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National Learning Report

Support for staff following patient safety incidents – supplementary materials

Independent report by the
Healthcare Safety Investigation Branch I2020/015b

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Contents

Introduction to supplementary materials

These supplementary materials complement HSIB's national learning report **'Support for staff following patient safety incidents'**. They should be referred to when reading the report. The national learning report is available via HSIB's **website**.

1 Specifics of the scoping review

HSIB was keen to discover which interventions have been tried in healthcare to support staff after patient safety incidents and understand their impact. A previous systematic review on supportive strategies for healthcare staff was identified exploring the literature published up to September 2010 [1]. To establish how the field has developed since 2010, a scoping review was undertaken by HSIB to explore the literature.

1.1 Approach to the scoping review

A scoping review was undertaken following a recognised approach [2]. The following question was formulated: 'what interventions have been developed to provide support to healthcare staff following patient safety incidents and what has been the impact of these interventions?' and a protocol was developed.

The review included work about interventions in support of healthcare staff after patient safety incidents, immediately following an incident or during subsequent investigation. All papers published from 2010 until March 2020, written in English and with full texts available were included.

The bibliographic database Medline (Ovid) was searched using a developed strategy. Grey literature (that is, material published outside of traditional academic routes) was identified using Open Grey and an appropriate search engine using strings of words.

Three HSIB reviewers were involved in the review. They undertook a collaborative review of the literature to identify full texts for inclusion in the final review. Any literature rejected following full text review was discussed between all three to reach consensus.

1.1.1 Selection of literature

The original search yielded 2,636 potentially relevant citations. After removing duplicates, screening and review of full texts, 24 research papers, reviews and editorials met the eligibility criteria and were included in this review. A further 19 research papers, reviews and editorials were included following searches of reference lists, review of full texts and grey literature. HSIB felt saturation was reached. The search strategy can be seen in table 1.

Table 1 Search strategy in Medline (Ovid)

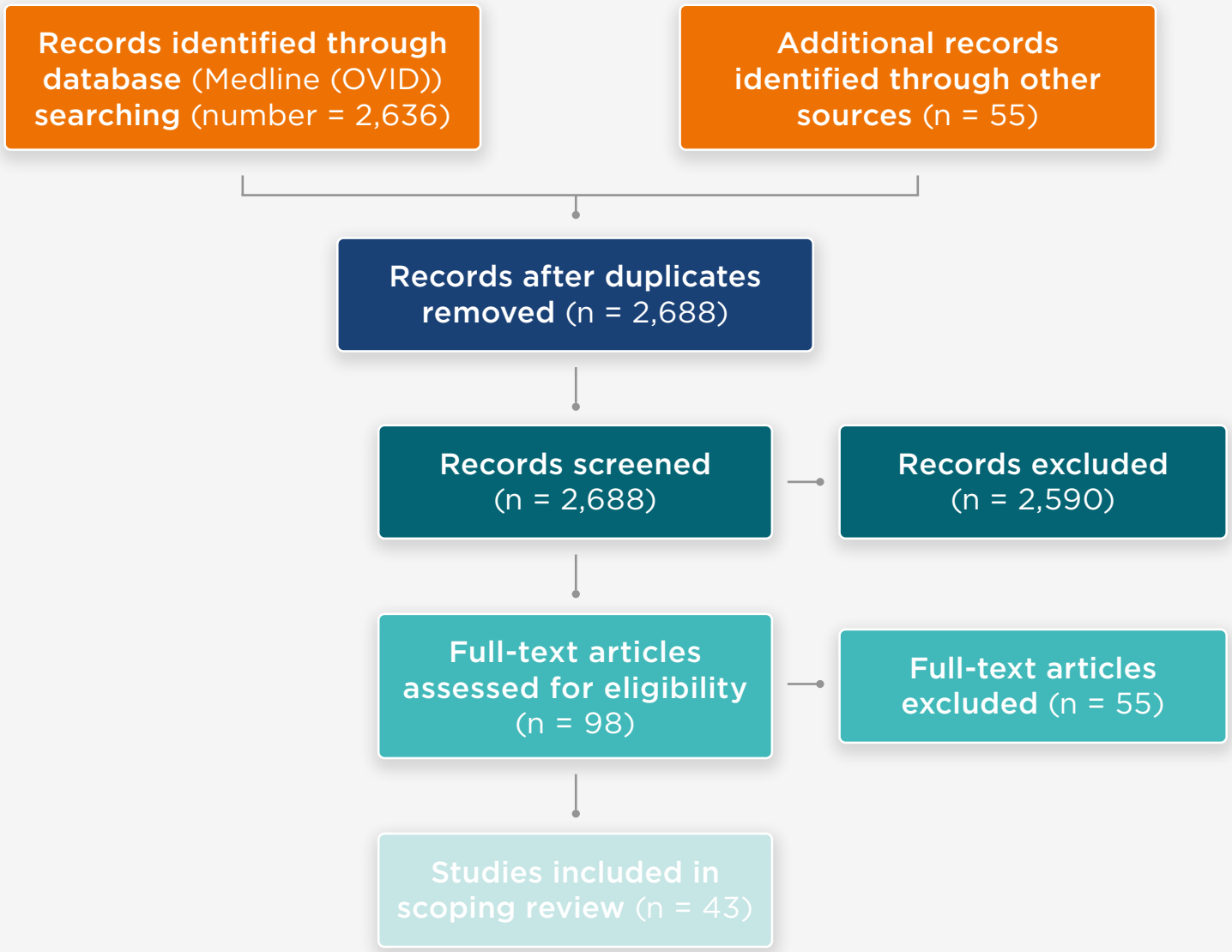
1	Exp Health Personnel/
2	"Second victim".mp.
3	victim.mp.
4	1 or 2 or 3
5	Exp Patient Safety/
6	incident.mp.
7	Exp Medical Errors/
8	5 or 6 or 7
9	support.mp.
10	wellbeing.mp.
11	9 or 10
12	4 and 8 and 11
13	limit 12 to (abstracts and English language and yr="2010 – 2020")

1.2 Literature characteristics

The 43 papers included in the review (see figure 1) were published from 2010 onwards; seven were from 2019/20. There were 33 original research studies, six reviews and four editorial papers. Papers originated from all over the world, but most commonly from North America. Most papers considered support within hospitals. Only two papers specifically explored primary care contexts. A small number of papers looked specifically at specialties such as midwifery, paediatrics, surgery, pharmacy and radiotherapy.

Data extracted included: country of origin, population and context of focus, details of the intervention and impact of the intervention. Limitations of the literature were also considered, but a formal assessment of the quality of the evidence was not undertaken.

Fig 1 Papers included in the scoping review [3]



2 Specifics of the interviews and focus groups

2.1 Approach

HSIB employees in the national investigation programme were approached as a purposive, selective sample for interviews or focus groups. The interviews were semi-structured and were facilitated by four employees from HSIB's Intelligence Unit. An appreciative inquiry approach was taken meaning that the focus was on good practice around staff support, rather than flaws.

The facilitators had extensive experience of working within healthcare and of using qualitative interviewing techniques. Interviews and focus groups were undertaken face to face initially, but then remotely during COVID-19, and lasted between half and one hour. They were audio recorded with consent and transcribed for thematic analysis.

2.2 Analysis

A standard approach to thematic analysis [4] was undertaken by two employees from HSIB's Intelligence Unit (the reviewers). Both reviewers had facilitated the interviews and focus groups and had experience of working with qualitative data. A commonly used thematic analysis software programme was used [5].

The reviewers initially familiarised themselves with the transcripts from the interviews and focus groups and generated initial themes using the question structure from the interviews/ focus groups. A collaborative approach was taken to ensure consistency and any discrepancies were rectified.

The draft themes were presented internally to the Intelligence Unit and investigators. This provided an opportunity to review and challenge the themes. The final coding framework is available in table 2.

2.2.1 Interviews/focus groups undertaken

HSIB's project team undertook 10 interviews and 3 focus groups during March to June 2020. In total 22 HSIB employees involved in the national investigation programme took part as participants. The project team believe that data saturation was reached meaning that no new information was identified by the end of the interviews/focus groups.

2.2.2 Interview and focus group questions

1 Please share an experience you have had, during a HSIB investigation, where local staff have (in your opinion) been supported well by their local organisation. What made it a good example of support?

2 What do local organisations do well?

3 What, in your experience, are best practice principles for local organisations in support of their staff during a patient safety investigation?

4 What experiences of best practice can you bring from other organisations outside of healthcare?

5 What do you think staff value most in the way of support by their local organisation, during a patient safety investigation?

6 If we were to meet again in one year, how would you like to have seen support for staff by their local organisations evolve over that time?

7 What little things could be done to improve staff support at a local level?

8 What are the big things that would make a difference at a local level?

Table 2 Coding framework in Nvivo [5] for thematic analysis

1	**The case for staff support**
2	**Definitions**
	Support
	Victims
3	**Examples of support in healthcare**
	Negative cultures in healthcare
	Organisational safety culture
	Professional cultures
	Positive examples from healthcare
	Support during investigations
	Support following events
	Counselling service
	External systems
	Immediate aftermath
	Managers and individuals
	Organisational support programmes
	Peer
	Symbols of caring
	Just culture programme
	Wellbeing hubs and service
	Simple things
4	**Principles of effective staff support**
	Culture and leadership
	A culture of support
	Just
	Learning
	Open and trust
	Systems thinking
	Team ethic in it together
	Normalising the need for support
	Appreciate impact on staff
	Leadership
	Empower staff
	Modelling
	Delivery and availability of support services
	Availability
	Types of support
	Before events
	During the investigation

	Further support after events
	Informal v formal
	Organisational structures, for example line manager
	Peer
	Professional or trained
	Resources
	Senior colleague (not line manager)
	Wider support
	Immediately post event
Delivery	
	Provision of support
	Access and always offering support
	Clarity
	On purpose
	What is available
	Confidential
	Dependent on person
	Evaluation
	Structure support programme
	Consistent
	Independent
	Needs assessment
	Support the supporters and training
	Available time
	Resources
	Support for supporters
	During investigation and interview
	Before interview
	Preparation
	During interview
	Accompanying person
	Environment
	Interview technique
	Rapport
	Post interview
	Follow up
	Time after

3 Full findings from the scoping review

3.1 What interventions are being used to support staff in the aftermath of patient safety incidents?

The literature showed that staff support structures are regarded as important in healthcare, but they are often lacking, leaving staff in need [for example: 6, 7]. There may also be an unmet need within specific staff groups, for example, doctors [8, 9] and in particular settings, for example, primary care [10, 11].

Support services can be formal or, more commonly, informal [12], proactive or reactive [13], and internal or external to organisations. There are multiple different examples of support available to staff which can be grouped into services, coping strategies, professional changes after adverse events and learning from adverse events [12]. Support services include peer or colleague support, emotional first aid, counselling, debriefing, team meetings, and employee assistance programmes (see figure 2 in the main report). Many organisations might report that they have a support process and protocol in place, however, this does not necessarily mean it is effective [9, 15–18]. Staff may also not always be aware of the available support services.

3.1.1 Peer support

A peer or colleague is the most common source of support discussed in the literature [8, 9, 12, 15, 16, 19–36]. Several examples of peer support programmes were found [8, 22, 24, 25, 28, 30, 32, 33] which often involved a curriculum for training of multidisciplinary peer supporters. Training is required to equip peer supporters to provide support [23].

Peer support offers a chance to reflect in a safe, confidential environment with colleagues. Helpful actions during peer support included active listening, being sensitive, and not validating anger [35]. Peer support programmes were thought to be more effective when available 24 hours a day, seven days a week and proactive in approaching people to offer support [9, 33]. Effective supporters ensure they are not undermined by blame or gossip [37, 38]. This peer or informal emotional support approach seemed to be preferred by staff [6, 12, 15, 16, 19–21, 24, 26–28, 30, 32–34, 39–41].

3.1.2 Other forms of support

The literature did identify other forms of support available to staff after incidents, but to a much lesser degree. Emotional or psychological first aid, for example, was thought to have potential application and benefit [42]. Debriefing of staff after

significant events was considered by a number of papers [14, 15, 31], with a keenness for prompt debriefing [15]. The concept of debriefing was not specifically explored in the scoping review, but is understood to be controversial.

Other support interventions such as counselling and employee assistance programmes (often private, external programmes to support staff with personal problems) were mentioned across different studies but not formally explored by the literature. In respect to counselling, a number of studies found this one of the less desirable options for staff [15, 21, 27, 40], as was the employee assistance programme [27]. Other simple interventions such as releasing staff from duties after events were also identified [38], although was not for everyone [15].

The investigation process itself can also be thought of as a potential support process. It can be therapeutic to help staff get a sense of perspective and be involved with safety improvements [13, 15, 35]. The investigation process must be timely, transparent, provide feedback and be undertaken within a just culture [34].

Papers also considered a more proactive approach to support with education around resilience and preventative programmes [11, 14, 20, 31]. Mira, Carillo et al developed a website to help explain the affect incidents can have on staff [11].

Finally the safety culture of organisations was discussed in a number of papers [41, 43, 44]. Ensuring an environment that promotes effective support by leaders and fosters a just response to incidents shows a commitment to support staff after patient safety incidents.

3.1.3 Organisational support structures

A number of studies described organisational support structures which provide more than just peer support [29, 31, 45] and available toolkits to help develop these structures [31, 33, 46]. Van Gerven et al explored the content of organisational level support systems in their country [17] against the international resources for staff support [31, 47] and found that often structures did not include vital elements of those resources.

Mcdonald et al described their pillars for responding to patient safety incidents which encompass identification and provision of support including peer support, individual and group employee assistance and fitness to work assessments [29].

Scott et al described their rapid response team which was developed after identifying the support needs of their staff. They developed the structure to include emotional first aid, trained peer supporters and access to chaplains, employee assistance programmes and psychologists [31].

3.2 What is the impact of these interventions?

Timely and effective support for staff after patient safety incidents helps to salvage something from a potentially negative experience [35]. Staff generally find support services useful when they are available [39].

3.2.1 Peer support programmes

There has been limited formal evaluation of the impact of peer support programmes on individuals and organisations [6, 18, 31].

Studies have addressed measures such as usage and the perceived value of the programmes [10, 15, 19, 20, 22, 25, 46] and perception of therapeutic value [35, 36]. Some studies are also limited by the small number of staff involved [for example: 28].

A few studies have assessed the impact on staff and organisations of peer support programmes. Winning et al found that peer support moderated the association between experiencing an event and anxiety and depression [36]. Merandi et al described improved emotional states and return to work metrics, but this was not explored further in the paper [30].

Peer support programmes may also impact in other ways such as improving individual contribution to changes after incidents and organisational changes to reduce recurrence [35], as well as perceived improvements in departmental safety culture [25].

One study also identified no association between having an organisational peer support programme or guideline in place and the impact of and recovery from the event [18].

3.2.2 Other support services

There was more limited exploration of the impact of other support interventions in the literature. It should be noted that debriefing approaches were not specifically searched for and there will be extensive literature surrounding this, much of which highlights controversial views on its benefits.

Blacklock explored the use of a critical stress debriefing model [48] after staff suicide [14]. They found their model had highly favourable feedback showing that it was beneficial and the cost to the system was negligible. Evaluation was limited to one incident, but staff who reported being affected by the incident early after its occurrence were symptom free after a three-month period.

Beyond the support services themselves, getting the culture right in an organisation is important. Nonpunitive responses to error and a leadership commitment to support staff may be associated with reductions

in staff distress [41, 44] and supports the implementation of programmes [25]. The support programmes themselves may also improve safety culture [45].

The review also noted a tool to assist organisations to implement and track the performance of support resources for staff called the 'Second Victim Experience and Support Tool' (SVEST) [21]. SVEST has 29 items corresponding to seven dimensions and two outcome measures. The seven dimensions are: psychological distress, physical distress, colleague support, supervisor support, institutional support, non-work-related support and professional self-efficacy. The two outcome measures are turnover intentions and absenteeism.

3.3 Barriers to accessing support

While not the focus of the literature review, a number of papers helped explore barriers to the use of staff support services after patient safety incidents. There were multiple perceived barriers associated with utilising them. These included confidentiality and efficacy of the programmes, and judgement by colleagues [9, 23, 25, 26, 43]. Some of these concerns were found to be longstanding [9] and show that even when support services exist, staff might not access them [26, 43]. In certain countries there are also wider concerns around risks of legal disclosure of contents of discussions in support sessions [49].

3.4 Addition of other literature

Grey literature refers to information and materials produced outside the traditional academic publishing routes, including by government agencies and academic institutions. Six grey publications and 16 websites relating to staff support were explored further.

3.4.1 Grey publications

Internationally there is a desire for organisations to better support staff after incidents. The United States Joint Commission, a body that accredits healthcare organisations and programmes, urged organisations to take actions to support staff [50]. This includes instilling a just culture, leadership commitment, executive champions, engaging teams in debriefing, offering of peer support and evaluation of employee assistance programmes. This needs to be undertaken with appropriate governance arrangements and protection of confidentiality.

Conway et al from The Institute of Healthcare Improvement described key considerations in the aftermath of incidents, which include ongoing support for the healthcare team and consideration of when they are safe to return to

work. Staff should also be invited to participate in investigations as this promotes learning and healing, while exclusion promotes blame [47].

The Canadian Patient Safety Institute described how to create a safe space to address the psychological safety of healthcare workers and that peer support programmes often remain isolated pockets of excellence [51]. They described a variety of peer support programmes and proactive education tools, some of which were considered in the literature review. They described peer support as the provision of non-clinical emotional support to health professionals who are experiencing emotional distress. A peer support programme needs a strong organising team, a clear goal, support from the organisation and a process for implementation.

Publications identified examples of the development of staff support programmes. This included a UK-based pilot project utilising the three-tiered model described by Scott et al (2010) which involved training a network of peer supporters and which was valuable, helping staff who accessed it [52]. This project also identified the importance of ongoing training and support of the peer supporters themselves via internal counselling services.

Further examples of toolkits being developed to support institutional support included the Royal College of Emergency Medicine [53] and the University of Missouri Health System forYOUteam [54]. Both are based on the Medically Induced Trauma Support Service (MITSS) (see below) [55].

3.4.2 Websites

A variety of websites explore the impact of adverse events on staff. These are predominantly North American and share resources for the support of staff. The North American websites provide links to locally based work, workshops and training around staff support [56–58]. They again highlight the use of peer-to-peer support programmes for non-judgemental discussions as a potentially useful approach [56, 57]. Some of the programmes identified in the literature review have their own websites. The ‘You Matter’ programme [28, 59] has an associated website sharing its approach which includes peer support, a critical response team, stress and resilience, an employee assistance programme and Schwartz rounds. Further toolkits are referred to such as the Communication and Optimal Resolution (CANDOR) process [60] and Adverse Event Response Team (AVERT) development [61].

In the UK, the Yorkshire Quality and Safety Research Group, with the Improvement Academy, has launched an extensive website exploring staff support [62]. This is designed to recognise that staff are not alone and provides insights for managers and organisations about how to develop staff support programmes. It includes case studies of programmes that have been developed in the UK, based on Scott et al's model [31]. It highlights the importance of organisational culture and that there is a need for ongoing research to determine the most effective emotional support for staff. Other work has been undertaken in the Academic Health Science Networks [52]. This has highlighted that staff need support, there needs to be dissemination and communications around programmes, and peer supporters need structured support and ongoing training themselves.

In wider Europe, an example was identified in Belgium of the development of a peer support programme [63], referring to both MITSS and the Institute of Healthcare Improvement work. In many cases the MITSS toolkit [55] has been used to develop programmes locally, as well as the Scott et al model [31].

MITSS was identified as a toolkit considered in several studies in the literature review [for example: 46]. MITSS includes consideration of safety culture, organisational awareness, developing an advisory committee, leadership buy-in, risk management, policies, operational delivery, training of staff, communication strategies and ongoing learning and improvement [55]. Pratt et al describe how MITSS has been downloaded multiple times and is used by several organisations who feel it is useful, easy to navigate and has made positive changes in their institutions [46].

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