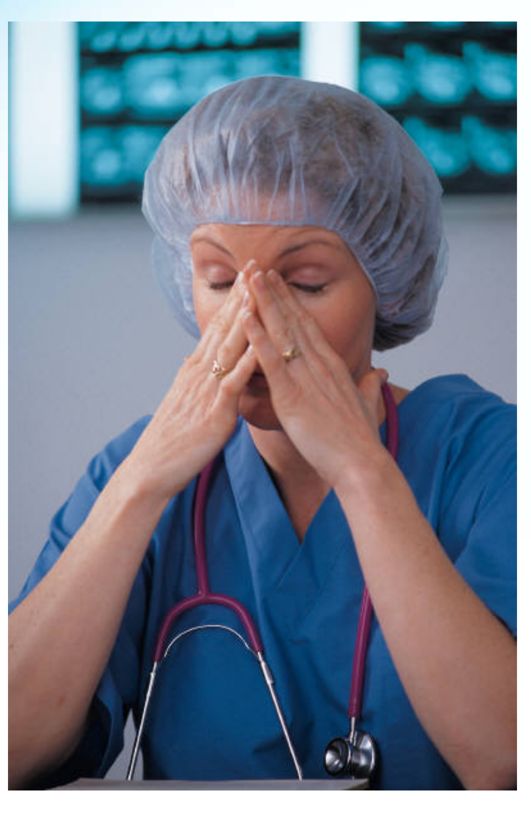
Fatigue Management for Medical Officers

A Risk Management Approach

Susanne Le Boutillier, A/Director Medical Workforce Queensland Health

Why an Alert Doctors' Strategy?



- Incident in regional hospital – Ombudsman's' Report and now Coronial Inquest
- Industrial concerns with indemnity
- Morris/Davies Commission of Inquiry and QH Systems Review
- Govt. adopted new approach to EB negotiations in 2005 – Interest Based
- MBQ Healthy Work Practices Discussion Paper

Original environmental scan

Culture
Leadership
Consumer Expectations
Service Redesign
Education & Training
Patient safety
Medical culture
Employer of choice
Reward and recognition – perverse incentives
Knowledge of fatigue
Stand
Elective surgery only hospitals
Private sector partnerships
Fee 4 service medicine
Role of trainees
Working Patterns
Alert Doctors Strategy
Alertness Management
Rest patterns
Shift work
rosters
Cancelling lists
Regulate max. hours
NHS hospitals at night
NP roles
Budgeted positions
Funding new roles
Facility design
Life balance
Fit 4 work
Self awareness
Nutrition
Physical Activity
Role Redesign
Demand Management
New practitioner roles
hospitalists
New Roles -Doctors - Others
Resource Allocation
Employee Responsibility

Highly complex environment

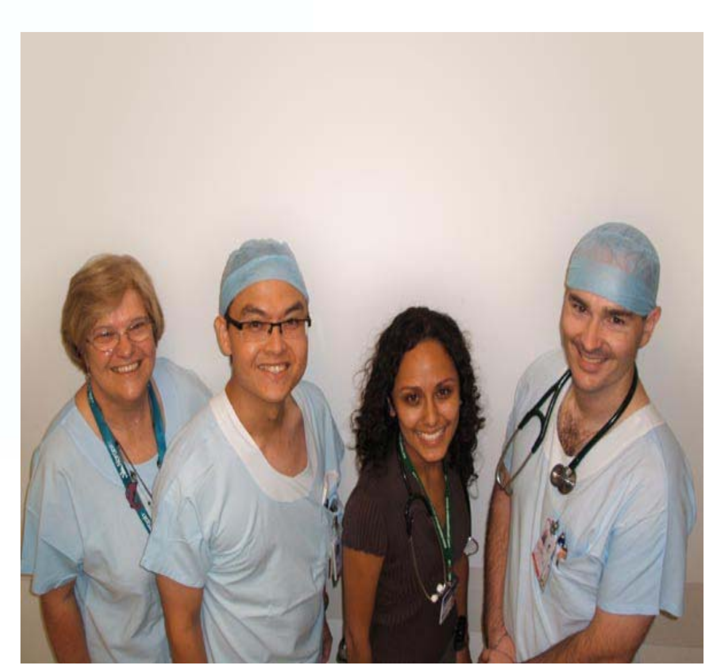
- Multiple drivers
  - Workforce availability and distribution
  - Finite pool of financial resources with competing priorities
  - Changing workforce preference for hours of work
  - Sustainability of developing the future workforce ie Clinical Education and Training capacity
  - Not the only quality and safety show in town.

Strategy needed to:

- Be evidence-based
- Involve experts external to QH
- Empower local champions and facilitate change on the ground
- Be acceptable to internal stakeholders, unions, the AMAQ and the MBQ

Wanted a solution that …

- Wasn’t one-size fits all
- Recognised the complexity of and diversity within the health care system
- Focused on more than rostered hours
- Had the potential to improve the health and safety of doctors and their patients
- Was more likely to be able to be implemented



What made up the Alert Doctors Strategy?

Focusing on Fatigue

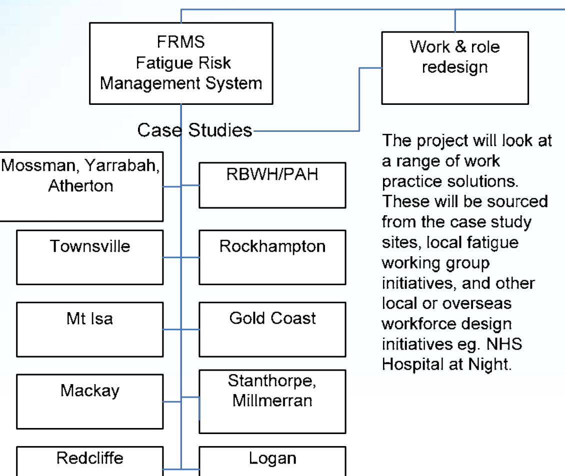
ALERT DOCTORS STRATEGY
STRUCTURE OVERVIEW

MWAC
Medical Workforce Advice & Coordination

MIBB
Medical Interest Based Bargaining Group

Alert Doctors Strategy Steering Committee

ALERT DOCTORS STRATEGY PROJECT



For the introduction of the FRMS, 10 case study sites have been chosen. The process at the case study sites will consist of:
- Establishing a FRMS working group
- Developing a tailored FRMS policy and procedures to address the specific needs of the site
- Conducting fatigue risk assessments
- Developing action plans
- Training for staff
- An audit system

The case studies will be conducted over a 9 month period. The outcomes from the case studies will provide the framework to introduce the FRMS to all QH facilities.

Work & role redesign

The project will look at a range of work practice solutions. These will be sourced from the case study sites, local fatigue working group initiatives, and other local or overseas workforce design initiatives eg. NHS Hospital at Night.

Implementation Standard

Under Occupational Health and Safety Policy, QH will develop a comprehensive Implementation Standard in relation to the management of fatigue. Guidelines and procedure templates will also be provided as part of the FRMS framework. These will be refined to meet the specific needs of the site eg. workload and work tasks, work environment, team composition.

On-call facilities review

A review of on-call facilities will be performed at QH sites. Some funding will be available to improve facilities.

Communication

A communication strategy to inform staff and all relevant stakeholders of the progress of the strategy. Existing channels of communication will be utilised (intranet, email, newsletters)

Education Material

A training program for doctors to increase awareness about fatigue causes, consequences and risk reduction strategies. A range of training options and mode of delivery will be available.

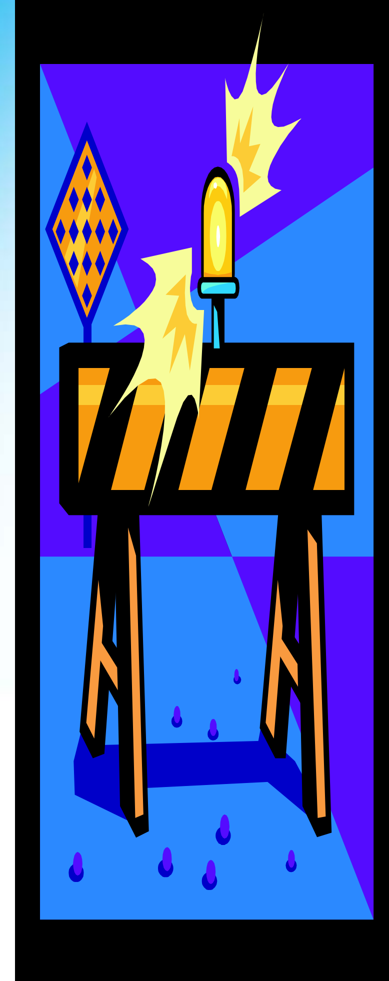
Short-term strategies

- **Systematic Reporting** – Excess overtime and fatigue penalty reports
- **Local Fatigue Working Groups** – Working groups at 8 QH hospitals developing local initiatives
- **Interim Fatigue Reporting & Management Arrangements** – Self reporting of fatigue instances & required management action
- **Interim Continuous Hours Procedures** – Reporting and escalation procedures for long hours of work

Case Study Process

- Identified sites
- Sought local agreement to participate
- Environmental scan
- Hazard assessment
- 2 week sleep and alertness study
- Report findings
- Commence development of FRMS

Typical on the ground reactions included …



Courtesy CFSR, Uni SA

- The trainees won't get enough exposure to cases.
- Continuity of care will be affected.
- I did it this way.
- There's no-one else.
- You have to be able to function under pressure – including sleep deprivation.
- I don't need much sleep.
- We work shifts, there isn't a fatigue issue.
- This won't change anything.
- We don't know what they do away from here.

Behavioural/cultural barriers to change:

Courtesy CFSR, Uni SA

The following did not necessarily apply to all case study sites or facilities:

- cultural acceptance of unsafe practice (compared to other industries and defined by literature)
- minimal appreciation/understanding of risk management
- lack of empowerment of OHS and patient safety officers
- unwillingness to engage in conversations about patient safety
- erratic rostering practices driven by preferences rather than safety (for Dr. and patient)
- limited acceptance/assignment of responsibility for managing fatigue-related risk throughout organsiation
- leadership on the issue absent at various levels
- incentives to work long hours without risk management strategies in place

Lessons learnt from case studies

To achieve sustainability in a FRMS need to:

- Clearly define ***responsibility*** and ***accountability*** within each facility (EDMS and Directors)
- Develop strength in ***local clinical champions*** - the future success of FRMS lies here…
- Assist facilities in ***finding time for FRMS development***
  - you can't build an FRMS in a 20 minute meeting - interrupted by 4 pages / phone calls
- Recognise that non-clinical project officers are not empowered to build FRMS for departments
- Provide Clinical management with time to fulfill their responsibilities

Expanding beyond case studies

- Local Fatigue Working Groups
  - Small funding grants to bring appropriate person off-line for set periods to support LFWGs
  - Number of sites mandated because of risk identified through overtime reports
  - Volunteers encouraged through offering $ to support

Expanding beyond case studies

Stakeholder Forums

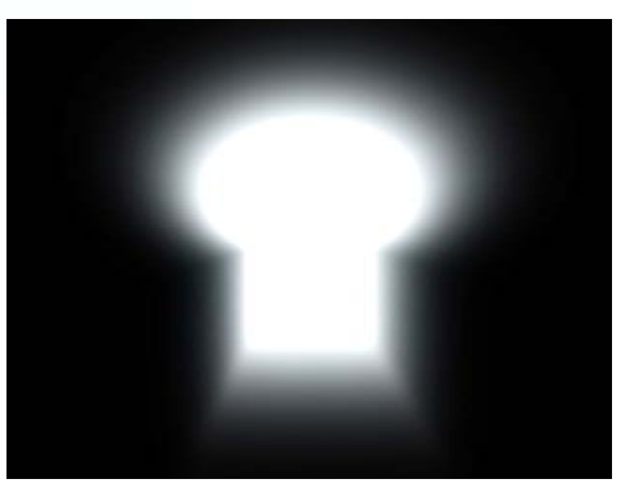
1st	2nd	3rd
- **Mainly case study and mandated LFWG sites** - Explained the theory - Exposed to practical approaches being undertaken by others - Opportunity to workshop ideas with like facilities	- **Broader audience** - Lean thinking, change management, clinical handover - Providing ideas and encouraging innovation - Opportunity to workshop ideas with like facilities	- **Broader management engagement** Showcase of case study and project outcomes - Summarise case study and project outcomes - Overwhelmingly positive - Desire to spread and embed what has been achieved to date

On 1 July 2008, a new HR Policy on Medical Fatigue Risk Management will take effect and require:

- Mandated use of a FRMS in all Queensland Health facilities and/or departments.
  - All Districts will be required to have a District-wide FRMS and specific protocols for Units with Extreme level risks in place by 30 June 2009

From this …

To this …



Defences in Depth

- Using hours as the only defense misses a whole range of other risks:
  - no consideration given to the multiple challenges to sleep.
  - nothing in the system that detects increased risk due to inadequate sleep or extended wake and no actions to manage that risk.
  - nothing in the system to detect or act on fatigued behaviours.
  - no information collected to determine whether the time provided for sleep actually translates to sleep.
- The Defences in Depth model forms the major practical or day-to-day aspect of the FRMS and includes tools, strategies and control measures for monitoring and managing fatigue-related risk.

The Defences In Depth Model

	Hazard Assessment	Incident Trajectory	Control Mechanism
Proactive	Adequate Sleep Opportunity?	Level 1	Hours of work guidelines
Proactive	Acceptable levels of Prior Sleep and Wake?	Level 2	Individual fatigue likelihood score Prior sleep/wake assessment
Proactive	Are there fatigue related behaviours?	Level 3	Subjective Reports Individual/Collegial Symptom Checklist
Reactive	Fatigue related errors?	Level 4	Analysis of fatigue related errors and near miss reports
Reactive	Fatigue related incidents?	Level 5	Incident Analysis Address Levels 1-4

Courtesy CFSR, Uni SA

Sample of a Medical FRMS

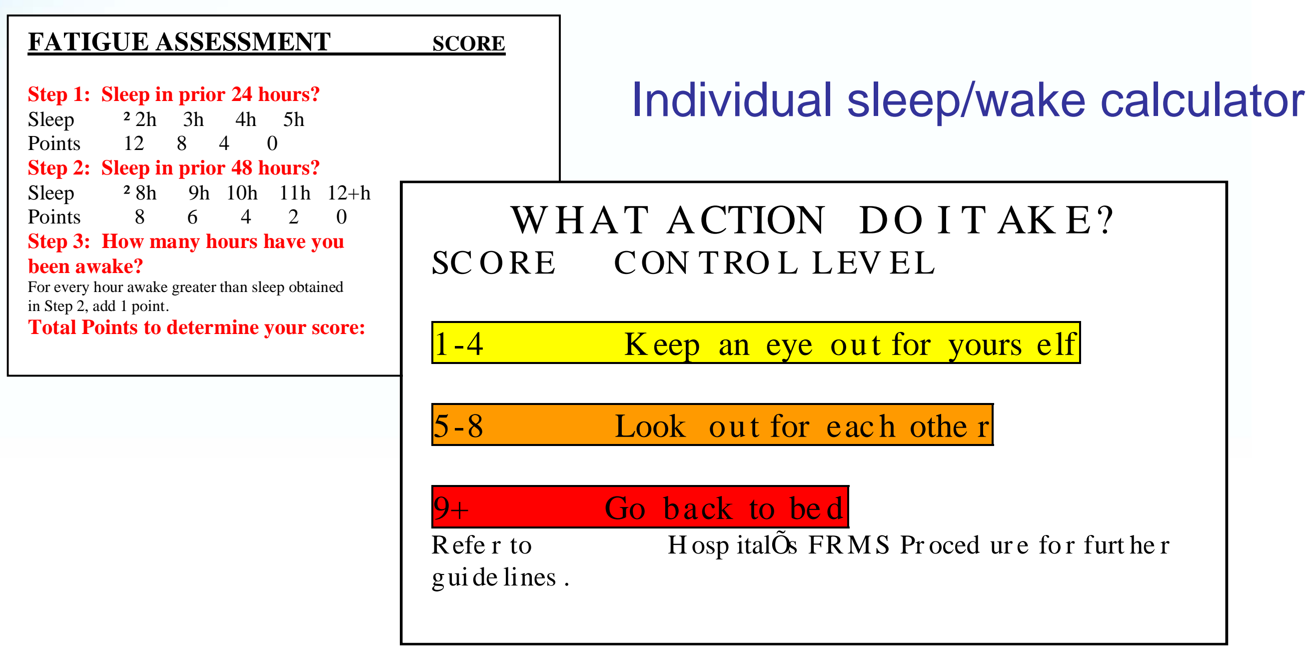
- Level 1: Redesign of schedules to ensure adequate average sleep opportunity [some 24h shifts were OK]
- Level 2: Establish minimum sleep/wake requirements to be Fit-For-Work [e.g. 5/12 rule] and agreed behaviours table for when staff are not FFW
- Level 3: Discussion groups for self or peer identification of fatigue to team and appropriate use of countermeasures
- Level 4: Major fatigue-proofing program. A priori identification of likely errors and development of SOP's to minimise risk
- Level 5: Incident analysis to include Level 1-3 evidence in databases. Level 4 data used to determine if proximal errors was consistent with fatigue-related cause.

Courtesy CFSR, Uni SA

Underlying Principles

- The risk of withdrawing a medical-related service must not exceed the risk of a fatigue-related error occurring.
- The level of hazard control must be matched to the potential consequences of a fatigue related error.

Using evidence based tools to start the conversation …



FATIGUE ASSESSMENT SCORE

Step 1: Sleep in prior 24 hours?

Sleep	² 2h	3h	4h	5h
Points	12	8	4	0

Step 2: Sleep in prior 48 hours?

Sleep	² 8h	9h	10h	11h	12+h
Points	8	6	4	2	0

Step 3: How many hours have you been awake?

For every hour awake greater than sleep obtained in Step 2, add 1 point.

Total Points to determine your score:

WHAT ACTION DO I TAKE?

SCORE	CONTROL LEVEL
1-4	Keep an eye out for yourself
5-8	Look out for each other
9+	Go back to bed

Refer to Hospital's FRMS Procedure for further guidelines.

Individual sleep/wake calculator

… And change culture!

Move from subjective to objective responses

Score	Agreed response
0	Do nothing unless higher level [3+] hazards are present
1-2	Document locally with supervisor and undertake approved individual countermeasures. Self monitoring for symptoms, napping, strategic caffeine, team monitoring by colleagues, task rotation
3-5	Document externally by supervisor. Organise supervisory checks. Complete symptom checklist, task re-assignment
6+	Document externally, do not engage in any safety-critical behaviors, do not recommence until fit-for-work.

Courtesy CFSR, Uni SA

Tools to guide action and evidence based decision-making at a local level

Working Group Resource Kit

FRMS Resource Pack explains use of:

- Hours of Work Risk Controls
- Symptom checklists
- Colleague assessment tools
- Sam–Perelli fatigue scale

Sam–Perelli fatigue scale	
1. Fully alert, wide awake 2. Very lively, responsive, but not at peak 3. Okay, somewhat fresh	LOW
4. A little tired, less than fresh 5. Moderately tired, let down	MODERATE
6. Extremely tired, very difficult to concentrate 7. Completely exhausted, unable to function effectively	HIGH

Length of Shift	Risk Levels	Controls
<10	Acceptable	No additional controls necessary except in the presence of higher level indicators of fatigue (i.e. symptoms, errors).
10-12	Minor	Document with local supervisor. Utilise Individual Controls including but not limited to: - symptom monitoring - strategic use of caffeine - personal monitoring
12-16	High	Document with Clinical Director. Utilise approved additional controls including but limited to: - task reallocation - napping - increased level of supervisory monitoring
>16	Extreme	No individual rostered beyond this threshold. Escalate to District.

Post Alert Doctors Strategy – 30 June 2008

- $1.6M committed over next 2 years
- Focus on achievement of implementation KPIs
- Governance to move to:
  - HR for policy
  - Areas for implementation

End of the beginning vs end of the project

Move from Fatigue reducing to:

- → Fatigue proofing
- → Sustainable work practices

For more information email
Alert_Doctors@health.qld.gov.au