

Ethics of communication: Clinical Governance in Obstetrics

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Objectives

- Assess the impact of investigations of serious incidents on staff in Maternity.
- Ascertain if feedback was directed more towards learning or contributed to a feeling of a blame culture.

Design

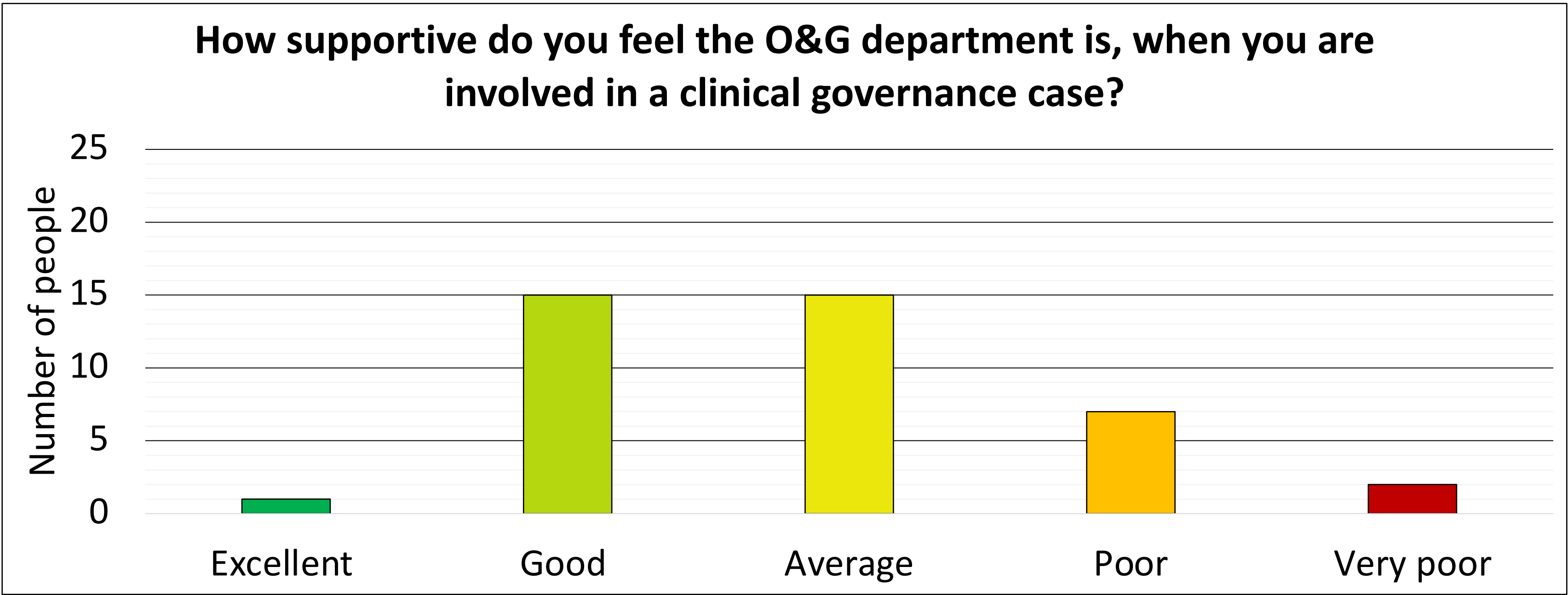
- A quality improvement project at Newham University Hospital to establish what maternity staff took from investigations of incidents.
- A teaching programme on risk management was conducted, the training for staff included reassuring them on the philosophy of investigations and aimed to improve psychological safety of the staff.

Methods

- A anonymous staff survey was sent to Doctors, Midwives and Health Care Assistants (HCAs) and results were collated and presented.
- Key themes were generated on people’s feelings towards investigations. A teaching programme was conducted and changes made to feedback given on serious incidents.

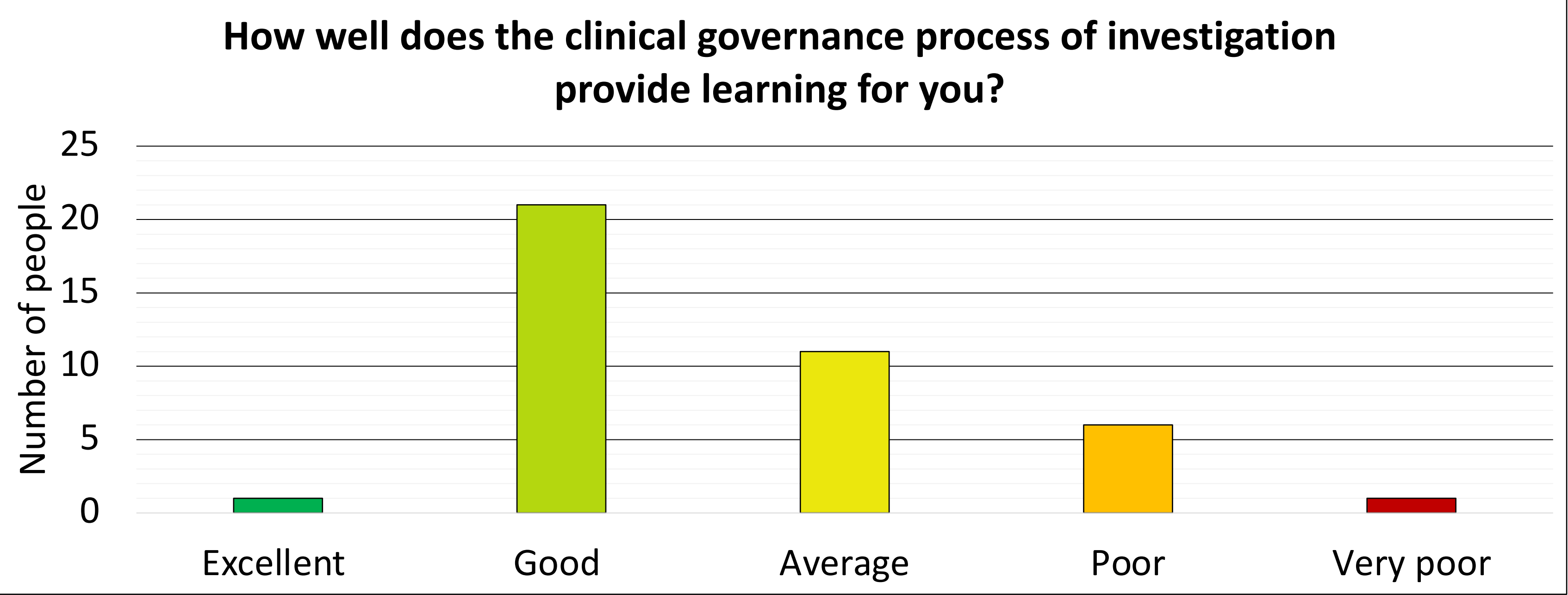
Results

- We received 40 responses, 50% from Midwives, 10% HCAs, 40% from Doctors of varying grades.
- The majority of staff felt that the risk team were supportive however they often felt blamed in investigations as opposed to being given constructive feedback on learning points.
- They felt they would benefit from it being directed towards a teaching culture and could benefit from increasing support of each other.



The teaching provided and work completed to change the staff view of governance in the unit included:

- Regular teaching during the risk meeting on people’s feeling towards investigations and the purpose of investigations.
- Two visits from HSIB to the unit to walk around and speak to staff.
- The Governance team held a ‘Governance Awareness Week’ attended by the Freedom to Speak up Guardian. Each day had a different focus including:
 - Teaching on complaints
 - Focus on Ockenden
 - Walk arounds discussing incidents, learning and audit
- The Governance team have introduced immediate debriefing following incidents followed by a psychological debrief 6-8 weeks later with a trust Psychologist as part of a staff support pathway following incidents.
- In 72 hour reviews the first questions now asked are: ‘what can we learn from what we have done right?’ and ‘what learning and actions need to be taken forward in the future?’

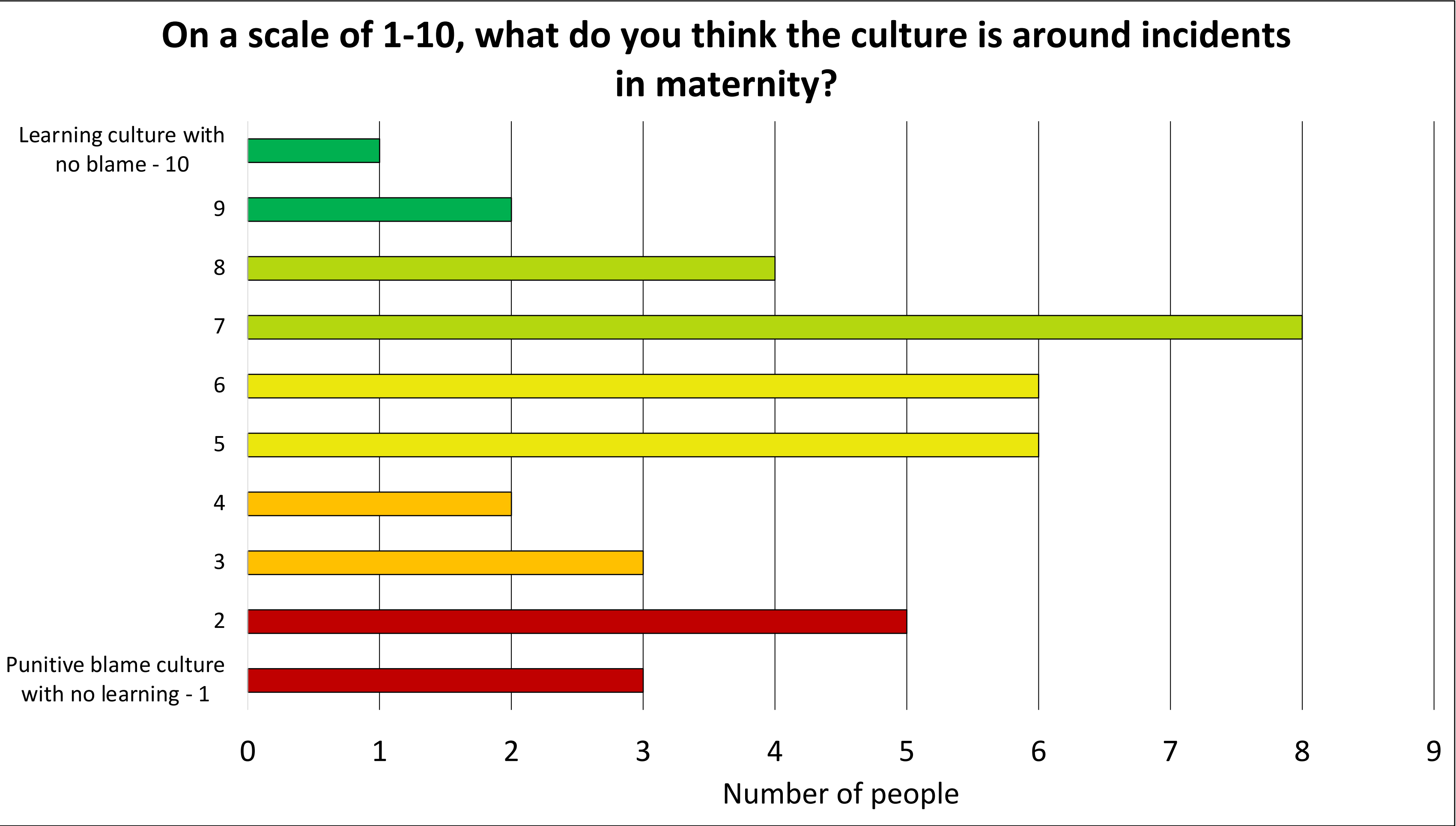


Survey results - How do you feel when a case you’re involved in is investigated?

“Already feel bad enough”
“Stressed about being in this situation / about statements / interviews”
“Sad especially if involves a poor outcome”
“Annoyed with yourself if you know you could have done something different”
“Can feel divided within the team e.g.: Dr’s fault / Midwife’s fault”

Survey results - What do you think when you hear someone else has been involved in a case?

“Feel sorry for them and try to offer support”
“Willing to learn what happened to help with future cases and avoid being in a similar situation”
“Upset for the patient / family / staff involved”
“Grateful its not me in that situation”



Conclusions

This quality improvement project emphasised some key points:

- We often claim to be ‘non-blame’ but we need to change the culture and way we communicate to reflect this.
- We need to aim to give feedback to the department as a whole and not focus on individual practice.
- Ensure individuals are aware that their statements are used to help assess if patient care has been provided according to best practice from the whole department and does not relate to them individually.
- Focus on key learning points in cases to prevent recurrence.
- Continue to support each other and be acutely aware of the impact these investigations have on the psychological well being of individuals.