Junior doctors' views on reporting concerns about patient safety: a qualitative study

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ABSTRACT

Background Enabling healthcare staff to report concerns is critical for improving patient safety. Junior doctors are one of the groups least likely to engage in incident reporting. This matters both for the present and for the future, as many will eventually be in leadership positions. Little is known about junior doctors' attitudes towards formally reporting concerns.

Aims To explore the attitudes and barriers to junior doctors formally reporting concerns about patient safety to the organisations in which they are training

Methods A qualitative study comprising three focus groups with ten junior doctors at an Acute Teaching Hospital Trust in the Midlands, UK, conducted in 2013. Focus group discussions were transcribed verbatim and analysed using a thematic approach, facilitated by NVivo 10.

Results Participants were supportive of the idea of playing a role in helping healthcare organisations become more aware of risks to patient safety, but identified that existing incident reporting systems could frustrate efforts to report concerns. They described barriers to reporting including a lack of role-modelling and senior leadership, a culture within medicine that was not conducive to reporting concerns, and a lack of feedback providing evidence that formal reporting was worthwhile. They reported a tendency to rely on informal ways of dealing with concerns as an alternative to engaging with formal reporting systems.

Conclusions If healthcare organisations are to be able to gather and learn from intelligence about risks to patient safety from junior doctors, this will require attention to the features of reporting systems, as well as the implications of hierarchies and the wider cultural context in which junior doctors work.

INTRODUCTION

Errors, adverse events, and sub-optimal care remain common in healthcare and pose significant risks to patient safety.⁽¹⁾ Many staff working on the frontline will experience adverse events; learning from these experiences is an important way for organisations to improve the quality and safety of patient care.⁽²⁾ In the UK, healthcare staff have a professional duty to raise and act on concerns about patient safety,⁽³⁾ and recent years have seen the widespread adoption of formal incident reporting systems in hospitals to enable staff to report on their experiences of adverse events and unsafe care.

The need for healthcare organisations to collect and learn from patient safety issues has been strongly re-emphasised in the wake of the Francis enquiry.⁽⁴⁾ Junior doctors in particular have been recognised as an important yet undervalued resource in the improvement of patient safety in the NHS, with the potential to act as 'eyes and ears' for improvement.⁽⁴⁻⁶⁾ They spend much of their time 'on the ground' in clinics or on hospital wards, and are closely involved in day-to-day care of patients. In the course of their rotations they have an opportunity to observe practices in different settings within the hospital, and they can act as 'fresh eyes' in identifying problems and risks. They also may become aware of wider organisational problems that impact across different wards or units within the hospital. As such, junior doctors are well-positioned to identify risks to patient safety.

Evidence suggests that although junior doctors commonly reflect on patient safety issues, they display low levels of formal incident reporting.^(7,8) Research has identified a number of reasons why staff fail to report patient safety issues, including the usability of incident reporting systems, lack of training, uncertainty about what counts as a reportable incident, fear of the consequence, lack of feedback, and perceptions that reporting the incident will not make any difference.⁽⁹⁾ There may be particular barriers for junior doctors, including worries about the negative consequences of incident reporting for their future careers.⁽⁸⁾

Although there is some evidence about the factors that impact on junior doctors' engagement in incident reporting, research to date has used quantitative methods such as surveys, in which responses are limited by predefined categories. In addition, the focus has been on reporting of *incidents* – events in which harm has occurred – rather than the broader issue of *concerns* – experiences of and worries about a broad range of factors that might pose a risk to patient safety, such as poor systems, lack of staffing and resources, or poor teamwork.⁽¹⁰⁾ Qualitative research is needed to generate an understanding of the barriers and facilitators for junior doctors of formally reporting concerns, grounded in the experiences of junior doctors themselves. We undertook a qualitative study to explore the views of junior doctors on reporting concerns about patient safety to the organisations in which they are training.

METHODS

Participant recruitment

Junior doctors in grades FY1-CT2 (see Box 1), working in an acute University Teaching hospital in the Midlands, UK, were recruited to participate in focus groups. Permission was sought to approach junior

doctors from their training programme directors, and from the hospital. Junior doctors in grades FY1-CT2 working within the hospital were invited to participate via several emails sent by the foundation programme coordinators, junior doctor administrators, and junior doctor representatives, using local email lists. The aim was to reach all eligible junior doctors in grades FY1-CT2 working within the hospital (a total of approximately 60). Participant information sheets describing the study were included in the email. Interested doctors indicated their availability using survey monkey, and were contacted by the study researcher (PH) with details of the focus group.

Data collection

Focus groups lasting approximately one and a half hours were conducted by PH on hospital premises, between July and September 2013. Focus group discussions aimed to explore junior doctors' attitudes and experiences of reporting concerns about patient safety. The focus groups were managed to facilitate discussion, with attention to group dynamics. The facilitator was careful to allow for all group participants to contribute their perspective. In the discussions, the concept of concerns was kept deliberately broad and not limited to 'incidents'. Barriers and facilitators to formal reporting, and features of an effective and acceptable system for reporting concerns, were explored. A topic guide was used to structure the focus groups (see Box 2), but participants were encouraged to discuss issues that were important to them. Focus groups were digitally recorded, transcribed verbatim, and anonymised.

Data analysis

Transcripts were analysed using a thematic approach,⁽¹¹⁾ facilitated by NVivo 10. PH undertook a process of familiarisation through reading transcripts and producing transcript summaries. Analytic questions relating to how concerns were defined, and the barriers and facilitators of acting on concerns, were kept in mind at this stage. All transcripts were then open-coded, and codes grouped to develop a thematic coding framework, which was independently reviewed by CT before a final framework was agreed. All data was coded to the final framework to ensure consistency, and data summaries were produced for each theme. Data interpretation was undertaken by PH, DK and CT.

Research Ethics

The study was granted ethical approval by the University of Leicester ethics committee (June 2013). Written informed consent was obtained from all participants. At the time of conducting the focus groups PH was a doctor in training, on a one-year Education Fellowship at the Trust. She was not working clinically with focus group participants.

RESULTS

Ten junior doctors participated in three focus groups, including one FY1, two FY2, three CT1, four CT2 level doctors. Five were male and five female.

Participants were supportive of the idea of reporting concerns about patient safety, but identified barriers to using formal reporting systems, and argued that encouraging junior doctors to engage in

reporting concerns required education and leadership, improved reporting systems, and evidence of the impact of reporting on improvement.

Attitudes towards formal reporting of concerns

Positive attitudes

Participants in our sample shared the assumption that reporting safety concerns was intrinsically a 'good thing', and recognised the value of reporting broader safety concerns, not just adverse events.

You want [reports] to be lesser incidents that then hopefully over time, years, you address all the lesser incidents and the harm becomes less. So [...] we report things that we see nearly daily probably where you think, 'oh god, that should have been done a bit differently' or 'that could have been done better'. (Focus Group 1)

Despite this positive attitude, junior doctors reported relatively low levels of engagement with the current formal electronic incident reporting system. They highlighted a number of issues that impacted on their willingness and ability to use formal reporting systems.

Leadership

One issue that impacted on attitudes to reporting concerns was limited leadership by senior clinicians. Participants did not feel that they had been encouraged by consultants to formally report concerns, and reported a lack of exposure to role modelling of incident reporting by the medical community during their training.

I've never had a consultant say to me 'you should fill in a [incident] form'. (Focus group 1)

Up until now I've had very little exposure to anyone else who does things like fill out [incident] reports. [...] Looking back there have been a lot of instances where I think 'that should have been raised', but because the culture in our previous jobs wasn't to do it I had no idea about the processes. (Focus group 3)

Uncertainty about what to report

Junior doctors felt that at times concerns and incidents were more complex than was assumed by the established reporting mechanisms and policies. As a consequence, they experienced uncertainty about which incidents or concerns were candidates for reporting.

I think you are supposed to report significant adverse events, and then you are also supposed to report near misses. But if you report near misses you have to spend another 8 hours each day. I think sometimes that's sometimes the nature of especially acute medicine isn't it. There is always the chance, if you look at any situation there's always the chance that something could have gone wrong. (Focus group 1)

Inflexibility of formal reporting systems

When they did try to use formal reporting systems, they encountered significant practical difficulties. The majority of participants felt that online systems were cumbersome and time-consuming to use. The

structured nature of the incident reporting forms, with drop-down menus and tick boxes, and the requirement that a number of mandatory sections had to be completed before submission, were seen as frustrating their efforts to report.

I tried to fill out the [incident form]. Forty-five minutes later, furious because I really wanted to tell somebody, and because I couldn't find the right location, and because it was a compulsory box, and there was no 'other', I couldn't submit it, so I ended up writing a letter instead (Focus group 2)

More importantly, junior doctors highlighted a mismatch between the purported purpose of incident reporting systems, and the nature of things they had concerns about. The types of concerns that junior doctors wanted to report related to issues such as problems with staffing, clinical roles and local systems; omissions or things that had not been done; or minor problems that had the potential to generate risks to patient safety. These types of concern were difficult to fit into the mandatory categories required to submit an online report. One specific issue related to the fact that the structured forms required users to identify specific persons involved in the incident, and this was seen as incompatible with concerns that related to systems and roles.

[Incident reporting system] does ask you to put names on I think about who was involved in the incident. Patient safety issues normally [involve] something that hasn't happened. As in [...] that nurse didn't do it or it that HCA didn't do it. [...] I'm not saying anything about that HCA but there's something to do with their role that meant they couldn't do it. (Focus group 1)

Lack of evidence of impact of reporting

Participants also expressed uncertainty about the effectiveness of formal reporting of concerns about safety. This was not because reporting was seen as ambiguous in principle, but because existing practices and mechanisms provided junior doctors with little feedback. This meant they could see little evidence that formal reporting had any impact on improving safety. Uncertainty about the effectiveness of formal reporting systems weakened their willingness to invest time and effort in reporting in the first place.

Any time that I have tried to report any concerns via the incident form reporting, [...] it takes forever, [...] then it seems to disappear into the ether. So it makes you feel - what is the point of spending an extra hour, two hours after work to submit forms when nothing ever happens? Or if it does you don't hear anything about it (Focus group 2).

Speaking out and up

When junior doctors had concerns about patient safety that they wanted to raise, they often chose to deal with these concerns by speaking out or speaking up.⁽¹²⁾ raising the concern informally with peers or with a senior member of staff. Junior doctors felt that speaking about their concerns was more effective than using formal reporting systems as it meant (near) real time reporting. Directly raising concerns with others was seen as being more likely to result in immediate and visible action in dealing with safety issues. Resolving a safety concern through this route meant, however, that once junior doctors had spoken, they saw little need to formally report their concerns. This was reinforced by perceptions that

the prevailing medical culture tended away from formal reporting of concerns. Therefore, this intelligence was unlikely to reach higher levels of the organisation.

I prefer talking to people directly anyway so I'll talk to the consultant who it was related to or who was in charge rather than filling in [incident report form], because they get so many, they get such a high volume and I don't see them being used in a meaningful way. (Focus group 2)

I feel like my consultants in particular would rather keep issues 'in house' as it were. [...] Deal with it within that ward area rather than highlight it to a higher level. (Focus group 3)

Engaging junior doctors in reporting concerns

Culture change

Participants felt that engaging junior doctors in formal reporting of concerns required significant culture change. Early education of junior doctors about reporting concerns, supported by the buy-in of senior staff in the workplace, was seen as critical for achieving this.

It's got to be part of the induction so it's integrated into the culture [...] so all new doctors have to know about it. I think you really need to get consultants on board as well to start, making it part of the ward round and say 'come on', accost us to fill it in (Focus group 1)

Improving reporting systems

Improving the design and operation of the reporting system was also seen as key. Participants argued for a system that was quick to use, more user-friendly and flexible, and less constraining in terms of what they had to include in their report, to enable reporting of a more diverse range of concerns. They suggested that there would be value in junior doctors having allocated time to report safety concerns. They also felt strongly that having the option of secure access to the reporting system outside of the ward environment would be beneficial, both to avoid feeling under scrutiny from other staff when completing a report, and to enable them to fill in reports in their own time.

Actually to be able to do it at home.[...] You don't want to stay late after work to fill them in, and a lot of the time you just don't have time to do it mid-shift. (Focus group 3)

Anonymity

Although they recognised that enabling anonymous reporting of concerns was important, there was evidence that they were less worried about the potential consequences of reporting concerns about patient safety, as compared to incidents and adverse events.

[It's] not supposed to be waiting until it gets to a severe stage, it's supposed to be about identifying problems earlier on, it's not supposed to be about naming and shaming [...] I don't really need to be anonymous for that. (Focus group 1)

Evidence of impact

A significant theme in discussions was the need for evidence that reporting concerns through formal reporting systems was worthwhile: junior doctors wanted feedback to confirm that their concerns were

being listened to. This didn't mean that they expected a personal response for every report they made, except perhaps in the case of a serious adverse event. Instead they recognised that the value of gathering broader information about concerns was that the organisation would be able to detect and act on patterns of concerns; feedback about these patterns, with evidence that they were being addressed, was seen as sufficient to assure them that their reports were having an impact. They also argued that their need for feedback would lessen if reporting and responding to concerns became embedded within the organisation.

Possibly having some kind of tally on you know, number of incidents reported this month. So you somehow know that actually it's not just you reporting it. There have been 50 issues raised this month about staffing. (Focus group 3)

If it is easier and we are reporting less significant things, because it has become part of our culture, then we won't need such a big long explanation about what's been done (Focus group 1)

Learning from concerns

Finally, participants also wanted to see information on concerns being fed back and used actively inform improvements in care, and as a learning opportunity for frontline staff to, for example through discussion in meetings such as the regular mortality and morbidity meetings and education sessions.

There are a lot of parts that could be really improved.[...] Maybe there could be a monthly forum or well somewhere where these would be discussed, [...] it would be like 'this was a problem, this was a problem, this was a problem' (Focus group 1)

DISCUSSION

This qualitative study found that junior doctors were supportive of playing a role in helping healthcare organisations become more aware of risks to patient safety, but barriers included: a lack of role-modelling and senior leadership for formal reporting; a mismatch between the types of concerns they wanted to report, and the design of incident reporting systems; and a lack of evidence that their reports were being used to improve patient safety. Junior doctors felt that raising concerns informally to peers and seniors was more effective than formal reporting. Junior doctors highlighted the need for better education about reporting concerns, role-modelling and leadership, and the development of more effective mechanisms for feedback, in order to encourage them to engage in reporting their concerns about patient safety.

Our study identifies some practical recommendations for improving the design and operation of formal reporting systems to facilitate reporting of concerns by junior doctors. One key lesson is the need to avoid making forms onerous and restrictive; this was a significant deterrent to reporting concerns. Forms should be designed to be short and quick to complete, avoiding the use of pre-set answers, drop-down boxes and compulsory fields as far as possible. Making time available during clinical shifts to report any concerns about patients safety (in tandem with other educational activities), and exploring means of making reporting systems accessible to junior doctors outside of the training establishment may also facilitate reporting. Our study also highlights the importance of ensuring that junior doctors

can see that their concerns are being acted upon. Evidence suggests that when patient safety incidents are reflected upon and used as an opportunity to learn and improve care in a non-threatening way, this increases levels of reporting.⁽¹³⁾ Alongside improving the design of reporting forms, healthcare organisations need to develop systems to feedback information about reported concerns and actions taken in response, and to develop ways of sharing learning from concerns across the organisation.

Our research has also highlighted the importance of recognising that junior doctors may use a range of strategies for raising concerns. This concurs with findings from other staff groups suggesting that staff often choose informal channels to raise concerns.⁽¹⁴⁾ The implication of this is that intelligence about concerns may not always reach higher levels of the organisation. Formal reporting systems may need to be complemented by other approaches to gathering soft intelligence about concerns that arise in day-to-day work. This might include running informal forums that provide 'safe spaces' for groups of staff to share and collate concerns that have arisen in day-to-day work.

Junior doctors at the start of their career are in the position of developing habits and attitudes that they will take forward with them in their career as doctor, and this provides a window of opportunity to promote the development of positive attitudes towards reporting concerns. This is important in terms of individual doctors' willingness to engage in reporting about patient safety concerns throughout their future career, but also in their role as future leaders and role models for others. Healthcare organisations can support the development of positive culture, attitudes and practices around reporting of concerns by junior doctors by integrating messages about reporting into local induction and education, ensuring clarity about local reporting policies, and promoting the buy-in of senior staff. The responsibility does not, however, rest solely with individual trusts and healthcare organisations. Education about patient safety and reporting of concerns needs to be embedded throughout training from early medical school through to postgraduate curriculae, in line with WHO recommendations.⁽¹⁵⁾ It is essential that Medical schools, Postgraduate Deaneries and NHS trusts facilitate formal and experiential training for junior doctors to become aware of their professional duties in relation to reporting safety concerns, and to be confident in accessing and using local reporting systems.

The contextual factors identified in this study resonate with other research into barriers to incident and error reporting by medical staff, which has identified organisational culture and climate, procedures around incident reporting and feedback, and a need for education about patient safety and raising concerns, as critical factors.^(16,17) Interestingly, although fears about consequences for oneself and others have been identified as barriers to incident reporting,^(8,9,17) in our study we found that junior doctors felt less threatened by the idea of proactive reporting of safety concerns as compared to incidents and errors.

Many of the barriers faced by junior doctors are likely to be shared by staff in other roles, in particular, challenges arising from the design and operation of formal reporting systems. Other issues such as senior leadership and role-modelling are likely to be particularly pertinent for junior doctors, because their learning about how to be a doctor – what the role involves, the expected attitudes and behaviours – draws heavily on their observations of others in more senior roles, and their experience of local cultures (often described as the 'hidden curriculum'⁽¹⁸⁾). Also, it may be particularly challenging to

involve junior doctors in identifying patient safety concerns, and to ensure they receive feedback, given their short periods of rotation in different areas of the hospital.

This study adds to previous work⁽⁸⁾ by focusing on attitudes to reporting concerns about safety, not just incidents. There is growing recognition that improving patient safety requires more than a reactive approach to mistakes. Monitoring of patient safety concerns, as well as incidents, can allow healthcare organisations to act proactively to prevent errors and harm occurring, and can generate a deeper understanding of the local organizational influences and preconditions which may present risks to patient safety.^(19,20) This study highlights issues that need to be considered if healthcare organisations are to be able to gather the valuable intelligence that junior doctors hold about risks to safety and weaknesses in systems.

The study is limited by its scope, in that it draws on a small sample of junior doctors. The response to the initial invitation to participate in focus groups was relatively low. Although we do not have data on reasons for not participating, the low response may be due to the sensitive nature of the topic, and it is possible that the junior doctors who attended focus groups were particularly interested in the issue of reporting concerns. The doctors included were in the pre-resident grades FY1-CT2; senior doctors were not included. Junior doctors were recruited from a single NHS trust, but the incident reporting system used in this Trust is typical of systems widely used across the NHS. Focus group participants were also invited to discuss experiences relating to reporting concerns in other organisations in which they had worked.

This study identified features of the design and operation of formal reporting systems that could be barriers to reporting concerns. Further research is required to develop improved reporting systems, and to evaluate whether implementing a well-designed system with mechanisms for feedback can successfully engage junior doctors in reporting diverse concerns about patient safety. Our study also identified the importance of role modelling and senior leadership in encouraging reporting; there would be value in further research to explore how to engage senior staff in supporting junior doctors to report concerns.

CONCLUSIONS

In this paper we focused on junior doctors' attitudes and experiences of formal reporting of patient safety concerns, and how this could be facilitated. Although improving the design of reporting systems is likely to be important, this study has found that barriers to reporting cannot be solved by a simple technical fix. Reporting systems are nested within a broader socio-cultural context which influences the willingness of junior doctors to report their concerns about patient safety through formal reporting systems. If healthcare organisations are to be able to benefit from junior doctors' insights into risks to patient safety there is a need for education, local leadership, organisational commitment to acting on concerns and feeding back, and an appreciation of how formal reporting is positioned in relation to other strategies for raising concerns.

MAIN MESSAGES

- Junior doctors are supportive of playing a role in identifying concerns about patient safety
- Barriers to reporting concerns include a lack senior leadership and role modelling, the design of existing incident reporting systems, and a lack of evidence of positive outcomes from reporting.
- Encouraging reporting of concerns requires attention to the features of reporting systems, as well as the wider socio-cultural contexts in which they are embedded

CURRENT RESEARCH QUESTIONS

- Can a well-designed system with mechanisms for feedback help engage junior doctors in reporting concerns about patient safety?
- How can education providers promote engagement of junior doctors in reporting concerns about patient safety?
- How can senior medical staff be engaged in supporting junior doctors to report concerns?
- Will gathering intelligence about junior doctors concerns have an impact on patient safety within healthcare organisations?

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Ethics approval Ethical approval for the research was obtained from the University of Leicester Ethics Committee (July 2013).

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Box 1 Postgraduate medical training in the NHS

The current structure of postgraduate medical training in the English NHS consists of a three step hierarchy: Foundation Doctor – Specialty Registrar – Consultant. Foundation Doctors undertake a two-year, general postgraduate medical training (FY1 and FY2). Specialty Registrars in a hospital specialty train for a minimum of six years. This study recruited pre-resident junior doctors within four years of qualification, up to CT2 grade.

Box 2 Focus group topic guide

1. How do you feel about reporting concerns about quality and safety?

How do you feel as trainee doctors about the idea of having a system for feeding back concerns about quality and safety to the Trust?

What would be the benefits?

What barriers and difficulties might there be?

Is it always clear when something is a matter of concern? How would you decide what to report? How 'severe' does a concern have to be?

What barriers are there to reporting?

What would encourage junior doctors to engage with reporting concerns?

2. What do you think about the draft tool?

3. How would it work? What would be the features of an acceptable and effective reporting system?

- Format (e.g. the feasibility and acceptability of electronic methods of reporting, including online and text reporting);
- views on relying on proactive reporting vs requesting feedback from all trainees on a regular basis;
- how and when the tool could be completed;
- how often the tool should be completed.

What information & guidance would you need (e.g. instructions on how to complete it and what to report, who will see the reports, what will happen as a result of reporting)?

4. What sort of feedback would you like?