International Journal of Integrated Care

Macdonald, S et al 2019 PlayDecide: Patient Safety – A "serious game" learning tool to discuss medical professionalism in relation to reporting and patient safety. *International Journal of Integrated Care*, 19(S1): A183, pp. 1-8, DOI: dx.doi.org/10.5334/ijic.s3183

CONFERENCE ABSTRACT

PlayDecide: Patient Safety – A "serious game" learning tool to discuss medical professionalism in relation to reporting and patient safety

19th International Conference on Integrated Care, San Sebastian, 01-03 April 2019

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Introduction: In Ireland, and internationally, healthcare errors and incidents are frequently under-reported(1-3), undermining the utility of reporting systems as a source of meaningful learning for policy formulation and behaviour change. Common barriers to reporting include fear, deferred responsibility, and a belief that reporting would not lead to improvement(2-4). To address this challenge to patient safety, it is necessary to build shared understanding that reporting improves service quality, and aids professional development.

Description of policy context and objective: Ireland's Health Service Executive and Health Information and Quality Authority emphasise supportive organisational cultures, and sustained commitment to improvement by all actors within the health and social care services(4,5). This is not yet fully realised across institutions, and under-reporting remains a challenge. Our objective was therefore to create a tool for healthcare teams to openly discuss patient safety and error reporting. We used an inclusive co-design process to adapt the PlayDecide "serious game"(6), which tasks players with exchanging and discussing perspectives and information, then working towards a shared group policy position.

Targeted population: The game initially targeted junior doctors, and was then revised for multidisciplinary healthcare team members and management staff.

Highlights (innovation, impact, and outcomes): Patient representatives, academic researchers, hospital staff, and state actors were involved throughout the co-design process. Anonymously-contributed personal accounts of patient safety issues were adapted into short case stories for use in the game. A major strength is the game's embedded learning approach, using educational content that is contextual to the targeted population's work.

The game was initially played by over 100 junior doctors. 98% of participants supported the policy position that staff should report all concerns. However, it was felt that the current environment did not support this – only 32% of the participants who had recently witnessed an incident had reported it – and previous training around incident reporting was insufficient. We also tested the game among members of acute care teams, including nurses, speech and language therapists, and others, who also found the experience valuable, and emphasised the need for error reporting to become more normalised in hospitals.

Comments on transferability: Game content is broadly transferable due to a focus on challenges that might occur in any healthcare setting – e.g. lack of standardised protocols, difficult senior

colleagues, or systems failures. The game occasionally references features of the Irish health system, but this could easily be adapted to other country contexts.

Conclusions: Participants’ reported value of discussions with colleagues outside their own cadre, and the educational utility of the reality-based content, suggest that PlayDecide: Patient Safety would be a valuable addition to training and professional development initiatives. The embedded learning approach, with a focus on building knowledge and encouraging change from the “ground-up”, may be a useful strategy for change within healthcare organisations. PlayDecide: Patient Safety represents a novel tool to build understanding and encourage productive dialogue around error reporting and patient safety. The co-design process is also a valuable means of creating contend that is highly authentic and relevant to key stakeholders.

Keywords: patient safety; error reporting; professionalism; multidisciplinary teams; educational interventions