Serious Untoward Incidents

Last year I was involved in the management of an unexpected inpatient death. A Serious Untoward Incident (SUI) investigation was carried out by the Trust involved and as part of that investigation I attended an SUI meeting. I'd never even heard the term "SUI" before then. The meeting did not proceed as the simple fact finding exercise I was lead to expect and left me feeling unsupported, upset and doubting my actions and abilities. I sought and received good advice and support after that meeting, but I wish I had been better prepared before the incident happened.

While writing this article I asked some of my trainee colleagues how many of them had been involved in an SUI investigation and what the experience had been like for them. Four out of five sitting in the room had been involved in an investigation and they all felt that it had been confusing, unduly stressful and they had not been prepared or supported in the way they should have been. I feel that as doctors in training we have to take some responsibility for this.

In this article I am going to attempt to outline how an SUI investigation is performed and set out an approach for any trainee involved in one. I'm not going to go into the details of what happened to me, but the following points are lessons I learned. Managing an SUI is unfortunately something we will all face as consultants and I think it's reasonable to be asked about it at a consultant interview. In addition, we all have a responsibility to support our colleagues, even if we are lucky enough to avoid an incident ourselves.

What is an SUI?

Having looked at many online resources it is obvious that different Trusts in the UK have slightly different perceptions of what constitutes an SUI. In essence if an incident causes risk of, or actual, permanent injury or death to someone who falls under the responsibility of the NHS it may be treated as an SUI (that includes us as employees). In cases of doubt, defaulting to an SUI should occur. If it will create widespread public or media attention it is more serious.

Within 24 hours of an SUI occurring it is registered on the Strategic Executive Information System (STEIS), a national database maintained by the Department of Health. This allows monitoring of the further investigation and dissemination of avoidable errors to a wider audience. The incident is submitted to root cause analysis locally by an independent investigator and is reported anonymously. The incident may be stepped down, but STEIS will need to be informed. Risk managers based at Trust level are responsible for this process. The ultimate aim is safety and avoidance of replication of error, in a system based approach.

It is important to remember that the SUI investigation is a fact finding exercise, to record and analyse what happened and recognise any failures in the system that are avoidable in similar situations in the future. It is designed to avoid a blame culture.

Local investigators have a responsibility in certain circumstances to involve outside authorities. For example, in the case of equipment failure the Medicines and Healthcare products Regulatory Agency will be informed. A Coroner or Procurator Fiscal may need to decide whether an enquiry is necessary if there has been a death. If a criminal act is suspected the police have to be informed. The General Medical Council (GMC) may need to be informed and a doctor may be suspended during ongoing investigation for the protection of themselves and patients. In the case of trainees their Deanery and Royal College may need to be involved. Some of these investigations can and do unfortunately take considerable time to complete and the following points become more crucial if this is the case.

How can you improve your experience of an SUI investigation?

Know the local process

Familiarise yourself with local policy, even if it is only because an incident has happened and you're involved in the investigation. All trusts have their own local policy, but generally all subscribe to the same idea – look for the risk management pages on your trust intranet site or type "SUI" into its search facility.

Be contactable

You must regularly check your trust email; it is your responsibility to do this. It will be management's default contact for you. This may seem annoying if it is not your main email contact, but unless you are personally registered in accordance with the Data Protection Act the Trust should not be emailing anything involving patient details to a personal email address. You will miss the chance to take part in the investigation if you do not receive these communications. This may result in you being unable to defend yourself and/or to learn from the experience.

Keep good quality written records

It is the presence of your name in the medical notes that alerts the investigators to involve you when an SUI is investigated. The GMC's

"Good Medical Practice" says you should "keep clear, accurate and legible records, reporting the relevant clinical findings, the decisions made, the information given to patients, and any drugs prescribed or other investigation or treatment", and that you "should make records at the same time as the events you are recording or as soon as possible afterwards". This can sometimes be difficult, but it is vital. If something is not entered in the medical notes it will be regarded as not having happened or not having been done even if you know it was. If the documentation was delegated to someone else (as often happens if you are acting as part of a team) you should check this entry and countersign it. Legally you have 72 hours to make an additional entry in the patient's notes, but you cannot make alterations to any previous entries.

Personal records

It is good practice to write a reflective summary of what happened for your own records and this can provide the basis for an SUI statement. Try to write a summary straight away, while it is fresh in your mind. This will be before you are even aware of whether or not an SUI investigation will be undertaken. You must store this securely and anonymously. Writing these summaries as often as you can, even about small events as part of your everyday practice, will make it easier to write something sensible when a serious incident has caused you distress and anxiety. Reflective practice has become part of our ongoing professional development. Evidence of self-reflective practice will be sought in the future (possibly as part of re-validation). This reflective practice can encompass evidence of good practice too!

Debriefing

A debriefing of everybody involved in the incident should be held. Ideally someone who is a trained facilitator should do this. Critical Incident Stress Debriefing involves the giving of information aimed at preventing psychological morbidity and aiding recovery after a traumatic event. Techniques and communications skills for debriefing are now fairly widely taught (e.g. Training the Trainers courses). Using constructive criticism skills, for example, can make this process far less stressful for the person receiving it. Take an active role in the debriefing process if you feel you are equipped with these communication skills, you may be able to support others.

Get yourself support

Don't underestimate the psychological effects of being involved in a serious incident. Ensure you receive the support you need from an experienced senior Consultant or Mentor who you trust. Your Clinical Director has a responsibility to ensure your emotional well-being. If you find it difficult to find support within your own department speak to another close colleague or make use of the support networks set up outside of your local workplace e.g. AAGBI or BMA.

Your department should ask themselves whether it is good practice to expect you to fulfil your immediate service requirements. If you feel unable to cope with your usual workload you should talk to someone about this and request time out. Be alert to signs of anxiety; don't cope by drinking alcohol excessively or causing undue stress to personal relationships. These symptoms of stress can manifest themselves much further down the line.

Representation

Don't go to any meetings without senior representation. A Consultant from your department should attend meetings with you.

Informing your medical defence organisation is crucial in the event of an unexpected death but they will not mind if you have a low threshold for involving them in untoward incidents that may lead to your practice being questioned. You pay them a lot of money for their services; use them, get your money's worth. They are there for YOU, as opposed to the patient, your department, the hospital trust or your primary care trust. If there is any chance of a dispute between you and the Trust their services will be invaluable. If the incident does involve an external investigation they will appreciate early involvement. You are not covered by your Trust for criminal prosecution or GMC hearings.

Statement

If you are involved in an incident you will usually be asked to prepare a statement. This should record fact; what happened and why, not your opinions about what should/could have happened. Before handing in your statement get other people to read it and give feedback. They will be look at it from a more objective perspective and will help you prevent it seeming angry, personal or judgemental.

Final report

When the investigation has been completed you are entitled to see a copy of the report and it is advisable to review it. If you don't agree with the way the incident has been reported or the conclusions the investigation has reached you have a responsibility to raise this. Raising concerns about this is probably best done within your department as a first call, but do not be afraid to take it higher if you are unhappy. Again, your medical defence organisation will advise you about this.

Closure

Closing the episode is important; you should not be left questioning any aspect of the care you provided for your patient. You should be clear about what occurred and whether you acted optimally or whether there are aspects of your practice that can be improved.

Seek out a clear ending to the process. Make sure you are able to reflect on what you have learned from the experience, be that clinical practice or communication skills. There is always room for improvement, which is not a negative thing.

I hope this article has helped you to be better prepared if you experience an untoward incident. Hopefully you won't, but I think the points covered are part of a professional approach to achieving our responsibilities both to ourselves and others within our workplaces.

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Further reading

"Catastrophes in Anaesthetic Practice (2005)", AAGBI publications.

"Good Medical Practice", GMC publications.

Information is available online from The Department of Health website (www.dh.gov.uk)

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