Clinical Medicine 2014 Vol 14, No 1: 42–3

Adverse incidents and patient safety – improving the learning experience of junior doctors

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ABSTRACT

The need to ensure patient safety in the National Health Service (NHS) is a national priority. However, it has long been recognised that a culture of blame impedes learning from previous adverse incidents. It is important to feedback the outcomes of investigations into incidents to NHS staff, but junior doctors have little knowledge of learning points from investigations into adverse incidents. Learning from past mistakes would improve practice and the level of care provided by junior doctors. A forum for learning from mistakes could also provide an opportunity to review past incidents in an open and supportive environment. This could, in turn, start to change the current culture of blame in the NHS and contribute to higher standards of patient safety in the future.

Patient safety is a priority,[1] and learning from adverse events in the NHS is vital to the improvement of patient care. It is recognised that within the NHS, one barrier to learning is that adverse events have historically been attributed to mistakes made by individuals just before the event occurred.[2] This does not contribute to overall improvements in patient care, because it does not identify underlying systemic causes, and also serves to create an unsafe culture in which staff do not feel able to confront, report or discuss errors.[3] While the culture of blame surrounding adverse incidents is widely acknowledged, few realistic or practical suggestions about how to change this have been made. Such change is particularly needed by junior doctors, as our training will shape our practice, which in turn will help shape the nature of the future NHS.

Learning from adverse events involves many steps, including monitoring such events, analysing possible causes and developing potential solutions to prevent or mitigate these causes.[2] These steps are well established in the majority of NHS trusts. There are systems for reporting and investigating incidents. Root cause analysis (RCA) is used to establish systemic causes and to identify solutions. In order for changes to take place, however, it is vital that lessons learnt are fed back to NHS staff.[2,4] Without this step, the risk of the recurrence of serious incidents remains high, and potential improvements are unlikely to be translated into clinical practice.

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Junior doctors are a group of front-line staff who are in training. The curricula for trainee doctors, across specialties, emphasise the importance of reporting, assessing and managing serious incidents, reflective practice and learning from mistakes.[5,6] Junior doctors could benefit a great deal from learning about problems identified in 'serious incidents requiring investigation' (SIRIs), and indeed, about examples of good practice. If handled in an open and blame-free way, educating trainee doctors about past mistakes could start to change the culture of fear that currently surrounds serious incidents in the NHS. These things would contribute enormously to improving the standard of care that we provide for our patients.

There is clear national guidance that all staff should learn from SIRIs, and this is echoed in local guidelines. In reality, however, junior doctors have very little involvement in the process of learning from SIRIs. An unpublished survey of all junior doctors in one trust showed that only 23% knew about any SIRIs that had happened in the trust. None knew about any of the learning points arising from a sample of recent, relevant, SIRI investigations. One doctor had even been indirectly involved in an SIRI, and yet had had no feedback from the resulting investigation. Personal experience and informal feedback from colleagues suggests that these findings are not unique, and are likely to be common to the majority of junior doctors in the majority of trusts.

Junior doctors change jobs and trusts frequently. This may make them harder to communicate with than other NHS staff. Nevertheless, there are clear ways to access junior doctors, such as teaching sessions, journal clubs and academic meetings. Email lists are also set up for contacting all trainee doctors as soon as a new cohort of doctors start in a trust. Another channel by which information can be fed back to junior doctors is in morbidity and mortality meetings. These are used as a forum in which deaths and complications are presented by trainee doctors, and reviewed by senior doctors, but they are not well established in many medical specialties. Furthermore, they have been criticised for focusing excessively on individual errors, and for creating a fear of humiliation and blame in participants.[7]

It seems clear that doctors and patients would benefit from improving feedback to trainee doctors about SIRIs. The morbidity and mortality meeting format could be adapted to share particularly important and relevant lessons from SIRI investigations with junior doctors, with an emphasis on learning from the cases and investigations. By reviewing cases that have already been investigated, using a technique such as RCA that focuses on systems

rather than on individuals, the pitfall of blaming and 'finger-pointing' might be avoided. This would provide a channel by which information could be shared, and could be a powerful learning tool. Much more importantly, it would help to create a more open culture around adverse events in general, which in turn, would have a positive impact on patient safety.

Much of the current discussion around patient safety and cultural change focuses on ensuring that staff feel able to whistleblow when they have concerns about others.[1] This in itself seems to imply that breaches in patient safety are caused by negligent individuals, propagating an ongoing culture of fear. If our training included a forum for supportive and open discussion of adverse events, trainee doctors could feel empowered to discuss, review and improve any areas of concern they might have about their own practice. This might even help to negate the need for whistleblowing by others in the future. Taking steps such as these now to decrease the culture of blame and fear around SIRIs could be an extremely effective measure in ensuring patient safety in the future.

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