Introduction to Patient Safety

Presenter notes – Module 2 *Managing a clinical incident*

To be used in conjunction with PowerPoint presentation

Slide 2

Confidentiality

While it is important to create an environment where JMOs are safe to discuss medical error there needs to be a caveat to the usual understanding of confidentiality.

Suggestion:

"Everything discussed within this room shall remain in this room. However, if any information is discussed that poses a threat to ongoing patient safety, that information will need to be handed on to the appropriate person. All efforts to de-identify information will be made."

Slide 4

Outcome Definitions

This slide can be omitted if the definitions have previously been discussed in Module 1.

Slide 6

Faultlines video

If this module is being delivered separately to Module 1 (ie. on a different day) this short clip from the Faultlines video can be used to set the scene.

Slide 7

Adverse events happen

Remind the participants that it needn't be a serious adverse event which caused harm. It could be a near-miss that they observed or were involved in, which may be easier for them to disclose.

Slide 8

What should happen after an adverse event?

It encourages participation if only the title is shown, and the participants are asked what they think should happen. The 'answers' can be introduced via a mouse click.

Slide 9

Open disclosure

The four steps outlined are contained in the National Open Disclosure Standard. (Australian Commission on Safety and Quality in Healthcare)

Slide 10

Reporting

Before introducing the text, ask 'What percentage of junior doctors do you think would report a medical error they witnessed'?

Slide 11

Why doctors may not report

Again, it's helpful to gain the views of participants before displaying the 'answers'.

Slide 14

How does incident reporting lead to improved patient safety?

Junior doctors should be encouraged to explore each step in their own workplace and identify weaknesses and particularly how they can contribute to this. They often get stuck on incident reporting systems-takes too long; not enough computers etc. Suggest explore with them whether reporting is a good thing. If so, then question how they can do this. There are many ways to report and sometimes a discussion with a local safety officer, or a

ward based paper system can work really well. Relies on leadership, which will be a factor for discussion.

Slide 15
Why report?
It is helpful to have a 'local story' of an incident which led to action and subsequent improvement in care.

Slides 16 & 17
Wayne Jowlett case
This case can be used to identify many issues relating to medical error. In this session, we focus upon 2 things:

1) The fact that this error had occurred several times before, leading to deaths. Either because it wasn't reported widely enough or because it wasn't acted upon, several subsequent preventable deaths occurred.
2) Once it was widely realised to be a problem, action was taken (re-designing the needle for example) to prevent any further similar errors

This particular adverse event had occurred frequently before this highly publicised case, and unfortunately has occurred since this case (including two cases in Australia in the last two years).

Slides 18 & 19
How to report
Replace these slides with your hospital's own local reporting system. Do not spend too long on this as it will almost certainly be covered in a stand-alone session. This is merely a reminder.

Slide 20
What happens after an error is reported
This was one of the issues that clearly came out of the previous medical error project: JMOs want to know in some detail exactly what happens if they complete an incident report.

Slide 21
The 'second victim'
Ask: Think back to the beginning of the session when I asked you to think about an adverse event or near-miss that you had experienced or witnessed … now think about how you felt or how the other doctor felt.

Slides 22-24
The 'second victim'- The Andrew Hobart case
Andrew was a first year consultant who was dealing with a child with a febrile convulsion. At the time, it was common practice in ED departments in the UK to have a 'Boyles' anaesthetic machine, which was often used to deliver oxygen to patients. In this case, pure nitrous oxide was given instead and the child became hypoxaemic, suffered a cardiac arrest and died. Again, this case can be used to discuss many elements of medical error, but in this session we use it to focus on the emotional impact upon the doctor. He was devastated and for a while it was thought that he wouldn't work again. Even several months later at the trial he broke down sobbing.

The highlighted text on Slide 24 emphasises the initial response of relatives of victims of adverse events. It contrasts nicely with Slide 25.

Slide 25
The highlighted text emphasises the personal effects suffered by doctors involved in serious adverse events. This inquest was almost a year after the event and the doctor is obviously still seriously distressed.

The second highlighted text illustrates how relatives are, on the whole, very forgiving about adverse events, as long as they believe that their concerns have been addressed and that there is genuine honesty on the part of those staff involved.

Slide 27
Coping strategies
The bottom two points are in brackets as they are clearly not healthy reactions (although they are understandable and unfortunately very common).

Slide 28
Where to go for support
This slide should be modified according to local protocols.

Slide 30
Summary
Ask participants to complete a workshop evaluation before leaving. Provide participants with handouts including a list of resources.