



The Experiences of Doctors in Training Involved in Significant Adverse Event Reviews (SAER)

"The consultant told me it was likely to go to a SAER and told me to write a statement and reflect on it"

"It was chance that I had found out anything had happened"

Identifying the Incident

"I didn't find out until weeks later anything happened "

"The only reason I knew anything happened was because I heard two of the other doctors talking in the corridor"

"Huge efforts made by the consultant to undertake a hot debrief with all members of MDT"

"A bit of empathy (from the consultants and management) would have gone a long way"

Immediate support

"I know the nursing staff had their own debrief with the consultant, the junior medics weren't invited- it made me feel worthless"

"I was new to the job... I felt so unsupported"

"I felt so alone"

"I sat down with an AMD and they explained exactly what the process involved an why we were doing it- to make things safer"

"The lead investigator contacted me directly and explained everything"

Comissioning the review

"Nobody told me that I had support available"

I had no idea why I was there, I hadn't even been told that the patient had died before I went to the interview"

"One of the investigators ran through the entire timeline of events with meline of the that they really valued my input"

"The interview felt like an interrogation, like I was being blamed"

"It felt like I was so alone"

Review process

"(around the the review) I felt off my game, *struggling*, for months afterward. It would have been nice to have someone check on me"

"I felt so much guilt- like it was *my* fault"

""(The interview) was traumitising, I don't like to think about it"

"It was only when read the report that I fully understood what had happened to the patient"

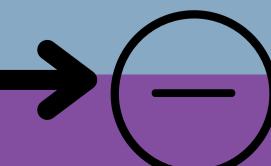
"I still haven't heard anything, its been seven months"

Feedback

"I had to declare it at ARCP and show that I had reflected but I didnt know what to do as I never heard back"

"I felt lost from follow up, no contact- I became a more anxious doctor"







NHS, WHAT IS A SIGNIFICANT ADVERSE **EVENT REVIEW (SAER)?**

A GUIDE FOR DOCTORS IN TRAINING



WHAT IS A SIGNIFICANT ADVERSE **EVENT (SAE)?**

An significant adverse event is defined as an event that could have caused (a near miss), or did result in, harm to people or groups of people.

WHY DO AN INVESTIGATION?

To identify if systems failures occured that contributed to the incident. This is not about the individual. Learning from adverse events is crucial to continually improve person-centred, safe and effective delivery of care.



WHAT HAPPENS DURING THE REVIEW?

The Review Team will review documentation (for example the electronic patient record) in order to start building a factual timeline of events.

You will be asked for a written recollection of events that will inform this. Often the team will interview a smaller number of people. This is routine and nothing to worry about. Incidents are often complex and from speaking to people we better understand the context which helps to understand why things happened the way they did!



WILL I GET FEEDBACK?

You will get a chance to review a copy of the final report and recommendations.

This is an important opportunity to reflect on the event and direct your own learning.



WHAT SUPPORT IS AVAILABLE FOR ME?

You should have a senior clinician identified to support you throughout the process. This will usually be your education supervisor, clinical supervisor or clinical director who can also signpost you to other sources of support if required.

Further written information is available on the SAER process and how to produce a written statement.





Top Tips for Supporting a DiT through a SAE Review

A significant advere event review (SAER) can be an intimidating prospect for a Doctor In Training (DiT). While we can't change the event they have been involved in we can support them in the aftermath and prevent secondary harm during the review process.

No.

Reach Out

Make contact with your trainee and find out how they are getting on. This can be a useful opportunity for reflection and to discuss anything that may be worrying them. You can emphasise the aim of the review process is to improve care rather than assign blame to individuals. Further information for you on the SAER process is available on StaffNet to help you with this and address any initial questions they may have



Encourage them to write things down

Staff involved in a SAER will have to provide a **written statement**.

Emphasise the need to do this as soon as possible after the incident. A **reflective piece** will be required for ARCP but this is separate and for the DiT's personal learning

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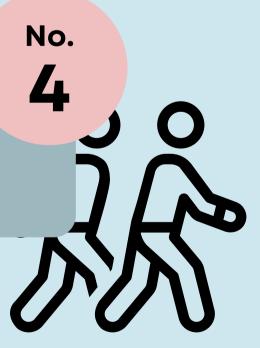
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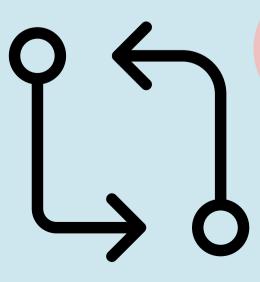
Signpost

All staff involved in a SAER should receive three documents including how to write a statement, information about the process and what support is available. These can be found on the intranet and you can signpost to them if your DiT has not received them. Depending on their needs you can signpost to other services for example peer support and psychology.

Offer to go along

All staff can take someone with them if invited for interview. For DiT it may be appropriate for you to be that person. You would not be expected to answer questions for them, but you would be there for support.







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Follow-up

You should aim to follow-up with your DiT. The frequency should be dictated by them, though it is suggested times such as after an interview. Given the length of some reviews this may mean keeping in touch with a trainee after they have left the department. You may need to complete transfer of information documents for their next educational supervisor if they rotate while the review is ongoing.