Final report

Patient Advocacy for Prescribing Safety (PAPS). Using implementing science to involve service users in education and practice

Principal investigator

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Introduction

We were awarded ASME's Excellent Medical Education prize to continue a programme we had established to involve 'Patient Advocates' (PAs) in medical students' and foundation trainees' prescribing education. We selected insulin prescribing because, par excellence, it represents a situation where patients have expertise that can increase doctors' capability, and where ignoring that expertise can worsen patients' experiences of care as well as physically harm them.

The context in which we implemented PAPS was a larger-scale project, originally called 'Making Insulin Treatment Safer' (MITS), now renamed 'Act Wisely – Diabetes'. Act Wisely (AW) helps doctors take appropriately considered action in the face of uncertainty. Put differently, it helps doctors act wisely when there is no single right answer. AW assumes that patients are active participants in clinical care, rather than passive recipients, and that clinicians should at all times involve patients. AW is a practical pedagogy in that it helps clinicians learn to involve patients by involving patients. It is now used in the basic education of all insulin prescribers in Northern Ireland: medical students, foundation doctors, nurse-prescribers, and pharmacist-prescribers.

We had piloted patient advocacy in the first two rounds of MITS. ASME's EME award allowed us to put this on a firmer footing so that patient advocacy could be sustained beyond the initial, exploratory phase, disseminated, and made transferable to other education programmes in other settings. ASME's generous grant of £5000 funded the contributions of Martin Adams (person with type 1 diabetes and skilled PA) and Florence Findlay-White (diabetes specialist nurse, expert in empowerment education, and advocate for person-centred care) to patient advocacy for prescribing safety (PAPS). Tim Dornan, Rosie Donnelly, and Neil Kennedy made contributions 'in kind'.

We use table 1 and figure 1 to structure our report. Table 1, which was in our original application, uses Implementation Science to define success criteria. Into that table, we have added the details of our implementation, and our 'success', by which we mean the stage we have reached in an ongoing programme of work. This is complemented by Figure 1, which shows PAs' developmental pathway and the progress of our cohort of PAs along this.

<table>
<tr><th colspan="3">Table 1: Success criteria and means of achieving these</th></tr>
<tr><td>Characteristics of the implementqtion</td><td>Activity to achieve success</td><td>Success criteria</td></tr>
<tr><td>Outer setting (policy context)</td><td>Survey how existing policies affect patient advocacy</td><td>Criterion 1: Report how patient advocacy can be facilitated</td></tr>
<tr><td colspan="3">Attainment of criterion 1:
Patient advocacy is strongly advocated at national level and has been embraced by NHS Trusts, which have facilitated its adoption by identifying Trust employees whose job it is to promote patient involvement. For example, the South-eastern Health and Social Care Trust has embraced co-production (between patients and caregivers) as a core institutional value. Adoption of patient advocacy was facilitated, also, by policies that guide the education of medical students and foundation trainees. Medical student education is led by the Medical School of Queen's University Belfast, which sees the PAPS programme as consonant with its values. It keenly supports the involvement of PAs to conduct educative conversations with students. Foundation Education is led by the Northern Ireland Medical and Dental Training Agency (NIMDTA – Deanery equivalent), which supports PAPS in principle, provided it fits with the in-training education requirements of the Foundation Programme. AW procedures are fully compatible with these requirements. It was possible for GMC-registered practitioner to delegate 'case-based discussions' (CBDs) to PAs (just as they do to nurses and pharmacists) so that the PA could sign off the documentation on behalf of foundation trainees' supervisors. Facilitating AW discussions online, rather than in person, avoided complications that would have arisen from PAs meeting trainees on NHS premises. PAPS has identified no structural obstacles, posed by existing policies, to service users facilitating educative discussions with medical students or foundation trainees.

Unresolved issues:
• We do not yet know if PAs can be officially classified as accessors who are allowed to sign off CBDs on trainees' e-portfolios and are looking into this
• We have approached the NI Diabetes Network to provide part-time funding for an individual in each Trust (eg pharmacist or specialist nurse) to be an AW champion, overseeing approximately 5-10 facilitators per Trust, including PAs when available. PAs may need either to be paid or registered as volunteers by individual Trusts</td></tr>
<tr><td>Intervention (Operating procedures)</td><td>Quality-improve PAPS and MITS operating procedures, as specified in the project plan</td><td>Delivery of transferable procedures
Criterion 2: Delivery of implementable procedures</td></tr>
<tr><td colspan="3">Criterion 2:</td></tr>
</table>

<table>
<tr><td colspan="3">Since we trained PAs to follow precisely the same procedures as doctors, nurses, and pharmacists were already doing, the AW suite of procedures and documents proved fit-for-purpose without amendment. The training of PAs, though, required some development from existing procedures: notably, observing and co-participating in several AW reflective discussions before leading them. We instituted a mentor scheme and developed a new procedure to prepare PAs for meetings with mentors. The document we developed to guide PAs through this is attached. (Annex 1) We also provided recordings to PAs of CBDs between members of our team and final year medical students who gave permission. This enabled observations to continue during the summer quiet period. The online training programme is included as Annex 2.</td></tr>
<tr><td>Inner setting; (Receptiveness of Trusts and Deanery to PAPS)</td><td>Broker patient advocacy and keep an audit trail</td><td>Evaluation of context
Criterion 3: Delivery of narrative evaluation of implementation</td></tr>
<tr><td colspan="3">Criterion 3:
As stated above, institutions were either receptive to or agnostic about PAPS. What we learned, above all, was that PAs needed more training, developmental support, and encouragement than our original pilot research had suggested. Narrative evidence in the form of a PA's reflective account, is attached.(Annex 3)</td></tr>
<tr><td>Processes; (the implementation)</td><td>Quality-improve PAPS and MITS processes, as specified in project plan</td><td>Process evaluation
Criterion 4: Evaluation of processes
Outcome evaluation
Criterion 5:
Evidence that CBDs conducted by patient advocates met MITS criteria</td></tr>
<tr><td colspan="3">Criterion 4:
There are two pieces of evidence that PAPS met this criterion: Figure 1, which shows the flow of PAs recruited to the project along the pathway, and obstacles to their completion of it; Annex 4 is a facsimile of a published article, reporting the success of our project and how we adopted our processes to stay on track during the COVID-19 pandemic. Whilst they facilitated only a small minority of the 77 CBDs reported in this article, PAs took their place alongside doctors, nurses, and pharmacists in the project.

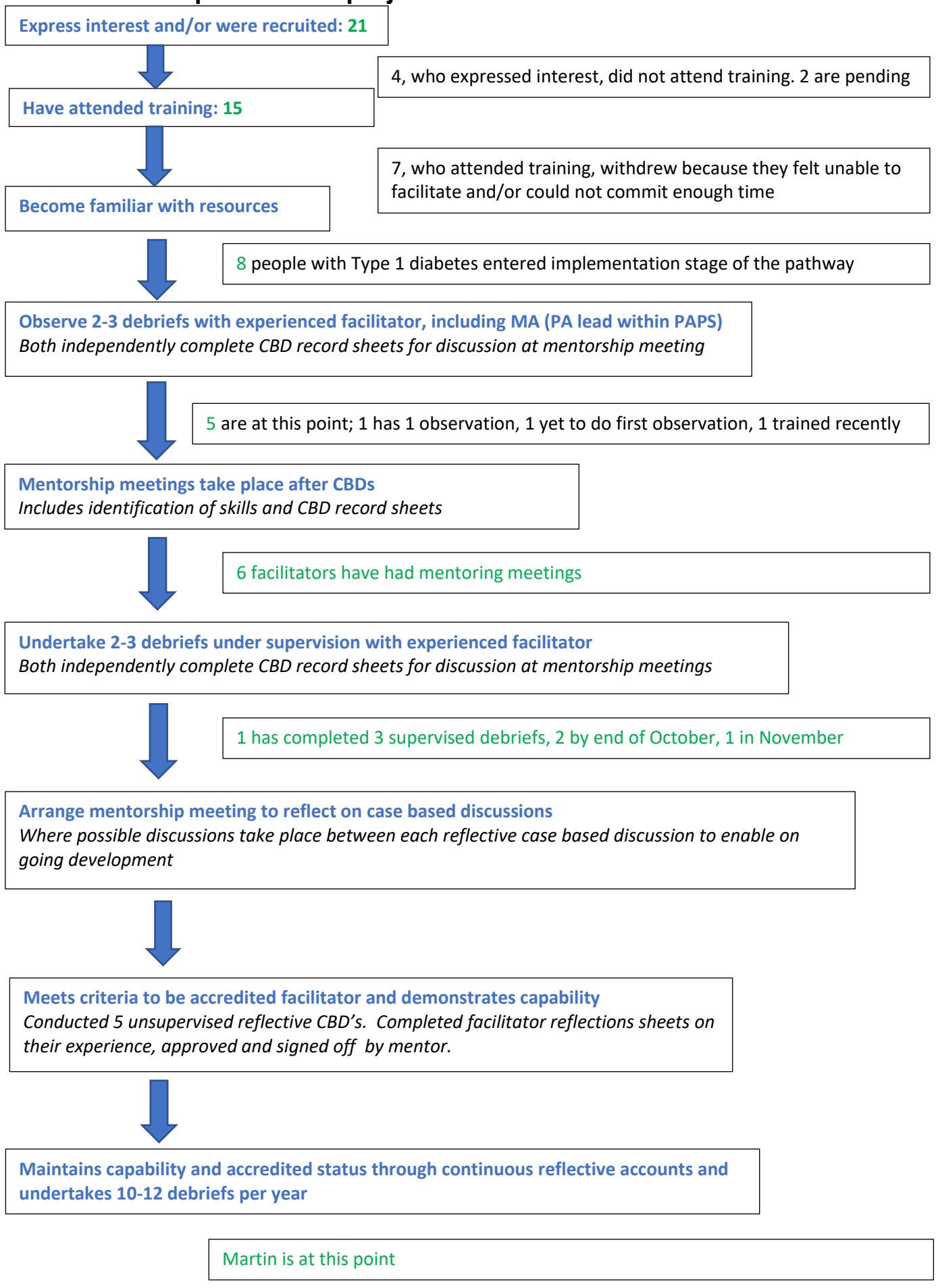
Criterion 5:
We have identified the need not just to train PAs to conduct CBDs but to mentor them and ensure they complete these to MITS criteria. This aspect of the project is uncompleted, but continuing. We now quality-assure PAs' documentation of CBDs.</td></tr>
<tr><td>Individuals; (patient advocates, trainees', and staff experiences of PAPS)</td><td>Optimise stakeholders' experience per project plan</td><td>Evaluation of stakeholders' experiences
Criterion 6: Evaluation of stakeholders' experiences</td></tr>
</table>

Martin Adams became a PA in earlier stages of our programme because he was keen to advocate for patients' rights (for example, to self-administer insulin while in hospital), which provides evidence of the validity of the PAPS approach. Annex 3, reporting another PA's experience, provides further evidence. On the other hand, the 'fall-off' shown by Figure 1 between the number of people who expressed interest in PAPS and the number who independently facilitated PAPS reflective case discussions shows that this can be a daunting task, for which PAs need to develop confidence. PAPS has identified a pathway that helps PAs do this, which could be transferred to other settings.

Partly because of COVID-related restrictions, staff experience of PAPS was primarily confined to Florence Findlay-White, whose opinion is not impartial. We have, however, involved PAs in our programme for several years, to which staff reactions have generally been positive.

Learners reactions have, likewise, been generally positive:

Fig 1: Development pathway for Act Wisely Facilitator and activity data for the completed PAPS project



Conclusions

PAPS has demonstrated the feasibility of establishing a patient advocacy programme so that medical students and foundation trainees learn to learn with and from patients. ASME's grant augmented funding from early grants to make this possible. PAPS also shows, however, that establishing a quality-assured patient advocacy programme is no simple matter because it depends heavily on the motivation of project staff and the goodwill of patients.

The fact that establishing a programme is no simple matter might also have been said, in the past, of setting up a simulated patient programme to participate in medical students' and doctors' communication skills training. Simulated patient programmes are now more or less ubiquitous, at least in UK medical schools.

PAPS would have been more likely to reach its present stage if more secure funding had been available, but funds alone would not have been sufficient. The self-evident value of PAPS to clinicians, patient advocates, and students, together with the selfless commitment of the project staff, has allowed it to reach this point. Now, we depend on policy-makers to insist that patient advocacy should be an integral part of health professions education. If they do that, familiarity and economies of scale will allow patient advocacy to flourish. Ultimately, there is no reason why patient advocacy could not follow the example of simulated patient programmes and become a ubiquitous feature of high quality health professions education.

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Annexes

1. **Proforma guiding PAs to reflect on observing CBDs in preparation for mentorship meeting**
2. **Online programme to train PAs**
3. **A PA's description of his experience of being trained**
4. **Facsimile of published article describing the PAPS intervention**

Annex 1

Making Insulin Treatment Safer

Please complete after each of your observed CBD

How did you find completing the CBD record sheet during the observation?

What about this observation would you like to discuss at your mentorship meeting?

What facilitator skills did you observe?

What behaviours supported the act wisely approach to this reflective CBD?

How was the SMAC 2 Card utilised?

Would you have done anything differently?

What did you see as the challenges for you if you had been the facilitator?

How could you overcome these challenges?

What is the learning for you from this observation?

_____
_____
_____
_____

Have you identified any personal learning needs?

_____
_____
_____
_____

Annex 2

Making Insulin Treatment Safer Online Facilitator Training

This training session is scheduled for 2 x 2 hour sessions

Programme

Welcome and introductions Zoom etiquette - using Chat – using Mute	Heather & Florence
Using Chat please respond to the following questions. • What do you want to achieve from today? • What are your concerns? • What do you know about MITS?	Heather
Presentation to explain MITs and the training booklet	Florence
What would you expect from a facilitator /what would you not expect	Heather
Discussion to include how does your personal experience influence this process and what are the potential challenges	Group discussion with Heather
Think of a personal experience professional or personal where you have felt criticised and judged • What did they do? • What did they say? • How did you feel? • What did you do as a result of that experience?	Group discussion with Heather
Feedback	
Think of a personal experience professional or personal where you were able to reflect on an incident or mistake you had made • What did they do? • What did they say? • How did you feel? • What did you do as a result of that experience?	Group Discussion with Heather
Feedback	
What skills does a facilitator need?	Group Discussion with Heather
Feedback	

Presentation of the Carl Rogers 3 core qualities, skills, and a model for learning through reflection	Florence
Video of CBD with Florence & final year medical student	Florence to introduce

Role play in pairs of Case Based Discussion (CBD)

Round one (10 minutes)
Using the prefilled MITS CBD proforma one of you be the

- Facilitator and the other the Foundation Doctor. Use the outline described on pages 6 of the training booklet to structure the role play and the Trainee case-based discussion briefing sheet (page 8)

After the role play reflect on the process. (10 minutes)

- Facilitator and Trainee to use the 'Guide to facilitating a MITS debriefing (page 7 of the training booklet)

Repeat this process in pairs changing roles (20minutes)

Review of the CBD Record Sheet (10 minutes)

Revisit Post-its (5 minutes)

Next steps (5 minutes)

Training pathway part of introduction
New record sheets
New reflection sheets
MITS CBD proformas sample a and b

Annex 3

My MITS training experience – Robert Stevenson

MITS training (Making Insulin Treatment Safer in Hospitals) is an extremely worthwhile initiative where involvement of people with diabetes has arisen out of a sub-committee jointly led by Martin Adams and Florence Findlay-White. Its objective is to facilitate reflective practice in recently qualified doctors and in final year medical students on their experiences in relation to prescribing of insulin whilst on placement.

As someone with type 1 diabetes of 38 years standing, I have taken this project to my heart. Though I am fortunate enough not to have needed any hospital admissions (diabetes-related or otherwise) since being started on insulin in July 1983, I am aware that many diabetes patients do not have my quality of control; I am also aware that my present quality of general health and diabetic control is not guaranteed in the future. Hence, any improvement in junior doctors' confidence in their decision- making surrounding insulin prescription in hospitals will have benefits for all. Best practice can be established from the outset of these young people's careers. Most of the insulin prescribing pressure points appear to arise during night shifts in hospitals when there are fewer senior clinicians around to ask for advice. During the day, DSNs, consultants, pharmacists and senior nursing staff will be there in greater numbers. Typically, there may only be one FY1 and the registrar available after hours.

As a retired English teacher, I find that my passion for things medical, together with my presentational skills and interest in people, find their ideal vent in this project. Moreover, since the lockdown due to the Covid-19 virus, it has been necessary to do the practical training via Zoom, with which I had already become familiar through online private tuition, church meetings and other activities. This is such a convenient medium for sitting in on the debriefs which Martin Adams and Florence Findlay-White and others facilitate. It works well on so many levels. There is less inconvenience than in a face-to-face meeting, for example if somebody has to cancel at short notice or if a doctor has to be called away in an emergency. It is also better from the environmental point of view. Another big advantage is that the most precious commodity of all – time - is saved! Everybody wins!

Regarding the actual debrief itself, the junior doctor or student selects an incident or example of something involving the prescription of insulin and fills in some paperwork reflecting on the experience in advance of the debrief. Thus far I have been 'sitting in' via Zoom and taking notes as the debriefer (in my case, Florence or Martin) take the candidate through the SMAC2 sheet and fills in a CBD record sheet (taking notes during the Zoom call to be written up in full later). The Assess Respond and Reflect prompt boxes on the SMAC2 card are helpful in establishing what is to be recorded where. As a lay debriefer, I am very aware of my limitations and have learnt that there is no shame in asking for clarification if the young medic being interviewed uses jargon or abbreviations with which I am unfamiliar. My role is merely to facilitate and not to guide or to teach as such; I am learning how to draw out of the doctor what procedures are available to him / her, what avenues of assistance they might avail of; what opportunity there has been to integrate with the patient in question; what they feel they did well; what they may do differently on a subsequent occasion. It is about encouraging them to consider the matter from all angles and to establish reliable, best practice.

I have not yet been the main debriefer during one of these conference calls, but I have submitted a CBD in parallel with Florence as she interviewed a final year student. Then Florence and I arranged a subsequent Zoom call as a debrief on the debrief, when she passed on helpful suggestions to me regarding what might have been recorded which I had omitted and she passed on advice regarding the relevant part of the form to record each element.

The final year students I have observed to date have been able to see but not hear me, as my microphone is muted. It has been an absolute privilege to rub "virtual" shoulders with these young enthusiastic professionals and I have learnt so much – about the pressures young doctors face, about diabetes and diagnosis, about prescribing and about human nature. Something which four decades of teaching has taught me is that "**The best way to learn is by doing".** I am very much looking forward to doing some debriefs of my own, initially - and for as long as proves necessary - supported by one of the trainers of course who will be there on Zoom ready to intervene when appropriate for clarification or explanation

If any of the above sounds like the sort of thing you might like to get involved with, please don't hesitate to speak to Florence or Martin at paps.actwisely@gmail.com
Robert Stevenson

Annex 4

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MEDICAL EDUCATION ADAPTATIONS

Enhancing workplace learning at the transition into practice: Lessons from a pandemic

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1 | WHAT PROBLEMS WERE ADDRESSED?

Taking responsibility for prescribing is one of newly qualified doctors' greatest stressors.[1] Despite being a routine task, prescribing insulin is particularly stress-inducing. The coronavirus disease 2019 (COVID-19) pandemic has made it more important to minimise the stress experienced by transitioning students, yet there are fewer clinicians to support their accelerated transitions.

We had planned an intervention during the 9-week 'clinical assistantships' that students undertake immediately before he or she qualifies. Students were to write insulin 'pre-prescriptions,' which supervisors would endorse as prescriptions that were appropriate to dispense. Trained health care professionals or individuals with diabetes (debriefers) were to conduct one-to-one case-based discussions (CBDs) to help students learn reflectively from his or her experience.

We were unable to carry this out as intended: clinical placements were cut short and students who had been exposed to COVID-19 posed a risk to our debriefers with diabetes. Despite that, we set out to enhance, rather than abandon, our novel form of reflective, experiential education.

2 | WHAT WAS TRIED?

We encouraged students to gain experience of pre-prescribing insulin for hospitalised patients, as intended, but under the COVID-19 pandemic conditions. Face to face CBDs were impossible, yet one-to-one reflective discussions play an essential part in students' learning and therefore we made a rapid decision to migrate these sometimes very personal discussions on to an online videoconferencing platform Zoom™ (Zoom Video Communications Inc., San Jose, CA, USA).

A curriculum administrator took over responsibility for booking CBDs from 11 teaching hospitals. The central organisation of technology-supported reflective conversations made optimum use of available resources, aligned the availabilities of debriefers and students, minimised missed appointments and made a CBD available to every interested student.

We revised our operating procedures so that, as intended, deep reflective discussions took place, allowing students to reflect on experiences and make commitments to safe and appropriate future prescribing behaviour. Records of these CBDs provided rich, anonymised descriptions of students' reflective learning; qualitative analysis of these allowed us to evaluate the intervention.

3 | WHAT LESSONS WERE LEARNED?

A total of 77 students (approximately 25% of the cohort) participated. Detailed records were available for 25 of these students, who both wrote an insulin pre-prescription and completed a voluntary CBD, yielding over 7000 words of evaluation data for qualitative analysis.

The COVID-19 pandemic helped students learn three key lessons: (a) participants who had navigated indeterminate situations, in which factors such as COVID-19 created ambiguity and made prescribing decisions complex, were able to verbalise how he or she would manage experiences like these in future; (b) reflecting on an instance of prescribing helped students situate individual prescribing decisions in the wider context of patients' trajectories of care, in which insulin prescribing must be reconciled with other medications and co-morbidities, and (c) participants learned he or she were not alone and could develop collaborative expertise by seeking help from fellow professionals, patients and senior colleagues.

We learned lessons too: (a) it is tempting to abandon workplace education when students are numerous and clinicians are busy, yet the COVID-19 pandemic conditions encouraged us to use good learning opportunities creatively; (b) transitioning to an online communication platform made supporting student reflection on workplace learning so much easier that conducting CBDs online is our new normal, and (c) helping students seek out educational opportunities can 'engage their brains' and encourage them to 'ask why things are being done the way they are.' This applies to medical education as much as it does to clinical medicine.

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