LEARNING ABOUT SHARKS BY READING ABOUT SHARK ATTACKS

LET'S LEARN ABOUT SHARKS

- According to the International Shark Attack file, between 1958 and 2016 there were 2,899 shark attacks around the world
- 548 of these were fatal
- Australia has the highest number of fatal shark attacks
- The Great White, Tiger and Bull sharks are responsible for most fatalities
- In 2011, a 3 metre long Great White shark jumped onto a research boat in South Africa
- "Attacks are basically an odds game based on how many hours you are in the water".

ADVERSE EVENTS – THE SHARKS WE MEET AT WORK…

- Adverse events occur in 10% of admissions
  - Half are preventable
- Cost £2 billion a year in additional hospital stays
- 400 people a year die or are seriously injured in adverse events
- NHS pays £400million annually in settlements of clinical negligence claims
- Human error is the cause of the majority of errors

WHY DO ERRORS HAPPEN?

- We're all rubbish?
- We're careless and negligent?
- We're malicious?
- It's all our fault?
- There should be consequences…

WHY DO HUMAN ERRORS REALLY HAPPEN?

- Slips and lapses
  - Unintended actions
  - The plan was right but something went wrong
- Mistakes
  - Intended action, but the plan was wrong

WHAT MAKES ERRORS MORE LIKELY?

- Poorly designed equipment
- Poorly planned out systems
- Lack of appropriate guidelines
- Adverse environmental factors
- Lack of resources
  - Including poor staffing
- Lack of support

REDUCING ERRORS – ESTABLISHING A SAFETY CULTURE

OPEN CULTURE

- Staff feel comfortable talking about patient safety issues
- Issues can be discussed with peers and with seniors
- Safety concerns are taken seriously

JUST CULTURE

- Staff, patients and carers treated with empathy and consideration when a safety issue is raised
- The focus is on learning and making things better, not on blame
- Sanctions for behaviour that is unacceptable

REPORTING CULTURE

- Staff have confidence in the incident reporting system
- Staff are not blamed for submitting reports
- Constructive feedback is given
- The reporting system is easy

LEARNING CULTURE

- The organisation is committed to learn safety lessons
- These lessons are communicated to colleagues
- The organisation remembers lessons learnt
- Management wants to know when bad things happen

INFORMED CULTURE

- The organisation seeks out information
- The information is used to improve the organisation
- Emphasis on continuous improvement

SO… WE JUST NEED TO REPORT ALL THE ERRORS AND IT'LL BE FINE, RIGHT?

SECOND VICTIMS

- Health care providers involved in an adverse patient event or medical error
- Traumatized by the event
- Feels personally responsible
- Feel as though they have failed the patient
- Second guess clinical skills and knowledge base

- Study in Missouri of over 1000 clinicians
- 1 in 7 reported a patient safety event had caused personal problems
  - Anxiety
  - Depression
  - Concerns about clinical ability
- 68% of these did not receive support at work

- ‘The darkest hour of my professional career’
- ‘I cried a lot over this case and I guess I still cry when I think about her’
- ‘Even though I hadn’t thought of it for months, I had that woman’s name seared into my memory and as soon as I saw that name, my chest was up in my throat’
- ‘I thought, “These people are never going to trust me again” ’

RECOVERY

CHAOS AND ACCIDENT RESPONSE

- The clinician recognises that an error has been made
- Chaotic scenarios
- Internal turmoil
- Patient may be unstable
- Clinician needs to manage patient in crisis but is distracted by their awareness of having made an error

INTRUSIVE REFLECTIONS

- ‘A period of haunted re-enactments’
- Feelings of inadequacy
- ‘What if?’

RESTORING PERSONAL INTEGRITY

- Seeking support from a trusted individual
  - Colleague
  - Senior clinician

ENDURING THE INQUISITION

- Awareness of possible repercussions
  - Job security
  - Litigation
  - Long term patient consequences

OBTAINING EMOTIONAL FIRST AID

- Getting support to deal with the fall-out
  - Family
  - Friends

MOVING ON

- Thriving
  - The experience has made me stronger
  - I've learnt from what happened
  - It's made me a better clinician

DOES EVERYONE THRIVE?

- What if you don't know who to turn to for support?
- What if your department makes you feel you are inadequate?
- What if everyone is gossiping about the mistake you made?
- What if you've got a good support network but you don't know how much you're allowed to mention to them?

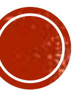
SOME OF US JUST ABOUT SURVIVE…

- ‘I figured out how to cope’
- Unable to forgive myself
- Unable to forget…

SOME OF US CAN'T GO ON…

- 'It made me question my abilities'
- Am I just not cut out for this job?
- Can't cope with being in the department any more
- Leave the department
- Leave the hospital
- Leave medicine…

The Nation



THIS IS ALL A BIT DEPRESSING...

- Innate negativity bias
  - More likely to read a negative than a positive news story
  - Value loss greater than the equivalent gain
- What about at work?
  - Simulation
    - Worst case scenarios
  - Appraisal
    - Focus on shortcomings
  - Reflection
    - What went wrong??

LET'S ELIMINATE THE NEGATIVE

- Majority of healthcare interaction not negative
  - We aren't that bad!!
- Staff morale improves patient experience
  - Better healthcare experience in settings where caregivers happy and well supported

LET'S ACCENTUATE THE POSITIVE

- Positive experiences triggers dopamine surges in the brain – improves neural processing and future performance
- Nurturing positivity improves resilience and ability to deal with adversity

- By studying groups who perform well, methods of best practice can be identified
- These can be disseminated to improve the performance of others
- Reporting and analysing success
  - Augments learning
  - Improves patient outcomes
  - Encourages quality improvement work
  - Promotes resilience

LEARNING FROM EXCELLENCE

- Excellence is everywhere
- We all see excellent practice at work
  - Going the extra mile
  - Effective communication
  - Great diagnostic pickup
  - Getting that vital cannula
  - Innovative use of equipment
- How do we let people know they're great?
- How do we learn from it?

EXCELLENCE REPORTING

- Formal method of identifying, feeding back and learning from excellence
- Excellence is peer-assessed – no restrictions on what is deemed excellent
- Anyone can submit a form about anyone else
- Recipient receives a copy of the form
- Learning points are shared with the department

DOES IT WORK?

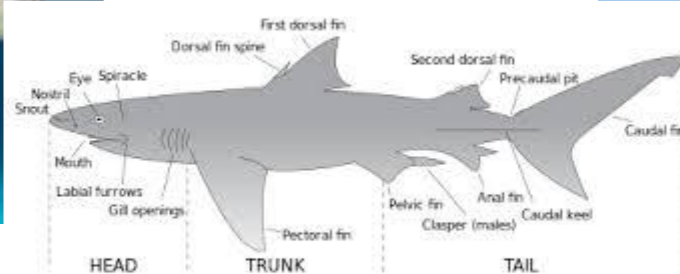
- Birmingham's experience
  - Started in PICU
  - 'viral' spread
    - Other wards
    - DGH's via transport team
  - Received over 700 reports
  - Staff survey
    - 93% felt it improved morale
    - 87% felt it improved care quality

THE NWTS EXPERIENCE

- New initiative
- Forms submitted online via NWTS education website
- Recipients informed via email
- Learning points fed back to team

THE FUTURE…

- CMFT – online reporting similar to incident reporting system
- On the grapevine – several centres introducing or considering similar systems
- Should excellence reporting be as widespread as incident reporting?
- Start-up guide…


First dorsal fin
Dorsal fin spine
Second dorsal fin
Precaudal pit
Eye
Spiracle
Nostril
Snout
Caudal fin
Mouth
Labial furrows
Gill openings
Pelvic fin
Anal fin
Clasper (males)
Caudal keel
Pectoral fin
HEAD
TRUNK
TAIL

REFERENCES

- Kelly, Blake & Plunkett 2016 ***Learning from Excellence in Healthcare: a new approach to incident reporting*** Arch Dis Child
- Cheshire and Merseyside Patient Safety and Simulation Centre ***Human Factors in Healthcare Trainers Manual***
- Scott et al 2009 ***The natural history of recovery for the healthcare provider 'second victim' after adverse patient events*** Qual Saf Health Care
- Scott 2011 ***The Second Victim Phenomenon: A Harsh Reality of Health Care Professions*** Patient safety network