Confronting Errors in Patient Care

Report on Focus Groups

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Executive Summary

This study addresses the issue that, within clinical governance and the lessons from An Organisation With a Memory, health care organisations must use error to enhance patient safety, which entails the development of a reporting and learning culture. As a first step in learning what might encourage this process we used focus groups of nurses and doctors to ask: what do they actually do when they see an error occurring, or when they make one themselves; what stops them confronting or reporting the error; what would assist reporting. We used 6 groups: house officers, SpRs, consultants, general practitioners, 3rd year nursing students, and senior nurses. The findings in the report provide the overall themes as well as more detailed themes for the individual groups.

What do staff actually do when an error occurs?

- In deciding what to report, staff distinguish different types of errors (minor/major; one-off or pattern, etc.) in ways which appear to allow the majority of error to go unreported. This was consistent across all groups. Although serious errors were said to be reported, examples were given where this did not occur. Bad behaviour and attitudes were rarely reported since they were difficult to challenge. No one reported near misses but nurses agreed it would be useful. Clarity about what needs reporting should be provided.

- Clinical error was easier to confront in junior staff rather than peers or seniors, and also easier than dealing with poor behaviour or attitude.

- Cultural norms about doctors’ behaviour from doctors and nurses may jeopardise safety and need to be tackled.

- Examples of learning from error well were provided but seen as rare because they were almost always team-based and this took time. Local learning was seen as superior by most groups to learning from national data.

Barriers to reporting were:

- Defining reportable errors too narrowly
- Length of contract provides reasons to do nothing.
- The workload involved in reporting and the lack of resources to tackle this.
- The persecutory ways error is handled – the culture of fear and the desire not to lose “an otherwise good” nurse or doctor.
- The fact that reporting has not been seen to bring about good change.
- Uncertainty about what was right or wrong.

Ways to encourage reporting involved:

- Improving leadership generally and in terms of safety and error.
- Treating younger staff as professionals.
- Ward based learning groups and time-outs
- Clearer lines of authority across staff groups.
- Annual appraisal.
- Cultural change to make clear what is acceptable or not in terms of behaviour.
- Appropriate discretion in nursing procedures.
- Listening and action on the part of management seen to bring about useful change.
- Consistency across trusts and parts of trusts.
- Training on safety and the handling of error for doctors, nurses and management.
- A person in authority to turn to.
- Middle grade staff on policy committees.
- Support for each other and from management.
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Confronting Errors in Patient Care

Helping people to break their silence or to find their voice, hitherto unheard or unacknowledged, is one of our major moral imperatives. Roger Higgs, 1997[1]

I never checked the pump setting, I just whacked the thing in when I was doing a few other things and I suddenly looked at this guy’s blood pressure and went ‘Holy God!!’, and that was it. The sweat was pouring off me, I thought I was going to be sick on the floor. He was absolutely fine, laying flat for a while but…. I remember this absolute battle axe of a nursing officer coming up, and she said to me every matron’s made a mistake, she said, but how you feel is how everybody will feel when they’ve done it but what have you learned from it? [Senior nurse]

Background

Errors in health care have become a major concern for the media, the public, the government and for the professions concerned. An Organisation with a Memory was a Department of Health publication, which directed itself to ways of recognising and reporting errors and learning from them so that their reoccurrence was made impossible or less likely. This study concerns the first steps in that process, exploring in particular what people do when they see a mistake or inappropriate behaviour occurring in others and in themselves, and what could help them to do more.

Although recent studies have provided some indication of the amount of reported error within health care [2], it is generally agreed that cultures of silence are the norm, at least within medicine [3]. We have guidelines and protocols and even mandates about the need to report poor care when we see it; nevertheless, it is clear that a considerable amount of error goes unreported [4-5]; for example, it is estimated that only 25% of medication errors are reported [6]. Research is still in its early stages looking at the reasons why individuals fail to report adverse incidents or on what would make reporting easier, though a recent study of attitudes to whistle-blowing by doctors and nurses [7] does begin to throw some light on this area.

Another study [8] considered obstetricians and midwives at two units and found their knowledge about the local incident-reporting system was not high, though most knew that a system existed. Their views on what warranted reporting varied considerably, and midwives more often said they were likely to report than doctors did, especially senior doctors. However, we do not know whether in actual incidents they did or did not go ahead and report or confront the person creating the incident. The main reasons found for not reporting were to do with feeling it was unnecessary, that junior staff would be blamed and that they were too busy and it increased workload.
The role of overload in stopping reporting was also considered by pharmacists to be influential in causing dispensing errors which were seen as occurring in numbers well above reports to regulatory authorities [9]. Medication errors have themselves been shown to increase with workload, measured by number of patient days per month and shifts worked by temporary nursing staff [10]. This is important in that it may be that as workload increases the chance of error, so too it decreases the chance of reporting. Nevertheless, workload may be a way of avoiding more difficult barriers to reporting. In other questionnaire studies the main reason for not reporting was seen by nurses as a fear of reprisals [11]. Nurses have said they will report medication errors which are life threatening to patients, but do not want identifying information collected about themselves [12].

Although these questionnaire studies are very useful in guiding us towards the right questions to be asking, it is important that qualitative data are gathered too about actual incidents, whether people went ahead or not, and what were the barriers there towards reporting. We need to consider such issues in junior and senior staff, in doctors and in nurses, and ask them too what would make a difference to their ability to either confront the person making the error or to report it. Reporting one’s own errors is equally important in this regard. With this in mind the present study ran focus groups of house officers, SpRs, consultants, general practitioners and third year nurses. Others, involving senior nurses, are still to take place. The principal questions given to the groups were:

- What do they actually do when they notice error or poor behaviour in themselves or others?
- What could they do?
- What stops them intervening usefully?
- What might encourage them to speak up sooner and to whom?

These basic questions were added to and adapted as the groups progressed, with changes coming from the preceding group’s data.

**Method**

The groups were organised from the London Deanery, The Northern Deanery, and the nursing courses at the University of Northumbria at Newcastle. They consisted of:

- Pre-registration house officers, London (9)
- Specialist registrars, North-east (6)
- Consultants, North-east (9)
- General practitioners, London (5)
- 3rd year Student Nurses, Newcastle (9)
Senior nurses, London (6)

The SPRs and consultants covered a wide range of specialties including A&E, surgery, O&G, psychiatry, anaesthetics, laboratories, occupational health, etc. One senior nurse group is still to take place, and we are hoping also to organise a midwives group.

Groups were for two hours for hospital doctors and one hour for student nurses and GPs, and were audio-taped. They began by explaining the patient safety agenda arising from *An Organisation With a Memory*, the purpose of the groups, and the questions to be considered. Additional questions developed from previous groups. In Newcastle, traditional focus group techniques were used [13, 14]. In the London group a slightly different method, nominal groupwork, was used. In these PRHOs and senior nurses were given post-it notes and asked to spend 5-10 minutes writing on them what they actually do when they notice errors or poor behaviour in themselves or in others - one item per post-it. They were also asked to indicate whether what they wrote down related to major or minor incidents. They were asked to do this individually, not in discussion.

All the post-its were placed on flip charts. One by one the group members took 1 post-it from the flip chart and were asked to place them in groups, if what was written on them could be linked with others in a theme. Once all the post-its had been grouped in this way the participants were split into 3 groups of 3 and were asked to give the themes headings. The group leader then listed the themes that had emerged on a summary flip chart which was put on the wall during the discussion period which followed.

Audiotapes were transcribed and sorted into themes under the appropriate questions for each staff group. The overall themes were then elicited from these. They are collated as answers to the first, third and fourth questions above, since the second question tended to blend into the others.

**Collated themes are identified in bold type. Any recommendations are in bold italics.**
Results

KEY THEMES TO EMERGE
AND RECOMMENDATIONS THAT FOLLOW

1. What people actually do when they notice error or poor behaviour in themselves or others.

• Participants in all groups distinguished between different types of errors, bad behaviour, etc. as to whether they would report or not. Specifically the distinctions made were:

• Minor vs major error; one-off mistakes vs patterns of poor care; unintentional vs intentional. All groups considered that minor or unintentional mistakes, “genuine or honest” errors, one-off errors, or ones for which a subordinate is obviously sorry or has insight need not be reported. The only group who altered slighted from this were the student nurses who considered that they do report their own mistakes in this category to protect themselves from litigation. However, they and the senior nurses were the only groups who discussed mistakes which they had made themselves. Student nurses also found it easier to report minor error than major, although it depended on the actual effect on the patient.

Reasons for not reporting more minor or one-off mistakes involved the time it took, the expectation that it was unlikely to happen again, and that everyone made similar errors themselves. There was an expression from doctors that if someone was “otherwise good” a one-off error or rare bad behaviour should go no further. However, it was pointed out that partial shifts made recognition of patterns more difficult.

In house officers there were statements that they would do nothing in the face of error, because no one would listen. However, almost all the group had been told by consultants that they should go to them.

• Unavoidable error. This was raised only by consultants. Most considered reporting it would not be useful, though challenges to what was avoidable or not (e.g., in terms of equipment design) were made.

• Senior nurses pointed out the following guidelines may produce inferior or even negligent care at times. Was their action or inaction the error in these cases?

• Error vs bad behaviour or attitudes. It was considered that the former was easier to be sure about and to challenge than the latter, and this has been found in a recent survey of attitudes to whistle-blowing (6). With some bad behaviour, staff use humour to try to change things. There was a distinction made here from some groups between “good doctors” clinically who may not have a good way with patients or staff and so should not be
challenged, and those who are not good clinically. There were cultural norms that appeared accepted by doctors and nurses about doctors’ behaviour, including HOs still being intoxicated by alcohol from the night before.

- **Serious errors** were generally discussed with medical colleagues and/or reported (but see “Doing Nothing” below). General practitioners appeared to have a higher threshold for serious error or behaviour than hospital doctors or nurses. This might be because their problems with recruitment are severe and so there is a conflict over what is most appropriate – to have no doctor at all or one about whom you have doubts.

- **Doing nothing.** Several incidents were discussed – some extremely serious – where nothing had been done in terms of reporting, although whole teams were aware of the event. (see Senior Nurses)

- **Near misses.** No one was reporting or collecting near misses.

- *It is recommended that guidelines are produced on what is error, and perhaps different pathways established for different severity of errors or behaviours; otherwise reporting and learning from minor error and near-misses is unlikely to take place.*

- **The cultural norms around alcohol use need to be tackled with clarity.**

- **Learning from error.** Most groups gave examples of where they or others had learnt from error that was discussed locally. However, with a few notable exceptions, learning was usually haphazard as to whether it occurred or not. It was agreed by the nurses that learning is intense when it involves one’s own errors.

Local anonymised learning was regarded as preferable to lessons from a central agency by consultants and HOs, but SpRs were more at ease with the usefulness of national amalgamated figures as a basis for learning. (see suggestions for change below)

- **Handling the situation.** All groups reported ways of handling the situation as much as they could to make sure the patient was protected where possible, often instead of reporting. The more junior groups and the senior nurses emphasised the need to record everything they had done in order to protect themselves. The consultants and SPRs demonstrated ways they had worked with failing colleagues in a mentoring role over time, and how this was successful but slow in changing both clinical expertise and inappropriate behaviours.
2. Barriers to confronting or reporting poor care

- **Errors which are small, unintentional, one-offs, commonplace (in that everyone does them at some time).** (see above)

- **Difficulty in reporting or confronting those above.** This emerged consistently in the junior groups, and in senior nurses in terms of consultants. There was less problem seen in dealing with subordinates or with peers, though consultants did have difficulties in handling situations with peers. All junior groups thought that confronting and reporting error would be much easier when they were more senior, had more authority and were more experienced. However, the consultants appeared to still have some difficulties with it.

- **Length of contract.** The time one was in post affected all groups, though not always in the same way. Whereas consultants and, to a lesser extent, senior nurses felt they were “here for the duration” and so maintaining relationships might stop them confronting error or behaviour, it was the limited duration of other groups that led to this. Some wanted reporting to take place when they had gone, some pointed out that they would soon be gone and so it would then not be their problem; others said that the individual causing difficulties would soon be gone. *This may need to be addressed within contracts.*

- **The workload involved.** Consultants and house officers both said that trivial errors could be ignored because of the workload involved in challenging them. For consultants, this needed to be weighed up against seeing patients – what would provide the better ultimate quality. *Clearly anything which can be done to make reporting error streamlined and easy will be beneficial.*

- **Resources.** A lack of resources has not been a significant theme in these groups except, to some extent, from the consultants and senior nurses where it is seen as underlying in particular the question of time to deal properly with error, including systematic learning, multi-disciplinary meetings, etc.

- Resources are also implicated in the idea that we must not lose “an otherwise good doctor”, and also in general practice where you may be choosing between a less than ideal doctor and no doctor at all.

- **Medical culture.** This is seen as a difficulty, clearly by the nurses, but underlies many of the reasons for not confronting error suggested by the doctors’ groups. Culture around:
  - alcohol use
  - bullying
  - sexual harassment
  - challenging peers and particularly those above you
• macho non-adherence to safety rules
• Consultant’s choice taking precedence over nursing procedures

There was also a perception in HOs that consultants cannot be told about errors, despite most consultants informing them that they should do so. **Much clearer messages about absolute responsibility need to be given in order to reduce the fear of reporting in these groups. Cultures can be changed when the messages about what is appropriate or not are given unequivocally** (e.g., smoking in restaurants, drinking and driving).

• **Nothing ever changes.** This is a serious barrier coming from more senior doctors and nurses with more experience. It concerns relationships with management in terms of handling the changes that are necessary to deal with risk and error. **Consultants and other staff must be given the experience that the NPSA, for example, does effect useful change. Also management may need help in following through in this area and planning for the medium term in terms of change.**

• **Fear and the dog-eat-dog culture.** This was particularly salient with house officers and, to a lesser extent, nurses, despite the fact that they could give few examples of where careers had been ruined by more open reporting. However, since the HOs had no real experience of open reporting they may still feel that this is evidence that their careers depend upon keeping quiet. Student nurses were more open at reporting their own mistakes and usually had reasonable experiences of it with their mentors, but senior nurses reported instances of serious effects on later careers.

• **The blame culture and a lack of anonymity.** There was a feeling in the medical groups and with senior nurses that there was often almost instantaneous knee-jerk reactions to errors and that this resulted in “otherwise good doctors” or nurses being suspended and their careers wrecked. Whether this is true or not, there were often examples given of where this had happened through the involvement of management and subsequent actions. Reporting error anonymously would not help since it is seen as almost impossible to be anonymous in most areas of health care.

• **Uncertainty.** As in the study of whistle-blowing [6], not being sure if you are right or not is a significant barrier to change, particularly in matters of behaviour, and people were usually quite able to accept a more senior doctor’s judgement even if it went against what they had thought or considered to be right. Wherever possible, clarity about acceptable practice and behaviour needs to be spelled out.
3. What might encourage them to speak up sooner and to whom?

There were some excellent suggestions made by all the groups. These all become recommended interventions to evaluate.

- **Zero tolerance** where safety is concerned.

- **Being treated as professionals.** There was a feeling that the lower grades involved being everyone’s dogsbody and so they tended to behave in less than professional ways at times. *Treating everyone involved in healthcare, from students up, as professional may elicit more professional behaviour. This would also involve giving all members of health care staff a voice in terms of change and the experience that their opinions have value.*

- **Improving leadership.** Senior nurses suggested this strongly, and gave examples of how error reporting increased under good leadership, which then led to changes and a decrease in actual errors.

- **Discussion groups.** These occurred in various ways – through multi-disciplinary groups for HOs and nurses, time-outs to discuss ward practice, anonymous analysis of missed fractures, and critical incident analysis using a well-trained outsider. These were seen as immensely useful by most, though not everyone had good experience of CI reporting since “nothing ever changed”. Although local discussion and learning was seen as so important, it nevertheless occurred somewhat haphazardly, and it would clearly be worthwhile providing dedicated time to this in the way we did with audit. *Local learning* was seen by most as superior to any nationally learned lessons. In particular it was emphasised that *discussion and learning took time and space* and could not be fitted in over and above everything else without affecting other aspects of care.

- **Multi-disciplinary work and discussion could be useful, but clear lines of authority between the different professions need to be established.**

- **Annual appraisals** and RITAs were seen as useful though were not likely to affect the routine collection of minor error.

- **Systems and mechanisms to record and tackle minor errors and near-misses** were needed.

- **Cultural change.** Making it clear what is appropriate or not.

- **Appropriate discretion** in terms of nursing procedures and policy.

- Ensuring that reporting is followed by *action on the part of management.*

- **Consistency** in different parts of the trust.
• **Training.** Consultants and HOs in particular emphasised their need for various aspects of training around risk and safety. HOs discussed their need for a more realistic approach to error while they were students, so they did not feel that it only happened to a few. Consultants also outlined ways that management training could be improved in terms of handling difficult situations around error and risk.

• **Peer review.** This was found particularly helpful by senior nurses.

• **Someone in authority to turn to.** Most groups suggested that this would be a good idea. Most members had not heard of any mechanism for this in terms of a person to hear the whistle, etc.

• **Support for each other and from management.** Supporting each other – knocking on doors when unsure - took time away from the other person and that was difficult to do. Greater support and understanding from management and risk management in this whole process was emphasised.

• Getting the right “**shop floor**” **staff (middle grades) on policy committees** is essential.
Themes from the Groups

House Officers

This group was conducted using nominal group techniques (see method). They were asked first to think about recent incidents which they had witnessed or been a part of.

Lack of continuity of care which has left patients open to a number of my mistakes which have gone unnoticed until much later because I was a house officer with only 3 weeks experience.

For example INR not being checked or tests not being carried out that should have been because things haven’t been documented that should have been – there’s no continuity of care, no-one tell you this should have been done, that should have been done.

Minor things like once I noticed a drug signed on the wrong date – a previous date – and did bring it to the notice of the person who did it but she denied it, said she didn’t do it although it was her signature. But I did try to correct it and brought it to her notice.

I was on call – surgical house officer and I was asked to write up the warfarin for the patient – a medical patient – and INR hadn’t been checked for about 7 days but they’d been giving warfarin every day and I checked the INR myself and it was above 7 so I just had to document in the notes and did the warfarin.

One major incident – a patient who I started to look after on call who had received 5.5 litres of fluid in 24 hours, even though they had clinically obvious congestive cardiac failure and they died the following morning, due to fluid overload.

An aneuretic patient receiving fluid containing potassium.

A patient that hadn’t passed any urine after an operation was brought to my attention on call at 11pm – not fair on me or the patient.

A little girl came in after a road traffic accident with a very badly fractured ankle and the orthopaedic team failed to attend the crash call and she ended up almost losing her foot.

A surgical patient looked after by an inexperienced surgical house officer was given fluids and the patient subsequently went on to acute renal failure and the surgical registrar refused to come to see the patient overnight.
Having to look after patients who are not from your normal consultant and looking after patients on one site for a consultant who normally works on another site and they simply do not get seen by a senior medic.

Their examples were used for them to think about what they actually did in these situations. Appendix 1 sets out their answers to the following questions as they appeared on the post-its. These have then been grouped by participants. What follows comes from the discussion after each post-it exercise.

**What do you actually do when you notice error etc.**

**Distinguishing errors.** Members made several fine distinctions between the types of error they would report and those they would not. On the whole these are very much in line with other groups:

**Major/minor error.** In a situation when there’s a major mistake – like the one I was talking about earlier with the pulmonary oedema - then I document everything in the notes. I do the expected history examination, my findings, my impressions of the patient and my plan, and I just do that objective assessment. I will not try and write an offensive report but I will make sure that the condition of the patient is documented in the notes and that the team are aware of the situation.

I think there is a big difference between incidents which happen which could be dangerous and those which are an honest mistake – someone’s signed the wrong box, written up the wrong day, not checked allergies etc. and then things which are either a situation which is dangerous or an ongoing problem. I think I’d be far less likely to point out something that was an honest mistake because there’s no criticism implied with it, it’s just ‘look you’ve signed the wrong box’ or ‘if you turn over I think there’s an allergy’ whereas if it’s a situation or a lack of action which is dangerous then I think by bringing it up you’re almost implying criticism of that person’s actions and I think I’d be far less likely to mention that.

That kind of thing is a genuine mistake, a really minor thing, it could be minor but when you think somebody’s making major mistakes, but nobody else backs you up. My experience isn’t good so I don’t really know what’s going on that well. But if I think ‘oh god he’s making a really big mistake’ but nobody else is saying anything then you wouldn’t make a comment, you wouldn’t like report it at all. I wouldn’t do it because I’d be really fearful that I’d get them into trouble, I’d get myself into trouble and as I say, maybe it isn’t a mistake at all, it’s just that I have a poor judgement.
I’d distinguish between two situations one where there’s an honest mistake or a minor mistake or the other where there’s an actual act of negligence or a major mistake which had repercussions. So in a situation where there’s a minor mistake that’s been made or an honest mistake I’d bring it up very sensitively perhaps with… if they were a colleague of mine….with them…in a very informal way because I could have made that mistake too could I learn from this as well as you and in a situation when there’s been actual negligence I’d discuss the case anonymously with this third party which would perhaps be a consultant or a medical director who’s mature and senior enough to give me the right advice and then I would decide from there whether to go on to maybe putting in a clinical incident form, taking it further.

Doing nothing. On the flip charts rather than the discussion the following points were made: “Why both if others (seniors) do not care!” “Thought that the person who you report to might not take you seriously or considered what you’re talking about irrelevant.” “Do nothing. Lack of support from fellow colleagues.”

Correcting the error. All the mistakes I’ve come across are mistakes that I’ve noticed when I’ve been on call, looking after patients I wouldn’t normally look after, when there’s been a problem come up and I’ve looked in the notes previously or looked at the patient and assessed the situation fully and objectively and come to the conclusion that something’s gone wrong with the previous management. Now I wouldn’t then run to that team, run to that consultant saying ‘oh look, what’s going on’, I’d just make sure that that patient’s care is optimised, that’s the first thing I’d do and the second thing I’d do is to write down how I’ve done that in the notes. But I wouldn’t directly try and attack or criticise the person involved because if it’s in the notes that is the system by which it can come to light and that is the system by which the team can look at the picture, the whole picture, and then discuss what had gone wrong. Because it’s often not one single person, it’s often many contributory factors. I think that you need to use the notes in that respect.

In an informal way I think that just in the mess things get discussed and I think if it’s one off errors versus an actual on going problem, like you were saying, with problems in other reports that have gone on, everyone knew it was going on but no-one ever mentioned it. I think for on-going problems if you go and sit in the mess for half an hour you’ll find out who the good people are and who the bad people are. You can see when the new house officers turn up and everyone goes ‘who are you working for’ and you can see if someone says ‘oh, such and such’ there’s a few SHOs who go ‘oh, right’ (group laughs) and you know, they’ve worked for them before, everyone knows what’s going on and I think you can say in a jokey way ‘oh, this happened.’ There’ll be a couple of SHOs who’ll chip in and go ‘I think what you should do is this’ and I think it’s a lot easier once you’ve discussed it then you can go back and talk to maybe your own SHO or your own reg and say something, because you’ve got
confidence that somebody else has agreed with you. And I think it’s a good place for that sort of thing.

**Tackling things yourself.** You have to blackmail people to turn up, you say well I’m going to document it in the notes that you’ve been called etc etc etc and they’ll turn up pretty quickly. (group agrees)

**Barriers to reporting**

- **Minor errors.** I think that’s more for minor problems especially if you’re on call and you notice something on the wards that’s written up wrongly or whatever it’s not your patient and you can change it or not depending on what’s wrong. Is it worth the hassle if it’s a minor one-off error that someone’s made, an honest mistake. Just change it – do you really need to track someone down across the hospital the next day to say oh, I see you wrote something up wrong. It’s quicker to do it yourself.

- **Financial.** On an already financially strained NHS it’s going to be adversely affected by claims for compensation which could arise from complaints. I don’t understand the situation. Presumably if there is a complaint and there’s found to be a shortfall or negligence, presumably the patient must know. But often the patient will just be oblivious because they don’t know what kind of care they’ve received and they don’t know what’s right and what’s wrong.

- **No one taking responsibility.** I had a patient with acute pancreatitis, very dehydrated, the registrar specifically told me that we were going to write up lots of fluids. The patient received no fluids for 8 hours. So I go and speak to the sister who ducks for cover - wasn’t me, wasn’t my shift - and eventually this gets so irritating you think well, let them deal with this.

- **Consultants and the medical culture.** I think when there are these meetings, grand round or what have you once a week, you know it’s meant to be there to discuss things, bring up this kind of thing but I think that unless something is blatantly, screamingly wrong, consultants are very reluctant to sound as if they’re criticising one another. Whenever they’re going to say something about one another they always start ‘this isn’t a criticism but maybe you could think about…’ and it’s a very softly worded, even if they’ve obviously having a go at each other. And it’s only for consultants and registrars (agreement). No one else…everyone else sits behind the boss and we’re just there to give information. Like this is a patient who’s been in for 2 weeks, they’re on blah blah, and everyone else sits behind and not part of the thing. There are these meetings but they’re not a discussion of management.

I think some senior consultants are frankly deluded. They will swan onto a ward and their juniors will tell them what they think they want to know. So
even before the mistake is made you’ve created an environment that is ripe for mistakes to be made because there’s no rocking the boat.

[Consultants not coming to see their patients.] I think that is a systemic problem. There are patients who are not getting senior care and everyone knows that & it’s very difficult to actually do anything about it. You’ve got to actually pin your colours to the mast and say ‘I think that a senior member of staff is not doing their job as far as these patients are concerned’ and that’s a very big step up.

It’s also a notion that goes back to the playground at school – don’t rat. [Laughter. Agreement.] You leave them alone, they’ll leave you alone and you’ll do just fine.

Doing surgical, a lot of it higher up is a boys club. I think one of the surgeon consultants who’s just come in is a women but all the others are men. I don’t know if it’s a clubby thing or if it’s ‘well it’s our team and if there’s a complaint about one of us it’s a complaint against the team

• “You can’t go to consultants”.’

The group leader challenged the idea that you can’t go to a consultant if you see error or make one yourself: “You’re all anxious about consultants and what they might do, but of the 9 of you four consultants have actually said ‘come to me’ and told you what the system is, a further two have been told what the system is although the consultant hasn’t said directly ‘come to me’ and one of you has been to your consultant and it’s been fine. There’s only two of you who are outside that and none of these things has happened.” This was grudgingly admitted: “My consultant actually said ‘document everything because if something happens I have to go to the court, write clearly, etc.’”

• The system. [It would be easier to discuss error in private medicine] because there’s that feeling, we’re trying to do our best here rather than we’re trying to get the patient out of the door to free up a bed…

• Inexperience. At the maximum we’ll see this person over six months period and we’re inexperienced, we’re not necessarily in the right….we might not be in the right to judge that.

• Lack of confidence in your own judgement, where something is actually a mistake.

• Getting on in your career. I wouldn’t want to damage my own career because I would feel that if I pointed out something to a senior colleague that they’d done wrong then I would be….become known as somebody who isn’t….particularly good to work with and who will eventually not receive particularly good references at the end of the job. [ Agreement]
Especially…at the Bristol enquiry… the anaesthetist couldn’t get a job anywhere in Europe …you know….that sort of thing. Makes you quite worried really

I was going to say it’s also the worry that you won’t get the support you need if you start complaining, or start pointing out errors. When you really need some help they won’t come

- **It’s a dog eat dog world out there.** You can’t miss it. You go to another consultant and they’ll see your name or they’ll get a reference from your previous consultant which they’ll have to have because they want to know about you and that will be tainted in some way..

[Is that something you’ve experienced? Or something that you think might happen? [(general agreement …think might happen)]

Because you’re guilty until proven innocent these days especially the breast case one, the government had a knee jerk reaction…..

It can spiral out of your own control as well. You just want to make a comment, or you know, and then things can happen at a rate….you can’t stop it and then what can you do?

I mean, you’re an easy scapegoat because you’re expendable, you’re at the bottom of the team and if you are seen to be the cause of the problem, the cause of this rift, then ….goodbye, you know

- **Short house jobs.** I think …you’re sort of either finding your feet in a job or about to move on from a job. You’re never just sort of turning up every day for you know getting with the team. It’s sort of….it’s like people on rotations doing four month jobs it just strikes you that bloody hell I’m nearly coming up to the end of it and it’s only just started whereas……

- **Not trained to deal with error.** Yeah, it’s really difficult because in medical school you don’t think of mistakes happening. You just think you will do this and it will happen and, people get better whatever you do. Then you realise when you start working that mistakes do happen, they do happen, you know . We’re all thinking that it shouldn’t happen because we’ve been trained to think this is what you do and this is the result - but in reality….It’s not black and white

Yeah, we’ve learnt it in black and white and now we’re seeing what really does happen

- **Lack of anonymity.** …unless you want to involve somebody else…if you just wanted to keep it between yourself and that person…. the options are to go and talk to that person or an anonymous incident form and there’s not much in between and then there’s a big jump between house officer comes up and says ‘what happened there, I’m not sure, could you just explain to
me’ and somebody’s filed an official complaint against you. And apart from that as well, an anonymous complaint… There’s nothing secret in a hospital. Within five hours of it happening everybody knows, and I doubt – even if anonymous – I doubt there’s many incident forms that go in that people can’t go ‘well I can figure out who wrote this in 30 seconds, who was there’.

I think it’s fear more than anything. In our hospital somebody who’s not actually medical but part of the administration said if anybody has any problems with anything then come to me as a completely confidential source. But at the end of the day if a complaints been made about something that’s happening with a particular team then there’s only 3 people that it can be so it’s not that anonymous at all so there’s always that fear that when it’s found out that it was me that said something what’s the consequences going to be?

• **There but for the grace of God…** [You’ve made] this mistake yourself, so you can personally empathise with the problem. But not when it’s made by a consultant [laughter]. The empathy arises when it’s another house officer.

I think you do have empathy with everyone involved because a lot of mistakes are being made because everyone’s got a lack of time. There’s just not enough staff and because everyone is so overworked…. At the end of the day the consultant can’t do everything himself, he relies on his team to do the jobs so he can do the management. It’s the whole system that’s messed up.

**What might encourage you to speak out sooner?**

• **Recognition of amount of error.** Perhaps an anonymous audit every week – who makes a mistake, you tick a box. Then people would have to be honest about it and every two weeks you put the results up and people would be shocked. If there was a no-blame way of doing it, just to flag something up rather than saying I think you’re wrong.

• **Open discussion:** A lack of fear. Fear of the consultant, fear of everything. [What would that involve?] Informal discussion groups…

...Where you’re not actually blaming anybody but you’re just bringing some things out, in a situation that can be anonymous and objective and you can learn from it

For the more minor things that maybe involve lots of different parts of the team in the hospital I know that we have these regular mess meetings where the nursing co-ordinator comes, phlebotomy comes, biochemistry comes, everybody and anything can be brought up then. Things like when patients are in side rooms phlebotomy don’t bleed them but they don’t bleep you to tell you that they haven’t and so it doesn’t get done until the
next day you find out the results aren’t there. Things like that. For that you could bring it up in those kind of meetings

- **Someone to turn to.** …especially the higher up the line is the person that you’re making a complaint about. I think you definitely need someone that you’re confident about that it’s going to be confidential & you feel that the retribution’s less.

But there won’t be any less retribution because there’s no anonymity, there’s no confidentiality. That consultant’s going to find out.

I think the anonymity thing is quite a big thing or being able to check out anonymously whether a serious error is being made. I think that goes back to the experience and confidence thing. If there was some way you could anonymously say ‘look I’ve noticed this but I don’t know if it’s seriously wrong’

Yes, that’s why something like a helpline would be good, outside your trust or whatever so nobody knows you.

You can say ‘what should I do’ and they can say ‘yes, I think really there are some issues you’re misunderstanding there and this was probably the right thing to do’ or ‘that is serious and it does warrant a mention’

- **The multi-disciplinary team.** Regular meetings with the nurse you deal with most often are useful. It puts you in the picture of what they’ve been doing for the patient, what you’ve been doing and it does bring everything together.

- **Clarifying lines of authority.** It was clear that HOs did not know with whom they should discuss nursing problems. I think things like that on the nursing side of it are difficult because it’s difficult to say whose responsibility that is. It becomes the team’s responsibility, more of a nursing team than this is the person who should have done it. It’s less easy to go up and say ‘next time could you do it this way?’ You’d have to speak to the sister and then get her to say something.

- **Training for error.** I think the new thing that they started at Imperial where they shadowed for however many weeks and then, hopefully you get to do a locum, that kind of thing. If you shadow for a long enough time you get to know the mistakes that are made and then you know how to avoid them.
Specialist Registrars

What do you actually do?

As with other groups, this discussion centred around “it depends”. In it we explored the types of distinctions made, both by doctors and nurses, of minor and major errors. In addition we asked them to consider any differences they perceived between clinical error, bad behaviour and attitude problems.

“One-off” errors: There was a strong distinction made between patterns of error and one-offs throughout the group. The idea of repentance was particularly important.

Example: HO hasn’t examined a patient properly and the operation has to be cancelled: “I talk to them about it and explain and that’s the end of it. But if the HO isn’t suitably sorry or embarrassed about it I let them know I’m not impressed and if it happens again I’ll report it. I have reported people to my boss. I expect what he does is not write a good reference, which isn’t very much I suppose. If something happened on a regular basis then it would all be different, but I’ve not been in that situation.”

“I suppose whether or not it’s a serious event depends on what’s happened to the other staff or the patient. It depends on the pattern – whether it’s a one-off or not, and the context.”

But others said you might not see it more than once because of partial shifts, etc.

“If something is a one-off then I have a quiet discussion and point it out, but if it’s a culmination of things that have built up I will be rather more critical. If I find someone isn’t sorry, then that’s when I start fishing round my peers [to see what he was like before].”

Being otherwise good. Example: An “otherwise very good” SHO turning up still very worse for wear with alcohol. “I suppose because he’s otherwise good, and because we’ve all been there at some stage – maybe not that bad – there’s empathy and also we accept it’s a one-off thing. We sent him home. If you go down a formal line then someone who’s actually an excellent doctor may end up with a recorded disciplinary offence. One person may get off an offence because their face fits and another may not, and that’s a real difficulty. It was interesting one of the nurses’ reactions to the SHO’s drunkenness – they said, if this was a nurse she’d be disciplined.”

There was cultural agreement that alcohol is almost expected in HOs and SHOs but not in later years. “Being the worse for wear on alcohol is very, very common – the norm in fact - but I find it gets much less common as people get higher, not often in consultants. It takes you a year or two to get into that professional role.”
**Clinical error vs bad behaviour:** “Clinical error is easier to feel justified in speaking out, whereas bad behaviour...”

“Often the bad behaviour is known about by everyone and the powers-that-be are just waiting for someone brave enough to speak up. You don’t want to be the one that stuck their head above the parapet.

“Attitudes are even more difficult to recognise than bad behaviour. At the end of the day if a doctor is good but doesn’t have a good bedside manner, where do you draw the line?”

Bad behaviour is rarely confronted directly: “I can usually tackle that sort of bad behaviour [sexual harassment, bullying] with humour”. “If a surgeon’s throwing a tantrum I just raise my eyebrows to let the others know it’s him, not them.”

What are the barriers to reporting?

See above: one-off mistakes; person was sorry; cultural norms; bad behaviour and attitudes are hard to judge. In addition:

- **Worries about losing a “good doctor”:** “[Alcohol abuse may be an illness] and if you tackle it that this person needs help, then that’s a very different route from one that will come to the notice of the chief executive, for example. If he gets suspended, then that’s not necessarily productive.”

- **It depends on your personality** whether you report or not: “I am a much more down-the-line sort of person. Other people have a much more relaxed attitude to things. I’m perhaps not as tolerant as other people are.

- **Short-term contracts.** The length of one’s contract and other people’s affects reporting in various ways: “I thought, it’s not a problem to me – I’m off soon. All they did was say, he’ll retire soon.”

  “It needs to be remembered that we’re not permanent staff – we’re just passing through. It makes it harder. If we go to another consultant about his peer we’re putting him in a difficult position.”

  “It needs to be remembered that we can move on as juniors and not have to deal with bad seniors.”

- **Reporting a consultant is always difficult:** “It’s hard for any of us to complain about the behaviour of consultants – sexual harassment, or bullying.”

  “If X is a very good surgeon, and very busy when he makes an error or whatever, we’re not going to report him.”

  “It gets even harder to know you’re right when it’s a consultant concerned. If the clinical director had said that’s OK what he’s done, I’d have said fine.”
“I reported someone to the GMC – a persistent alcoholic – nothing was done and he killed himself. Health authority knew about the problem too. We didn’t want him struck off. He was a nice guy.”

“It’s always scary, trying to deal with a consultant’s error. I’ve done it twice… gone to my clinical director. First occasion, the damage to the patient was limited – it was rescued; on the second occasion, I had to write a statement which would be used if anything happened again. Harm could have come to the patient, and I felt anxious it might happen again, but it was unusual and so not likely. He was a locum.

What if he hadn’t been a locum? “Locums tend to get the blame for everything throughout medical culture. They’re never here to defend themselves”

• “How do you know you’re right – that the big problem, especially when it concerns a consultant.”

What might encourage change in dealing with errors?

• Systems. “You need one mechanism for the one-off [and minor error], and another for repeat offenders.” “In reality, now, we still tend to deal with them in the same way – a gentle chiding.”

“We probably need a system where even one-offs are registered as an event locally and only when they get to a certain level is anything more serious done about them. We do this informally – checking someone out with your peers.”

• Consultation with peers. I am very cautious about taking any action against anyone unless I’ve checked it first with my peers for their opinion – this is more difficult when the person you’re not happy with is a peer too. It’s particularly important if the person is the consultant – you can do it as a group and that sort of anonymises the complaint.

We need to have an informal way of tackling error. Now we just try out ideas vaguely – “What do you think…” We need a way of checking out our opinions with peers, etc.

• Using patients. “I’ve encouraged a patient to complain.”

• Audit can be helpful in benchmarking good clinical standards. Cross-speciality audits can be used to make a point in another specialty.

• Critical incident analysis can be helpful for errors and near misses. Some people found this helpful and some change occurring; others had found nothing had ever change. “Often it seems to change the culture in the team too – discussing it can make discussing error more acceptable. What is a critical incident is often subjective, however – someone has to fill
in the form. This leads to a discussion of everyone involved.” “We’re good at filling in critical incident forms when it’s equipment at fault, but not an individual.”

- **Anonymous reporting** won’t work in medicine – too hard to do, especially in small specialities. But you have to be assured of confidentiality.

- “**Annual appraisals and RITAs** are a solution – they push people to ask, how am I perceived. Consultants are probably the people who’ll give you the jobs, so you need to know what they think of you. [How developed are they in being able to appraise their SHOs? – group members did not answer this.] There was considerable hope that the appraisal system would help this area.

- No one knew there was a **named person to whistle-blow** to.

- **Cultural Change.** “It’s about making cultural change, like we’ve done with drink driving. We have to make it culturally unacceptable – to come to work drunk, to bully, and so on.

- **Near misses** were not recorded, but should be so they could be discussed within the team.

- **Establishing appropriate and inappropriate behaviour:** “[Consultants] first have to recognise that what they’re doing is unacceptable. This has to be established in the trust. Then it would liberate us to act more easily.”

- **Central reporting.** “We would be happy to learn from a central body. As trainees we’re probably happier with that. We have it in blood transfusion, obstetrics – we attend to what they say.” “On the other side, change is still very complex and personal and there must be a local element to it.”

How do these national messages get filtered? “There are things from the MDA which we need to know but which don’t come to us. They need to be filtered appropriately and made relevant to those who may need them.” “We don’t want to get everything: there obviously is filtering now, but it’s not always right.”

- **Treating junior doctors as professionals:** “I made a shift myself when I got my MRCP, I became a professional. You’re not a professional till then because you’re treated as a dogsbody, and so you may not always behave like one. You don’t have a sense that your opinion is of value. I could be more certain of my opinion after that.”[one of the surgeons disagreed with this]
  “Consultants are different. They have the authority to do things, make decisions.” But do they have the skills to manage bad behaviour? And how do they deal with colleagues? “With influence and understanding.”
Consultants

**What do you actually do?**

Like most groups, this discussion focussed on the question of what was an error or not, and when error should be reported.

‘You have to **understand it in the context** of the resources & the knowledge people have.’

There was a discussion throughout about **what was an error and a near-miss in medicine, and how this relates to learning.**

‘There’s peer pressure, and standards often lack clarity. What is the standard?’

‘The ideal behaviour has to be different. What you see are accepted differences in ways of approaching a problem, partly caused by resource issues and partly by custom and practice.’

‘We have figures about the cost of hospital acquired infection. Our consultants say they haven’t got time between every patient on the ward round to wash their hands. Yet that is something basic. Every time that happens is that a near miss?’

‘How long does it take to wash your hands properly, and if it does take time, which patients do you not see, or what do you not do? What do you facilitate at the bedside to enable them to wash their hands?’

‘**There is a point before errors occur** which relates to risky behaviour. You can see patterns of behaviour or group behaviour on a ward which in future may lead to problems. For example, the nurses are not going round and seeing patients but prefer to sit at the desk. Perhaps there may be more pressure sores on that ward compared with other wards.’

Like most groups, consultants distinguished **major and minor incidents** and felt that little was achieved by reporting ‘minor’ incidents and “one-offs”, though this was often seen as not done because of time-wasting or as pointless since “nothing would happen” (see under Barriers).

‘Probably 20 **minor things** happen over the course of a day, but if I took time to fill in paperwork about these, I would see fewer patients.’

*I would not report one-off incidents* where nothing untoward happened.
Nevertheless, error was also seen positively as an important arena for learning when handled anonymously:

“I think in my practice there are some errors which are avoidable, but which we prefer not to worry about. We miss 150,000 fractures a year in UK A & E departments, but yet they are a good learning tool. We feel doctors in training need to miss and learn. There are mechanisms in most A & E departments which identify missed fractures within 48 hours. You could avoid missing them altogether if there was a senior doctor, or radiologist on site who reported them immediately, but this would involve resources. So we let the doctors make the mistake. If we protect them too much, the junior doctors could complete the job, and not be able to read the X-rays. Mostly the patients will accept this. We recall them and apologise and treat it. They will react at the time but, for some reason, they don’t seem to push it too far. The ones we have problems with are the ones who haven’t been X-rayed.’

How do we use it as a learning tool? The doctors are not told who missed it. The X-rays are shown as a learning tool. The doctors are given a history and the X-ray is put up. Generally if one SHO missed it most of the others would have missed it as well. By July, the material available has tailed off. In February there are 10 per week, but by July there are sometimes none to be discussed, and those we have are the more subtle ones”.

Some errors are seen as unavoidable. Whereas most group members felt they would not report these, one said s/he would since they can’t apportion blame on errors like that.

‘Changes occur in the patients - even with the best will in the world. IV lines tissue - even if you are sitting looking at the baby you may not notice that happen’

‘The IV lines have pressure alarm set on a pump which reads pressures. Despite all these safety measures, we still have events that occur - even with an experienced person watching, one minute the blister isn’t there and the next minute it is; that’s the nature of the beast’

‘There’s no way we can prevent some of those things from happening.’

‘You can look at the system. We’re fairly organised on this aspect. We fill in an incident form and we take the incident apart to see if there is a fault within our system, but in a lot of cases there isn’t. Patients are sick, they are in a high risk environment and things will go wrong, but unfortunately in the current culture, we still get sued for it.’

Note: Although there were examples of people redesigning their own mini-system, few considered tackling other systems in the causation chain.
Managing errors made by trainees and others was not thought to be a particular problem usually:

‘That’s easy for us - we’re consultants on the spot. An error goes straight up the chain to the consultant who speaks to the family more or less immediately. We document it all and apologise and then wait and see if we’re going to get a letter or not.’

‘This is about chain of command as well. But what is the chain of command to the medical school?’

‘We had a distraught medical student in our department. She had gone to watch a vascular surgery procedure and she’d asked for the visor - I’m sure at university they’re told to put on the protective gear. The consultant got abusive to her. He thought she was accusing him of being a useless surgeon. She came to us really upset. I spoke to the theatre manager. Sister agreed that it had occurred, and she would speak to the consultant involved. Interestingly she hadn’t spoken to him before I mentioned it. Within that theatre the culture was that you didn’t put on the safety gear which is something we’ve been working at them for ages. This is typical of medicine - the consultant thinks it is his duty to harden the medical student up, and teach her not to be worried about this sort of thing’.

Tackling bad behaviour. “Sometimes you recognise there is a difficulty as soon as a person arrives, but tackling that behaviour is extremely unpleasant for everybody to do, particularly if it is going to end up with someone’s career being stopped. It takes real skill to broach the subject with someone and to work together, addressing what it is they find difficult. A huge amount of careful documentation is needed. Everyone walks away feeling that they have failed that person.”

There can be good outcomes, but this requires considerable work. “I had a trainee who we all felt was having difficulties with communication. The patients relatives didn’t seem to understand what he was saying, and the nurses found instructions difficult to follow. Although he had passed his RITA assessments, when I spoke to people on the other units he had work on, they recognised similar problems. We talked to him about this, designed a learning plan, and worked with him while he was with us. This took an immense amount of time, and a good deal of skill, but now his communication is much better.”

Medical directors and managers need training too. ‘Another consultant and I went to see a colleague who’s in a management position to discuss how the service should be re-configured. We were balled at and screamed at. To me, this was hard evidence of unacceptable behaviour. There were numerous similar episodes, involving staff of all levels, but nobody had been brave enough to actually raise it. I took that to the medical director. This was a mistake and I’ve learned from that. I should have addressed it with the individual initially, but I had previous experiences to suggest that this would not be fruitful, so actually took this to management. I commented about behaviour,
and not about the person as an individual, but made the point that these behaviours are damaging to the way that service development will progress. I don’t think the medical director managed it very well at all. He got straight on the phone to this colleague, with the result that I was never spoken to again. I feel that he could have found a much more subtle and constructive way to address what was perceived as a real issue by 20 people in that department. I wasn’t the only one.

**What are the barriers to reporting?**

- **Nothing ever changes.** Although most groups were completely in line on all other issues, for consultants the largest barrier to change involved the fact that “nothing is ever done”. For example:

  ‘A lot of people are saying that reporting error isn’t worth it because nothing gets done.’

  ‘We have disasters, so we have risk management, but it’s window dressing. To keep the public happy, we have a body that oversees things when they go wrong.’

  They questioned the value of reporting near misses:

  ‘I’m not convinced of the value of reporting near misses. You’d be listened to but nothing would happen.’

- Their experience was that **problems were only addressed when adverse events had occurred:**

  ‘People threatening self-harm were discharged from Accident and Emergency because of lack of resources again and again and again, until we had an incident in which someone killed themselves. It completely changed the way we work to the point where we have never had another incident. It makes you wonder whether something has to happen to make managers see the true result of lack of resource.’

  ‘My experience is that nothing happens until a member of staff is injured and goes off sick. When they are coming back to work, there’s panic, and something is done - policy changes are made.’

  ‘These things go on for months and months before anything is done especially on the health & safety side. This creates a feeling of apathy, that there is no point in filling in needle stick injury form, or a blood splash form.’

This sense of disillusionment that things could change was extreme in most of these consultants and was a very obvious distinction from the other medical groups and the student nurses. Both the SpRs and student nurses were convinced that they would be able to effect change once they had
seniority. These consultants – all still quite young – indicated that they no longer believed this, and this has implications for the National Patient Safety Agency’s collection of data:

“People would have to convince me that some good will come of it”.

- **Adverse Publicity.** The action taken might not be appropriate, and reporting could lead to difficulties for the individual and **negative publicity** for the hospital or department.

  ‘Who reports these things - and sends it off to the managers and the NHS safety department. Which committee is going to decide whether we should chase up this individual - to make sure they learn from this and don’t do it again? Should we publish this so that nobody does this again?

  'I did a small audit with a registrar. This concerned something that most people in the specialty would recognise as a small potential risk which we are trained to manage. It was published in a journal recently. Without my knowledge, they issued a press release. It caused far more interest in the press than we were expecting, and escalated out of all proportions. The Royal College and DoH got involved. I certainly would not publish another audit.’

The group discussed a similar experience in Leicester, where publishing an audit report got the department into difficulties, even though what they were commenting on is a recognised challenge.

- **Time in the post:** There was the issue about the length of time people were employed in a post which ran right through the medical groups. In consultants it was about being the only group who were “there for the duration” and this had implications for how they dealt with error:

  ‘When you are talking about long term problems that are to do people’s attitude and behaviour, you’re the one who is going to be there 20 years needing effective working relationships with these people as colleagues. They are the nurses and peers that you value and want support from and work with. Deciding should we say something or not depends on what it might do to our working relationships. It would be more sensible for us to learn and be supported in trying to develop our working relationships than to chastise.’

  'NHS managers aren’t always the right people to be looking at this. There’s no point in getting the non-clinical managers, even the Chief Executives to do anything - because they’re only in the organisation for such a short time. There’s no point in having someone who is there for only a short time try and deal with a really difficult long-term problem.'
• **Workload:** Excessive workload, perhaps on top of disillusionment about change, was seen as a serious barrier to reporting at least minor incidents:

> ‘We are under such workload pressure that to be told day in day out that this is another risk where we have to think about doing it differently - we are absolutely exhausted by that.’

>The will’s there, but you have to have energy to think about it and do it differently and a bit of space to get your brain in gear.’

> It’s about me driving the whole thing - it’s about finding the people with the skills. If I stopped annoying people and saying come on, let’s have a meeting, we wouldn’t have made such progress. It takes lots of energy and it takes time.’

What would help to change culture and help learning?

The consultants spent a longer time than other groups putting forward proposals to bring about change with examples of where they had succeeded.

• **Having space and time to plan and implement change.** ‘To me there’s a step before incidents happen - if there is space and time to say something, really that’s where risk behaviour should be identified and minimised. Drug errors occur everywhere. They can be minimised, but you need to give the nurses and doctors space to talk. So that the nurses can say ‘Your writing isn’t legible, or you can’t have 2 cardexes, everything should be transferred to one.’ and the doctors can say, ‘You knew this drug was essential but you didn’t give it, or why aren’t you telling us when you can’t get drugs from pharmacy.’

> ‘Recently, my ward was given a week out by the Trust. They actually took all the staff away from the ward for a week, got nurses from another ward to look after the patients. We used that opportunity to discuss nursing and medical issues on the ward, and from that there came an action plan. I think the Trust was able to do this because they have what they call a swing ward, which they use for surgical patients in the summer, and medical patients in the winter. They put our patients on there. They would find this difficult to do for every ward, but there would be lessons to be learned, which staff could apply when they worked on any care of the elderly or other medical wards.’

• **Feedback.** ‘At my appraisal, I discovered that one of the things I had done was introduce the behaviour of knocking on each other’s door and asking a colleague when we are uncertain about a clinical situation. This is valued by our group’.
• **Support for each other.** "We get sued regularly. We each have a complaint a week. They don’t all go the distance, but it doesn’t make you feel good about yourself."

’The parents know something has happened, and you’re put through the wringer over it. I think that’s a lot of the problem in doing something about complaints. Professionally you feel fairly low.”

’One perception is that there is no support in hospitals. It is there but it’s patchy.’

’We need to have a culture in which we can talk about our concerns about own work, our trainees, and our organisation, which is confidential, but helps us identify ways in which we can manage these issues.’.

’We have decided to have get-togethers for the new consultants.’

’If you are valued by the organisation you are more likely to feed things back but until that happens, we need support networks, doctor to doctor, where we can discuss problems & opportunities.’

• **Support from the organisation.** “What is the NHS’s, the organisation’s, responsibility to us? Is it to support us, to protect us? If you are valued by the organisation you are more likely to feed things back, but until that happens we need support networks, doctor to doctor, where we can discuss problems and opportunities.” “But then you are taking another colleague’s time?”

• **Management’s understanding and action.** Consultants are more likely to report incidents if management share a sense of urgency in identifying and implementing solutions. Group members expressed feelings of apathy, frustration and resentment when action is never taken about the matters they report.

’Risk management people don’t take action. They just listen to us, file it & tell me why the Trust cannot address the problem. Nothing ever happens.’

’Another aspect which for me is very frustrating: I can encourage people to report & report - but feel that I can’t do anything. We just file it - it becomes part of the risk management figures.’

’We fill in an incident form, which goes through this huge process of risk management which seems to employ thousands of people & do bugger all.’

’Although this is a bit more open in the organisation, it still goes on. People say let’s cost it up - let’s see what the options are.’
Managing change takes time, energy and skill. Consultants considered that they had a key role to play in risk management, but that this was a joint responsibility with management. However, they felt that the short-term nature of many managers' posts made them less effective at embedding change.

'The challenge is to get the information about organisational failures to the right people in the right context and in the right time frame.'

'NHS managers aren’t always the right people to be looking at this. There’s no point in getting the non-clinical managers, even the Chief Executives, to do anything, because they’re only in the organisation for such a short time. There’s no point in having someone who is there for only a short time try and deal with a really difficult long term problem.'

Training doctors and managers. They identified a number of key skills which managers and doctors should learn, sometimes together, to make the process of learning from critical incidents or near misses more effective. For doctors these included:

- The statistical basis of risk management.
- Asking for another opinion and seeking appropriate help
  ‘I remember dealing with an outbreak, when I was first a consultant. I was working on my own, then eventually rang a colleague. He asked why I hadn’t asked for help earlier. But I had never seen consultants asking each other for help. We should include this in our teaching of trainees, so they realise we speak to each other.’
- Teaching to question and to think independently.
  ‘You’re taught to think independently, and logically. But then you’re told to wear gloves to prevent needle-stick injury. Clearly a rubber glove will not protect you from a needle.’
- Learning about systems approaches to risk.
- Learning to explain risk to patients.
- The skills of team working.
- Interpersonal skills:
  When you are talking about long term problems that are to do people’s attitude and behaviour, you’re the one who is going to be there 20 years needing effective working relationships with these people as colleagues. It would be more sensible for us to learn and be supported in trying to develop our working relationships than to chastise.’
- Change management:
  ‘To me the nugget is how you take responsibility. Are you just taking responsibility for what you do, or are you taking responsibility for what
your organisation and you don’t do? Are you prepared to talk to people and come up with innovative ways of looking at it, and I don’t think in medicine I was taught that at all. I was taught you follow something from a to b and you’re a good doctor. You’re not taught to say ‘this isn’t the best we can do, we’re all highly intelligent people, we can do this better. Let’s sit everyone round a table, come up with some suggestions and implement it’. I didn’t experience any of that in my training, and yet that’s what actually improves the situation.’

‘It’s not about logging it and leaving it with someone else. It’s only going to change if we suggest different ways of managing a situation. Managers can’t do it without information coming from us.’

• Training for managers included:

• Managers need to understand risk and be able to quantify and explain risks of organisational changes
  ‘What formal training do senior health service managers have in risk management? Some of the organisational changes they propose are highly risky. As a doctor you want to be supportive, you see the need for change, but it’s very difficult to articulate your concerns and ask them to quantify the risks of the changes that they are proposing.’

• Managers handle things badly
  ‘The publication didn’t go down well in my hospital. Before they read the paper they feared this was going to be negative about the hospital. They are terrified of negative publicity.

• Managers need skills to handle people sensitively and effectively
  ‘NHS managers aren’t always the right people to be looking at this. There’s no point in getting the non-clinical managers, even the Chief Executives to do anything - because they’re only in the organisation for such a short time.

  ‘His previous hospital experience was limited, and involved working in a unit well known as having the worst form of macho management.’

‘What are the characteristics of the individuals, managers and colleagues, in your organisation that take that responsibility away from you as an individual to being a group responsibility. I think that’s quite interesting to look at. There are some people who you tell a concern to, and it’s knocked back to you, and you are weak or moaning, but there are other people who you tell who are concerned. They don’t take it on personally, but they acknowledge it and legitimise it. Whatever they suggest takes you forward, and gives you an opening to address it. There are different individuals with different packages of skills, and we need more people with the latter skills.’
• Managers should work closely with doctors and others.  
  ‘It’s not about logging it and leaving it with someone else.  It’s only going to change if we suggest different ways of managing a situation. Managers can’t do it without information coming from us.’

• Involving occupational health. Like all people, doctors suffer from physical and mental health problems. Many of them work under great pressure, and ignore their own or colleagues’ symptoms or explain them away as the stresses of a busy job. It is important that an opinion is sought from an Occupational Health physician when poor performance is noted, and before disciplinary action is taken.

  ‘Someone was being disciplined for performance, but was actually ill. It was only when they came to see me as an occupational health physician, that I took a medical history and it became clear the doctor was ill. We are useless at recognising that we, or our colleagues, are ill.’

• Local learning from incidents. Real learning, especially those involving peoples’ attitudes and behaviour is much better achieved locally. I would contrast this to systems analysis, which is good for errors in drugs, machines, etc.

Learning is more effective if it is done sensitively in the workplace.

  ‘You get so much spin-off from everyone learning together.’

  ‘If somebody else does that learning can you actually integrate it into your own practice? That’s what worries me about having big top heavy arrangements for doing the thinking and learning from incidents. To have that learning delivered from on high would mean that it would not have a reality connecting it to your own world of work.

  ‘Collective information going centrally which doesn’t involve the people thinking and talking together will be harder to assimilate into practice. I’m not sure it will work when risk is caused by people’s interaction and working relationships.’

  ‘If managers identify that your ward has a high number of drug errors, and then come up with mechanisms that the nurses don’t necessarily understand or appreciate, the nurses and doctors are less likely to manage their own risky behaviour, and want to change it. It’s about nurses and doctors working together to find solutions. If they’ve thought of it they are more likely to put it into practice.’

• Resources: We have to come up with a solution, but solutions cost money. This also may involve changes in practice – patients may have to go further away for assessment. We’ve been to the manager, the other director, and all say this should not be happening, we have to come up with a solution, but nothing changes.
**General practitioners**

What errors get reported?

Overall, GPs' reported a tolerance of error that appeared greater than other groups. However, most of the same divisions between reportable and non-reportable error were apparent.

“We’re all human. We all make little errors. It’s a matter of picking out the more serious ones [to report or discuss].”

“If I thought something criminal was going on, I’d tell someone.”

“If it’s frankly dangerous then you have a duty to tackle it, either with the doctor or outside. But if it’s not dangerous, then I would probably think, well we all do things differently. You have to support your colleagues as well with patients – when you see a prescribing error you can’t tell the patient that she’s on the wrong things, you have to say I think now we’ll add some progesterone to your oestrogen, or something like that. You have to maintain the trust of the patient with their doctor. It’s difficult to get the balance right.”

What if you’d committed an error which no one else had noticed, what do you do?

“I declared giving the wrong dose in A&E, but nobody wanted to know.”

“I missed fractured ribs. I rang up the patient who was fine about it, and I told the consultant.”

“One of the nurses gave the wrong medication, and we all had a discussion about what we should do about it. The drug company said it probably wouldn’t matter. We thought about doing nothing, but in the end we rang the patient, and he was completely fine about it.”

Every practice has one or two things that aren’t good. If it was one or two things, I’d probably let it go. [What if it was 10 things?] Then I might discuss it with a colleague to see if they thought it was outrageous too.”

“I think if they have insight into the problem, then I would be less likely to report it.

“I was a locum in a practice where some very dodgy prescribing going on. They were very overworked, one partner down, everyone completely overwhelmed. He clearly needed help. I did mention it to the clinical governance lead of the PCG. I didn’t feel uncomfortable doing that, but I guess I was able to pass the buck. If I hadn’t know the clinical governance lead it would be quite a bit more difficult.”
Sometimes it is difficult to know when something is not right, and then staff tend to check up with others’ perceptions before acting: “I twice heard a receptionist shouting at a patient. I spoke about it to the practice manager and she said several people had mentioned it and that made me feel better. She dealt with it well.”

**Barriers to reporting**

- **Conflicts over what provides the better quality** – for example, a doctor where you have doubts about some aspects of his/her clinical skills, versus no doctor at all.

  Example: The practice had a locum who was generally quite good, could speak with the large number of Turkish patients, etc. There was a complaint about his handling of a prostate problem, and there was poor documentation about it too. Also the partners had asked him to handle the statistics and that wasn’t done. “It’s difficult because we valued the doctor and didn’t want to lose him. It’s so hard to get locums. If it was a really serious mistake it would be different.”

- **Treating error as commonplace and so doing nothing.** “I was a locum and someone complained about me and the partners said ‘don’t worry – we get complaints all the time.”

- **Refusing to look at one’s own errors.** “A lot of practices don’t discuss complaints about themselves – it’s easier to discuss an outsider’s complaints”.

- **Not being sure.** “Things are often highly negotiable. You can’t be sure.”

**How Would You Encourage Change?**

- **Changing culture.** “In some environments you get the impression that you can really discuss error in a useful way. There is no judgmental element in it. That makes it a lot easier. Face-to-face meetings over lunch [are the best place to do this]. That lot down the road do that, but I’ve seen them with their kids and they’re the same with their kids. I don’t know if it’s culture or personality or both.”

- **Taking error seriously.** “Perhaps we should ask how we deal with error more seriously. Perhaps it’s a good question to ask when you first go into a practice: it would be very difficult to change things as a junior partner.”

- **Peer support.** “We have a system of peer review. We don’t have to report these things at meetings – we just go and chew it over with somebody. That works really well.”
“It is easier to report if you feel that you are going to be plugging the doctor into a support network, not that he or she will be reported straight to the GMC or something.”

- Feedback and Learning. “I wouldn’t want feedback on all my errors – it would be too much feedback. …You end up not doing anything, not reading the post-it notes telling you to do this, do that. You get snow-blind.”

“I get a volume of notes too – like, you forgot to refer… - but it’s always wrong, so you just ignore it. Nobody talks to each other…”

“Face-to-face feedback is much nicer – why did you do this this way; have you thought about doing this…”

“Saying, have you thought about doing this, is a much nicer way of giving feedback than saying ‘you did this’ – it’s much more positive.”

Don’t just say: people do make mistakes. That doesn’t give anyone a chance to discuss it or get support where you feel you have really made a mistake.
Senior Nurses

What do they actually do when they notice error or poor behaviour in themselves or others?

All groups made fine distinctions about what they thought of as error or not. Senior nurses were also particularly thoughtful about their own actions, whether various things they did or did not do should be counted as error or not. For example:

Sometimes, particularly as a more senior member of staff, you can be doing something like drawing up drugs, on your own, but you know your mind is not on that task, it’s on the next 10 tasks that you’re going to do and you’re looking at a drug or you’re looking at a bag of fluid and you’re thinking ‘yeah, sodium chloride’ and you’re not consciously thinking of it. It’s not actually an error, so you don’t actually do anything about it.

Sometimes it’s very difficult to actually identify that an error has taken place initially. Especially an error one makes oneself. It’s not until maybe you’ve finished your shift or a couple of days later that you actually realise that. I’ve given patient blood before without checking it. I didn’t check it with anybody, didn’t even check the name badge or anything like that. And it wasn’t until about two days later that I actually realised that I had done that. So that’s how it’s difficult to identify when an error has actually been made.

And I think you sanitise some of the minor errors to a degree when you think well, you know, these things happen. Generally everything’s ok so ….

Near misses. I think one of the things that amazes me when we talked about minors and majors was that a lot of the stuff is the near misses, all the near misses that we watch every day, every hour, how we manage them. But it’s this tranche of stuff that’s just waiting to happen. It’s going to happen.

One-off and repeated errors. If you see them do it again then it suddenly becomes an incident. The first time you talk it through, and if they do it again you say I personally know I’ve explained this to you.

Their response to errors. I think as well if someone makes a mistake or whatever you want to call it, it’s the response you get back from them that when you address it with them. If they’re willing to sit down and discuss it and realise what has happened and look at why, then in some ways you don’t feel like punishing them. Whereas if they’re sitting there very blasé and like yeah, so what, it brings out an anger in me, like how can you sit there an not even care. And it’s that they haven’t recognised the problem.
**Major errors.** I think you actually just intervene yourself rather than standing back and watching [the doctor] and saying perhaps I’ll talk someone through this or maybe go along and give them a hand. You actually say, don’t do that, or switch off the infusion. [But see “Doing nothing” below.]

**Doing nothing.** Although nurses frequently point out that errors are seen, there are still even major errors which are not being reported, almost as an unspoken team agreement. For example:

One that was very major, a patient sent to theatre with the wrong blood results, and had an operation as a result of the wrong blood results being put on the patient’s pre-operative notes, wrong name and everything completely. Got to theatre, got opened up, we thought this person was bleeding, they weren’t bleeding, and was brought back. And that was made by a very senior member of staff. So that was a major one. Then the one that was alongside it was that another patient who had obviously been bleeding, had a slow bleed for x amount of hours, had had no obs done for 24 hours and nobody had picked it up until the houseman went along and thought oh my god this woman’s in a pool of blood, why has this happened. The interesting thing, two major incidents, if you look at the staff involved you would not believe that they were involved with it and there has to be something about the stress and strain of the environment that that has happened and then again we never reported either of the incidences, they were picked up by somebody else.

**Conflicts over what is the right thing to do -** and its corollary of what is an error - were much more of a feature in the nurses than the doctors. For example: Routinely every single day we expect junior staff to interpret things that are not in policy, that either custom and practice, that are consultant preference. I know that I work with X and this is how it should be done and if I don’t do it when the ward round happens I’m going to get absolutely whatever. And then I have to ask do I adhere to the policy, do I apply custom and practice or do I do what I think is ethically right?

I think you have to look as well at action or inaction, in that situation (agreement from group). And could I stand up, I could probably stand up in front of the UKCC and say ‘no, I didn’t give it, it wasn’t prescribed’ but could I ethically and morally say that I knew that patient needed that and I wasn’t prepared to give it.

**Covering yourself.** Much of what nurses do in terms of safety and error is governed by rules or policy. Nevertheless, this again can cause them considerable conflict at times:

Sometimes it’s never even got on the drug chart and it will never get on the drug chart until about 6 hours later but you, as a senior person, will find this guy needs some 2.5 of diamorphine before his infarct and I’m going to shout across the room to the houseman or whoever and say ‘I’m giving it, I’m giving it’.
In these emergency situations you take on the mantle of having the experience to do it and then you cover your backside afterwards by (unclear) or you might even go off for a day and then think ‘oh my god’ …

**Needing others to tell you.** Senior nurses were healthily aware of their own possibilities of making errors and of these errors being picked up by others. For example:

It’s your own clinical standards – you can’t check them out as much against other people, whereas when you’re on duty you tend to check things out against what other people are doing around you but it gets a lot harder as you get more senior. So you do need people to ask you what are you doing with that pump, or did you know about this, or whatever. And then of course it’s harder for people to come and tell you that because of your position.

But there are the opposite difficulties in being senior; for example:

As a ward manager it’s difficult sometimes to confess because of the idea of having respect, so you don’t want to say ‘I made a right old cock up with the dopamine’ or whatever because they’re thinking well what clinical knowledge has she got then, how come…

**Handling doctors.** Senior nurses appeared to have few problems in confronting junior doctors concerning their error. However, they still go through a verbal exercise to lessen the confrontation, and this may actually slow down the correction of error. For example:

… I went over to the pump alarm but even though I said to him do you want a hand he said ‘No, I’m fine’. It’s that he was totally unaware that he was unsafe. I said ‘Do you want that drug running that fast?’ ‘No’, he said, but he carried on looking at the pump, so I said ‘I think we’ll turn it off’. I said to him ‘It doesn’t bother me that you don’t know how to work the pump. It’s the fact that you didn’t call for help and say I don’t know what I’m doing.’ But we could talk all day about him …..

**What are the barriers to reporting?**

- **Nothing changes.** Like senior doctors, the nurses were convinced that, from their experience, nothing changes even when reporting takes place. For example:

  I’ve worked in about three different intensive care units and this has happened in the three different places I’ve worked. I’ve brought it up but nothing’s been done. It’s adrenaline - infusions of 1 in 1,000 compared to 1 in 10,000. People accidentally mix up 1 in 10,000 instead of 1 in 1,000. And both are stored together in the same cupboard right next to each other and I’ve suggested to them several times that they shouldn’t be stored right next to each other because people pick them up. It’s happened in the unit I work in three times and it’s happened on other units as well and both of
them are still stored like that. I’ve spoken to the pharmacists and stuff like that and they’re still stored together. And it still happens.

Or you can’t see the benefit of reporting an awful lot of things. It’s the time thing. There’s hardly any dedicated time to actually analyse and review and then communicating to the general staff what incidents are taking place and things like that. So therefore if you can’t see any positive outcome or improvement then you’re less likely to report minor incidents because you can see it as just a paper exercise, there’s no particular improvement or outcome or patient care.

• **Lack of confidentiality.** The points made concerned the fact that the process of reporting was not anonymous and that serious repercussions can ensue. For example:

It’s interesting that the incident forms that I see mostly, are not always around the stuff that I should be seeing if you like. They’re written quite often by a third party. Then a lot of what you sometimes see is almost like a witch hunt sometimes around how incident forms get picked up and how they’re dealt with. They’re not dealt with very discreetly in any organisation. There’s great confusion over who should review them and the methods they use and sometimes if you’ve got somebody who is perceived to be a poor performer or doesn’t fit in or whatever, you may find that there’s a pattern that emerges there. And then you start hiding if there is poor practice and that’s a worry.

The general incident book, it’s left sitting around the office, so anybody can go in and pick it up and read about what’s happened on the unit. There’s no confidentiality about it. I think people are treated badly [as a result]….  

• **A culture of fear, blame and punishment.** The barrier of a lack of confidentiality leads into the fact that people get punished as a result. Fear of this then stops reporting. Fear comes from the organisational culture, the UKCC and from patients. For example:

I really don’t like filling out incident forms and I very rarely fill them out. Because I think there isn’t a culture to deal with them. We have a critical incident review meeting once a month and I’ve been to a few of them and people sit around and discuss… but the whole atmosphere I think… I don’t know if it’s in the whole of the NHS, but within nursing it’s not open, you’re not allowed to make mistakes, and if you do make a mistake we’re going to punish you.

You do see that if people make mistakes they are punished. Punishing somebody isn’t necessarily going to make their practice any better. Sometimes you can isolate a person, they will just do things a lot more secretly.
I think it’s the subtleties around the punishment (agreement). Somebody’s
done something and it’s wrong and they put their hands up and the
situation has been reviewed and all that, but they don’t get the promotion or
they don’t get the course. It’s the subtleties of punishment in the NHS
which are worse than the obvious. You’ve got a letter that says x,y,z and it
tends to hang around people and they take it with them. It’s a really awful
thing to happen in some ways.

I think also as well, there’s a fear of reprisals. It’s like you say, we are
governed by the UKCC and any omission or action by us. We’ve got this
hanging over our heads.

I think one of the hardest things is informing patients of mistakes. Because
talking of reprisals, there’s been so much in the press about mistakes in
hospitals that you may not fear very much from your colleagues if you’ve
got a supportive environment and we analyse the error and what went
wrong in clinical risk and all that, but the fear of a patient having been told a
mistake has been made, what are they going to do? Are they going to sue
the hospital, are they going to sue you as an individual? To me that’s more
fearful as a practitioner than my colleagues or my trust.

• A backlash in reporting others. Reporting others can cause them
unnecessary blame (see above) but it can also results in interpersonal
difficulties for you. For example:

There was a girl I was working with and she actually did it and somebody
reported her and for about four months of that person’s life it was made hell
at work basically because of it. It wasn’t dealt with properly. She just left.
I’ve seen it a few times and I went and spoke to the person individually
instead of filling out an incident form and actually reporting it because the
nurse didn’t benefit from the action taken against her.

Someone got there in time, the patient didn’t wake - no harm came. And I
made the person do an incident form. And one of them was fine about it,
was like oh, ok. I explained it, she understood why, that something very
dangerous could have happened, if no-one had been there and heard it the
patient could have woken up, could have exubated themselves, you know.
But the other girl went absolutely ballistic about it and threatened unions
and said, nothing happened, the patient didn’t wake up, I don’t know why
you’re having a go at me. I said I’m not having a go it’s just that it’s the
second time this has happened so therefore there must be something in the
training we do that isn’t teaching you how to set these pumps up right,
because it should never have happened with these pumps.
• **Needing to get along.** Senior nurses, like senior doctors, see themselves as here for longer than other groups. This means that maintaining the interpersonal equilibrium where possible is particularly important to them:

> And I think you informally do that don't you. You make an informal judgement that something, whether it is something worth going the full hog with.... Because we have to work together as a team and if you're constantly picking people up on little things then that doesn't do a huge amount for morale.

• **Other nurses’ mistakes make me look bad.** It was only senior nurses who raised this point; for example:

> It's quite interesting as a manager that it's like if you see incidents occurring that may be relatively minor and it's an obvious thing that maybe it's to do with that they weren't told about a particular policy or whatever, you may not intervene because it actually reflects on you. But if you’re thinking maybe we should just actually rethink how do we orientate people, maybe we need to be investing more time or, yes I know about the MRSA policy but I know that the person who started two weeks ago doesn't so I can't really have a go at them because they've not seen MRSA on the ward since they started. And I think that's what stops you intervening is because it actually reflects on your management of the ward. And that's because maybe you'd need to rethink something or maybe there hasn't been time or you know. That's one of the things that stops me.

• **There but for the grace of God...** The other thing is if you've made the same mistake. If you have been either close or done something and you think there but for the grace of god, I've been there.

• **A shortage of time.** Like most other groups, the weighing up of the sometimes lengthy process of reporting against other demands is an equally important barrier to senior nurses too. For example:

> I think that one big constraint is time. If you filled out an incident form for absolutely everything that you knew was bad practice you'd spend your whole shift writing out incident forms.

> You're trying to balance clinical, managerial, that sort of thing, so you never get one right. You haven't got enough time to do the administrative or not enough time to do the clinical.

> There's hardly any dedicated time to actually analyse and review and then communicate to the general staff what incidents are taking place and things like that. So therefore, if you can't see any positive outcome or improvement, then you're less likely to report minor incidents because you can see it as just a paper exercise - there's no particular improvement or outcome or patient care.
And the other thing is if the clinicians don’t have the time to deal with it, and it gets bumbled through the process and it lands in HR or wherever, it’s very easily picked up as a disciplinary issue or a performance issue or a capability issue.

• **It’s not their fault.** Nurses felt that where the mistake was due to a lack of education or knowledge of procedures because a person was new, then reporting was wrong.

  Where I work, I’ve worked in ITU for four years, and somebody else joined with me at the same time but left after 2 months because they just couldn’t handle it because they didn’t know what they were doing. So I think you have to invest in education. You see people making mistakes you don’t want to formally report it because they haven’t been taught any better, they haven’t been taught how to do this properly.

• **Staff morale.** Similarly, nurses do not think error should be pointed out when morale is particularly low since again, it’s not their fault. For example:

  You look at some areas and you know that the staff are very tired and you can almost see it coming. You know it’s coming and then when it does come if you jump up and down, if you just kick a dog when it’s down it….

  Because we have to work together as a team and if you’re constantly picking people up on little things then that doesn’t do a huge amount for morale. (agreement) Even if you do it in a supportive way if you’re nit-picking all the time, which you can feel very tempted to (agreement) but at the end of the day you have to form a judgement don’t you?

• **Staffing.** Issues were also raised of the difficulties of getting everyone together in health care, and how this stops learning from error or anticipating error taking place.

  By the time you’ve got round all your staff to tell them about this particular incident, you’ll never get hold of everybody, you can’t just sit all your staff down in one go and say this has been happening, can we think about this, what are we going to do about it. You never get a situation in medicine or nursing when you can get all your staff off the ward together unless you close the ward.

• **Health care is not like other cultures.** Nurses brought up the fact that the culture also involved the alleviation of guilt - that someone might die as a result of error.

  And I think that’s why, when you think about errors in relation to healthcare, it’s a lot harder to say why people don’t report because there are hidden codes that unless you’re part of it you wouldn’t know it. And also because when an error occurs it can be a fatality which if you work in a shop and you lose some money, well you lose some money but nobody’s dead. I think
that’s one of the things that makes people hesitate possibly before discussing errors.

- **Confronting someone senior.**

  I think the other thing you were talking about, that someone’s going to bite your head off for reporting them, it’s also if someone is more senior than you and you see them doing something that’s not good practice, then it’s like how on earth do I report that ward sister, or that consultant? I’m just a mere D grade or whatever. It’s very hard to overcome those barriers of hierarchy.

**What might encourage them to speak up sooner and to whom?**

- **Changing the culture.** This can occur in a number of ways – through reducing the fear, having someone in authority to report to, improving leadership, etc.

  I think we need to be promoting two different things. One is better practice and making sure that everyone is up to standard and using the protocols. And the other one is promoting this feedback mechanism about making sure that people aren’t scared to report things.

  There’s now a zero tolerance when it comes to safety in our trust. If we’re not happy with the house officers or whatever’s conduct, and the consultants of those house officers aren’t doing anything about it, say it’s regarding staff safety at work, then we have been given the go ahead to speak to the clinical director at home and I have noticed a change just in the last few weeks that because that facility is now in place for us to speak to the big boss.

- **Improving leadership.** Nurses were enthusiastic in this as a way to discourage the fear of reporting. In particular, the first quote demonstrates the possibility of clear cultural change fast, given the right leadership.

  I worked on a unit where the manager hadn’t been there very long – well she’d been there a long time but not as a manager – and she noticed they got no incident forms but suddenly they started to get hundreds of them because people felt comfortable filling them in. It looked awful on paper, all these awful mistakes were happening, but the reality was it wasn’t. And then they started to disappear again because the mistakes started to be picked up and rectified and new policies came in.

  I think some of that also comes back to generating openness and having role models, because if they don’t have the confidence in the person who is in charge, if you don’t think what they’re doing is correct or they’re very laid back, you might not want to bother asking them because you think well I don’t actually have much respect for you anyway. Or if I ask you you’re
going to bite my head off so I’m not going to ask you, I’d rather just get on with it.

I think that’s a major point, not actually having respect for the people in authority. Gone are the days when respect is automatically given to somebody who’s in a different colour uniform or a with a different title. I think respect is so much earned.

- **Consistency.** I know where I work now I might pull some nurse up on something and go through it with them, but I know that someone else on the unit probably wouldn’t bother.

- **Ensuring that things change.** The importance of actually getting change to happen fast enough for people to still be there to appreciate it was felt strongly.

You know what you were saying about clinical governance? If there was some mechanism whereby you had somebody, or a team of people, who would review the incident forms that come through and say well, this one, this is process, we can sort that out.

The other thing is real-time action. Sometimes there’s such a huge delay between you sending the form off or the communication and you think was it worth my while.

- **Tackling conflicts between systems and discretion.** Although nurses have numerous systems and rules – far more clearly than doctors do – these can also cause them conflicts because there are times when these rules need to be broken in order to provide better overall care. There are also instances where nurses’ and doctors’ “rules” appear to be different; for example, in hand washing [see under SPRs and student nurses].

I think what I was trying to say is that there are sometimes systems or things in place that actually make it quite easy for an error to occur. In other words, if the system was better. It’s about getting a culture and getting a way of doing things that there is no alternative way of doing it, there’s only one way of doing it, but also I think some people do make mistakes because of the systems that are in place or the pressures that are on them. Students obsess about obs because it’s the only thing they can do. And I sometimes look at my patients and I think I haven’t actually done an ob on my patient for 6 hours, but that’s because I’ve been looking at my patient from the point of view of experience and intuition and I know, or I think I know by looking at them that they’re generally ok (agreement). But it’s sometimes a shock to me that I haven’t done a set of obs on somebody….

But then there’s the other side of the obs thing. I feel bad now because I think I’m confessing to not doing obs. But also the other side of that is doing obs and not looking at the patient. Or doing obs and not doing anything with the results. Or doing obs inappropriately, just to keep people happy. On inappropriate patients
...and the other is having absolutely inappropriate obs so you have someone who’s just come in for a hernia operation on four hourly obs, waking them up, but you have someone who’s come in with dizzy spells or a falls, query bleeds, doesn’t get obs or gets the same and there’s no differentiation between the obs.

The problem is that when policy is laid down without discretion, nurses and doctors will always get round the system for the sake of their patients. For example:

We’ve just introduced a locked policy, so I actually have got some potassium in my bag (laughter), so if I’m working away from where the potassium is stored in the middle of night - because working on a cardiac unit we give lots of potassium - and so sometimes there aren’t the resources for me to physically go and get it, so I’ll go and get four ampoules. And I just happen to have one in my bag.

In that situation what I would do is every time I couldn’t get potassium to that patient quick enough I’d write an incident form out. I’d do a clinical incident form - this was an incident, I couldn’t give the patient potassium when they needed it - until they were bombarded by it, they’d have to change the policy.

One aspect of having strictly adhered to policies and procedures, is that it may form a rule to be got round but also it takes away not only people’s discretion, but sometimes their sense of personal responsibility.

We went in the office and she said you haven’t made me do that form, laughing. I said I haven’t forgotten it. She said I thought you’d remind me again and I said I was hoping you’d be professional enough just to do it having asked you. She said oh, I’ll do it then. She was fine, we laughed about it but she was waiting for this person to come and stand over her with big stick and say do it. But she did it, no problem. She was laughing but she said you didn’t make me do it and I said it’s not for me to make you do it, it’s your responsibility.

• Peer review. You edit your own environment, and that’s why having an audit or an independent party, someone who’s not familiar, like peer group or whatever, is quite useful because they can look at it and you can say, oh right!

One of the things that we do every year at X, which always causes a great furore when it comes out, is we take case notes from every ward and we take ward sisters from each ward and area and they audit each other’s practice. And that is hilarious when the results come out because the front row’s all sitting there thinking mine will be perfect (laughter) and you look at things like number of falls, patient documentation, but then what they do is an observation for a couple of hours as well.
Newness to a ward allows people to see things as error more easily: *You come into a unit new you see faults in the systems whereas people who’ve been there a while don’t see it any more.*

**Being given time.** This was thought necessary in all sorts of ways, whether to work through the types of changes that are needed so that the actual system changes as a result of error reporting, or to be on the policy committees which lead to change.

*You need time to manage all this!*

Sometimes it’s quite easy to address the things with the individual but then actually when you’ve analysed what’s gone wrong and you think oh, it’s to do with the type of document we’re using or whatever. That actually takes the time and that’s when I think the support tends to drop away at that stage, for you the manager to try and change that. It means going to the documentation group or it means going through whatever, and it just takes forever. So that makes you reluctant to take it on. You actually deal with the individual and deal with that as a situation, as a one off, but you maybe never properly resolve the things that led to that error occurring which is frustrating.

The problem is the people who should be on the policy group are the people that you’d miss most from your clinical areas.

**Away days were considered a way to tackle some time problems.** I’ve worked on ward where they do that. … get all your staff off the ward together unless you close the ward. Two medical wards work in exactly the same way. One ward staffs the other ward while the whole of that ward go for an away day. And then vice versa. Basically for that one day staff who are on days off or annual leave cover both sides and then we reciprocate.

**Litigation.** If you’ve got a culture like in America where there’s the fear of litigation, then I think you’d then end up reporting everything and that’s what would encourage you to report things more is that if you felt that you could positively be sued.

**A more sensitive risk management department.**

One of the things that worries me a little bit is that we have a clinical risk department in our trust, and although there are nurses in it I sometimes feel that if something goes passed and doesn’t get stopped by whatever at ward sister level, it just goes straight to clinical risk. It can be blown out of all proportion.

*I watch our medical colleagues and how they use that system, and they go and talk to the risk manager and they say this is what happened whereas the nurses don’t get that option at all.*
People judging folk, judging current practice - people who are so far removed from practice that they cannot really make a sensitive judgement on it.

- **Consultation on policy with those doing the work.**

  *If the policies that were drawn up actually had engaged clinical people like yourselves, that were actually practically implementable. (agreement)*

  *But I've come to the conclusion that one of my E grades, or even my D grades, may be better on that group than me. And also, when I've been at those groups you don't always see regular representation from all areas.*

  *You need a balance. You need your ward sister there to say this is what should be happening, but someone to say this is what we're actually doing. And pulling those two together.*

- **Defining error.** Throughout the meeting, the problem of what was an error – both of commission and omission – was vexing to the nurses, and it was apparent that some way of defining major and minor errors and possibly of introducing different ways to tackle each would be appreciated.

  *But then you come to the difference between mistake and negligence again (agreement). Was it a genuine mistake? Or was it that someone was actually negligent, they didn't actually stop and think…*
Third year student nurses

What do they actually do when they notice error or poor behaviour in themselves or others?

Example: A patient in the community was being given morphine by a district nurse who was chatting to the student and the patient while she filled the syringe. The student noticed she had filled the syringe to twice the normal dose and pointed it out to her “in a questioning way” so she would not take offence. She rectified the error and later she and the student discussed it as a learning experience for both of them: don’t chat while you are attending to the correct dose. The incident was logged “because more morphine’s been used than should be and otherwise it would look like it was missing”, but not as an event from which learning could be extended. The group agreed with this.

Faced with error, their own or others’, students said they:

- Told colleagues
- Told their mentors
- Told someone in charge usually after the event
- Discussed the incident with the other people involved.

In the discussion, they constantly distinguished different types of errors in saying what they did. On the whole, students agreed that they did not cover up on their own more serious mistakes: “It’s only when you feel that sort of panic – oh my God, what have I done – that you learn things properly. It’s only when you’ve had the experience. Before that you just think it won’t happen to me.”

One student nurse said that in a part-time job she had had, she had reported a nursing home because of its abuse to patients. She felt unable to discuss this anywhere and so had written an anonymous letter to the area manager and the culprits lost their jobs.

Student nurses said they had to discuss errors – their own or those they saw around them – with their “mentors”. These mentors are both their supervisors and evaluators. They agreed that usually this combination was reasonable and they could talk about error, but occasionally they felt unable to talk to a mentor because of their evaluator role.

All the student nurses agreed that they would not report errors of their own or others which were minor. “Big drug errors got reported or serious falls, but usually small ones did not.” They defined small ones as “like giving an extra paracetamol”, but would report major errors, such as the potential morphine overdose described above. Their agreed reason for reporting was that they had all been told in a variety of different contexts that they were protected legally so long as they wrote down accurately what had happened.
Half the student nurses agreed with one who said she would probably not report another person who had made a single unmalicious error – only those who were obviously repeating the errors or where they saw continuing bad care of patients.

**What they could do**

All participants felt that, as students, it was much more difficult to report incidents and they usually speak to their friends the most and give each other peer support. They felt that they could tell their mentor. Participants reported that being able to do this depended on their rapport with their mentors and could consequently be easy or difficult to do.

A participant described a situation occurring at mealtimes on one of her placements. “I was watching the auxiliaries giving the patient their meals when I noticed one of the patients couldn’t feed himself and he wasn’t being given any help and so he wasn’t eating. I went over and fed him and I did this for the next couple of days but I started wondering what would happen to him once my placement was over.” She told her mentor who had a word with the staff to resolve the problems.

Participants agreed that increased confidence would help them report any incidents and some of this would come after they were qualified as they thought they would have more respect from the doctors then. They felt that now most doctors just brushed them off as they had no status but this was not true of all doctors. All participants agreed that when they were qualified and had gained experience they would find it much easier to report any incidents.

When asked about an external confidential system to report incidents most participants reported that this would be useful in theory but in practice with the excessive workload it would probably not be viable. As this would have to be done after the event some participants said that as time passed they would lessen the importance they attributed to the incident and may not report it. Perceived seriousness was seen as very important as to whether the incident would be reported.

Respondents felt they could also go to University members of staff and would probably do this before going to someone in the hospital.

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1 A mentor is the person who assesses you but also the person you are supposed to go to with any grievances. They work along side you, teach you and you should be able to confide in them. They are also supposed to ensure that individuals achieve their outcomes.
**What stops them intervening usefully?**

The discussion covered the following reasons:
- Lack of status or experience
- Brief placements
- Not having a thorough knowledge of hospital protocol
- When it’s a doctor (sometimes)
- If the incident is a one-off or accidental
- If the incident was not serious and no harm was done
- Near misses were not reported if minor (but sometimes in order to get emotional support if more serious)
- Doctors sticking together and often being in groups on the wards

Participants felt very strongly that there was no situation where you could definitely not say anything. Nevertheless, they often find it difficult to report in a way which would help others to learn.

One participant described her first day on a new ward in her first week of placement. She reported to the staff nurse and explained that she was new and did not know any of the patients. The ward was very busy and the staff nurse asked if she could go around and help out. On her way around she was approached by a patient’s family member who told her that her relative had been given food by another patient and they wanted to know if this was ok. She said she wasn’t sure and said she had to go and find out and it turned out that the patient was, in fact, nil by mouth. The patient’s family was distressed and she felt they took this out on her and was consequently upset. After the event she went to her mentor and voiced her concern and her mentor felt that she was justified in her concern and that she would have a word with the ward staff. The participant only had two weeks left on the placement and said she would rather the mentor did not say anything until she had finished her placement as she was worried about the reaction on the ward.

One reason for not reporting to their mentor was that they had to placate the mentor as they were writing their report, and so they would go along with things which, under normal circumstances, they would not. One example of this was reported by a participant on a placement in a nursing home. She was asked to give a patient some tablets but he was having a lot of difficulty swallowing the tablets. She went to her mentor to ask what the best thing to do was and she simply replied “oh well, he was not having any problems before today” indicating that it was her fault he was not swallowing them. She consequently went back to the patient and had another attempt at making him swallow the tablets. She managed to get him to swallow a couple of tablets but could not manage to make him take them all. “*When the mentor wrote in the notes she reported that the patient had refused to take the tablets which was not the case. If the mentor had not been writing my report I would have said more. I felt guilty about it for a long time.*

Participants reported that they found it difficult to tell doctors if they thought they were doing something wrong and reported that it was easier to do something after the event. For example, one student was observing a senior
house officer putting in a dialysis line on a renal ward. The student had seen
the procedure performed a number of times and was aware of the correct way
of doing it. The senior house officer in question was performing the procedure
differently from previous times and his technique was very poor but she felt
that she could not do anything at the time as she was just a student.
“Afterwards I went to my mentor who arranged for the senior house officer to
be observed performing the procedure and so he was re-trained.” Most
participants agreed that a lot of senior house officers had bad techniques but
as student nurses they felt they could not do anything. All agreed that senior
nurses did tell the doctors.

Hospital cultures played an important role in not reporting incidents.
Participants agreed that it was widely accepted by nurses in general that
doctors do not perform the simplest of protocol such as infection control.
“Nurses have to wear gowns and gloves at all times but doctors often just walk
into the room - into ITU - with no gown or gloves.” Another respondent said
that some doctors were poorly organised for surgical procedures such as
catheterisation and these procedures would perhaps go more smoothly if they
were better prepared. They also left sharps everywhere and expected the
nurses to clean up which some reported having challenged. They all agreed
that these were widely accepted cultures which they could not challenge due
to their status and the fact that they often did not know many people on the
ward. The participants did not know whether the doctors knew they were doing
anything wrong and therefore they were not making a ‘proper’ mistake. “The
trouble is there’s so many of them. They come on the ward in these large
groups.” The group agreed doctors seem to “stick together” which made it
harder to speak up.

Nurses often felt their opinion wasn’t wanted. “It depends on the doctor
though. Another doctor would ask me about the patient, what I thought.”

Participants said that, rather than report incidents concerning doctors, they
would rather “have a moan” with colleagues. Many incidents were simply
accepted because the person was a doctor.

A one off error/accident was not perceived as important as something
that was done intentionally or with malice and was widely thought that
these did not need to be reported as much. It was widely accepted that there
was a difference between negligence and a genuine mistake. They felt that
if it was a mistake then the person knows what they have done, can rectify it
and learn from their mistakes. If they did not know they could make them
aware that they have made a mistake and give them a chance to sort it out.
There was a general consensus that many policies in place for nurses came
from people’s mistakes.

Participants also distinguished between minor and major errors. Minor
events were perceived to be easier to report and they could probably be
brought up at the time with the person concerned whereas major errors would
be more difficult to report and would have to be brought up after the event with
another person. Minor events would be more likely to be overlooked than major events. *Mostly it depends on the effect on the patient.*

**Near misses** were also perceived as not as important and often not worth reporting as ‘no harm was done’ to the patient.

**What might encourage them to speak up sooner and to whom?**

- Qualification and more experience
- Someone approachable in authority, preferably in the hospital
- A confidential method in theory, but they did not believe it would work in practice
- The threat of litigation

“*Lots of experience helps; for example, I see our staff nurse – she wants to let a doctor know he’s making a mistake so she turns the situation around and question it - light-heartedly – she makes it seem that it’s the doctor’s idea. This happens a lot on the ward.*” [General agreement]

“As I get more senior I would expect to be able to report more, as I get more esteem and experience.”

“It would help if there was someone in authority that we could go to.” However, they worried about confidentiality and did not think that it was easy to keep reporting anonymous. Participants did not know about their being anyone to whom they could “blow the whistle” and said that they would go to someone senior in the University first.

**The threat of litigation.** Participants said that it was important to report things to “cover their own backs”: “*You need to report everything in case of litigation so you have some evidence and support for yourself*. “Litigation is really strong at the moment.” One participant reported an example when she could have not reported an incident as no one would have known but decided to in case the incident went any further. She was helping an immobile man to stand up and he fell over. At first she thought about not reporting it as no one would have found out but decided to and felt that her mentor was very approachable. “*If you report it then you’ve got your side of it. I don’t think that’s what everyone does though.*”

The end
References:


