explanation of arrangements for the crash team at the Trust

• **1.00pm** Lunch during which stands / poster presentations could be available from various clinical and non-clinical departments, to provide information (including written) to help with the PRHOs' practicalities of joining the Trust and answer individual queries. For example:

- Pathology
- Radiology
- Clinical Audit
- Accommodation Services
- Mess President
- Personnel / Medical Staffing (providing clarification of post' details for those appointed at a late stage, provision of rotas if necessary, payroll information, contracts of employment / conditions of service, & the opportunity to have photographs taken for ID badges if possible)
- Occupational Health
- Bed Manager
- Clinical Risk Manager / Complaints & Litigation
- IT Services (to register for a computer login ID if necessary)
- Library Services (to apply for a library card)
- Car Parking / Security (to make a parking permit application if necessary)
- Catering
- Telephone Manager / Switchboard (to administer bleeps etc.)
- Estates / Site Services (to provide maps of the hospital site etc.)

• **2.30pm** A talk from the Health & Safety Officer / Fire Officer / Security, including information on:

- health & safety at work
- fire procedures within the Trust
- security
- personal safety
- use of chaperones

• **3.00pm** A talk from Occupational Health, including information on:

- occupational health services
- needlestick injuries

• **3.15pm** Training in the basic principles of safe manual handling

• **4.00pm** Refreshments

• **4.15pm** A talk from the Trusts' Solicitor, or other suitable legal professional, to include information on:

- complaints and litigation
- the importance of good documentation
- obtaining informed consent
- membership of the Medical Defence Union/ NHS indemnity insurance

• **4.45pm** A talk from a suitable individual (e.g. Medical Director), on:

- sources of support available in the Trust and how to access them, in relation to work, educational and personal issues
- policies on harassment within the Trust, and procedures for reporting such

• **5.00pm** Postgraduate Tutor / Centre Manager to end the day with a general session to answer any questions which may have arisen throughout the course of the day and remain unanswered, or advise PRHOs on appropriate alternative individuals to whom to direct specific queries.

• **END** A social event such as a buffet, meal out, drinks at a local pub etc., to which all existing, out-going, and in-coming trainees, as well as colleagues of all levels whom it would be useful to meet informally, have been invited. This would facilitate informal swapping of information and building of support networks for the new trainees.

EXAMPLE 2: A HOSPITAL INDUCTION FOR PRE-REGISTRATION HOUSE OFFICERS IN FEBRUARY / THEIR SECOND POST

This example presumes that at least one half day is available for the induction of PRHOs in February, and that they are new to the Trust.

PRIOR TO INDUCTION PRHOs HAVE:

- Received their 'Junior Doctors Handbook' or equivalent, plus as much other available written induction material as possible, along with contact name(s) and number(s) for general enquiries relating to this information.
- Been given the opportunity to contact the outgoing postholder by telephone, for a discussion of the post or to arrange to meet informally.
- Details have been provided of the Consultant to whom each PRHO is to be attached, along with their specialty and wards to be covered. The name and contact number of the Consultant's Secretary for enquiries, as well as the name and bleep number of their SHO in preparation for their first day, have also been given.
- The rota for at least the first few days in post has been supplied.
- Accommodation arrangements have been confirmed.

THE INDUCTION PROGRAMME:

- **8.30am** Arrival, registration, distribution of remaining written information etc.
- **9.00am** Welcome and talk from the Postgraduate Clinical Tutor & Centre Manager, including information on:
 - the Royal College of Physicians and Associate Tutors
 - appraisals, individual performance reviews, assessments etc.
 - details of on-going training programmes and regional study days
 - research opportunities within the Trust
- **9.15am** Interactive small group discussions according to directorate, with an outgoing PRHO (or SHO / suitable other if necessary), on what it is like to be a PRHO at this hospital.
- **9.45am** A talk from the Health & Safety Officer / Fire Officer / Security, including information on:
 - health & safety at work
 - fire procedures within the Trust
 - security
 - personal safety
 - use of chaperones

- **10.05am** A talk from Occupational Health, including information on:
 - occupational health services
 - needlestick injuries
- **10.15am** A refresher talk from the pharmacy, including information on:
 - general prescribing guidelines, specific to this Trust
 - documentation in relation to medication
 - good use of the BNF
 - safe handling and administration of medication
 - use of the pharmacy for reference and advice
- **10.25am** A talk from the Trusts' Solicitor, or other suitable legal professional, to include information on:
 - complaints and litigation
 - the importance of good documentation
- **10.55am** A talk from a suitable individual (e.g. Medical Director), on:
 - sources of support available in the Trust and how to access them, in relation to work, educational and personal issues
 - policies on harassment within the Trust, and procedures for reporting such
- **11.05am** Refreshments to accompany stands / poster presentations which could be available from various clinical and non-clinical departments, to provide information (including written) to help with the PRHOs' practicalities of joining the Trust and answer individual queries. For example:
 - Pathology
 - Radiology
 - Clinical Audit
 - Accommodation Services
 - Mess President
 - Personnel / Medical Staffing (providing clarification of post' details for those appointed at a late stage, provision of rotas where necessary, payroll information, contracts of employment / conditions of service, and the opportunity to have photographs taken for ID badges if possible)
 - Occupational Health
 - Bed Manager
 - Clinical Risk Manager / Complaints & Litigation
 - IT Services (to register for a computer login ID if necessary)
 - Library Services (to apply for a library card)
 - Car Parking / Security (to make a parking permit application if necessary)
 - Catering
 - Telephone Manager / Switchboard (to administer bleeps etc.)
 - Estates / Site Services (to provide maps of the hospital site etc.)
- **1.00pm** CLOSE

EXAMPLE 3: A HOSPITAL INDUCTION FOR SENIOR HOUSE OFFICERS & SPECIALIST REGISTRARS IN AUGUST OR FEBRUARY

This example presumes that at least one half day is available for the induction of SHOs / SpRs in August, and that they are new to the Trust.

PRIOR TO INDUCTION TRAINEES HAVE:

- Received their 'Junior Doctors Handbook' or equivalent, plus as much other available written induction material as possible, along with contact name(s) and number(s) for general enquiries relating to this information.
- Had the opportunity to contact the outgoing postholder by telephone, for a discussion of the post.
- Details have been provided of the Consultant to whom each trainee is to be attached, along with their specialty and wards to be covered, as well as the name and contact number of the Consultant's Secretary for enquiries.
- The rota for at least the first few days in post has been supplied.

THE INDUCTION PROGRAMME:

- **8.30am** Arrival, registration, distribution of remaining written information etc.
- **9.00am** Welcome and talk from the Postgraduate Clinical Tutor & Centre Manager, including information on:
 - appraisals, individual performance reviews, assessments etc.
 - details of on-going training programmes and regional study days
 - research opportunities within the Trust
- **9.15am** A talk from a suitable individual (e.g. Medical Director), on:
 - sources of support available in the Trust and how to access them, in relation to work, educational and personal issues
 - policies on harassment within the Trust, and procedures for reporting such
- **9.35am** A talk from the Trusts' Solicitor, or other suitable legal professional, to include information on:
 - complaints and litigation
 - the importance of good documentation
- **10.05 am** A talk from the Health & Safety Officer / Fire Officer / Security, including information on:
 - health & safety at work
 - fire procedures within the Trust
 - security
 - personal safety
 - use of chaperones

• **10.25am** Refreshments to accompany stands / poster presentations which could be available from various clinical and non-clinical departments, to provide information (including written) to help with the trainees' practicalities of joining the Trust and answer individual queries.

For example:

- Pathology
- Radiology
- Pharmacy
- Clinical Audit
- Personnel / Medical Staffing (providing clarification of post' details for those appointed at a late stage, provision of rotas where necessary, payroll information, contracts of employment / conditions of service, and the opportunity to have photographs taken for ID badges if possible)
- Occupational Health
- Bed Manager
- Clinical Risk Manager / Complaints & Litigation
- IT Services (to register for a computer login ID if necessary)
- Library Services (to apply for a library card)
- Car Parking / Security (to make a parking permit application if necessary)
- Catering
- Telephone Manager / Switchboard (to administer bleeps etc.)
- Estates / Site Services (to provide maps of the hospital site etc.)

• **12.30pm** CLOSE