Creating a Safe Space

Section 1 : Survey of Healthcare Providers' Perceptions related to the Second Victim Phenomenon

cpsi icsp Canadian Patient Safety Institute
Institut canadien pour la sécurité des patients

This publication is available as a free download from: www.patientsafetyinstitute.ca

The Canadian Patient Safety Institute would like to acknowledge funding support from Health Canada. The views expressed here do not necessarily represent the views of Health Canada.

ISSN 2562-010X

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Thank You

Thank you to patients, providers, operational leaders, regulators and funders for your passion and commitment to improving the safety of patient care and promoting a supportive and psychologically safe work environment for providers. We invite you to share your successes and challenges on this journey.

Disclaimers

This publication is provided as information only. All examples are provided as illustrations. This publication is not to be used as a substitute for legal advice. It is not an official interpretation of the law and is not binding on the Canadian Patient Safety Institute (CPSI).

Foreword

Chris Power, CEO | Canadian Patient Safety Institute

I started out in healthcare with the long-term goal of becoming a doctor. However, in nursing I found a profession that kept me constantly connected to patients and their families. I knew it was where I could have the greatest impact on their lives. I didn't really think much about the impact they could have on mine – especially if someone came to harm while in care. Harm within the healthcare system has such

a real, permanent effect on the lives of patients and their families. And while I speak every day about the consequences of patient safety incidents for patients, only rarely do we talk about the effect these incidents have on providers as well.

The Canadian Patient Safety Institute was established in 2003 as the result of a rallying cry by dedicated healthcare providers working within the healthcare system who couldn't experience one more incident of a patient getting harmed. Patient safety incidents are the third highest cause of deaths in Canada. According to our studies, over the next 30 years, 12.1 million people will be harmed within the Canadian healthcare system.

The Canadian Patient Safety Institute has issued an urgent call to action to demonstrate what works and strengthen commitment to patient safety in Canada. Best practices need to be translated into sustainable, committed standard practices for practitioners and providers at all levels of the health system. And at each level, people need support.

Nurses, doctors, and other healthcare providers are human. When mistakes happen – or when the worst possible outcome presents itself after a procedure – the impact on these care providers can affect their work, their lives, and the safety of their patients. I would have appreciated a non-judgmental, peer-to-peer support program when I was practicing. The questions raised in relation to the confidentiality of peer-to-peer support are well worth discussing.

We hope the conversations already happening around the world about provider support will continue. The ultimate goal for all of us is to build a healthcare system in which every patient experience is safe, and healthcare providers are supported.

The Canadian Patient Safety Institute is proud to partner with the Safe Space Working Group to help make this goal a reality. Let's challenge the status quo together.

An ever-growing body of evidence demonstrates that health professionals feel emotionally distressed after a patient safety incident (PSI)[1-4], and there is an emerging recognition of the potential negative impact on both the health professionals' health[5-11] and on patient safety[12-13]. As a result of this recognition, healthcare organizations are seeking ways to support health professionals who are emotionally traumatized after a PSI.

Creating a safe space

Introduction

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Introduction

Working in healthcare can be emotionally distressing [1-4]. There is a general recognition among both academics and healthcare organizations of the importance of emotional support for healthcare workers, especially because of the very real potential for the profession's negative impact on both the workers' physical and mental health[5-11] and on patient safety[12-13]. As a result of this recognition, there has been an impetus within the patient safety movement and healthcare organizations to find ways to support healthcare workers.

While patients and families will always be the first priority in healthcare, workers also need to be supported as a result of what they experience in their profession. Peer support programs (PSPs), where healthcare workers can discuss their experiences in a non-judgmental environment with colleagues who can relate to what they are going through, are now seen as a useful approach to helping them cope. A number of support programs are emerging in the US and Canada, as healthcare organizations are beginning to recognize that this is an appropriate and valuable service for their staff.

This manual provides a comprehensive overview of what peer support is available in Canada and internationally. Most importantly, it provides best practice guidelines, tools and resources, to assist policy makers, accreditation bodies, regulators and healthcare leaders assess what healthcare workers need in terms of support, and to create PSPs to help them improve their emotional well-being and allow them to provide the best and safest care to their patients.

The components of this manual include:

1. A survey of Canadian healthcare workers: Their views on the experience of a patient safety incident and the support they need. Through a pan-Canadian survey conducted in partnership with the University of Ontario Institute of Technology (UOIT), we sought input from healthcare workers themselves to determine what support they needed and where the gaps were across Canada.

2. Global environmental scan of peer support programs: Report on a scoping review of peer support practices across Canada, the US, and globally, based on global literature research led by the IWK Health Centre. The aim was to gather knowledge from international literature around the world so that we could learn from those who had established or studied healthcare PSPs.

3. Creating a safe space: Confidentiality and legal privilege for peer support programs: This document was informed by a team of lawyers, physicians and a patient advocate who had extensive experience with the issue of confidentiality in healthcare. It is a key resource for organizations who are planning a PSP, as it gives clear explanations about what is and is not privileged information, and how best to strengthen confidentiality.

4. Creating a safe space: Best practices for workplace peer support programs in healthcare organizations: This document was created in collaboration with a team of Canadian healthcare experts in the field of PSPs, whose experience and understanding of how to establish a PSP was vital to developing the comprehensive and informative document. These guidelines provide a step-by-step approach to help healthcare organizations succeed by building leadership support from the beginning, establishing a committed team of healthcare workers to initiate the PSP, clearly identifying the goals of the program and clarifying policies, processes and responsibilities before

the program is launched. The guidelines also make recommendations on how to recruit and train peer supporters and how best to ensure the spread and sustainability of the program.

5. Creating a safe space: Peer support toolkit: We undertook a thorough environmental scan to uncover as much relevant educational and informational material as possible to facilitate the development of peer support programs across Canada. This toolkit is an excellent source of information for healthcare workers, leaders, regulators and policymakers templates, and includes examples and recommendations for anyone who is embarking on creating a new PSP.

CPSI's position

CPSI is committed to improving patient safety in Canada, and does so through a number of initiatives. Each of our endeavours is part of a comprehensive strategy to keep patients safe including the Patients for Patient Safety Canada program, which recognizes the wealth of experience and knowledge members of this program can share to improve patient safety and *Safer Healthcare Now!* interventions. These interventions facilitate the implementation of best practice. We also developed substantial resources with our partners such as the *Canadian Disclosure Guidelines*, *Communicating After Harm in Healthcare* and the *Patient Safety and Incident Management Toolkit,* which provide practical strategies and resources to manage PSIs openly and effectively while engaging patients throughout the process.

This manual is no exception. It is our hope that by fully exploring how best to support healthcare workers, we will contribute to system safety by providing tools and resources to everyone who makes up the system – patients, families, workers and healthcare leaders – that allow them to learn, collaborate and improve care for patients.

The following guiding principles underpin the development of this manual:

1. It is important that healthcare workers have a psychologically safe environment that provides them with an opportunity to speak confidentially to a peer about their experiences:
    - it will help them cope with emotionally traumatic experience; and
    - it will improve patient safety since health professionals will be in a healthier emotional state to care for their patients safely.
2. These support programs are not intended to affect transparency about the facts surrounding patient safety incidents or other distressing events, or to withhold material facts surrounding events from patients and families, but rather to provide a safe space to help health professionals cope with traumatic and stressful events.
3. Those promoting PSPs should be transparent to prospective participants about what can and cannot be kept confidential. This is an important way to align expectations and avoid further negative experiences.
4. Advocacy for, or the establishment of, a PSP does not in any way lessen the importance of reporting patient safety incidents and other events for quality improvement efforts. It also does not diminish the importance of disclosing the facts around the incidents and events to patients and families, and other incident management activities.

Definition of a Peer Support Program

Peer support is a supportive relationship between people who have a lived experience in common [14]. Co-workers who have had similar experiences can provide support and referral assistance through peer support, improving the mental health of their peers and helping them towards recovery, empowerment, and hope[15]. Peer supporters are trained to provide compassionate support and resources or referrals, but because they are not trained professionals, they do not diagnose mental health injuries or recommend specific treatments.

There are many variations in the meaning and/or composition of a PSP in healthcare. This disparity is likely the result of the grassroots nature of PSPs, where each organization develops and implements a program that is suited to their structure and adapted to the specific needs of their staff. At the heart of any PSP, however, is the desire to embed and sustain a psychologically safe environment where those who are part of the healthcare organization feel supported by their peers and the organization when they experience distress at work.

For the purposes of this document, we have defined a PSP as follows:

> A peer support program includes any program that provides non-clinical emotional support to health professionals (and in some cases other individuals who work, volunteer or train at organization) who are experiencing emotional distress and this support is provided by a peer. The need for emotional support can be the result of:
>
> 1. A patient safety incident: an event or circumstance that could have resulted, or did result, in unnecessary harm to a patient. There are three types of patient safety incidents:
>
>   - **Harmful incident:** a patient safety incident that resulted in harm to the patient (replaces "preventable adverse event");
>   - **Near miss:** a patient safety incident that did not reach the patient and therefore no harm resulted; and
>   - **No-harm incident:** a patient safety incident that reached the patient but no discernible harm resulted.
>
> 2. A critical incident or trauma: “Any sudden, unpredictable event that occurs during the course of carrying out day-to-day duties or activities that poses physical or psychological threat to the safety or well-being of an individual or group of individuals” (as per SickKids definition in their Trauma Response and Peer Support Policy). Examples include:
>
>   - unexpected death of a patient;
>   - suicide of a colleague;
>   - a workplace accident resulting in critical injury to a staff member;
>   - internal or external disaster;
>   - mass casualty situations;
>   - life-threatening illness, injury or untimely death of staff or co-worker;

- natural or man-made disasters; and
- any incident charged with profound emotion.

3. Other work-related stress (**excludes** issues related to Human Resources such as job action or performance). Examples include:

    - work environment;
    - assault, harassment or violence involving staff or patient and/or family;
    - workplace conflict;
    - workplace re-organization or downsizing;
    - complaints/lawsuits;
    - cumulative stress;
    - work-life balance issues;
    - compassion fatigue;
    - vicarious trauma; and
    - events that attract media attention.

Box 1.0: A note on the term "second victim"

Albert Wu coined the term “second victim”[5] and many others subsequently adopted the term to describe a health professional who experience a PSI. The first victim is the patient who was harmed, while the second victim is the health professional who is traumatized by the event.

The use of the term “second victim” has been heavily debated in healthcare. For one, this label often does not resonate with healthcare workers as the term implies weakness, and this is not a characteristic they associate with themselves[11]. Also, the label “victim” implies healthcare workers do not have a role to play in the incident, and that something has been done *to* them which they had no control over. Patients and families do not always appreciate the term either, as calling the health professional a victim has the potential to lessen the impact of the incident on the patient.

In addition, the term “second victim” refers exclusively to the distress healthcare workers feel following a patient safety incident. However, there are a variety of situations that may lead to damaging emotional impact on healthcare workers[16]. One study evaluating the impact of a peer support program for healthcare professionals noted that the majority of the incidents for which they sought support were not related to medical error[17]. For 80 of the encounters, 45% included death of a patient and 21.3% involved a patient safety incident; the remainder of calls were about other difficult situations, such as difficult decisions, burnout, staff assault, interpersonal conflict among staff and others[17]. The RISE programme notes: “Hospital workers face many challenges following the occurrence of stressful, patient-related events. A few of those involve medical errors, but the large majority are simply related to the extraordinary stresses incumbent in the job” [17].

Another reason to question the use of the term “second victim” is that creating a label for what is a normal and healthy psychological reaction to a distressing situation risks pathologizing the healthcare worker’s experience and further stigmatization.

When it came out in 2000, the term “second victim” was very useful, especially because it brought attention to the impact of PSIs on health professionals and set us on a path to recognize the traumatic experience of PSIs in healthcare. However, the label is no longer useful nor widely accepted.

Considering the reservations both healthcare workers and patients have for the term “second victim,” the reality that the distress experienced by healthcare workers goes beyond the distress they feel after a patient safety incident, and the importance of not pathologizing what is a normal reaction, CPSI is electing not to use the term “second victim” and indeed not to label the experience at all. Instead, we will refer to the emotional distress experienced by a healthcare worker.

The term *second victim* is still used in literature and many support programs throughout Canada and abroad. The term *second victim* will be used in this document when referring to external programs or work where this terminology has been used.

Background

Healthcare workers function in an increasingly complex and technical environment, often under tremendous time pressures and growing demands for resources, where they are working interdependently with others in systems that are not always effective, all the while striving to provide the best of care for their patients. At the same time, they carry an added emotional burden of the risk of something going wrong, and the potential of a patient safety incident where the patient is harmed or almost harmed. They work within a system full of ambiguity, uncertainty and morally complex choices.

Within this environment, there are a number of specific causes of emotional distress, as suggested in the definition of peer support. For example, a healthcare professional may feel emotionally traumatized after a sudden or unexpected bad outcome, a patient safety incident, the loss of a patient with whom they feel close, workplace conflict, or when dealing with multiple trauma cases.

Healthcare workers can experience strong emotional, physical, cognitive, or behavioural responses to events or to the stress of the workplace. Signs and symptoms that someone may be reacting to workplace conditions may include the following[15]:

Table 1.0: Signs and Symptoms

Physical	Emotional	Cognitive	Behavioural
Sleep disturbances	Numbness	Intrusive thoughts or images	Increase or loss of appetite
Fatigue	Feeling overwhelmed or helpless	Poor concentration	Crying spells
Dizziness and weakness	Guilt	Impaired decision-making	Increased alcohol consumption
Increased heart rate and blood pressure	Grief or depression	Difficulty doing calculations	Withdrawal
Chills	Loss of emotional control	Disrupted thinking	Change in activity
Nausea and vomiting	Anger	Blaming	Irritability
Muscle tremors and/or twitches	Panic or fear		Change in personality

Individuals seeking support might be experiencing distress in the form of anxiety, depression, post-traumatic stress disorder (PTSD), chronic work-related stress, and burnout or compassion fatigue. They may not always need professional help, but simply need someone to talk to who understands what they are going through.

Peer support is rooted in the belief that "…hope is the starting point from which a journey of recovery must begin[18]." Peer supporters can inspire this hope by not treating their peers like a victim, but by helping them leverage their own resilience and discover their own sense of empowerment, recover their self-esteem, learn new coping skills and experience personal growth.

A PSP can foster a supportive culture and provide timely access to mental health support. It can be a safe way for healthcare workers to talk about their experiences and challenges with someone who is empathetic and can understand what they are going through because they have "been there." A peer supporter draws from their own experience to help their colleagues get through the immediate consequences of emotional distress, and help them process what they are going through in a positive manner. The Mental Health Commission of Canada maintains that connecting with another person who has lived with similar problems, or is perhaps still doing so, can be a vital link for someone struggling with their own situation[19]. When healthcare workers are able to quickly share their experiences in a safe, trusting, accepting and validating environment, it can reduce the risk of more traumatic or cumulative stress.

The BCEHS outlines the following benefits and outcomes in their overview of healthcare worker support models[20].

Healthcare worker support models can:

- Humanize mental health challenges and take them outside the medical realm;
- Promote socialization, reducing feelings of isolation and alienation that can be associated with mental health conditions;
- Help people gain control over their symptoms and reduce hospitalization;
- Foster hope and recovery;
- Help people learn coping skills and improve resilience;
- Promote a better understanding of mental health issues and services for all within an organization;
- Create opportunities for increased employee engagement;
- Help peers reach life goals and improve quality of life; and
- Provide rewards and further healing for the peer supporter through the experience of listening to and helping others.

There are a number of challenges to setting up a PSP in a healthcare organization, not the least of which is that healthcare workers often have a difficult time reaching out for help. Asking for help or seeking mental health care is stigmatized as a sign of weakness[11,12,13]. According to de Wit et al., "… the very act of admitting you need help after a traumatic event carries its own powerful stigma in a culture that embraces the illusion that perfection can be achieved, and that falling short of this impossible standard is a sign of personal defect[12]." Further, some health professionals may not want to risk their credentialing bodies finding out that they sought mental health care[13]. Healthcare workers are also reticent to seek help because they fear being judged negatively by their colleagues, do not trust the confidentiality of the process or lack confidence in the value of the support.

Summary

CPSI is committed to improving patient safety by improving the well-being of healthcare workers. As we undertook this PSP project, we endeavoured to access all relevant resources to ensure that the product was comprehensive and evidence-based.

We hope that this manual is both useful and practical for healthcare leaders, managers and frontline workers who are about to embark on a new PSP or who have begun the process and are looking for recommendations, resources and innovative ideas.

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Section 1: Survey of Healthcare Providers' Perceptions related to the Second Victim Phenomenon

A Survey of Canadian Healthcare Workers: Their views on the experience of a patient safety incident and the support they need

Introduction

This section of the manuscript entitled Creating a Safe Space: Strategies to Address the Psychological Safety of Healthcare Workers is a key component of the Canadian Patient Safety Institute (CPSI) initiative to improve support to healthcare workers after a patient safety incident (PSI). The study was undertaken by a research team at the University of Ontario Institute of Technology (UOIT), in collaboration with CPSI to uncover what Canadian healthcare workers need in terms of emotional support after a PSI. The purpose of this study was to determine the perceptions of Canadian healthcare workers on their experiences of a PSI, and the support they received or wished to receive. This survey undertaken within this research will serve as a basis for identifying existing current support systems and assessing the needs of Canadian healthcare workers.

Methods

UOIT conducted a national self-administered online survey of healthcare workers in 2018. The details of the methodology used are detailed in the following sections.

Sample

The sample was identified based on an email listserve provided by CPSI. After excluding individuals on the listserve who did not fit the description of a frontline healthcare worker, the survey was sent to 750-850 individuals. However, due to the low response rate, the survey was later sent out through healthcare professional associations asking them to distribute the survey to their members. Not all associations were able to do so, however; many had policies in place regarding the number of surveys or studies they would send to their members.

Questionnaire

The questionnaire incorporated components from the validated Second Victim Experience and Support Tool (SVEST) instrument[2], including questions about psychological and physical distress, and about desired forms of support. It also included items on variables related to demographics, employment characteristics and educational history (See Appendix 1). The SVEST is used to collect responses on psychological and physical symptoms after a PSI, and the quality of support resources available [1]. The

desirability of possible support resources is also measured [1]. The SVEST has been assessed for content validity, internal consistency, and construct validity and confirmatory factor analysis[1]. The research team collaborated with the CPSI team to obtain feedback regarding the questionnaire and to make modifications (e.g., demographic, workplace characteristics, etc.) to reflect the Canadian health care environment. The researchers responsible for creating the SVEST gave permission to use the instrument.

In addition to the questions on the SVEST, open-ended questions were added to obtain information on:

- whether they had received support after a PSI in the past 12 months and, if yes, what type of support they received;
- what type of support they would like to receive;
- what they would do differently for a peer based on their experience; and
- what their advice is in terms of providing support.

Data collection

The self-administered electronic questionnaire was developed using the platform MachForm**,** which was hosted on a secure server at UOIT. The electronic questionnaire was distributed June 2018 by an email invitation in collaboration with the CPSI to maintain confidentiality of the sample. Arrangements were made by the CPSI to have the email invitation sent to the sample population. The email invitation included the consent form, explanation of the study, contacts for further information, and a link to the questionnaire. Participation was completely voluntary. To participate in the study and to indicate consent, participants were required to click on the link provided in the email invitation which took them to the questionnaire. Upon completion of the questionnaire, respondents were asked to click on a link to submit the completed questionnaire.

This was an anonymous survey and no personal identifying information was collected. If anyone felt uncomfortable answering any of the questions they were not required to provide a response.

Once the questionnaire was completed, the raw data was stored on a secure server at UOIT. The UOIT research team did not have access to the email addresses. The data was strictly anonymous. Access to the raw data was limited to the research team. Individual responses were kept confidential and only grouped and aggregated study data will be presented in any presentations, publications or de-briefings.

Data analysis

The analysis included descriptive statistics, factor analysis, and an analysis of variance. The data was analyzed by professional group, sector and years of experience and, in relation to questions #20 and #21, to determine if views differ within professional groups.

Responses were grouped and analyzed by themes based on the open-ended questions asked in the survey (ex. type of support received, type of support wanted, etc.).

Ethics

Approval was obtained from the Research Ethics Board at the UOIT.

Results

Demographics of the Respondents

A total of 390 self-identifying frontline healthcare workers responded to this survey. Those disciplines who responded included dietitians, medical laboratory technologists, medical radiation technologists, nurses, occupational therapists, paramedics, pharmacists, physical therapists, physicians, respiratory therapists and other. Table 1.1 presents the response rates of each discipline.

Table 1.1: Respondents by Professional Designation
(N= 390)

Professional Designation	Number of Respondents	Response rate
Medical Radiation Technologist (MRT)	229	58.7%
Nurse	39	10.0%
Physician	37	9.5%
Pharmacist	32	8.2%
Respiratory Therapist	24	6.2%
Medical Laboratory Technologist	10	2.6%
Paramedic	8	2.1%
Physical Therapist	6	1.5%
Dietitian	4	1.0%
Occupational Therapist	2	0.5%
Other	1	0.3%

Respondents were also asked to identify the area of practice relevant to their current work. Table 1.2 displays the breakdown of respondents by area of practice with the majority of respondents (69.2%) identifying acute care as their current area of practice.

Table 1.2: Respondents by Area of Practice
(N=390)

Area of Practice	Number of Respondents	Response Rate
Acute Care	270	69.2%
Primary Care	53	13.6%
Community Care	44	11.3%
Long-Term Care	14	3.6%
ALL*	5	1.3%
Other	4	1.0%

*The category “ALL” consists of respondents indicating working in all four areas of practice.

The majority of respondents to this survey reside in the province of Ontario (32.3%).The smallest number of participants was from Nunavut and the Northwest Territories (0.3% each). The breakdown of the respondents by their province of residence is presented in Table 1.3 below.

Table 1.3: Respondents by Province of Residence
(N= 390)

Province of Residence	Number of Respondents	Response rate
Ontario	126	32.3%
Alberta	88	22.6%
British Columbia	49	12.6%
Manitoba	33	8.5%
Nova Scotia	30	7.7%
New Brunswick	26	6.7%
Saskatchewan	21	5.4%
Quebec	9	2.3%
Prince Edward Island	4	1.0%
Newfoundland & Labrador	2	0.5%
Northwest Territories	1	0.3%
Nunavut	1	0.3%

Table 1.4 presents a breakdown of respondents by years of experience in healthcare. The majority of respondents indicated having 12 years or more of experience in healthcare. This was followed by 6-8 years and 9-12 years of experience in healthcare (11.0% and 10.8% respectively).

Table 1.4: Respondents by Years of Experience in Healthcare
(N=390)

Years of Experience in Healthcare	Number of Respondents	Response Rate
12 years or more	253	64.9%
6-8 years	43	11.0%
9-12 years	42	10.8%
3-5 years	35	9.0%
2 years or less	17	4.4%

Involvement in a Patient Safety Event

Of the 390 who responded, 58% indicated that they have been involved in a serious patient safety event[i] impacting one of their patients and 32% indicated that a patient safety event caused them to experience anxiety, depression or wondering if they were able to continue to do their job in the last 12 months (See Table 1.5).

Table 1.5: Involvement in a Patient Safety Incident Involvement in a Patient Safety Event
(N=390)

	Number of Respondents	Response Rate
Have been involved in a serious patient safety event impacting one of their patients	225	57.7%
A patient safety event caused them to experience anxiety, depression or wondering if they were able to continue to do their job	123	31.5%

Due to the disproportionately higher number of MRT respondents, these numbers were further analyzed to assess for any skew in the results. For the purpose of this analysis, MRTs were compared to a group of respondents with the next highest response rates (nurses, physicians, pharmacists and respiratory therapists). The results are presented in Tables 1.6 and 1.7 below.

Table 1.6: Involvement in a Patient Safety Event - MRTs
(N=229)

	Number of Respondents	Response Rate
Have been involved in a serious patient safety event impacting one of their patients	106	46.3%
A patient safety event caused them to experience anxiety, depression or wondering if they were able to continue to do their job	57	24.9%

Table 1.7: Involvement in a Patient Safety Event – Nurses, Physicians, Pharmacists and Respiratory Therapists
(N=132)

	Number of Respondents	Response Rate
Have been involved in a serious patient safety event impacting one of their patients	97	73.5%
A patient safety event caused them to experience anxiety, depression or wondering if they were able to continue to do their job	53	40.2%

[i] The term “patient safety event” was used instead of the term “patient safety incident” in the SVEST tool. Although CPSI has adopted the term “patient safety incident” in all its documents, the term “patient safety event” will be used in this document to protect the integrity of the results.

Based on the results in Table 1.6 and 1.7, it is evident that the group of healthcare workers in Table 1.7 shows a much higher positive response rate of 73.5% when asked whether they have been involved in a serious patient safety event impacting one of their patients. This indicates that this group of healthcare workers is more likely to experience a serious patient safety event compared to MRTs which make up a larger portion of our sample. The same is true for the second statement about their experience of anxiety, depression or ability to continue to do their job: the group of healthcare workers have a much higher positive response rate compared to the MRT group.

The next sections will outline some of the effects healthcare workers experience after a patient safety event. Each section presents the results from the scale questions and are supplemented with the qualitative responses.

Psychological Distress

Respondents were asked to rate their agreement with statements about psychological distress. Over 50% of those who responded to this question agreed that they experienced embarrassment from these instances and 54.3% indicated that the experience has made them fearful of future occurrences. Although not the majority, 39.9% said they felt miserable as a result of the experience, and 41.3% felt deep remorse.

Table 1.8: Psychological Distress - All respondents

	Disagree	Neither	Agree	NA	Total (N)*
I have experienced embarrassment from these instances	104 (35.6%)	7 (2.4%)	153 (52.4%)	28 (9.6%)	292
Experience has made me fearful of future occurrences	95 (31.5%)	15 (5.0%)	164 (54.3%)	28 (9.3%)	302
Experience has made me feel miserable	143 (47.2%)	13 (4.3%)	121 (39.9%)	26 (8.6%)	303
I feel deep remorse for past experience	123 (42.0%)	15 (5.1%)	121 (41.3%)	34 (11.6%)	293

*Total (N) excludes those who did not respond.

Separating out the MRTs from the rest of the data, it is interesting to note that over 50% of the MRT respondents disagreed that the experience made them feel miserable (55.6%) or deep remorse for the past experience (51.2%).This is in contrast to the results obtained from the group of respondents presented in Table 1.10. This group of respondents agreed with all the statements over 50% of the time.

Table 1.9: Psychological Distress - MRTs

	Disagree	Neither	Agree	NA	Total (N)*
I have experienced embarrassment from these instances	70 (44.0%)	0	67 (42.1%)	22 (13.8%)	159
Experience has made me fearful of future occurrences	72 (42.1%)	0	76 (44.4%)	23 (13.5%)	171
Experience has made me feel miserable	95 (55.6%)	0	56 (32.7%)	20 (11.7%)	171
I feel deep remorse for past experience	83 (51.2%)	0	50 (30.9%)	29 (17.9%)	162

*Total (N) excludes those who did not respond.

Table 1.10: Psychological Distress - Nurses, Physicians, Pharmacists and Respiratory Therapists

	Disagree	Neither	Agree	NA	Total (N)*
I have experienced embarrassment from these instances	26 (23.4%)	6 (5.4%)	74 (66.7%)	5 (4.5%)	111
Experience has made me fearful of future occurrences	20 (18.5%)	13 (12.0%)	71 (65.7%)	4 (3.7%)	108
Experience has made me feel miserable	40 (37.0%)	9 (8.3%)	54 (50.0%)	5 (4.6%)	108
I feel deep remorse for past experience	32 (29.6%)	9 (8.3%)	63 (58.3%)	4 (3.7%)	108

*Total (N) excludes those who did not respond.

Physical Distress

The majority of those who responded to this question disagreed with having experienced most of the physical distress symptoms in the list. However, 37.8% agreed that the mental weight of their experience was exhausting. This may suggest that the psychological symptoms after experiencing a patient safety event are experienced more often by healthcare workers in comparison to physical symptoms.

Table 1.11: Physical Distress - All respondents

	Disagree	Neither	Agree	NA	Total (N)*
The mental weight of my experience is exhausting	125 (33.1%)	84 (22.2%)	143 (37.8%)	26 (6.9%)	378
My experience can make it hard to sleep regularly	163 (43.1%)	72 (19.0%)	115 (30.4%)	28 (7.4%)	378
The stress has made me queasy or nauseous.	170 (45.0%)	77 (20.4%)	103 (27.2%)	28 (7.4%)	378
Thinking about the experience makes it difficult to have an appetite	182 (48.1%)	82 (21.7%)	88 (23.3%)	26 (6.9%)	378

*Total (N) excludes those who did not respond.

Table 1.12 displays the data for this subset of question for MRTs alone. The results are very similar to the overall respondent data presented in Table 1.11 with the majority of the respondents disagreeing with all of the statements referring to the experience of physical distress after a patient safety event.

Table 1.12: Physical Distress - MRTs

	Disagree	Neither	Agree	NA	Total (N)*
The mental weight of my experience is exhausting	83 (37.1%)	46 (20.5%)	74 (33.0%)	21 (9.4%)	224
My experience can make it hard to sleep regularly	106 (47.3%)	42 (18.8%)	53 (23.7%)	23 (10.3%)	224
The stress has made me queasy or nauseous.	108 (48.2%)	44 (19.6%)	49 (21.9%)	23 (10.3%)	224
Thinking about the experience makes it difficult to have an appetite	116 (51.8%)	44 (19.6%)	42 (18.8%)	22 (9.8%)	224

*Total (N) excludes those who did not respond.

Considering the responses from the nurse/physician/pharmacist/respiratory therapist group, a slight difference in responses can be noted. This group of respondents agreed that the mental weight of their experience was exhausting (43.8%) and that their experience of the patient safety event made it hard to sleep regularly (41.4%).

Table 1.13: Physical Distress - Nurses, Physicians, Pharmacists and Respiratory Therapists

	Disagree	Neither	Agree	NA	Total (N)*
The mental weight of my experience is exhausting	35 (27.3%)	34 (26.6%)	56 (43.8%)	3 (2.3%)	128
My experience can make it hard to sleep regularly	48 (37.5%)	24 (18.8%)	53 (41.4%)	3 (2.3%)	128
The stress has made me queasy or nauseous.	50 (39.1%)	29 (22.7%)	45 (35.2%)	4 (3.1%)	128
Thinking about the experience makes it difficult to have an appetite	55 (43.0%)	32 (25%.0)	38 (29.7%)	3 (2.3%)	128

*Total (N) excludes those who did not respond.

Support

Of the 123 who indicated experiencing anxiety, depression or wondering if they were able to continue their job due to a patient safety event, 89% of them did ***not*** receive any support at their institution (Table 1.14). Only 6.5% of respondents indicated receiving support at their institution. Very similar results are seen when the data is separated between the MRT group and the comparison group (Tables 1.15 and 1.16).

Table 1.14: Experienced an incident in the last 12 months vs Received support in the last 12 months - All respondents

	Receiving support in the last 12 months		
Experienced an incident in the last 12 months (N=123)		No (N=358)	Yes (N=14)
	No (N=267)	248 (92.9%)	6 (2.2%)
	Yes (N=123)	110 (89.4%)	8 (6.5%)

Table 1.15: Experienced an incident in the last 12 months vs Received support in the last 12 months - MRTs

	Receiving support in the last 12 months		
Experienced an incident in the last 12 months		No (N=218)	Yes (N=3)
	No (N=172)	166 (96.5%)	1 (0.6%)
	Yes (N=57)	52 (91.2%)	2 (3.5%)

Table 1.16: Experienced an incident in the last 12 months vs Received support in the last 12 months - Nurses, Physicians, Pharmacists and Respiratory Therapists

	Receiving support in the last 12 months		
Experienced an incident in the last 12 months		No (N=117)	Yes (N=8)
	No (N=79)	68 (86%)	4 (5.1%)
	Yes (N=53)	49 (92.5%)	4 (5.1%)

Type of Support Received

Those respondents who received support in the past 12 months were asked to specify the type of support that they received. The top three types included support from EAP, discussions with their manager, and discussion with their colleagues.

- "We have an employee and family health program that I have utilized a few times." – Medical Radiation Technologist
- "Discussion with manager and colleagues about event and impact on myself, client's family." – Physical Therapist
- "Follow-up with manager, support from colleagues, counselling through EAP." – Nurse
- "Discuss situations with Unit manager and trusted peers. I also go to an outside professional counselor on my own time." - Pharmacist

Satisfaction with Support Received

Of those who received support in the last 12 months, 35% of participants indicated being ***not*** satisfied with the amount and type of support that they received. In addition, some respondents indicated there was no acknowledgement of the incident, or that they were subject to inappropriate jokes or bullying by the manager and/or team members.

- A medical radiation technologist stated “My manager at the time made inappropriate jokes about the incident and offered zero support, including not mentioning how to get in touch with any form of employee assistance.”

- A physician responded “I am also traumatized by the institution's blatant avoidance of actually investigating the situation and dealing with it in an ethical and transparent way. I have been forced to be an important bystander whose patients have been hurt by malpractice committed by other members of the treatment team who have not been held accountable. I was not directly involved in the incident, but tried to advocate for my patient who was a young adolescent, only to see not only nothing happened, but the nurse involved continued to repeat her medically unsound actions on-going with no attempt by hospital to stop it. They did not want to deal with the nurses or their union and it was easier to just look away and ignore me.”

Desired Supports

Respondents were asked to identify their desired forms of support (See Table 1.17). Of the seven types of support that were presented to them, the majority of respondents identified having a respected peer to discuss the details of what happened as desirable (82.8%).The support that ranked second (76.7%) was having a specific peaceful location available to recover and recompose.

Table 1.17: Desired Supports

	Undesirable	Neutral	Desirable	NA	Total (N)*
Confidential 24 hours support	36 (9.5%)	87 (23.0%)	245 (64.8%)	10 (2.6%)	378
Opportunity to meet my counselor at my hospital	54 (14.3%)	95 (25.1%)	212 (56.1%)	17 (4.5%)	378
Discussion with manager/supervisor	47 (12.4%)	86 (22.8%)	232 (61.4%)	13 (3.4%)	378
Employee Assistance Program (EAP)	35 (9.3%)	53 (14.0%)	281 (74.3%)	9 (2.4%)	378
A respected peer to discuss	11 (2.9%)	43 (11.4%)	313 (82.8%)	11 (2.9%)	378
A specified peaceful location	20 (5.3%)	57 (15.1%)	290 (76.7%)	11 (2.9%)	378
Ability to take time away immediately	23 (6.1%)	58 (15.3%)	287 (75.9%)	10 (2.6%)	378

*Total (N) excludes those who did not respond.

When asked to describe further the type of support that they would like to receive, the top supports that were highlighted by respondents were confidential support (on and off site), peer support from their colleagues, support and/or conversation with their manager, and time-off immediately after an incident.

- “Time away from the workplace immediately after a serious incident to process what has taken place and my response to it.” – Nurse
- “Real time available online or telephone counsel or support” – Respiratory Therapist
- “Open discussion with my supervisor about the repercussions of the incident. And the opportunity to discuss with close peers about what may have contributed to the incident and how to prevent in the future. I do not think that talking to an outsider would be beneficial (at least for me).” – Pharmacist
- “Support from management and supervisors, less of a "blame culture".” – Medical Radiation Technologist

Support for a Peer

In addition, respondents were asked what they would do differently if they were supporting a peer based on their experience. The most common types of support respondents noted were being available (time and space), encouraging discussion and asking what support they wanted, being empathetic and understanding, and encouraging them to seek help.

- “When a colleague recently experienced a difficult patient care situation, I called her to say that I was available to talk if she needed it.” – Physician
- “Provide time and space to meet with that colleague in a non-judgmental way to indicate support. To receive structured training/ education about how to support and approach my colleague OR at least be able to provide resources to quickly point the way to this peer. To practice kindness and support from the whole team/ person perspective.” – Pharmacist
- “Encourage reaching out for help, even if they feel "fine" Sharing the experience with colleagues.” – Nurse
- “Listen, understand, enact policies and processes to support safer work practices, learn from incidents, and let them know they are not alone.” – Medical Radiation Technologist

While the majority of respondents provided comments on how they would support a peer who has experienced a patient safety event, there were others who experienced a backlash for supporting a peer and who stated they would be reluctant to do so again. Some also stated their own personal hardships as a barrier to helping a peer.

- “I just can't. I don't have the time at my workplace to support my coworkers in this way. I can say a nice word or give a quick hug, but then we have to move on with the work. That is its own form of trauma inflicted on staff - expecting staff to be in attendance and focused on work when they are experiencing their own personal hardships.” – Medical Laboratory Technologist
- “I did support a peer and colleague and got blamed for doing so. I don’t know what I would do differently. I didn’t believe we genuinely have a no blame culture in hospitals. Still too much fear.” – Pharmacist

Advice on How to Support

The respondents were asked their opinions about what would be the best support or guidance for a team member who is emotionally impacted following a patient safety event. The top forms of support suggested by the respondents included confidential support for everyone involved in the incident, debriefing, acknowledgement of the situation and sympathy, actively listening, follow-up and face-to-face support.

- "The best thing to do is to LISTEN openly and non-judgmentally." – Physician
- "Have someone available and checking in often. Not just immediately after." – Respiratory Therapist
- "Debriefs are helpful, but not just leaving it after the debrief - revisit in a few weeks/month to see if things are going okay, if there has been any impact to work, if they need more support." – Physician
- "Acknowledge the impact; make it easy for persons to seek help - not just in nursing but across professions." – Occupational Therapist
- "Confidential support from whomever is involved in the disclosure." – Physician

Conclusion

The results obtained from this study provide us with some insight into the effects of the PSIs on our healthcare workers. In particular, the results from this study further stress the psychological impact of PSIs over physical distress. These results support that healthcare workers who have experienced a PSI need to be supported emotionally[4, 6]

One significant finding is the number of survey respondents who experienced a PSI within the past 12 months but did not receive support. Of the respondents indicating they experienced a PSI, only 6.5% indicated they received support. Overall, 89.4% responded they did not receive any support. Without a supportive team, healthcare workers will have more difficulty coping with the incident and making a full recovery[4].

Respondents clearly indicated that peer support would be one of the most valuable types of support after a PSI. They also indicated that support from managers/supervisors and institutional support was important. At the same time, respondents expressed concern over support from higher authorities, with some respondents even indicating they were afraid to approach them for help. A large survey of physicians in the United States and Canada found that 90% of physicians indicated that hospitals and healthcare organizations failed to support them when coping with the trauma of a PSI [5].

In our survey, not only did respondents clearly indicate they wanted more support from their institution and higher authorities, but they also wanted to receive from them empathy and acknowledgement of what they are experiencing. These findings are supported by Denham (2007) who states that healthcare workers who have experienced a patient safety incident need to immediately be made aware that their peers respect and support them, that they remain a trusted and valued member of the team, and that they are supported by their higher authorities [3].

As a final note, a very high number of medical radiation therapists (MRTs) responded to this survey. Considering they made up for 59% of the respondents, their high interest in completing the survey warrants

further investigation; for example, it might indicate that this group is affected by PSIs and used this survey as a method of voicing their concerns over how healthcare workers are supported after such incidents. It would be worthwhile to follow-up with the MRTs via focus groups or key informant interviews to delve deeper into what these concerns are and where they are stemming from.

The results from this survey emphasize the importance of creating an awareness of the need for support after a PSI amongst frontline healthcare workers, higher authorities and institutions. CPSI hopes that healthcare organization will pay attention to what healthcare workers are expressing through this survey, and make use of the tools, resources and guidelines in the Creating a Safe Space: Strategies to Address the Psychological Safety of Healthcare Workers to develop support programs for their own workers.

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Creating a safe space

Conclusion

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Conclusion

The Canadian Patient Safety Institute (CPSI) is grateful to the many healthcare workers, experts in peer support programs, healthcare lawyers, patients, researchers and policy makers who have made this work possible. All have helped us along our journey to provide healthcare organizations with resources to help their workers when they experience emotional distress in the workplace. We are particularly appreciative of the Mental Health Commission of Canada for their inspiring advice and assistance, and for providing much fundamental information about mental health for our collaborative project.

Whether you are a leader of a healthcare organization contemplating how best to improve the mental health of your workers, a healthcare worker who is in the midst of implementing a peer support program, or simply someone with a germ of an idea to help support your peers, we hope this manual has been useful to you. We invite you to share your peer support program story with us, so that others might also learn from your experiences. If you have ideas about what else CPSI might do to help organizations across Canada implement successful peer support programs, please contact us at [info@cpsi-icsp.ca].

Creating a safe space

Appendix 1 – Second Victim Experience and Support Survey (SVEST)

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Appendix 1 - Second Victim Experience and Support Survey (SVEST)

The second victim describes a healthcare professional who is involved in a patient safety incident and is emotionally traumatized by the event. There is a common understanding that health professionals feel emotionally distressed after a patient safety incident (PSI), resulting in a negative impact on both the health professional's health and on patient safety. There has therefore been an impetus within the patient safety movement and healthcare organizations to find ways to support health professionals who are emotionally traumatized after a PSI.

The Canadian Patient Safety Institute (CPSI), a not-for-profit organization that exists to raise awareness and facilitate transformation in patient safety, is therefore reaching out to healthcare providers to seek for input on the second victim experience and support.

The following survey, conducted in partnership between the Canadian Patient Safety Institute and the University of Ontario Institute of Technology (UOIT), seeks to evaluate your experiences as a healthcare provider with adverse patient safety events and the support you may have received.

This study is intended **for Front Line Healthcare workers**, specifically targeting **clinicians, allied health workers and technologists** providing services in all settings, including hospitals, outpatient care, behavioral health, long-term care, and home healthcare. For the purpose of this study we are targeting clinicians, allied health professionals and technologists who provide direct care to patients. Those healthcare workers who have dual roles that includes management, teaching or research, must have **at least 20% of their work dedicated to direct patient care.**

The survey will take between 30-45 minutes to complete. If you have any questions regarding this survey, please contact …. at …. and …. Ext. ….Thank you for taking the time to complete the survey.

DEMOGRAPHICS

1. Please identify your role in healthcare:
   - ☐ Clinician
   - ☐ Manager
   - ☐ Executive
   - ☐ Other (Please specify) _____

2. Professional discipline:
   - ☐ Dietician
   - ☐ Medical / Laboratory Technologist
   - ☐ Nurse
   - ☐ Occupational Therapist
   - ☐ Pharmacist
   - ☐ Physical Therapist
   - ☐ Physician
   - ☐ Respiratory Therapist
   - ☐ Other (Please Specify) _____

3. Please identify the area of practice relevant to your current work:
   - ☐ Acute Care
   - ☐ Primary Care
   - ☐ Long Term Care
   - ☐ Community Care
   - ☐ Other (Please specify) _____

4. Please name the province or territory in which you reside_____ (*Dropdown menu)*

5. Please indicate your years of experience in healthcare:
   - ☐ 2 years or less
   - ☐ 3-5 years
   - ☐ 6-8 years
   - ☐ 9-12 years
   - ☐ 12 years or more

6. Have you ever been involved in a serious patient safety event impacting one of your patients?
   - ☐ Yes
   - ☐ No

7. In the last 12 months, did a patient safety event cause you to experience anxiety, depression or wondering if you were able to continue to do your job?
   - ☐ Yes
   - ☐ No

*Jonathan D. Burlison, Susan D. Scott, Emily K. Browne, Sierra G. Thompson, and James M. Hoffman, "The Second Victim Experience and Support Tool: Validation of an Organizational Resource for Assessing Second Victim Effects and the Quality of Support Resources", J Patient Saf, Volume 00, Number 00, Month 2014.

Second victim responses and support characteristics:

Please indicate how much you agree with the following statements as they pertain to yourself and your own experiences at your organization for those who have been negatively affected by their involvement with an adverse patient safety event. These incidents may or may not have been due to error. They also may or may not include circumstances that resulted in patient harm or even reached the patient (i.e., near-miss patient safety events).

Scoring: The responses to Question 1 – 9 are rated on a 1 to 5 Likert scale, where higher scores represent greater amounts of second victim responses, the degree to which support resources are perceived as inadequate, and the extent of the 2 second victim – related negative work outcomes (i.e., turnover intentions and absenteeism). Rate 1 – 5 [1-Strongly Disagree; 2-Disagree; 3-Neither Agree or Disagree; 4-Agree; 5-Strongly Agree]

8. Psychological Distress

	1 Strongly Disagree	2 Disagree	3 Neither Agree or Disagree	4 Agree	5 Strongly Agree	6 Not Applicable
I have experienced embarrassment from these instances.						
My involvement in these types of instances has made me fearful of future occurrences.						
My experiences have made me feel miserable.						
I feel deep remorse for my past involvements in these types of events.						

9. Physical Distress

	1 Strongly Disagree	2 Disagree	3 Neither Agree or Disagree	4 Agree	5 Strongly Agree	6 Not Applicable
The mental weight of my experience is exhausting.						
My experience with these occurrences can make it hard to sleep regularly.						
The stress from these situations has made me feel queasy or nauseous.						
Thinking about these situations can make it difficult to have an appetite.						

Second Victim Support Option Desirability:

Please indicate your **level of desirability** for the following types of support that could be offered by your organization for those who have been negatively affected by their involvement with an adverse patient safety event. These patient safety incidents may or may not have been due to error. They also may or may not include circumstances that resulted in patient harm or even reached the patient (i.e., near-miss patient safety events).

Scoring: The responses for Question 10 are rated on a 1 to 5 Likert scale, where a response of 4 or 5 represents the support option being desired and 1 or 2 represents the support option being not desired. The responses for these items are rated on a 1 to 5 Likert scale, where a response of 4 or 5 represents the support option being desired and 1 or 2 represents the support option being not desired.

10. Desired Forms of Support

	1 Strongly Disagree	2 Disagree	3 Neither Agree or Disagree	4 Agree	5 Strongly Agree	6 Not Applicable
The ability to immediately take time away from my unit for a little while.						
A specified peaceful location that is available to recover and recompose after one of these types of events.						
A respected peer to discuss the details of what happened.						
An employee assistance program that can provide free counseling to employees outside of work.						
A discussion with my manager or supervisor about the incident.						
The opportunity to schedule a time with a counselor at my hospital to discuss the event.						
A confidential way to get in touch with someone 24 hours a day to discuss how my experience may be affecting me.						

Questions 11-14 are open-ended questions. Please complete the following 4 open-ended questions:

11. Have you in the past 12 months or currently receiving any type of second victim support at your institution?
    a. If yes, please describe the support received. [Open-ended question]
    b. Are you satisfied with the amount and type of support received? [Open-ended question]

12. What type of second victim support would you like to receive? [Open-ended question]

13. Based on your experience, what would you do differently if you were supporting a peer or colleague going through the same thing you went through? [Open-ended question]

14. What is your advice to us as we design for a ‘‘perfect world’’ where the best support/guidance possible is provided when a team member(s) is emotionally impacted following a patient safety incident? [Open-ended question]

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