Ag Rialáil Gairmithe Sláinte agus Cúraim Shóisialaigh
Regulating Health + Social Care Professionals

Check against delivery

Learnings from Regulation of Professions for Safe Patient Care

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Good morning,

Thank you for inviting me to speak at this important event. While the theme of the conference is learning from Investigation and Reviews, I have tweaked this slightly, to learn from the regulation of professions. I will talk about one case which has raised a lot of issues for professionals, services and regulators, but I will also talk about how regulation is working to keep patients safer, by concentrating on ensuring regulated professions are engaged and resilient in their work.

Protection of the public is key and the raison d'être for regulators - if the standards that are set and the actions taken by regulators do not contribute to patient safety and the protection of the public, there is no point to regulation.

We expect the public to put their trust in the professional who is serving them, often at a vulnerable time of life. Regulation is one way of reassuring the public that the professional working with them meets a minimum standard of education, is of good character, and can be held to account if there is a failing.

The history of regulation of professions is that professions have regulated themselves, which led George Bernard Shaw, in 1906, to state that

"All professions are conspiracies against the laity".

In Ireland, legislation since 2005 has meant that the governance of regulatory bodies is now made up of more lay/public members than members of the profession for doctors, nurses/midwives, pharmacists, and health and social care professionals. This is unusual in the regulatory world, where most continue to be self-regulated, but countries are beginning to move towards this model. In the UK regulation, it is now 50:50 – the governing bodies are 50% professionals and 50% lay members.

As Mary Harney, who was the Minister for Health at the time of introducing this change, said, when there was kickback from some of the professions, who wanted to maintain self-regulation

"It is fundamentally wrong for a profession to set the standards for its own profession without proper oversight by the public." (2016)

Ag Rialáil Gairmithe Sláinte agus Cúraim Shóisialaigh
Regulating Health + Social Care Professionals

CORU is charged with regulating 17 professions. Fifteen of these professions are being regulated for the first time. We have registers open for 10 professions and are working with five professions towards opening their statutory register. CORU will regulate over 35,000 professionals when the 17 professional registers are open.

Demand for regulation is increasing - not just from the public. Twenty-six other health and social care professions have advised the Department of Health that they want to be considered for statutory registration. While this is welcome, to deliver a sustainable regulatory model, each profession will need to be assessed in terms of the risks posed. Not every profession requires regulation.

Our role as a Regulator is to provide the framework within which health and social care professions can practice safely. CORUs' registrants must adhere to their professions' Code of Professional Conduct and Ethics and maintain Continuous Professional Development. We also set the standards of education for all of the training programmes in Ireland to ensure the graduates applying for registration reach the threshold standards of what is needed to practice safely. But registrants must also meet the "fit and proper" criteria, which include conduct/character and health requirements, before being admitted to the Register.

Our objective is to prevent a failing happening but, as in all walks of life, failings do happen and complaints against professionals are investigated under our Fitness to Practise regime.

The introduction of Fitness to Practise caused concern among some of our professions who had not previously had Fitness to Practise. However, there is now recognition that one of the benefits of Fitness to Practise is the learnings that emerge from each case shaping the standards that are being set for the future and the application of these learnings benefit the profession, the service user and the wider healthcare system.

I just want to pause here for a minute to talk about the actual level of complaints received. News headlines can suggest the impression of high levels of complaints. The reality is different. The numbers of cases are small.

In Ireland we have approximately 128,000 registrants, with approximately 635 complaints received in the past year. In other words, half of one percent of all registrants received a complaint against them. An estimated 30 per cent of these complaints (about 200) go into hearings. In keeping with international research, Medics receive the most complaints of all professionals in Ireland – this accounts for 1.7%.

However, Professor Marie Bismark, Melbourne University, who used the data from the Australian Health Professionals Regulatory Agency (AHPRA), who regulate over 700,000 health and social care professionals, shows that in Australia 3% of doctors who are complained about are responsible for 49% of all complaints. Interestingly, other research she carried out with solicitors found that 4% of solicitors who are complained about are responsible for 58% of all complaints.

Ag Rialáil Gairmithe Sláinte agus Cúraim Shóisialaigh
Regulating Health + Social Care Professionals

Case study

I am now going to present a case study based on a presentation to regulators recently made by Alan Clamp, the CEO of the Professional Standards Authority, who supervise health and social care regulators in the UK.

Let me introduce you to Jack Adcock, a 6-year-old boy with a known heart problem.

Jack was admitted to the Royal Leicester Hospital on 18 February 2011 at 9.30am, with vomiting, diarrhoea and breathlessness, referred by his GP – he was declared dead at 9.21pm on the same day.

Dr Bawa Garba was a Medical Registrar who had just returned to work following maternity leave. Jack was admitted under Dr O Riordan, a Consultant, who had teaching commitments elsewhere and was not in the hospital. There were staff shortages on the unit and the blood IT system was not working correctly.

The working diagnosis for Jack was dehydration, but a drug he was on was left off the charted list. He had a chest x-ray and blood tests – his pH was a little acidic.

He received fluids and his pH was adjusting but there were insufficient blood tests taken to monitor his condition. The blood reporting system had gone down and the alert system was not working. If it had been working, it might have indicated that Jack's kidneys were beginning to fail. Dr Bawa Garba looked at the x-ray which indicated a chest infection and she prescribed antibiotics. She phoned for blood results, which again did not register any indication of kidney problems.

At 6pm Jack started to go downhill, was given his heart drug and at 8.15pm went into cardiac arrest.

To add to the confusion there was another boy on the ward who had a DNR, a do not resuscitate, instruction on his chart. Dr Bawa Garba thought that Jack was the boy with the DNR instruction and, through a confused couple of minutes, resuscitation was stopped and then resumed. Jack ultimately died of sepsis.

Investigations found that there were systemic failures, with errors from the doctor and the nurse, Isabel Amaro. There were 23 recommendations made with 79 different actions to minimise the risk of this happening again.

There were many Expert Reviews – they declared that the interruption to resuscitation was not material in Jack's death. Enalapril, used to treat high blood pressure, was deemed by two experts to be a contributing factor, while two other experts disagreed.

It was agreed that Jack should have been given antibiotics much earlier. The reviews led to an inquest in 2013, which referred the case to the Crown Criminal Prosecution Services.

Ag Rialáil Gairmithe Sláinte agus Cúraim Shóisialaigh
Regulating Health + Social Care Professionals

This case took place in December 2014 where Dr Bawa Garba and Nurse Isabel Amaro were charged with manslaughter by gross negligence, an incredibly rare action, and one that sent concerns through the medical fraternity. In November 2015, they were found guilty and received a 2 year suspended sentence.

Regulation response

In June 2017, the Medical Practitioners Tribunal Service (MPTS), the disciplinary arm of the General Medical Council (GMC), suspended Dr Bawa Garba for one year, taking into account that she had practised safety before and after the incident. They believed striking her off would be too unfair. However, Nurse Isabel Amora was struck off by the Nursing and Midwifery Council UK.

In January 2018, the General Medical Council appealed the decision of its own disciplinary arm to the High Court, saying the sanction was too lenient. The court changed the sanction to erasure.

Eight months later, in August 2018, Dr Bawa Garba appealed to the Court of Appeal and was reinstated but with a suspension order in place and conditions to practice added. Following maternity leave, she will be back in work in February 2020.

There was a major outcry with many doctors declaring “I am Dr Bawa Garba” because many felt that this doctor was being unfairly punished for mistakes made while working in an overstretched system and an under resourced NHS.

Nicky Adcock, Jack’s mother said

“We can’t believe that she is allowed to practice again after a conviction like this.”

Dr Bawa Garba said

“I am sorry for my failure to recognise sepsis. I apologise for the pain I have caused the family. The pain will live with me for the rest of my life.”

For regulators, for professionals and for healthcare providers this case throws up a number of questions.

No Consultant cover – should regulators take into account work force issues? Should regulators be involved in helping to address workforce issues?

Culture of blame – regulators have to look to see if there is a blame culture that regulation has contributed to.

Systems Failure – what was Plan B when the IT systems are not working? The British Medical Association (BMA-union) is now stating that doctors can refuse to work with systems failures and understaffing.

Team working – before practice does occur, who is responsible? In this case the nurse involved was struck off, but the doctor was not.

Law – the High Court/ the Court of Appeal – judging a doctor's career on the basis of one case with a tragic outcome. Should it automatically lead to a strike off?

Mistakes – blood test problems in many cases do not pick up sepsis – what about Dr O Riordan double booking himself when a junior member of staff was returning from maternity leave? What are the thresholds for mistakes?

Time – It took almost five years to charge and five years before there was a result. Dr Bawa Garba will return to work in February 2020, almost nine years after the death of Jack Adcock.

Communications – ambiguity and a lack of communication – for example knowing not to administer a certain drug could have made the difference – x-ray delay, the Blood IT system down, blood disorders, the consultant not being available to see something that may have been picked up.

Candour – to err is human, not to be candid is unforgivable, failure to learn is inexcusable.

As you can see, there are no easy answers. These are the current questions that are exercising regulators and need to be taken into account when we set standards, develop codes of professional conduct and ethics and identify the requirement for continuous professional development.

Where are we now?

It is a concern that we are seeing different outcomes for different professions as different regulators have taken different approaches to people doing different jobs. Currently, the Professional Standards Authority is researching this area and I am watching this closely as I believe it is an area in Ireland that we also need to pay heed to.

We need better and fairer regulation. Prevention of harm is at the centre of what is required for regulatory reform and helping professions to be good at what they do.

But to come back to Jack Adcock, and it's a question that can be asked of any Fitness to Practice case:

Would a different person in the same context have made the same mistakes?

While it is acknowledged that there are learnings from Fitness to Practise cases, it is really too late as harm has been done. Regulators are now looking to invest more in doing what we can to keep people away from Fitness to Practice and supporting registrants to practice safely.

An example of putting more efforts into supporting registrants is through Upstreaming, a system that is being developed by the General Medical Council in the UK and is also seen in financial regulation. This is about investing more in supporting the registrants to keep meeting the required standards, looking at work environments and also looking at the individuals, which is what I want to touch on now.

Ag Rialáil Gairmithe Sláinte agus Cúraim Shóisialaigh
Regulating Health + Social Care Professionals

Harry Cayton is a health regulation expert who recently spoke of the changes in how professionals work. He quoted Michael Warren, who has written extensively on this matter, looking at how professionals acquire and hold their sense of professional identity. It does not come from regulation, but from peers, from teachers, about how you are valued by other professionals. Regulation confirms who you are, but only to a limited extent.

He talked of 'Old Professionalism', meaning power, authority, status and social standing. It was a place where professionals had the freedom to act independently and you were a member of a club who set the standard for entry – a bit like self-regulation we talked about earlier.

Old Professionalism meant to have:

Mastery – of your subject, understanding the mystery of your profession.

Autonomy – in decision making, because so many were working on their own.

Altruism – selfless concern for the wellbeing of others – is this still there for many professions?

Cayton talks of 'New Professionalism' – a change in how people work because of changes in the work environment.

Nowadays we work in a more open culture with more accountability for decision-making and more inter-dependence of all professionals working with the patient directly and indirectly.

This led to a New Professionalism based on:

Expertise – rather than mastery, knowing how to find out what you need to know, smart phones, interacting with the knowledge that you need, keeping up to date.

Mutuality – moving away from autonomy, because of the interdependency on other colleagues and because of the increasingly complex work environment.

Empathy – with the patient but also within the team. Is shared responsibility being taken for doing the right thing to ensure the best outcomes for the patient?

Take the example of a modern operating theatre – a lot of modern professions, with highly complex tasks and roles, interconnected, working together, depending on each other – now much less deference, but the work of the team is centred on a successful outcome for the patient.

Cayton concluded:

Being a professional, if you have the right values, you will do honour to your profession.

Professionals have to ask themselves:

Who am I when I am at work?

Being aware of the personal qualities that matter for professionalism.

Honesty with ourselves and others, competency, humility, resilience and engagement.

Resilience

As an experienced regulator I believe that for registrants two factors are critical to patient safety:

1. That they are engaged in their work, and
2. Being resilient throughout their careers.

We have covered engagement in the need for ongoing learning throughout one's career.

Resilience of the registrant/practitioner is a crucial factor in delivering safe services.

To contextualise this, think of a career which can cover over forty years from the age of twenty-one to sixty-plus, through which life throws all it can at you – good and bad.

How can we assure ourselves that we can keep our heads in the game and deliver safe care, no matter what is happening in our personal lives?

As Hemingway states

"The world breaks everyone, and afterwards some are strong in broken places."

Or as Robert Jordan stated

"The oak fought the wind and was broken, the willow bent when it must and survived."

Jenny Bulbulia, former Council member, barrister, PhD student, looked at resilience lessons from research she conducted with over 800 social workers in Ireland, UK, New Zealand and two provinces in Canada. Some lessons learnt is that resilience appears to be the

"ability to cope with stress and crisis and then rebound quickly" (K Barton WITI).

This is the ability to deal with stress and crisis and to then recover. This is critical in modern health and social care services to avoid burnout. Self-awareness is one of the major protective factors – recognising when you are not coping with the pressures being placed on you. What tools do you have to keep you from burnout and to keep your head in the game?

An interesting German paper by Zwack and Schweitzer in 2013 is about doctors entitled "If 1 in 5 physicians are affected by burnout, what are the other 4 doing?" It takes a strengths based approach, learning from those who do not burnout.

What are their protective factors?

- Job satisfaction – interaction with patients, making a difference in a person's life/health;
- Work Management – controlling one's own working hours and allowing time out routinely;
- Professional development – proactive engagement within the limits of skills – learning from dealing with complications and treatment errors;
- Personal reflections;
- Self-demarcation;
- Cultivation of one's own professionalisation;
- Quest and cultivation of contact with colleagues.

Resilience Practices

- Leisure time activity to reduce stress.
- Cultivation of relations with family and friends.
- Spiritual practices (for some).
- Personal reflections.

Why is resilience important? The Harvard Business Review from 2002, looking broadly at business, identifies resilience as one of the most important protective factors to determine who succeeds or who fails.

As a service provider, registrants need to "have their heads in the game" to deliver the services required by the service user safely and effectively. As stated by Balint

The person of the doctor is the most powerful drug that a doctor gives his/her patient.

Arvay talks of the

Self of the counsellor is a fundamental tool of therapy.

Critically, the Health and Care Professional Council, CORU's UK equivalent states,

Where staff are engaged, patient and service user outcomes are better and quality improves.

The challenge is when services are being delivered by distracted or burned out professionals. What is the impact on communication? On safety? On quality of services?

There are plenty of examples of Fitness to Practice cases where burned out individuals have made poor decisions which unfortunately have led to bad patient outcomes, so clearly resilience is important for safe patient care.

We have to do our best to minimise harm to service users and patients, by promoting personal and professional wellbeing, equilibrium and balance. For a professional to practice safely throughout their career, I believe it is important that allowances are made for the different stages of life that we all go through and the impact these can have to be fully engaged in our work.

Supporting resilience is an important component of safety in the workplace but it's not exclusively the responsibility of the employer. Resilience is best achieved when the individual, the organisation and the profession as a whole all contribute to supporting resilience in the work environment.

Personal – Looking after one's self, being aware of when you need a break or when you can face the great demands of health care, but listening to your gut, about when you need to step back.

Critically, leaving work at work. An example was that one of the social workers in the study was at a park on a Saturday and saw an older man with a small child. She immediately worried that it might be an abuser only to realise it was a grandfather and grandson – understanding when your work is interfering with your reality in your life.

Organisational – The lack of workforce cohesion/ good teamwork can lead to stress for everyone and can also lead to an unsafe environment, where boundaries can be crossed. Resilience is important for an individual but also for teams working together.

I am heartened to hear about the Schwartz Rounds, which started in Ireland in Galway University Hospital. These are conversations with staff for one set hour a week to which everyone is invited. It focuses on the emotional impact of their work and provides an opportunity for staff from all disciplines across a healthcare organisation to reflect on the emotional aspect of their work. This is a great supportive initiative which I think and hope is expanding across the country.

Professional – It is critical that resilience is taught from first year at college – an understanding of how to protect yourself and how to cope with the challenges of providing health and social care services and how to bounce back and to recognise when you need to take a break.

Continuing Professional Development, supervision and reflective spaces with peers are all ways this can be achieved.

Ag Rialáil Gairmithe Sláinte agus Cúraim Shóisialaigh
Regulating Health + Social Care Professionals

As a Regulator, we consider these issues when setting standards, which is our direct responsibility, including taking the learning from Fitness to Practise cases and international research on how to keep professionals engaged and resilient.

We are also using our influence through presenting at meetings and conferences, supporting research into this area, and using our position as leaders in health and social care to bring this to the centre of good practice.

What does the future hold?

We know that we are facing an anticipated shortage of up to 50 million health and social care professionals across the world up to 2030. Ireland will not be immune.

The use of Artificial Intelligence in healthcare will become more embedded within the delivery of healthcare services. It's a reality all of us in healthcare have to plan for. One example is that in May 2017, a Chinese robot passed the final medical examinations!

As regulators, we have to ensure professionals continue to have the required knowledge to deliver care. A modern aeroplane is capable of flying across the Atlantic on autopilot, but it is still essential that a there are human pilots ready to act if there is any failure. This approach also applies to health and social care.

As a regulator, we also know that technology can make deception easier. For example, the forgery of papers. And we are looking at ways to address this.

I've spoken at length about resilience and this will become ever more important in our health and social care services.

Because of AI, because of the shortage of professionals, because of ageing populations worldwide and increasing demands on our health services, there must be an evolution.

Professions must evolve and we will need practitioners to work to the edge or their scope of practice. Sláintecare is built on the concept of 'care at the lowest level of complexity'. Not all healthcare pathways need to route through hospitals. Delivering upon this will mean that professionals will have to step up to provide the services they specialise in. Perhaps it may mean having to let go part of their work that could be provided by another worker in a step down fashion.

For example, occupational therapists used to provide bathroom aides – nowadays, this is more likely to be carried out by a well-trained assistant. This allows the occupational therapist to deal with more complex issues and adaptations to environments to allow patients to stay as independent as possible for as long as possible.

Ag Rialáil Gairmithe Sláinte agus Cúraim Shóisialaigh
Regulating Health + Social Care Professionals

CORU does not regulate by scope of practice but by title protection. This allows for flexibility for registrants to work in areas they are trained in, which is to the betterment of service delivery as registrants can work within the limits of their knowledge, skills expertise and competence. This is fundamental to developing the flexible professions we will need in the future and is how CORU regulate its professions.

As health and social care changes, the relationship between the patient and the care provider will always remain at the core of the delivering of services.

As Regulators, our role is to ensure that the standards change to take into account new learnings and research. We must ensure regulation supports innovation while retaining the core of its professionalism. This must be built around safe delivery of services to patients and supporting registrants to continue to be engaged and resilient practitioners.

Thank you.