

Faculty development: Mistakes and managing unintended consequences

Dr Laura Havens, Clinical Teaching Fellow, NHS Lanarkshire Dr Catriona Neil, ST5 in Learning Disability Psychiatry, NHS Lanarkshire

INTRODUCTION

Learning from mistakes in clinical practice can be a powerful force for change (1). Simulation based educators support participants to develop their clinical practice through reflecting on mistakes within a facilitated debrief (2).

Here we describe a pilot educational intervention, using group discussion, to open conversations about mistakes that occur during simulation.

AIMS

We aimed to establish:

- If group discussion represents a useful learning environment for this
- If faculty development on this topic increases openness to discussing mistakes
- If discussion of mistakes leads to changes in simulation faculty practice

METHOD

Simulation based educators with varying backgrounds and experience were invited to two small group discussions.

Written feedback was collected pre and post session. The session outline:

- Introduction and ground rules to support psychological safety.
- A group member shares a personal experience of an unintended consequence whilst facilitating simulation.
- The whole group then explores this, sharing their own perspectives and experiences.

In total 11 individuals attended the sessions. Over 50% of individuals had less than a year of simulation facilitation experience, with 36% having between 1-5 years experience, and 9% with over 10 years experience.

Key results:

- The greatest change post session was seen in average • agreement that individuals learn from others' mistakes.
- Individuals also showed an average increase of 0.3 in agreement that they learn from their own mistakes.
- Post session, average agreement with discussion of mistakes being uncomfortable reduced by 0.5.
- There was an average 0.1 increase in individuals' \bullet agreement that mistakes are something all faculty experience.
- The average agreement rating that making a mistake was an upsetting experience reduced by 0.2 post session.

- The average agreement with intention to discuss mistakes with colleagues increased by 0.3 after the session.

CONCLUSIONS

- creating space for regular discussion of perceived • mistakes with colleagues to support learning.
- developing techniques to ensure learners' psychological safety.

RESULTS

Fig 3. Free text answers to "What will you take away from the group discussion today?"

All attendees reported benefit from the session. Planned changes in practice included:

- Appreciating the complexity of group dynamics.
- As educators is it time we fully embrace the power of mistakes?





Fig 1. Average agreement with the statement "I have learnt from others' mistakes"

"We all make mistakes no matter how experienced we are" "Start thinking about sharing mistakes and experiences" "A safe space to share experiences and learn" "Encourages reflection on mistakes"

REFERENCES

Tabrizi NM, Masri F. Towards safer healthcare: qualitative insights from a process view of organisational learning from failure. BMJ Open [Internet]. 2021 Aug 1;11(8):e048036. Available from:

http://bmjopen.bmj.com/content/11/8/e048036.abstract

Palominos E, Levett-Jones T, Power T, Martinez-Maldonado R. Healthcare students' perceptions and experiences of making errors in simulation: An integrative review. Nurse Educ Today [Internet]. 2019;77:32–9. Available from:

https://www.sciencedirect.com/science/article/pii/S0260691718 30577X



Fig 2. Average agreement with the statement "It can be uncomfortable to discuss mistakes"

ACKNOWLEDGEMENTS

- Kirsty Freeman, James Tiernan, Bec Szabo and Susan Eller who ran the workshop 'Don't waste a good mistake, learn from it' SESAM 2023 who inspired this work.
- Catie Paton, Associate Director Medical Education, NHS Lanarkshire – for her support of the project.

CONTACT INFORMATION

laura.havens@lanarkshire.scot.nhs.uk