

(4). There are few studies of multicomponent interventions involving motivational POPDs and directional signs (e.g. footprints) in UK workplaces. We found a simple, inexpensive multicomponent intervention comprising motivational POPDs and floor-based directional footprints produced significant increases in stair use in a UK office building. The relative increase (82%) was much greater, and the absolute increase similar (11.8%), to previous studies (2). Journeys were over twice as likely to be taken using the stairs post-intervention. This simple effective intervention has potential for use in other buildings.

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Ethical Approval: This study did not require Research Ethics Committee approval as it was an evaluation of a service change. We reached this decision using the Health Research Authority decision aid (<http://www.hra-decisiontools.org.uk/research/>). We assessed that we did not need to obtain informed consent because we did not collect any identifiable information about individuals. The study was approved by the Public Health Agency Staff Health and Wellbeing Group and the Public Health Agency Management Team, which provided corporate oversight and governance.

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PATIENT SAFETY INCIDENTS AMONG FOUNDATION DOCTORS

Editor,

Unfortunately, patient safety incidents (PSI) occur in our complex health care systems. These can have a negative effect both on the patient and the doctor involved.^{1,2} Apart from the usual feeling of guilt, doctors also experience problems with job satisfaction, their relationship with colleagues, depression, inability to sleep, fear of going to work and low self-esteem.^{3,4} There is limited data on the extent of this problem, especially among junior doctors. Getting support after errors may be difficult for senior physicians, let alone for junior ones. There is data to suggest that discussing such events with supervisors giving constructive criticism leads to better doctor outcomes.⁵

Times during when Patient Safety Incidents Occurred

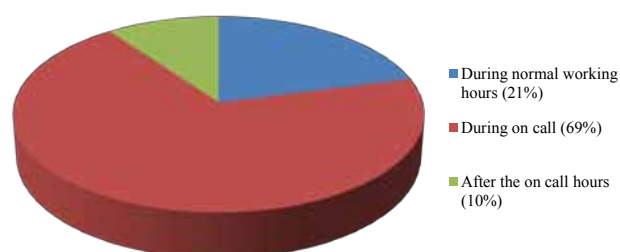


Fig 1. Time of PSI occurrence

The aims of our study were to determine how often foundation doctors are involved in PSIs and which are the most common incidents. An anonymous online questionnaire was distributed amongst Foundation Doctors working within the Malta and Severn (UK) Foundation schools, and 140 doctors completed the survey. There were no differences in the results between the 2 schools. Involvement in at least 1 PSI occurred in 58.5% of doctors. The remainder, (41.5%) claimed that they were never involved in such an event.

In most cases (48.9%), the PSI was identified by the doctor performing it. Doctors expressed different reactions after such events including; concern about the patient's health (25.6%), need for self-improvement (24.2%), disappointment (17%), shame (13.5%), guilt (12.5%) and desire to quit (4.9%). Only 1.35% did not demonstrate any apparent concern. The time of occurrence (Figure 1) and the type of PSI's (Figure 1) are demonstrated below.

In terms of learning events, 31.2% noted the importance of good communication between doctors and patients, re-confirming patient identity prior to any intervention (27.7%), the need to give more attention to clinical practice guidelines (22%), re-check drug allergies (9.9%) and check blood results thoroughly (9.2%).

In 80.8% of PSI's, doctors claimed there were no patient consequences. The rest did not give any answer. They considered fatigue (57.7%), time restriction (49%), doctor



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–doctor (12.5%) and doctor to other healthcare professional miscommunication (22.1%) as possible reasons for such events. Furthermore, 86.1% of those involved in a PSI, thought that it was avoidable.

The majority of doctors (67%) claimed that they had not been trained in how to communicate effectively when it comes to apologising. The remainder (33%) claimed that they feel confident to communicate effectively when it comes to apologising.

Types of Patient Safety Incident

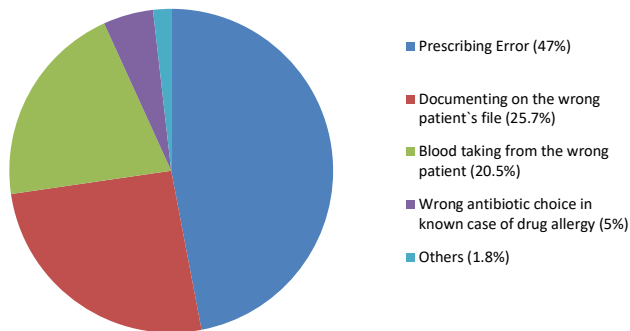


Fig 2. Types of Patient Safety Incident

Support and advice from a more experienced person was required in 74.2% of cases, with 26.7% of them mentioning that they would benefit from psychological support after a PSI.

This data demonstrates that most junior doctors experience emotional distress following PSIs. Formal training in communication skills, disclosure of information and the offer of counseling with therapists and physicians (including Lead Physicians) with personal experiences of medical errors could be provided to help doctors understand how to cope well after such events. Ineffective coping strategies may be adopted if doctors are provided with inadequate support and thus become the “secondary victims” of such events.

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VOLAR DISLOCATION OF THE FIFTH CARPOMETACARPAL JOINT

Editor,

A 25-year-old right-handed housewife presented with severe left hand pain resulting from a fall from standing height. Tenderness and swelling was present over the ulnar side of the injured hand and the little finger appeared foreshortened. No neurological deficit was noted. Radiographs of the injured hand demonstrated a volar–ulnar dislocation of the 5th metacarpal base (Figure 1 panels a and b). Under general anaesthesia, closed reduction and percutaneous wire fixation restored congruence and stability to the dislocated 5th carpometacarpal (CMC) joint (Figure 2). Six weeks post-surgery the wires were removed and hand therapy initiated. Clinically, the patient's left 5th CMC joint was stable and radiographs demonstrated joint congruency. The patient regained full function of her injured hand within 6 months.



Fig 1. (panels A&B): Posteroanterior radiograph (a) demonstrating dislocation of the 5th CMC joint with loss of convergence of the metacarpal cascade lines (4 white lines – only 3 converge); true lateral radiograph (b) demonstrating anterior displacement of the 5th metacarpal base (white arrow).

CMC joint dislocations most commonly involve the 5th CMC joint and are usually dorsal.¹ Isolated volar dislocation of the 5th CMC joint is a rare injury with sporadic cases reported in the literature.¹ The injury is thought to result from a direct blow transmitted to the dorso-ulnar aspect of the 5th metacarpal base resulting in disruption of the supporting peri-articular soft tissues.² The deep motor branch of the ulnar nerve lies volar to the 5th CMC joint as it courses around the hook of the hamate and is vulnerable to injury in volar dislocations.³ A careful neurological assessment of the injured hand is therefore essential.