NHS England
East of England

Supporting trainees involved in a serious incident

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Introductions

What would you like to get out of this session?

What Might a Trainee Wish to Know?

- Am I in trouble?
- What do I need to do?
- Who can help me? What if potential conflict?
- Do I have to have my own defence union or am I covered by the hospital?
- How do I write a statement?
- Who should do the Duty of Candor?
- I'm nervous about putting a reflective practice in my eportfolio – do I have to?
- If it goes to an inquest, will I have to go and what happens?
- Do I have to let anyone else know?

Changing Definitions and Process

Serious Incident Management at a glance

Serious Incidents in health care are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified. This Framework describes the circumstances in which such a response may be required and the process and procedures for achieving it, to ensure that Serious Incidents are identified correctly, investigated thoroughly and, most importantly, learned from to prevent the likelihood of similar incidents happening again.

Serious Incidents include acts or omissions in care that result in; unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm - including those where the injury required treatment to prevent death or serious harm, abuse, Never Events, incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services and incidents that cause widespread public concern resulting in a loss of confidence in healthcare services.

Serious Incident framework 2015

Moving away from SUI to SI …… to I

[NHS England » Patient Safety Incident Response Framework]

Educator Role

- Time and appropriate space to sit down with trainee, non-judgemental
- Duty of Candor
- Talk through process – why is it an SI, what is the Trust investigation process, is a coroners inquest likely?
- Encourage trainees to write down “recollection of Events” early
- If not you, who else can they turn to for support?
- Do they need guidance on statement writing?
- Practical help with access to notes needed?
- May be in a different Trust now – practicalities?
- Support with Reflection, need for Form R
- Support for Coroners inquest including debrief after
- Signpost to Wellbeing services
- Share outcome / learning

Supporting Trainee Wellbeing

Second Victim

"although patients are the first and obvious victims of medical mistakes, doctors are wounded by the same errors: they are the second victims"

"Physicians will always make mistakes. The decisive factor will be how we handle them."

Albert Wu BMJ 2000;320:726-7

- Guilt, shame
- Common stress reaction is normal
- Red flags if extreme stress reaction
- Small things appear overwhelming; burnout – error – stress - error
- Talk to people about the event early on to reduce risk of PTSD; tea and biscuits!
- Come away from situation, but don't go home/sent away as people feel worse
- Don't debrief immediately after, wait
- Hold on to what's normal, grounding techniques, life outside medicine.

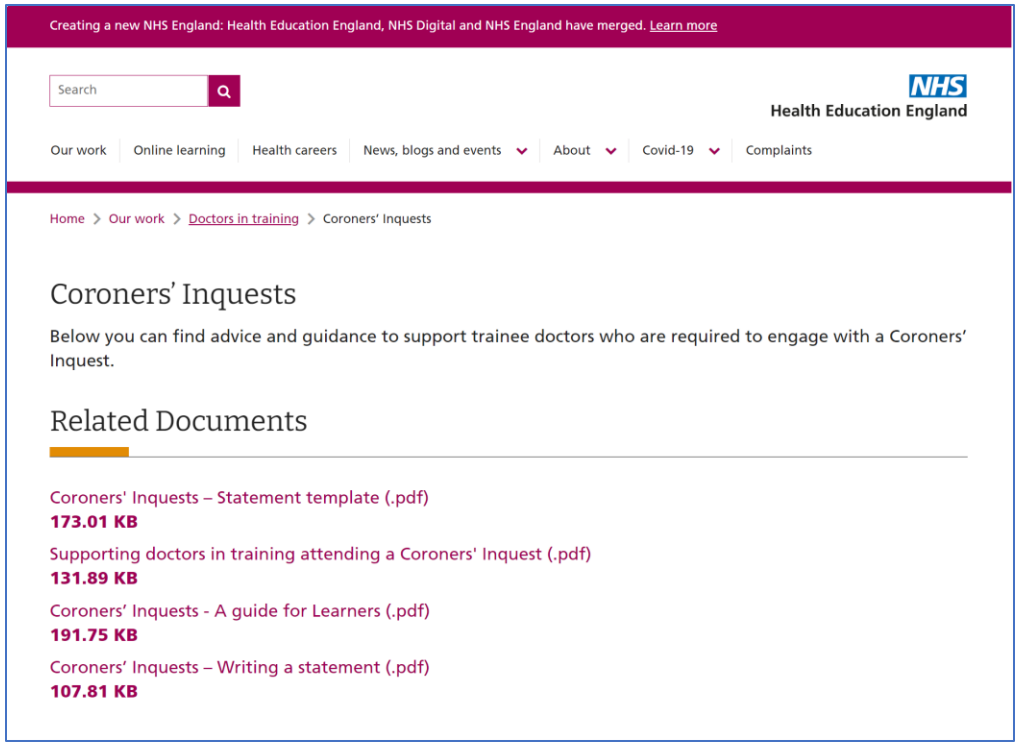
Other Sources of Support

- TPD, DME, HoS, College Tutor ..
- Risk Management Team, Legal Team
- Occupation Health
- GP
- Friends and family
- Trainees who have been through similar experiences
- PSW: SI training day, HSC referrals, coaching, resilience, listening ear

Take Home

- Trainees often feel fearful and anxious.
- Educator support with taking time to talk through the event early, the processes and timescales makes a huge difference.
- Support via PSW

Useful Links



[Coroners' Inquests | Health Education England (hee.nhs.uk)]

[NHS England » Patient Safety Incident Response Framework]

Thank you!
Any questions?