

# Understanding Serious Incidents- Information for Trainees

**Speciality: ANAESTHETICS**

**This booklet has been created to help trainees understand serious incidents (SI) and the investigation processes involved. It also provides information about support and teaching available in the aftermath of an SI.**

**It is also relevant for any incident that could have or did lead to patient harm including near misses**

## **SERIOUS INCIDENTS**

A serious incident (SI), (previously known as a Serious Untoward Incident) requiring investigation is defined as an **incident** that occurred in relation to **all Healthcare services** resulting in one of the following\*:

- **Unexpected** or **avoidable** death of one or more patients, staff, visitors or members of the public;
- **Serious harm** to one or more patients, staff, visitors or members of the public or an outcome which requires life-saving or major surgical/medical intervention;
- **Permanent harm, a reduction in life expectancy, prolonged pain or psychological harm;**
- A scenario that prevents or threatens to prevent a provider organisation's ability to continue to deliver healthcare services, e.g., actual or potential loss of personal/organisational information, damage to property, reputation or the environment, or IT failure;
- Allegations of **abuse**;
- Adverse media coverage or public concern;
- A **'Never Event'**. This is defined as a very serious, largely preventable patient safety incident that should not occur if the relevant preventative measures have been put in place. This list is published by the Department of Health and is intermittently modified but currently includes:
  - Wrong site surgery
  - One or more retained foreign objects post-operatively e.g. swab or instrument
  - Chemotherapy administered via the wrong route
  - Misplaced nasogastric or oro-gastric tubes not detected prior to use
  - Inadvertent administration of intravenous concentrated potassium chloride
  - Intravenous administration of epidural medication

The current full list can be found at the end of this guidance, but please note this may change over time

Some specialties have specific "triggers" which mandate a report (obstetrics for example). For specialty specific context and issues – see the attached appendix B

## **Background Information**

When a serious incident occurs it can have a devastating and far reaching effect. It may have an impact on those directly involved, patients, relatives, staff or visitors, and also on the reputation of the healthcare organisation, the service or the profession within which the incident occurred, and the wider NHS.

**As a trainee it is a distinct possibility that you may be involved directly or indirectly in a Serious Incident. Human error is usually the consequence and not the cause of many serious incidents unlike system failures. The purpose of this document is to clearly layout what support is available to you and how you can expect to be helped through a potentially difficult experience.**

## **SI reporting**

Reporting any adverse event should be encouraged and the SI investigation aims to identify ways to prevent errors recurring and not to apportion blame. Clinical incident reporting within each trust utilises an electronic +/- paper-based reporting system that is centrally collated within that trust. Any incident that is thought to be serious and could be an SI is flagged and has a further more comprehensive investigation undertaken by the Risk Management team. Incidents are reviewed nationally by the National Reporting and Learning System (NRLS) who produce reports regularly on incidents and patient safety alerts to share learning and good practice across the NHS.

## **What is the SI investigation Process and how long will it take?**

Each trust has its own SI investigation pathway that can be found on trust intranet sites or via the risk management team and should be made available to you at Induction to the Trust.

The processes will vary but generally once an SI is declared, within a 48 hour period, a lead investigator will be appointed who will interview staff (with transcription of the interviews), gather statements, review the notes and other evidence and develop a report. Interviews are especially important if inconsistencies are found within the information gathered from statements. If you are interviewed you should be given the transcript to check and amend as you see fit so that you agree with everything recorded in the final transcript

A panel will later review the investigator's report and recommendations and this panel will usually include a Trust executive as chair, a consultant(s), a nurse/midwife and may include external panel members who are experts in their field.

A root cause analysis of events is undertaken (National Patient Safety Agency guidance).

Very occasionally, at the same time as an SI is declared or during investigation, legal proceedings are started. In this very unlikely event, legal advice will be sought for the investigation so as not to prejudice the proceedings. Legal proceedings may not be commenced for some years after an incident.

The panel will then write a report (NPSA format) of the incident that is presented to the Clinical director and up to the Chief Executive. It is then passed on to the NHSE London Regional Office (All SIs), the NRLS and the North West London Commissioning Partnership to identify opportunities for learning outside the organisation. The time frame for this is 45 working days from start to finish for a Grade 1 Incident (e.g.: Avoidable or unexplained death).and 26 weeks/6 months for grade 2 incidents (e.g.: child protection incidents and never events). The following NRLS document clarifies the grading between incidents. (<http://www.nrls.npsa.nhs.uk/EasySiteWeb/getresource.axd?AssetID=68464&type=full&servicetype=Attachment>)

## **What am I going to Learn from the SI?**

Learning from an SI relies on several factors and should be carried out in an open and transparent environment. Importantly being involved in an SI gives you experience of risk management first hand. Risk management is an essential part of modern practice, particularly in the NHS after the Francis Report and complements reflective practice and a commitment to lifelong learning, which are themselves key parts of revalidation.

The learning points and recommendations of an SI will be disseminated through the department, or on a wider basis, providing important access to suggestions of improvement. Improvement may be needed generally within the whole department to tackle system errors. Most importantly the SI process gives you, the trainee, the chance to reflect on the events and come to conclusions of your own. When you are a Consultant, you will be asked to act as investigator so it is paramount that as a trainee you have a full appreciation and understanding of the SI process.

## **What to do if a serious incident occurs**

Whether your Trust needs it or not, it is good practice to write a statement as soon as possible after the event whilst recollection of the event is fresh. This should be separate to the clinical records. **NEVER ALTER THE WRITTEN CLINICAL RECORD; IF ABSOLUTELY NECESSARY MAKE A SEPARATE ENTRY, DATE AND TIME IT AND MAKE IT CLEAR THAT THIS HAS BEEN WRITTEN AFTER THE EVENT.**

## **Whilst the Serious Incident is being investigated what happens to me?**

Serious Incidents can lead to anxiety and stress for all involved. It is important to realise that there is support available to trainees involved in SI cases. At a local level the trainee's Educational Supervisor will provide sound objective advice and counsel. The College Tutor is another person nearby who can provide support when needed. The Clinical lead is also available for further support and may refer to the Trainee in Need group for further mentoring or counselling. The SI investigation is a confidential process that will not concern many others at work; however, immediate lessons learnt can be actioned as soon as possible after the incident. This may lead to the incident being discussed in the public arena before the investigation has started or finished. This discussion however should be anonymised and not be in the context of blame. The only foreseeable circumstance where departmental concerns may arise is if doubt has arisen about a trainee's competence.

Patient safety is paramount; in extremely rare circumstances there may be such clinical concern about a trainee that it is necessary to limit their practice, change the required level of supervision or exclude them. This might also occur if there are concerns about the trainee's well-being, or if it is thought their continued presence might interfere with the investigation. It is important to note that this is an extremely rare event, and very strict rules govern such action.

In particular Health Education North West London (formerly London Deanery)/ the Lead Provider will be closely involved in any incidents that highlight training concerns at an institution, raise concerns about a trainee's conduct, performance or health, or might lead to media attention.

When a doctor is involved in an SI their Responsible Officer needs to be notified and this is the postgraduate dean. In London this is done through an electronic portal to ensure appropriate confidentiality and consistency with information gathering. Health Education North West London (HENWL) unit is responsible for recruitment, quality assurance of training as well as Trainee Revalidation and support for trainees in difficulty. This

information is used to help support trainees and identify training needs where relevant. It may also be used to identify recurring events.

## **How you may react**

When you are involved in an SI it is likely that you will have many strong and conflicting emotions. This is normal! Following the incident itself you may have feelings of anxiety, denial, shame, fear, or guilt. Some doctors who are involved in incidents may even find their self-confidence suffers; they may feel like an “imposter” or even consider giving up their chosen career. Feelings like this are usually temporary, and discussion with others involved / supervisors/ colleagues and working through the SI investigation should be helpful and restore your equilibrium., Participation in the SI process is vital and helps avoid feelings of isolation which if not dealt with can lead to depression. It is vital that you seek support locally and /or centrally.

### Steps to recovery

- **Understand the process** of investigation – if you do not know what is happening – seek clarity – your clinical lead or the DME can contact the risk management department
- An adequate and thorough **debrief** is essential – this may be as part of the investigation or may occur outside the formal investigation. Being able to express your thought processes in a secure and confidential environment and being able to ask the “what if” questions can be very helpful. You do need to make sense of what has happened and re-establish your sense of self and professional capability
- Identify any **learning needs** you have – don’t be afraid to ask for more training, or focused discussions/training. Many incidents occur because of a combination of factors and are related to team working as well as system failures. If you feel the team needs some time together and help to be more effective – then say so. Taking control of how you can improve is immensely helpful to your personal wellbeing and healing.
- Don’t be afraid to revisit the problem in your educational meetings or departmental meetings. **Sharing your experience** will help others whether it is through your description of the medical decisions you made or how the incident investigation worked.
- **Seek help** from professionals – Appendix B has a list of people outside the Trust who can help you. This is important – your health and well-being must not suffer and you have a life long career to continue. You may already have a mentor who you can talk to. Speaking about events is an important part of the process to recovery and learning.

## **Will being involved in an SI hinder my training?**

One of the important features of the root cause analysis of any SI is to create learning points that all healthcare professionals can learn from – not just those directly involved in an incident. SIs provide each trainee with the opportunity to learn and modify their practice if necessary. Unless the SI has led to a suspension from clinical work or other local HR action there is no reason why you would be prevented from rotating to your next post. This is as long as you satisfy the standard criteria set for the yearly ARCP.

The vast majority of incidents are treated as learning experiences and discussed at ARCP panel meetings and HENWL clearly states that simply being involved in an SI is not a reason for an unsatisfactory outcome at an ARCP. However if locally devised remedial teaching has been put in place HENWL will support this and in this scenario an unsatisfactory ARCP may be of benefit to allow the trainee to undergo the pre-arranged further training in order to reach the appropriate competence.

## **Revalidation and your ARCP Enhanced Form R.**

Revalidation is the GMCs way of regulating licensed doctors. The aim is to support doctors in their professional development, helping to improve quality, patient safety and public confidence in the profession. As part of the revalidation process, you will now be asked to complete an enhanced Form R, which will require you to submit additional supporting evidence to enable your ARCP panel to make a recommendation to your Responsible Officer.

Reporting SIs, and co-operating with their investigation is an essential part of revalidation (Domains 1.1 and 2.1), and should be included in your annual appraisal. As a trainee this will be part of your signoff discussion prior to the ARCP, and the issues may be discussed at your ARCP.

For the purposes of the Enhanced Form R, you need to record any complaints and significant events that were **formally investigated** by your employing organisation/HENWL/professional body, or that are currently unresolved since your last ARCP. The ARCP panel is interested in what you have learnt as well and you should reflect on any significant events, complaints and investigations in your e-portfolio (see below).

The GMC state that a significant event is any unintended or unexpected event, which could or did lead to harm of one or more patients. This includes incidents which did not cause harm but could have done, or where the event should have been prevented, which is significant enough to be investigated by your employing organisation.

Within each trust, the postgraduate medical education department will also report any significant event that involves a trainee (all grades including Foundation) via a specific electronic secure portal.

Further details and information are available on the HENWL website: <http://www.lpmde.ac.uk/lpmde/policies-procedures/serious-incident-report-form/serious-incident-report-form>

You may be asked to write a statement by your clinical lead or educational supervisor if you were:

1. Present at the time, but not directly involved in the SI
2. Present at the time, not directly involved in the SI, but personally affected by the SI
3. Involved, but in a minor way, e.g. as part of the team
4. Directly implicated as contributing to the SI
5. Directly implicated in the response to, and management of, the SI
6. Or a combination of the above

Advice on statement writing can be found in Appendix A.

Your Trust Risk Management department will decide on the level of investigation required and the severity of the incident. Following this, your clinical lead and educational supervisor will determine whether it requires reporting to HENWL.

### **What is a Responsible Officer?**

This is a senior clinician in a Designated Body who ensures that the doctors for whom they act in this nominated capacity, continue to practice safely and are properly supported and managed in maintaining their professional standards. The Postgraduate Dean is the Responsible Officer (RO) for trainees, and the GMC requires all employers to inform the LETB when a doctor in postgraduate training has been involved in an SI.

The three London ROs are:

Health Education North West London - Dr Julia Whiteman

Health Education North Central and East London - Dr Tim Swanwick

Health Education South London - Dr Andrew Frankel

## **Reflective Practice**

Reflection is an important part of postgraduate education and helps to improve clinical practice as well as patient safety. In the aftermath of any significant event it is important to reflect on the event itself, your own practice and any learning outcomes that have been implemented.

In addition to reporting significant events or complaints on your enhanced form R, each incident should be accompanied by a note of personal reflective practice (this is also required at consultant level for the annual appraisal and revalidation; it is not limited to trainees).

## **Other possible outcomes**

### **Inquests**

Any SI which results in the death of a patient should be reported to the Coroner, The Coroner will decide if an Inquest should be held, which will inevitably be some months after the incident, and will almost always await the findings of the Trust's SI investigation. An Inquest is a fact-finding exercise and not concerned with findings of negligence or blame, Reports to the Coroner must be completed promptly, and you should always seek senior advice and/or discuss with your Indemnity Organisation.

### **Complaints**

SIs may also result in complaints from patients or their family. Each Trust will have a Complaints Policy, with a strict timetable for responses. A senior clinician will write the response, co-ordinated by the Complaints Department. You should respond to any request for information in a timely manner; this is both a reasonable expectation by your employer, and required by the GMC. If you have been named in a complaint this should be included in your portfolio and Enhanced Form R with a reflective practice report and these will be discussed as part of revalidation at your ARCP

### **Civil litigation**

Any civil claim arising from an SI will be against the Trust, and will be managed by the Legal Department in conjunction with the NHS Litigation Authority. Although it is good practice to apologise after any incident, you should avoid admitting liability, and seek advice from a Consultant and/or the legal department as soon as you become aware of any claim. Civil claims may take several years to conclude.

## **General Medical Council**

The GMC has a responsibility to inquire into any occasion where a doctor's actions may have put a patient in danger, or there are issues about a doctor's honesty. Patients and their families may make a complaint, as may other doctors (indeed in some circumstances they are required to). Only in extremely rare circumstances would a Trust respond to an SI by involving the GMC, rather than initiating local action in conjunction with the LEP, LP and LETB. The GMC would similarly make enquiries with these bodies, except in exceptional circumstances, to prevent patient harm or to protect the reputation of the profession.

If you are contacted by the GMC, you should inform your employer, Educational supervisor and your Medical Indemnity Organisation as soon as possible, and must cooperate promptly and fully with its enquiry.

## **What you can expect from your Lead Provider?**

### **Support**

Support is available locally from the Educational Supervisor, College Tutor and Director of Medical Education. Any decision about a trainee's working patterns or supervision must be made in conjunction with the clinical lead.

### **Education**

Many SIs will lead to identified learning needs, which may be delivered in a number of ways, and are most commonly managed locally. An SI you have been involved with may form the basis of, for example, case discussion or simulation training. Any such training should be on the basis of anonymisation, and you should never be identified. You would of course be able to share your own learning and reflection if you choose to, but this would not be expected of you in such a public environment.

### **Legal Advice**

You are strongly recommended to be a member of, and make use of, one of the Medical Indemnity Organisations (Medical Protection Society, Medical Defence Union or Medical and Dental Defence union of Scotland). These organisations can provide trainees with a wide range of assistance. This may include telephone advice, help writing a statement, in some cases an offer to attend an interview with you and assisting with making comments in response to an investigation. They extend their help further when dealing with disciplinary action or exceptionally rarely criminal proceedings. Possibly just as important they offer confidential counselling services if the in house support is not providing adequate guidance. You should also be able to contact the Legal department within your Local Education Provider to obtain advice.

## **Additional Information:**

### **The 'Never Event' List published by the Department of Health 2011:**

1. Wrong site surgery
2. Wrong implant/prosthesis
3. Retained foreign object post-operation
4. Wrongly prepared high-risk injectable medication
5. Maladministration of potassium-containing solutions
6. Wrong route administration of chemotherapy
7. Wrong route administration of oral/enteral treatment
8. Intravenous administration of epidural medication
9. Maladministration of Insulin
10. Overdose of midazolam during conscious sedation
11. Opioid overdose of an opioid-naive patient
12. Inappropriate administration of daily oral methotrexate
13. Suicide using non-collapsible rails
14. Escape of a transferred prisoner
15. Falls from unrestricted windows
16. Entrapment in bedrails
17. Transfusion of ABO-incompatible blood components
18. Transplantation of ABO-incompatible organs as a result of error
19. Misplaced naso- or oro-gastric tubes
20. Wrong gas administered
21. Failure to monitor and respond to oxygen saturation
22. Air embolism
23. Misidentification of patients
24. Severe scalding of patients
25. Maternal death due to post partum haemorrhage after elective Caesarean section.

## Appendix A

### Statement Writing Advice

Your statement should be an accurate logical recollection of events with explanation of any decisions that you made. By writing the statement as close to the event as possible you will be able to recall factors and events that a patient's medical notes may not reflect.

You should aim not to copy out a patient's notes verbatim nor use any abbreviations/clinical terminology remembering that your statement may be read by a lay person. **Your statement is a document of fact not opinion.**

In response to the Freedom of Information Act 2000 and the Data Protection Act 1998, the information in your statement is disclosable.

Simple guidance includes:

1. Your full name, qualifications and position
2. Type your statement and lay it out clearly with a title and page numbers
3. Stick to the facts but do add any other recollection of the incident that may not be in the notes that may be relevant (common examples here include being called to other work and sometimes itemising this is very helpful). Clearly say what your involvement in the case was and why you made any decision
4. Include dates and times wherever possible. If you are uncertain of these, say so.
5. When referring to other members of staff use their full name and position
6. It is very important that when writing a statement you do not blame or criticise others. Keep any such observations purely factual
7. Be as clear and concise as possible
8. Sign and date the statement
9. Keep a copy for your records

Further advice can be obtained from the risk management team in your unit or Consultants. In addition the MPS/MDU are happy to read statements and give advice on the content. An extra added benefit is that they will keep a confidential copy for you if you ever needed to refer back to it in the future.

## Interviews

If you are invited for interview it is important you attend and the sooner the interview occurs after the event the better your memory will be. Most people are happy to attend alone but you are entitled to be accompanied by someone and as learning outcomes are possible you may choose to ask your educational supervisor to attend with you. After the interview you should be given the transcript to check and amend as you see fit so that you agree with everything recorded in the final version

## Other avenues of support

### The Professional Support Unit (PSU)

The PSU provide an expert shared service of resources to support the professional development of clinicians working in the capital. Further information and advice on how to access the service can be found at: <http://www.lpmde.ac.uk/professional-support/professional-support-unit>

### What do the PSU offer?

- Careers support including psychometrics and occupational psychology
- Coaching and Mentoring
- Complex case advice and management including GMC referrals
- Fresh Start Courses (currently available to GPs)
  1. Consulting, keeping records and communicating
  2. Consultation skills
  3. Management in clinical practice
- Language and Communication Resource Unit (LaCRU)
- MedNet - Expert assessment and support for psychological aspects of doctor's health.
- Arranging and managing clinical placements and workplace supervision including retraining through:
  1. GP Induction and Refresher Scheme
  2. Medical Pre-CCT Return to Practice Scheme
  3. Refugee Doctor Foundation Clinical Apprenticeship Scheme
- Access to occupational health advice services.

## **Appendix B**

# Anaesthetics

### **Background**

From April – September 2013 the top four most commonly reported types of incident to the NRLS were: patient accidents (21.4%), implementation of care and ongoing monitoring/review incidents (11.5%), treatment/procedure incidents (11.0%), and medication incidents (10.7%).

### **Serious incidents in Anaesthetics include:**

1. Avoidable/unexplained death
2. Maternal unplanned admission to ITU
3. Drug administration errors
4. Failed intubation or oesophageal intubation
5. Cardiac complications such as hypotension, arrhythmias or cardiac arrest.

### **Never Events in Anaesthetics include:**

1. Transfusion of ABO-incompatible blood components
2. Wrong gas administered
3. Air embolism
4. Intravenous administration of epidural medication
5. Overdose of midazolam during conscious sedation
6. Wrong route administration of oral/enteral treatment

### **Support:**

#### ***Local***

The Trust you are working in is responsible for investigating any SIs and your Educational Supervisor / College Tutor and Lead Clinician (for the particular case) should all be available to help and support you. Similarly the Director of Medical education and Clinical Governance / Risk Management team can help to support and guide you. In addition never underestimate the help your peers and nursing colleagues can give: they are all part of the team and mutual support in difficult circumstances is invaluable and part of all of our roles

## ***Specialty Programme Directors***

The Specialty Programme Directors (SPD, previously known as the TPDs) have a key role in managing the specialist training programme. Their fundamental role is that of co-ordinator and communicator between Specialist Registrars, the Postgraduate Dean, the Specialty Training Committee, and the appropriate Royal College or Faculty. They are also present to offer counseling to individual trainees, particularly where local tutors are unable or inappropriate to fulfill this function,

Your Specialty *Lead for Anaesthetics* is:

Name: **Dr Michelle Hayes**

E-mail address: [michelle.hayes@chelwest.nhs.uk](mailto:michelle.hayes@chelwest.nhs.uk)

## ***Imperial Lead Provider***

The Lead Provider, led by **Dr Geoff Smith** ([leadprovider@imperial.nhs.uk](mailto:leadprovider@imperial.nhs.uk)), is also available to offer additional support in a confidential and individualised manner if needed. Examples of situations where this might be helpful to you include if:

- You feel bullied or isolated
- You feel you are being made a scapegoat
- Inferences are being made before an investigation is complete
- There is conflict

In addition to this the named individuals below are happy to be contacted if you need further advice and support.

Name: **Ros Bacon**

E-mail address: [drbacro@googlemail.com](mailto:drbacro@googlemail.com)

Name: **Terri Stewart**

E-mail address: [terri.stewart@imperial.nhs.uk](mailto:terri.stewart@imperial.nhs.uk)

## ***Deanery / Shared Services***

Outside the region at the deanery, **Dr Peter Brodrick** is the head of The London Academy of Anaesthesia. Further support from the deanery is available at the professional support unit (PSU) and they can be contacted at [PSU@southlondon.hee.nhs.uk](mailto:PSU@southlondon.hee.nhs.uk). In addition to any specific case that you feel you need help with the PSU also run services to help in career support including psychometrics and occupational psychology.

The London deanery also offers a mentoring service to trainees. The Coaching and Mentoring Service was first launched as The Mentoring Service in May 2008. 'It provides support and guidance to enable the mentee to drive change in order to fulfil their potential as a future leader in the NHS. The service provides insight for those facing decisions or going through a change. This helps to prevent 'burn out' and release their career potential in the health care system'. Since the inception of its coaching and mentoring scheme in 2008 the PSU has dealt with over 1500 applications from London deanery doctors. Further information is available at <http://mentoring.londondeanery.ac.uk/our-scheme>.

## Other involvement of the Deanery / Lead Provider

The Deanery/Lead Provider will also be closely involved in any incidents that highlight training concerns at an institution, raise concerns about a trainee's conduct, performance or health, or might lead to media attention.

Any decision about altering a trainee's working patterns or supervision or decisions made about their training, should be in conjunction with the clinical lead **Dr Michelle Hayes**. If you find yourself in this situation then please contact Dr Hayes at michelle.hayes@chelwest.nhs.uk without delay.

## Education setup in your area

