Serious Adverse Incidents

Support and guidance for trainees involved in a serious adverse incident

Northern Ireland
mdta
Medical & Dental Training Agency

What is an SAI?

An adverse incident is an event which causes, or has the potential to cause, unexpected or unwanted effects that will involve the safety of patients, staff, users and other people[1].

A serious adverse incident is one in which the consequences are so significant, or the potential learning is so great, that a heightened level of response is justified.

1. Reporting of an Adverse Incident; Northern Ireland Adverse Incident Centre (NIAIC); Department of Health.

Why is SAI reporting important?

It is essential that if you witness, or are involved in an SAI that you report it, or check that someone else has done so, for the following reasons:

- When an incident occurs, and is recognised and reported, it is an opportunity to learn and reduce the risk of this occurring again. Each department will have its own way of investigating SAIs but the key is that these investigations result in changes that will improve patient care and safety

- Duty of candour applies to trainee doctors, as it does to all healthcare professionals. This includes being open and honest when things go wrong and is stipulated in guidance provided by the GMC.

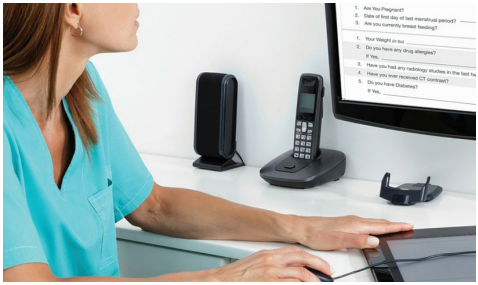
It can be difficult to report SAIs if you see one or are involved in one. It is recognised that there are barriers to trainees reporting SAIs including:

- Individuals being unsure what to report and what an SAI is
- Fear of repercussions of reporting, ie. potential disciplinary issues
- Concern over progression through career
- Perceived lack of time
- Perceived lack of impact

What are my responsibilities as a trainee?

Most doctors are likely to be involved in a serious adverse event at some stage during their career. Our aim as clinicians is to improve patient care and part of this is by aiming to minimise mistakes. However when mistakes do happen how we respond to them is of paramount importance.

One of the primary principles of Good Medical Practice is that of being open and honest when things do go wrong[2]. So whether you have been involved in the incident, or have witnessed it, it is your responsibility to ensure that it is reported.



Depending on where you work the procedures may vary. It is important to familiarise yourself with this and to speak to someone more senior within your department for advice on how to proceed. Patient safety is the priority, therefore follow up and learning from the event is vital.

Research has shown that involvement in SAI can have a significant impact on trainees. It is important that if you feel like this that you would seek help by speaking to a senior. This could be your clinical or educational supervisor, clinical lead of your department, or the Professional Support Unit at NIMDTA.

2. http://www.gmc-uk.org/guidance/ethical_guidance/27233.asp

I am aware an SAI has just occurred, what should I do?

Ensure the patient is safe. If the incident has caused actual harm to the patient it is essential that all measures are taken to rectify this urgently and it may be that urgent senior help is required.

Once patient safety is established it is important that any individuals caring for the patient are aware of what has happened, particularly in the event that it is relevant to their medical care (for example the need for increased monitoring in incorrect drug dosing incident).

Senior staff should be informed promptly. Initially this would usually be the consultant looking after the patient, or on call consultant if out of hours. In Primary Care this is your GP trainer in your practice. This should then be escalated to an appropriate department handling SAIs (usually the Governance Department in a hospital). There is guidance available for reporting procedures and the senior medical or nursing staff in a department should be aware of this. If in doubt ask a senior member of staff.

Most departments will have online reporting systems for SAIs. A report should be filled in. It is important that reports are completed promptly so that documentation takes place contemporaneously to facilitate completion of an investigation as soon as possible.

It is important that during the incident, and follow up, that the clinical team is open and honest with the patient and family. A senior member of staff should be involved in that discussion if an SAI has taken place.

Ensure that discussions and management of the incident are clearly documented in the medical notes.

What is involved in the SAI process?

The type of review that takes place is proportional to the significance of the event and is categorised into 3 levels. This is determined by the SAI review team however there is a Regional Risk Matrix which helps organisations determine the significance or seriousness of an incident. Every Trust has variations in how an SAI investigation is carried out but the Health and Social Care Board (HSCB) has an overarching policy for this[3].

Level 1
Review process to assess what happened, why it happened, what went wrong and what went well.

Assess what has been changed or agree what will change and identify local learning.

Report retained by organisation and NOT sent to HSCB.

Level 2
Report conducted with high level of detail with MDT involvement.

HSCB informed within 4 weeks and receive the report within 12 weeks.

Level 3
For SAIs that are particularly complex with either multiple organisations, degree of technical complexity or very high profile with public and/or media attention.

Involves any cases of alleged homicide by a service user with mental illness or disorder.

3. http://www.hscboard.hscni.net/download/PUBLICATIONS/policies-protocols-and-guidelines/Procedure-for-the-reporting-and-follow-up-of-SAIs-2016.pdf

The impact of involvement in SAIs on trainees

The concept of the 'second victim' is well recognised. It refers to health care providers who are involved in an adverse incident or medical error. The impact of being involved in such an incident can be very significant for some clinicians.

Studies have shown that trainees can experience feelings of personal responsibility about the incident, sometimes associated with considerable personal anguish.

It is important to recognise that trainees involved in self-perceived medical errors are more likely to experience a decrease in their quality of life, decreased levels of empathy, loss of confidence, shame, anger, stress and higher levels of burnout.

This is why it is important that you seek help if you feel your involvement in an SAI is having an adverse impact on your life or work. You will not have been the first to feel like this and you should take advantage of the support that is available.

Trainee Experiences

"I felt somehow to blame even though the consultant said I had done everything I should have"

"I was offered local and NIMDTA support and this was beneficial....I have had full support from NIMDTA and was prepared for my experience in Coroner's court".

Feeling of "uncertainty, fear of consequences, fear of lack of senior support"

"I was well supported and the change in practice was rolled out as a positive outcome from the process"

"When access is provided to help at NIMDTA, this is excellent. A well supported trainee with good mental health and preparation will ultimately perform better under the stressful situations in Coroner's court and at SAI interview"

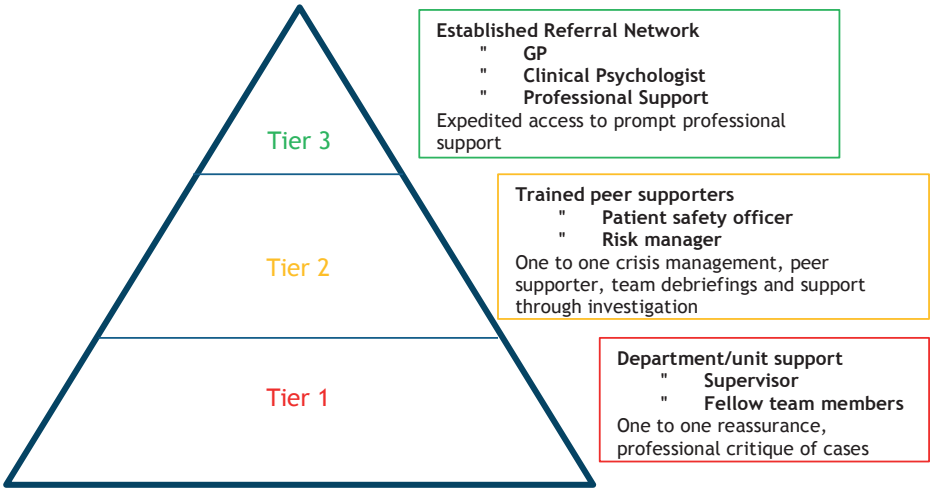
I was "nervous that I had not handled situation better, uncertain if investigation was carried out or if I should have been more pro-active finding out about this"

The personal impact is reflected
by clinician stories 'Healing the Healer'
http://www.youtube.com/watch?v=JmB8PCEXVgk

Seeking Support

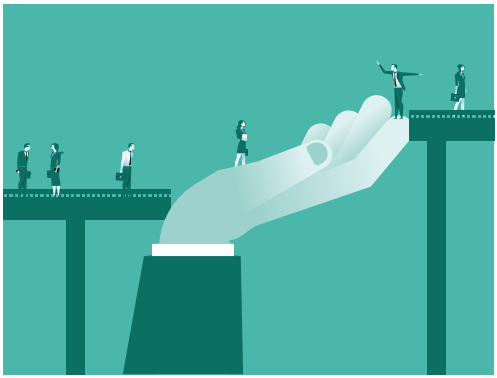
Everyone is an individual each with their different ways of dealing with situations or incidents. In this regard how any individual responds to a serious adverse incident will vary greatly and with this the level of support required. What is important is that you are aware that a variety of support interventions are available from different sources depending on what you need.

As a trainee, if you are involved in an SAI the investigation can often continue well after you have left that Trust. It is important that, for you to know what is happening with the investigation, you keep in touch with your supervisor from that Trust.



Professional Support

Support is available within the Trusts and will vary within each Trust. It is worth speaking with your educational or clinical supervisor to access this. NIMDTA will offer support to all trainees through the Professional Support Unit (PSU).



The PSU is there to support trainees through difficulties or concerns and to provide development opportunities.

You can contact the team directly yourself.

You can access contact details and further information through the NIMDTA website at www.nimdta.gov.uk/professional-support/

The services available to you at PSU include;

- Confidential 1:1 Support Meetings
- Coaching and Mentoring
- Confidential Counselling

If you are finding that your physical or mental well-being is being affected it is important that you access further professional support through Occupational Health or your GP.

You can also access confidential counselling services through Inspire (previously Carecall) on: **0800 389 5362**

Useful Resources

GMC guidance
http://www.gmc-uk.org/guidance/ethical_guidance/27233.asp

What to do if you are involved in an incident
https://www.medicalprotection.org/uk/for-members/doctors-in-training/new-doctor-articles/new-doctor-articles/dealing-with-adverse-incidents
https://www.themdu.com/guidance-and-advice/guides/significant-event-analysis/significant-event-analysis

Duty of Candour
https://www.themdu.com/guidance-and-advice/faqs/~/link.aspx?_id=45E10788BDFB44EF9C0DF964AB850B45&_z=z

If I acknowledge a mistake will it affect my fitness to practice?
https://www.themdu.com/guidance-and-advice/faqs/will-it-harm-my-gmc-fitness-to-practise-case-if-i-acknowledge-a-mistake

If I apologise for a mistake does this make be liable?
https://www.themdu.com/guidance-and-advice/faqs/if-i-apologise-for-a-mistake-will-i-be-liable-for-compensation
https://www.mddus.com/resources/resource-library/risk-alerts/2016/april/saying-sorry
https://www.mddus.com/resources/resource-library/news-digest/2015/september/poor-apology-most-common-patient-complaint

How to prepare for court
https://www.mddus.com/resources/resource-library/risk-alerts/2016/november/preparing-for-a-day-in-court
https://www.medicalprotection.org/uk/resources/factsheets/northern-ireland/northern-ireland-factsheets/uk-ni-giving-evidence
https://www.medicalprotection.org/uk/resources/factsheets/northern-ireland/northern-ireland-factsheets/uk-ni-inquests

Guide to writing a report
https://www.medicalprotection.org/uk/resources/factsheets/northern-ireland/northern-ireland-factsheets/uk-ni-guide-to-writing-expert-reports

Concept of the second Victim
https://www.rcem.ac.uk/docs/Safety/82e.%20Supporting-the-Second-Victim.pdf

Institute for Healthcare Improvement: Adverse Incidents are their aftermath
http://www.ihi.org/resources/Pages/AudioandVideo/WIHIAdverseEventsandTheirAftermathSOSfromClinicians.aspx

Medically Induced Trauma Support Services (MITSS)
http://mitss.org/

"To err is human, to cover up is unforgivable, and to fail to learn inexcusable"

Liam Donaldson