

Junior Doctor Focus Groups Review  
For the  
Third Healthcare Infection Report

Report for the National Audit Office

April 2008

Produced by Eleanor Murray, Imperial Consultants

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## 1.1 Background

The National Audit Office is undertaking a study on the Department of Health's progress in tackling healthcare associated infections. This follow up report is in response to a request by the Committee of Public Accounts to advise them of developments since their 2004 report (*Improving patient care by reducing the risk of hospital acquired infection: a progress report*), and also their initial report in 2000 (*The Management and Control of Hospital Acquired Infection in Acute NHS Trusts in England*).

One component of the underlying research for the report is a national questionnaire on infection control and prevention for doctors and nurses. An initial analysis of responses highlighted less favourable responses from doctors (in particular junior doctors) compared with nurses in the following areas; patient safety, direct leadership/supervision from a consultant/lead clinician, performance management, team working, reporting incidents, clinical compliance and hand hygiene.

To understand these results in more detail, the National Audit Office commissioned follow-up focus groups across the country to understand and test out the emerging issues in more detail. A number of hospitals, of differing sizes and from different geographical regions have been approached to run one focus group each.

## 1.2 Introduction

The aim of the study was to understand, in more detail, junior doctors' perspectives on the emerging issues from the national questionnaire on infection prevention and control. Supporting objectives included understanding; underlying cultural barriers to practice, specific behavioural issues and the impact of education.

## 1.3 Methodology

Postgraduate education managers were approached to participate in the study and to co-ordinate a junior doctor focus group in their hospital Trust. One focus group was held per Trust to which a range of junior doctors were invited. Postgraduate managers were encouraged to invite a broad range of doctors from different specialties and at different stages in their training programme (Appendix 1). Information sheets were provided in advance for junior doctors to provide background to the study and to cover any confidentiality or ethical issues (Appendix 2). On attending the focus groups, junior doctors were asked to sign a consent form, if they agreed to participate in the focus group (Appendix 3). Focus groups were facilitated by a research consultant and where possible, were supported by a representative from the National Audit Office who was available to answer any questions about the context of the study. A semi-structured questionnaire provided the format for the session and junior doctors were encouraged to respond as fully as possible to all the questions and provide examples, based on their experience to support their responses. All the focus groups were recorded and subsequently transcribed. Analysis was undertaken using a software package called NVivo, which enables a thematic analysis of emerging themes within the data.

## 1.4 Results

Overall, the results from the focus groups were reasonably consistent with the emerging themes from the national survey, but the focus groups revealed the drivers for junior doctor behaviour more clearly.

### 1.4.1 Patient Safety

#### 1.4.1i Infection Prevention and Control

Junior doctors described infection prevention and control as being a high priority on the patient safety agenda. Reasons given for infection prevention having a greater focus included:

*'they are big targets, everyone wants to cut down their rate of hospital acquired infections'*

*'it's something that's well known, that yes, you want to cut down the rate – it sounds good in the papers 'you've got to cut down your hospital acquired infections''*

*'well it costs and people are much more interested in that because the trust will be penalised, so that's why there is, I think, so much focus on it.'*

*'at the previous hospital I worked at there was a very strong emphasis on infection control, partly because they were due to have a visit from the Healthcare Commission and so on the day that the Healthcare Commission were coming through, they were literally mopping the floor constantly.'*

#### 1.4.1ii Safety initiatives and evidence base

Areas specifically mentioned included the Antibiotic Prescribing Policy and the use of hand hygiene light boxes. Other safety related initiatives that were known about were national patient safety alerts, manual handling, preventing pressure sores, managing nutrition, sharps injuries, using new and special cannulae, marking surgical sites and prevention of falls.

Some doctors perceived the other safety initiatives as being nurse-led and less related to doctors:

*'they're all very nurse led, there's no real ones that we use as doctors, that are applicable to us, to make sure that we carry out - we're not involved in that really at all.'*

Junior doctors were sceptical about the evidence-base to support certain infection-related safety initiatives:

*'I don't think I read every bit of evidence personally but I remember the consultants talking about it but there wasn't a **huge** amount of evidence for changing the policy as radically as they did.'*

*'They've got to be seen to do something because when someone's going to die because she's caught the dreaded MRSA, then you have to be seen to be doing something, so you can understand how it's in the public limelight.'*

*'I think as doctors it's more the knee-jerk reaction rather than something that's actually thought through'*

*'I'm a Muslim and I wear the head-scarf and ...long sleeves – now in every single Trust that I've worked in, everyone always says, 'Oh, you've got to be bare below the elbows.'.....this isn't something that's evidence based, there isn't any evidence out there to suggest wearing long sleeves increases the risk of carrying infection...it's frustrating for someone like me because it means I can't carry out my religious obligations as well as carrying out my job and I'm more than happy to make certain changes (like rolling up my sleeves if I'm examining a patient and whatever)...but I'll still be penalised'*

*'Keeping your elbows clear and your jewellery and things like that, that all seems to be a bit of a whim, to make it look like they're doing something rather than actually having a basis for it.'*

*'And it seems that there's lots of other things that we should be doing, which no-one's even thought of, like the tourniquet we've been using for the last few weeks (that's been on every single patient in the ward!) and the blood pressure cuff goes around every single patient in the ward or bay.'*

Other doctors could see benefits from one safety initiative on others:

*'It's having a positive impact on infection control, things like the canulas and the Waterlow thing for pressure sores and things, I guess they're kind of inter-linked in a way.'*

## **1.4.2 Direct leadership/supervision from a consultant/lead clinician**

### **1.4.2i Supervision**

Junior doctors described the level of leadership/supervision from a consultant/lead clinician as differing according to the consultant. This applied to general leadership and supervision as well as that relating specifically to infection prevention and control. The junior doctors in the focus groups had experienced extremely effective consultant supervisors and very poor consultants:

*'It depends on the consultant, some consultants like to bring people on and like to meet with them regularly and all that kind of thing and some consultants just don't care.'*

*'Some consultants will come round and look over your shoulder and ask you what you've been doing with the patients and other ones will leave you and come once a week, say, 'that's fine' and leave again!'*

In answer to a question, what's your general experience; *'all the way from poor to very good, depending on the consultant.'*

*'My consultant (Mr Y) doesn't come up to the ward that often. My other consultant, Mr Z was fantastic, amazing; he came up, he washed his hands, put the pinny on when he needed to.'*

*'It's very dependent on whom the consultant is; some of them are excellent and some of them don't really care.'*

The junior doctors noted that the level of input might depend on what stage the junior doctor is at in their career:

*'it all depends on you as well because with me, I'm at a different level to these two, I'm obviously applying for CT1/CT2 training, so I have had a lot more involvement with my consultants, maybe not my current consultant, but other consultants, like my educational supervisors, surgical consultants.'*

#### 1.4.2ii Role Models

Several junior doctors described very positive role models amongst their consultants:

*'I always see my consultant washing hands, rolling up sleeves, being very careful – so yeah, I think he's a very good example'*

*'Most of the consultants I've worked with are really good about setting a good example and stuff.'*

*'our consultant was Clinical Director and he'd come onto the wards and he would just blast all the consultants, he would say, 'you're not supposed to wear ties, you can't wear watches, change it!' right in front of everyone (it wasn't like an aside thing!) so it was a bit like a name-and-shame but it was effective because it made it happen.'*

*'our consultant happens to be excellent but she admits that that's just a personal thing because she takes it very seriously (hand-washing and everything) so she's very obsessed about it.'*

Junior doctors agreed that their practice would differ, depending on the behaviour of the senior medical staff in their team, whether specialist registrar or consultant:

*'I think if I see them doing it then it triggers my mind to do it as well most probably.'*

*'I think it always makes a difference, the example in front of you...it always influences you.'*

*'I think I'm much more likely to notice when a consultant does do a good job of hand hygiene – with our colleague, she washed her hands properly, like fully rolled up her sleeves, full 6-point technique, after and before every single patient we saw and that had a big impact on me because I didn't really notice when people don't wash their hands, I think.'*

*'if they were washing their hands and you'd been with the patient as well, you'd wash yours too.'*

### **1.4.3 Performance Management**

#### 1.4.3i Performance Reviews

The junior doctors described a comprehensive performance management framework for both GP and acute training practice. GP trainees described meeting with their clinical supervisor for a review at the beginning and end of each job placement, combined with two meetings every four months with their GP practice trainer and a formal review every six months. The acute-based doctors described six observed procedures a year and case-based discussions along a similar line to the GPs with 18 individual assessments in total. In addition, they described 3 meetings with their clinical or educational supervisor per placement, incorporating beginning, midpoint and end reviews of each rotation, equating to nine meetings a year.

The junior doctors did not feel they were set formal objectives. Instead their objectives were informal and focused on their development, rather than work tasks:

*'For junior doctors there is a review of what you've done and what the next step should be to improve – so the objectives are relatively informal.'*

In response to the question, 'Do you have objectives set for you' – *'but that's more for our learning.'* *'Yeah, professional development because at the end of the day, we need our programme as well.'*

*'You make your own ones; you make a Personal Development Plan and work alongside that.'*

Some identified objectives relating to infection control in broader aspects of the performance framework:

*'Yes, there's a lot of them. They're in the curriculum...everything has an 'infection control' element – so if you do a procedure, there's a bit that says, 'infection control; did you take the adequate infection control measures?' in every single bit.'*

#### 1.4.3ii Assessments

Junior doctors were familiar with infection control and prevention being incorporated into their assessments, rather than being part of the reviews:

*'in this trust, if you want to take blood cultures, there's a whole process that you're supposed to follow at all times and you're not supposed to do blood cultures unless you've been formally assessed by someone'*

*'we've had on the wards hand-washing exercises, where we've washed them and put them under the lights and then had some feedback there.'*

*'even for exams; for example, if I'm ever touching a patient, you **have** to use the alcohol gel and stuff, otherwise you fail: you will fail your MRCS completely if you don't – so you are sort of assessed.'*

*'you get assessed on those training sessions but that's only if you go along to them (obviously) and you're supposed to be signed off and then you can have a certificate that goes on your badge (that's what my ward sister told me)'*

*'I had to do an OSCE on my ward the other day; someone from infection control came along and pulled me away and I had to make sure I could wash my hands properly and answer questions about C.diff and MRSA and I got a certificate!'*

Assessments mentioned were hand washing and aseptic technique for taking blood cultures, although junior doctors were not convinced that these assessments were adequately evidence based:

*'the **pseudo** aseptic technique; you have to wear the gloves but they're not sterile gloves, so yes, in theory it is an 'aseptic' technique but actually it's not necessarily. So, all of these things are put in place because someone's shown that it reduces infection and organisms within the blood cultures that have been performed. If you really looked at that evidence I'm not convinced but you're forced to do that by someone above you and it's not worth trying to do anything otherwise.'*

#### 1.4.3iii Alternative performance mechanisms

Other mechanisms that influence junior doctors' performance, over and above performance reviews or assessments is; the extent to which the hospital promotes infection prevention and hand hygiene, the hand hygiene audits and infection control systems on the wards, the induction process and the hospital environment:

*'in this trust they do remind you every term, it seems, to make sure you wash your hands in between patients and all that kind of stuff. So, whilst there's not a formal thing set up, it doesn't mean it's not highly promoted.'*

*'there's always some kind of audit thing going on (like on our ward the other day) where somebody goes undercover and they just see how many people are washing their hands'*

*'at the last hospital I worked at they had a problem [C.difficile] a year or two before I went there and as a result they were really trying to cut down on their hospital acquired infections. It was on the surgical ward that they were really trying to cut things down and as a result they had a doctor assigned to the bays....and you had to wear a different kind of apron for different bays.'*

*'in the induction at this hospital they give you a formal talk and all the basic dos and don'ts of infection control is run through, so there is a session on 'good medical practice' and all that kind of stuff'*

*'I think I got formally assessed on hand-washing at the Trust induction and I've been audited on cannulation and there's definitely a box, 'adequate hand hygiene' or something.'*

*'they painted all the walls red as you go into each ward, with big hand-prints on, above the alcohol gel, in an attempt to catch people's attention.'*

#### 1.4.3iv Data Feedback

The junior doctors were questioned on whether they received data on infection prevention and control. The accessibility to data seemed sporadic, the doctors gleaned information



from the ward and where it was publicised through talks or on corridors, walls and notice-boards.

*'I guess each time those statistics come out, they do one of those talks to present how the hospital's doing; so every 6 months or something there'll be a C.diff and MRSA audit but we don't get it ward based.'*

*'It's on the organisms, they have a graph, with the number of cases on that ward but you can see it by medical and surgical as well, so I've seen a lot of graphs that are split by specialty.'*

There was general agreement that data did not help change or improve their practice as one junior doctor summed up:

*'I think everybody knows the gold standard of what you're supposed to do but ultimately it's a balance between time constraints and prioritising what you need to do and I think everybody, by some level, has reached their own equilibrium where they feel, 'this is my level of how far I'm going to take this, combined with my job requirements' and so whilst I'm sure in the back of their heads ideally everyone would like to do everything by the book, they do what they do and they've found what works for them best and if the statistics are improving then great and if they're not then I might make an attempt but it'll probably last like a week or something.'*

Another doctor commented:

*'Time pressure...so you might know that you should wash your hands but if everyone on the ward round did that before leaving every patient then you'd never get your ward round done – so it's the practicalities.'*

These quotes encapsulate the junior doctors' dilemma (as they present it) with infection prevention and control. They appear to have received adequate education to understand what is required of them (even though they may feel the evidence-base is limited), but this is balanced against the realities of day-to-day time constraints in working on a ward. The outcome is compromises in infection control techniques in order that they can cover the number of patients they are expected to treat. Two doctors outlined similar issues with time constraints in terms of the additional tasks required to meet infection control regulations:

*'but often you know, you have to put your stuff down, put on a gown, put on some gloves, open the door, get in, see the patient, take it all off, wash your hands, get out and it takes a long time.'*

*'when someone's quite sick with possibly something that's infectious, it's easier said than done when a patient's ill and requires tests and requires you to go in and out of the room several times – for example, if you're doing a procedure – and the patient's clinical state relies on you being quite hasty, then you don't have time to, for example, take off your gown every time, and if you've just got to pop and get something else for the procedure that you're doing to try and help potentially save someone's life, you're not able to wash your hands every time.'*

#### **1.4.4 Team Working**

The junior doctors understood their immediate team as the other doctors of different grades within their specialty team but described their focus of work as the ward:

*'As a house officer you're on the ward and then everyone who's on the ward; you know all the physios, OTs and nurses by name and then the sisters are the ward team leader in a way and you're just part of that.'*

Within this team, the junior doctors acknowledged the role of the nurses in addressing infection control issues with them:

*'I think the nurses are the best actually, when you're going into a side room or something to see a patient, **often** they will say 'you're supposed to be wearing gowns or gloves' and we forget because we're busy and we're seeing patients.'*

*'whatever level of nurse they are (whether they're a staff nurse or sister or matron) they will tell them to do it'*

Infection control issues were occasionally discussed in specialty, e.g. general medicine team meetings:

*'we have an antibiotic audit that we've got to present every Thursday, on how many people are on antibiotics, have they got a stop date or a review date and an indication written on 'is it the right medication for this bug? And is it given via the right route? And date it.'*

A more regular forum for discussion of infection prevention was in clinical governance-related meetings, either for audit purposes or part of mortality and morbidity meetings:

*'We have morbidity and mortality meetings and we follow patients through and inevitably hospital acquired infections happen all the time, so hospital acquired infections become a part of somebody's hospital stay and those patients are talked about and some teams in particular are quite hot on antibiotic prescribing and when they're prescribed.'*

*'We've had one lecture specifically on C.diff and MRSA cases, we've had a couple on 'generalised infection control' I think.'*

From the junior doctors' perspective these meetings appear to provide a forum where they can learn about infections and how to manage them from more senior team members. Sometimes this occurs in a developmental manner, other times, more dictatorially:

*'We usually sit down with the consultants, who give us a bashing for not dating our cannulas and not writing on the antibiotics.'*

It is possible that this type of activity may be more valuable to the junior doctors than training, as they are learning about the clinical management of patients from a practical perspective.

## **1.4.5 Incidents**

### 1.4.5i Reporting incidents

Junior doctors rarely reported incidents, for a variety of reasons from the time it takes and the lack of encouragement to complete the forms to the lack of feedback after submitting a form:

*'No. It's form filling. It's time wasting.'*

*'It takes such a long time, doesn't it?'*

*'And you don't get much feedback from it.'*

*'And I have to say, the incidents tend to happen on days when you're most busy and it's usually due to the fact and you keep meaning to do something about it.'*

*'There's not a huge amount of encouragement to do them though.'*

*'You're not able to change much from a near miss.'*

Although junior doctors do not use the official mechanisms to report incidents they described their own unofficial routes to providing peer feedback following an incident. They agreed that they would provide feedback to a colleague directly and that in practice, they do this all the time:

*'I saw a nurse doing some bloods incorrectly the other day; they took the needle out while they still had the bottle attached, so I told the nurse that they need to improve – they also tell us what we're doing wrong.'*

*'If you've prescribed something and they think you should have given something else, they'd generally tell you. Pharmacy's usually quite good at that.'*

*'if a patient hasn't been given their antibiotic appropriately, you're more likely to go and tell the nurse there and then, 'why hasn't the patient been given their antibiotic?...can they have it straight away?... this really should have happened' and then it's dealt with and yes, something happened, yes, it should have been done better but what is filling out a piece of paper, for somebody to go, 'Oh right, yeah, that happened.' We don't see how that helps matters!'*

The junior doctors might decide to complete an incident form if they were told to or if the incident was very serious:

*'It has to be pretty bad and very obvious that someone's done something, I think, for a doctor to fill in.'*

*'I haven't reported that many incidents at all. There was only one I reported but that was due to a surgical thing; the patient came in, it was an issue of beds, ra-ra-ra and I did that because I was forced to do that, otherwise I don't report them, I'm really quite bad.'*

*'Mine was a procedure that went wrong; somebody blew up the actual catheter in the patient's prostate rather than in the bladder and it caused him to bleed. So, I thought that it was unsafe practice and by reporting it, it would mean that the person who did it would get extra training on it, to make sure it doesn't happen again.'*

*[Having described a serious incident] 'so that's potentially very hazardous to the patient, so definitely needed, in my opinion, an incident report – so that sort of potential harm to the patient as a result of a mistake.'*

A further barrier to incident reporting was organisational culture or external influences on junior doctors:

*'I think it's what people perceive the consequences are going to be because if they think that they're going to get a disciplinary or they're going to get sacked or whatever, they'll be really resistant for you to make the incident report or actually sit down and write it together, you know, they just don't want to know or they'll just be really quite defensive about it.'*

*'I think you're basically worried that you'll get blamed.'*

*'There's an increasing culture, for example, to prosecute for manslaughter if you're clinically negligent and that's something that even though it's so far removed from what we do, it still has an impact on how you feel about your mistakes because you feel that some people who do stuff wrong end up in prison for trying to do their job.'*

*'I don't think it's so easy to go ahead and file an incident against somebody who's way more senior than you; I think you'd speak to your own seniors maybe and whether they want to file an incident, but I don't think I'd file an incident against a consultant.'*

The junior doctors contrasted their approach to incident forms with that of nurses, who they commented used incident forms to a much greater extent:

*'I think the nurses do a lot more incident forms that we do.....because they know that's their way they're going to get it done....that's their way to change stuff.'*

*'that's the problem with this reporting thing; the nurses will report 'doctor did not wash right shoe today' or 'doctor wearing two different socks; not acceptable' and you think, 'that's defeating the point, isn't it?'*

*'I think the nurses often do it more to cover themselves, they paperwork everything, they've got a lot more protocol.'*

*'we don't generally fill them in about nursing staff, do we, whereas they are quite often filling them in about us.'*

#### 1.4.5ii Analysis of incidents

Junior doctors did describe scenarios where they had been involved in some level of analysis on incidents that had involved other members of the multidisciplinary team, such as Infection Control staff and involved notes being taken of the discussion:

*'There are times when you sit down and you reflect on each individual case of C.diff and MRSA that comes through the hospital and work out who's responsible for it,'*

*'I had a patient who developed MRSA/septicaemia, so we went through; were things done properly? Yes, yes, no, no and then; what is the conclusion? Yes.'*

Junior doctors commented on their lack of involvement in analysis owing to the level they operate at in the team:

*'I think they don't ask the house officers really because the consultants get the hassle if there's a complaint made; the person who's emailed is the consultant – because I know a couple of patients who've had complaints but I've not even heard about it until I actually speak to the patient'*

Junior doctors described an alternative approach to analysing and reflecting on incidents that they felt they did informally already:

*'I think...if people take it on themselves personally to think, 'hang on, did I do everything right?' when that patient comes in with C.diff and I'd hope that most people would tend to do that anyway and think, 'hang on, why is this patient who's been on my ward for 5 days now, now become unwell?...is there anything we should have done differently? And I think people tend to do that anyway just informally.'*

*'You might make a mental note to do something differently next time, without really thinking about it more but it would be difficult to reflect back on the amount of things that we've seen that have gone wrong.'*

#### 1.4.5iii Practice change resulting from incidents

Junior doctors had mixed views on whether practice change resulted from incidents. Some junior doctors considered infections as complications of procedures and therefore not impacted by behaviour change whereas other doctors reported instances of practice change as a result of seeing patients' contract infections:

*'I think sometimes with infection though, people see it as an unfortunate but a potential complication of a procedure; so just like if you have an orthopaedic operation and you have non union at the end, it's not necessarily negligence because every operation carries with it a risk of non union and it's the same with infection; you want to avoid infection and you try to use the aseptic technique, you know, all those kinds of things but sometimes an infection is an unintended consequence of doing a certain procedure.'*

*'there were two other patients in the same bay who both got MRSA afterwards and they were actually negative before (because we had their samples) and so, you know, then you had to go through all the cleaning process and it does remind you that you should make sure you wash your hands in between and make sure you take all the necessary precautions.'*

### 1.4.6 Education and Clinical Compliance

#### 1.4.6i Undergraduate education

Junior doctors generally understood what was required in relation to infection control and prevention guidance. They described a variety of educational interventions and

assessments in both their undergraduate training as being important in reinforcing messages about hand hygiene:

*'we got it informally and formally – every year we had to do 'hand-washing' training and we had to be watched doing it and passed off on it and we had lectures (not very many).'*

*'I think there was certainly **some** formal teaching. I know, in some OSCE stations in some of your exams you will be given a mark for washing your hands and making sure that you use the alcohol gel that's sitting on the end of the patient's bed as you walk in.'*

*'from what we've had at medical school, it's definitely a routine that's been drummed into me, so I feel I know what it is'*

*'at our medical school we even had actual exam questions in the clinical scenarios of hand-washing; like you had to do your hand-washing in front of an examiner and then it was like a certain stage technique and you'd get marked on it'*

## 1.4.6ii Postgraduate education

There was a less consistent message about postgraduate training. Junior doctors agreed that the impact of seeing a patient acquiring a hospital-acquired infection and observing the practical implications on their practice was more significant than receiving further education:

*'all this teaching is good to a degree but, it's as you've said, it's inevitably **boring** and it's only after you actually, as I say, see people getting unwell as a result of a hospital acquired infection, that you change your practice, I think'*

However, assessment at key stages of postgraduate education on aseptic techniques was mentioned by junior doctors as important for their educational development:

*'if I'm ever touching a patient, you **have** to use the alcohol gel and stuff, otherwise you fail; you will fail your MRCS **completely** (you'll fail your surgical exams) if you don't – so you are sort of assessed'*

## 1.4.6iii Practical learning

Equally important as formal postgraduate education was promotion of infection control measures and hand hygiene by the hospital the junior doctor was based in. A range of measures were discussed including induction, clinical audit, hand hygiene audit, hand-washing champions with pictures on ward notice boards, assessments of aseptic techniques as part of progression through education, hand-washing practice using a light box (with sign-off in some hospitals), infection control nurses' presence, feedback from other groups of staff, infection control days, aseptic technique packs, clinical governance meetings and intranet prescribing guidelines.

Environmental factors were also mentioned as a barrier to clinical compliance. Junior doctors described situations where inadequate equipment was provided which impacted on the time available to complete their tasks on the ward:

*'Having alcohol bottles empty, that's quite irritating and that happens quite a lot, I've found anyway – but I've only worked here for a little while'*

*'Side rooms; trying to find a gown and gloves, when you're in a rush and want to see people quickly it's not always easy'*

One doctor working on a GP rotation in the community also raised the issue of availability of equipment:

*'when you're out on a home visit it's a very different matter and you might be looking at somebody's post op wounds and all that sort of thing and you try and remember to ask them if you can go and use their bathroom and wash your hands and things but you could have got a dirty towel or the house was **horrid**'*

#### **1.4.7 Hand Hygiene**

Junior doctors highlighted lack of time and the effect of hand washing on their hands as the main reasons for lower levels of hand washing:

*'by far and away the biggest one is just what we've been saying, it's just the whole time issue.'*

*'There needs to be more moisturiser around.'*

The junior doctors contrasted their attitude with that of the nurses around hand washing, noting that the nurses played a significant role in role modelling good hand hygiene and in enforcing it with the junior doctors:

*'the nursing staff bring their own bottles [of moisturiser] don't they and I think the nursing staff are really, really good at washing their hands and stuff and it is useful for them, so they do use it.'*

*'and also nurses are always going round – not so much in this hospital – I worked in x hospital last year and they were **military** (the nurses were), they were crazed (like on edge) hand-washing people and yeah, they were crazed but they really enforced it.'*

Based on the junior doctors' feedback, trusts have developed initiatives that promote hand hygiene:

*'they have hand wash champions for each ward and they have their pictures stuck up every month'*

*'at our clinical governance meetings the hand-washing things are discussed because that's as important as anything – it's once a month.'*

*'you're supposed to get signed off on a hand washing session, which kind of runs every so often – because the ward sister said, 'oh, you've got to go and get yourself signed off; you haven't been signed off yet. I missed the session.'*

All the junior doctors were aware of the compulsory hand washing audits on the ward:

*'Yes, we know about the audits. They have to do them; they're compulsory audits they have to do. We know that they're having them but we don't know when.'*

In response to the questions on the national survey relating to hand washing, the doctors felt that the survey result that 55% of doctors always wash their hands before patient contact was not specific enough. In particular, they considered it should have included whether alcohol gel or soap and water was used. They also highlighted the dilemma that if they are on a ward round and have washed their hands after seeing the previous patient, they would not automatically wash their hands before seeing the next patient, yet their hands would already be clean. They considered that if the question meant that doctors always wash their hands before seeing every patient then the 55% result was high and possibly not accurate.

In conversation, junior doctors had individual protocols for hand washing that they followed, that differed between them:

*'I don't usually draw a distinction between alcohol gel and washing, myself, usually...'*

*'I do...if I feel especially dirty, for some reason, or for example, if you see 5 patients those alcohol gels get all sort of manky, so you go and wash them but usually after or before I see a patient I'll just alcohol gel, I won't normally wash my hands, unless they've got C.diff.'*

The general consensus of junior doctors was that they were less likely to alcohol gel or wash their hands after contact with the patient environment. One group of junior doctors treated the concept with much scepticism, commenting:

*'What, just touching a bed and washing your hands?!'*

*'You'd just be washing your hands all day, wouldn't you?!'*

Other junior doctors were more open to the concept:

*'When I touch notes I alcohol gel; if I don't touch the patient I alcohol gel but if I touch the patient I wash my hands – that's how I do it.'*

#### **1.4.8 Concluding Remarks**

Junior doctors, by virtue of their training structure (with regular rotations) and postgraduate framework appear to be less integrated into the acute hospital structures and procedures than other professions. This is evidenced by their comments on risk, performance, safety, time and clinical management. They have developed informal mechanisms to manage safety, infection and risk which they view as a balance between time constraints, organisational bureaucracy and patient safety. They take their lead strongly from their supervising consultant – if their consultant role models effective infection control and prevention behaviours, then their juniors are likely to imitate them. Junior doctors acknowledged the role of nurses in giving them feedback or guidance on infection control matters but noted the contrast between the nurses and their way of working.



**Junior doctor representation by year and speciality**

<b>Grade</b>	<b>Specialty</b>	<b>Number</b>
F1	Infectious Diseases	1
F1	Orthopaedics	1
F1	Newly graduated	1
F1	General Surgery	4
F1	Respiratory Medicine	4
F1	Neurology	1
F2	Surgery	1
F2	A&E	1
F2	Care of the Elderly	2
Registrar	Endocrinology/General Medicine	1
Registrar	General Practice	2
Registrar (ST2)	Respiratory/General Medicine	1



## **Information Sheet for Junior Doctors**

You will be given a copy of this Information Sheet

### **1. Junior doctor focus group: infection prevention and control**

#### **2. Introduction**

You are being invited to participate in a focus group to gather junior doctors' views on infection prevention and control in hospital Trusts. Before you decide to take part in this focus group it is important for you to understand why the focus group is being held and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask questions if there is anything that is not clear or if you would like more information.

#### **3. What is the background to the review?**

The National Audit Office (NAO) is undertaking a review on the Department of Health's progress in tackling healthcare associated infections. This follow up report is in response to a request by the Committee of Public Accounts to advise them of developments since their 2004 report (Improving patient care by reducing the risk of hospital acquired infection: a progress report), and also their initial report in 2000 (The Management and Control of Hospital Acquired Infection in Acute NHS Trusts in England).

One component of the report is an anonymised national questionnaire on infection control and prevention for doctors and nurses with follow-up anonymised focus groups across the country to understand the emerging issues in more detail. A number of hospitals, of differing sizes and from different geographical regions are being approached to run one focus group each.

#### **4. Why have I been approached?**

In order to undertake this review we plan to run focus groups with junior doctors who are interested in the subject and willing to take part. The participants will be junior doctors from a range of specialties and at different stages in their training.

#### **5. What will it involve?**

If you decide to take part in this focus group, you will be invited to join other focus group participants at an agreed date and time. The focus group will take approximately one hour but may be less/more depending on what you, the junior doctors have to say. The focus group will take place in a meeting room, near to your place of work and on the same site. There are no right or wrong answers to any of the questions that the facilitator will ask you.

#### **6. Will taking part in this study be kept confidential?**

All the information which is collected during the course of the focus group will be kept confidential. The focus group will be tape-recorded and the recording will then be typed out

and anonymised. All data will be kept secure in password protected computers on a secure server and only NAO staff will have access.

**7. What are the possible disadvantages of taking part?**

We do not anticipate any disadvantages or risks as a result of taking part in this focus group.

**8. What are the possible benefits of taking part?**

The information we get from this review will form the basis of a nationwide review of infection control and prevention by the National Audit Office with the aim of developing ways of helping hospital trusts to develop their strategies for managing and preventing infection.

**9. Do I have to take part?**

It is up to you to decide whether or not to take part. If you do decide to take part you will be asked to sign a consent form and will be given a copy of this and the information sheet. Any information you provide will be completely anonymised. If you decide to take part you are still free to withdraw at any time and without giving a reason.

**10. What will happen to the results of the research study?**

The anonymised results of all the focus groups held in hospital Trusts will be written up as part of the NAO report. You will not be identified in this report or in any other publication.

**11. Who is organising and funding the research?**

This review is organised by the National Audit Office.

**12. Contact for further information**

If you would like further information about this study, please contact Eleanor Murray, Research Consultant on email [e.murray@imperial.ac.uk](mailto:e.murray@imperial.ac.uk).

You will be given a copy of the information sheet and a signed copy of the consent form to keep.



National Audit Office

**Consent Form – Focus Groups**  
**Junior doctor focus groups: infection prevention and control**

- I confirm that I have read and understand the information sheet for the above review. I have had the opportunity to consider the information and ask questions and these have been answered satisfactorily.
- I understand that my participation is voluntary and that I am free to withdraw at any time, without any reason.
- I consent to the processing of my personal information for the purposes of this review only and understand that my information will not be used for any other purpose by the National Audit Office. I understand that my information will be treated as strictly confidential and handled in accordance with the provisions of the Data Protection Act 1998 and the Freedom of Information Act 2000.
- I understand that data collected during the study may be looked at by responsible individuals from the National Audit Office, where it is relevant to my taking part in the review. I give permission for these individuals to have access to this information.
- I consent to the interview being recorded.
- I consent to take part in the above review.

\_\_\_\_\_  
Name of participant

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of facilitator

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date