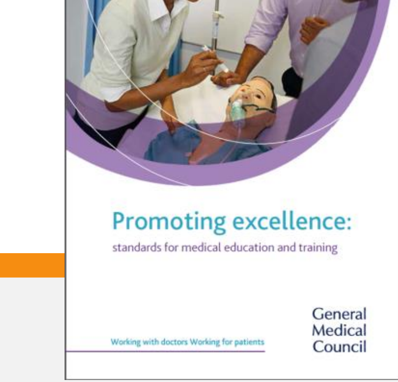
Clinical Incidents: What Feedback and Support Do Trainees Need?

Dr Alistair Thomson
Assoc. PG Dean
Educator Development, HEENW

Promoting Excellence and Incidents

NHS
Health Education England

- R1.3 Organisations must demonstrate a culture that investigates and learns from mistakes and reflects on incidents and near misses. Learning will be facilitated through effective reporting mechanisms, feedback and local clinical governance activities.



Introduction - 1

- Clinical incidents spectrum
  - No/low harm events
  - Serious clinical incidents: patient harm or death
- Reporting trainees need feedback for own learning and to encourage further reporting
- Trainees who are involved in SUIs are:
  - Required to reflect on these; and
  - May have to write reports on their involvement for investigations, RCAs or the Coroner

Introduction - 2

- Trainees need support and guidance
  - To record their reflections safely and
  - Write professional reports when requested
  - NACT UK guidance on Clinical Incidents
- Trust responses to the Autumn 2018 Self-Assessment Return (SAR) show that systems are under-developed and may not involve supervisors or senior educators

Aims

- This workshop
  – Explores how feedback from and support around incidents could be provided to trainees
  – How early involvement of trainers and senior educators can potentially reduce ‘second victim’ impact on trainees

Objectives

To understand:

- Roles/responsibilities of Senior Educators
- Roles/responsibilities of Trainers
- Trust systems
- Operational processes for HEENW
- Context for training programme delivery

Senior Educators Trainers and others

- Postgraduate Dean, PGD
- Deputy Dean, DD
- Associate Dean, AD
- Heads of School, HoS
- Training Programme Directors, TPD
- Directors of Medical Education, DME
- Foundation Programme Directors, FPD
- Medical Education Manager, MEM
- Trust Specialty Training Lead, TSTL
- Educational Supervisor, ES
- Clinical Supervisor, CS
- Local Faculty Group, LFG

Self-Assessment Return - Autumn 2018

- Lengthy questions
- Free text boxes for responses
- Section 8.1 about
  - Clinical incidents
  - Support for Coroner's Cases
- 32/34 Trusts responded
- Potential major limitations to data

Self-Assessment Return Autumn 2018

Questions in 8.1
Please provide an account of how your organisation identifies learner involvement in Serious Incidents. How is that degree of involvement defined?
What support systems exist to support learners? How are these systems monitored?
What feedback do you receive from learners about their experience of being involved in Serious Incidents?
What formal organisational links exist between the Governance team coordinating investigations and - the Postgraduate team supervising the trainees? - the HEIs supporting learners?
How many patient safety incidents have you reported to NHSI.
How many serious incidents impacting on trainees revalidation have you made to your HEE local office within the reporting period? What proportion of these have been resolved/closed after completion of investigations?
How does your organisation disseminate learning from Root Cause Analysis reports? How does your organisation promote a patient safety culture?

Coroners Hearings

Questions
What support is available for learners required to provide statements and/or attend Coroners hearings?
How is your organisation involving learners in responding to Duty of Candour responsibilities?

Self-Assessment Return Autumn 2018

Questions in 8.1
Please provide an account of how your organisation identifies learner involvement in Serious Incidents. How is that degree of involvement defined?
What support systems exist to support learners? How are these systems monitored?
What feedback do you receive from learners about their experience of being involved in Serious Incidents?
What formal organisational links exist between the Governance team coordinating investigations and - the Postgraduate team supervising the trainees? - the HEIs supporting learners?
How many patient safety incidents have you reported to NHSI.
How many serious incidents impacting on trainees revalidation have you made to your HEE local office within the reporting period? What proportion of these have been resolved/closed after completion of investigations?
How does your organisation disseminate learning from Root Cause Analysis reports? How does your organisation promote a patient safety culture?

Topic	n (%)	Comment
Reporting incidents	15 (50)	12 mentioned Datix; 4 other systems.
Identifying learners in serious incidents	14 (47)	Only 3 mentioned turnaround time (72h or 'early'). 3 cited systems which would identify trainees late, e.g. during investigation.
Staff Support for incident by ES +/- CS	23 (69)	Including 1 with implied later support.
Staff Support for incidents by others (i.e. non-medical)	26 (87)	Managers in most, but no details.
Staff Support / debriefing	22 (73)	Plus: 1 'no serious incidents'; 1 'at breakfast meeting'; 1 'in development'.
Schwartz rounds	5 (17)	Some apparently by other names.
Report to DME	16 (53)	Plus: incidents involving FYs reported to Local FYPD.
Feedback on incident to individual reporters	20 (67)	Little information about who gave feedback or how.

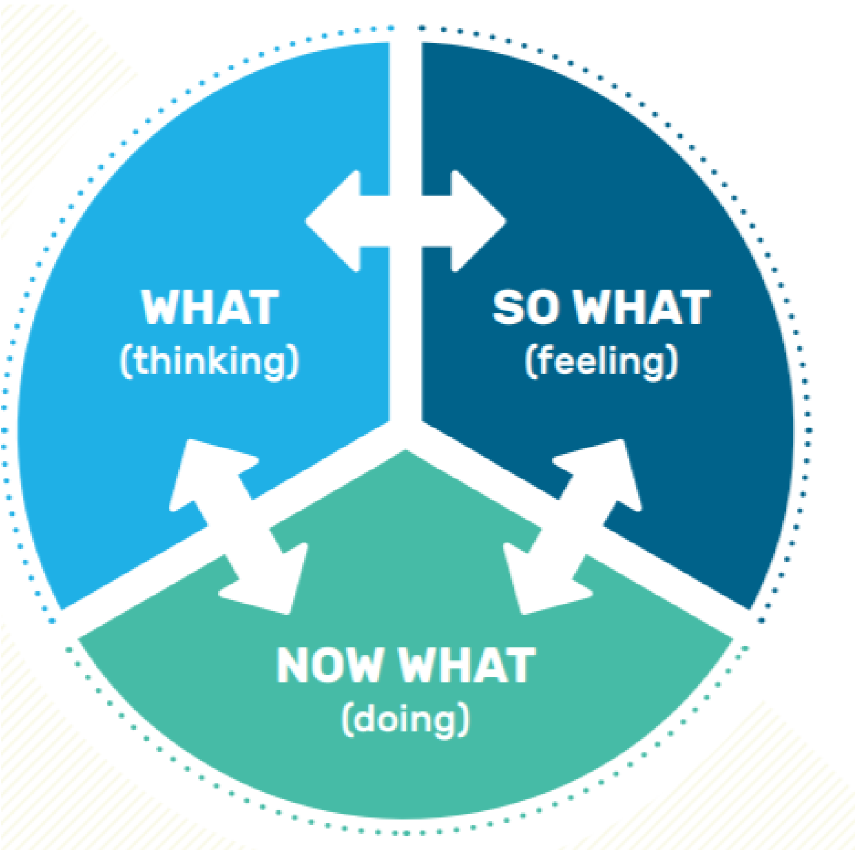
Topic	n (%)	Comment
Coroner's hearing – support from ES +/- CS	17 (57)	1 stated 'may be accompanied'
Coroner's hearing – support from DME	10 (33)	-
Coroner's hearing – support from trust services	27 (90)	Presumably managers in Trust's department for inquests. Nomenclature varied.
Coroner's hearing - support from legal department	20 (67)	Not clear across responses if this is external legal services.
Coroner's hearing – training provided?	16 (53)	1 mentioned encouraging attendance at an inquest to view proceedings.
Coroner's hearing – HEENW Website referenced?	0 (0)	-
Training on duty of candour	24 (80)	5 'information'; 3 'at induction'; 2 'for Foundation'; 1 'departmental'. Some did not expect trainees to have unaccompanied 'Duty of Candour conversations'.
Reflection mentioned	6 (20)	-

Data interpretation

- Data incomplete
  - Lack of & contradictory information
  - Suggest systems to identify healthcare staff are immature
- ‘Second victims’ not clearly supported
  - (Controversial, but recognised by Drs)
  - Confusion between mandated reflection for SUI and written statements
- GMC advice on reflection, August 2018

the reflective practitioner

Guidance for doctors and medical students



Specification: System *should* - 1

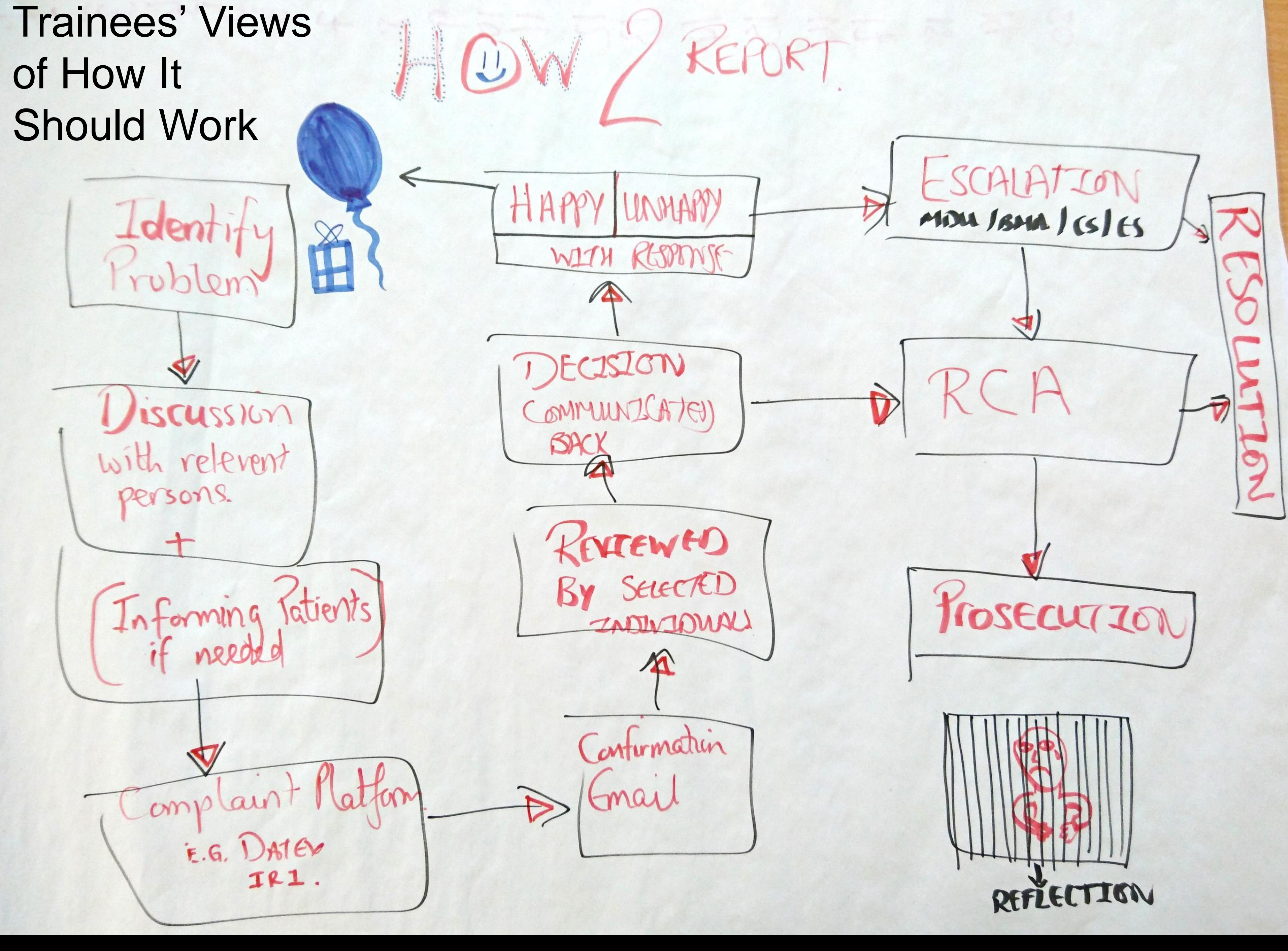
- Identify individuals involved in incidents
  - In < 48 h
  - From reports emanating via several sources
- Stratify incidents from trivial to serious
- Feedback on incident reports directly: or
  - Notify CS +/- ES to offer feedback
- For more serious incidents:
  - Notify CS & ES and DME (and TPD)

Specification: System *should* - 2

- Support the trainee in writing statements
- If a trainee must submit a report to, and perhaps attend, an event (RCA, inquest)
  - Identify trainee asap (even if left Trust)
  - Offer support through local processes;
  - Decide support for trainee and supervision of process (e.g. previous ES, etc)

Specification: System *should* - 3

- Ensure trainee's report to the inquest is of high standard (i.e. typed, headed, comprehensive, dated, signed, etc…)
- Consider coaching for attendance at Court (not over content of answers)
- Provide, or advise on, need for, independent legal advice


Trainees' Views of How It Should Work
HOW 2 REPORT
Identify Problem
Discussion with relevent persons.
+
(Informing Patients if needed)
Complaint Platform
E.G. DATEV IR1.
Confirmation Gmail
REVIEWED BY SELECTED INDIVIDUALS
DECISION COMMUNICATED BACK
HAPPY
UNHAPPY
WITH RESPONSE
ESCALATION
MDU / BMA / CS / ES
RCA
PROSECUTION
REFLECTION
RESOLUTION

North West

Health Education England

Home | Hospital Medicine | General Practice | Public Health | Dentistry | Foundation Training | Recruitment | Support

Health Education England - North West: Postgraduate Medicine and Dentistry

Search

Updates

Health Education England Latest News:

Read more

Promoting Excellence - Equality & Diversity Considerations:

Read more

The GMC has published its 6th annual report on the state of medical education and practice.

Read more

Revalidation Requirements for Trainees Undertaking Roles Outside of Training

Read more

Our Vision

Everyone associated with health care in the North West:

- will strive for ever-increasing standards of patient centred care

Policies and Procedures

Coroners Inquests

- Coroners Inquests - A guide for Learners
- Coroners Inquests - Writing a Statement
- Supporting Trainees attending a Coroner's Court
- Writing a statement - Statement Template

Health Education England

Coroner's Inquests – A Guide for Learners

Section 1: Introduction

Being called as a witness at an inquest is an infrequent event. It can however cause much anxiety and uncertainty. This guide is written to give advice to learners on how to prepare for an inquest and what support is available. A Coroner may be a Lawyer or a Doctor (or both), and is an independent judicial officer who must investigate sudden death of which the cause is unknown, violent or unnatural. Coroner's jurisdiction has existed for eight centuries but has been greatly reduced over time to narrow their field of inquiry currently to sudden or unexpected deaths.

Section 2: Who does this guide apply to

The aim of these guidelines is to provide advice and support to all learners involved in a Coroner's Inquest

Section 3: Definitions of abbreviations used throughout the guide

- HEE – Health Education England

Section 4: Roles and Responsibilities of the users

Coroner's Inquests will feature in many learners' careers. Learners should seek advice from their supervisors and mentors if they are unsure of any part of the process.

Summary

- This is where Clinical and Education Governance intersect and overlap
- Systems for feedback on reports of clinical incidents are often imperfect
- Trainees' own grasp of how systems should work is ahead of the reality
- Senior educators should be central to the process of managing trainees' incidents