

Creating a Safe Space

**Section 3: Addressing
Confidentiality for Peer to
Peer Support Programs for
Health Professionals**

Creating a Safe Space

Strategies to Address the Psychological Safety of Healthcare Workers

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Disclaimers

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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 harm happens – 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.

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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' health⁵⁻¹¹ and on patient safety¹²⁻¹³. As a result of this recognition, healthcare organizations are seeking ways to support health professionals who are emotionally traumatized after a PSI.

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Introduction

Introduction

Working in healthcare can be emotionally distressing¹⁻⁴. 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 health⁵⁻¹¹ and on patient safety¹²⁻¹³. 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

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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 common¹⁴. 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 hope¹⁵. 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;

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- 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 experiences 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 themselves¹¹. 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 workers¹⁶. 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 error¹⁷. 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 others¹⁷. 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 incurring harm 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.

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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 following¹⁵:

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

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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 begin¹⁸.” 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 situation¹⁹. 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 models²⁰.

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 defect¹².” Further, some health professionals may not want to risk their credentialing bodies

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finding out that they sought mental health care¹³. 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.

It is important that a PSP be built with this challenge in mind, and thus be planned and executed carefully and deliberately.

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 3: Addressing Confidentiality for Peer- to-Peer Support Programs for Health Professionals

Introduction

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Peer-to-peer support programs, where health professionals can discuss their experience with a PSI in a non- judgmental environment with colleagues who can relate to what they are going through, are now seen as a potentially useful approach to helping health professionals cope with the PSI. A number of support programs are emerging in the US, and Canadian organizations are beginning to recognize that this – along with other types of support such as Employee Assistance Programs and trauma crisis teams – is an appropriate and valuable service for their staff. It is also well recognized that such programs will improve patient safety since health professionals will be in a healthier emotional state to care for their patients safely and be able to more effectively participate in PSI reviews and disclosures.

One of the first challenges many organizations confront in exploring the feasibility of such a support program is the ambiguity surrounding what type of legal protections may be available against disclosure of these communications in legal proceedings like malpractice actions or professional disciplinary hearings, or in employment or college disciplinary proceedings. With these guidelines, the Canadian Patient Safety Institute (CPSI) endeavours to clarify the legal privilege and professional confidentiality considerations of implementing peer-to-peer support programs for health professionals who are emotionally affected by a PSI. We hope that this work will help healthcare organizations create psychologically safe support programs, assist health professionals who are seeking support to understand what is protected and what is not, enable patients to gain insight into health professionals' experience, and encourage policy makers to consider what might need to change – including enhanced protections for these communications – to ensure health professionals are supported after a PSI.

CPSI priorities

CPSI is committed to improving patient safety in Canada and does so through a number of initiatives. Each of our initiatives is part of a comprehensive strategy to keep patients safe: from 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, to *Safer Healthcare Now!* interventions that facilitate implementation of best practices. We also have substantial resources that we developed 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.

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The present guidelines are no exception. We recognize that there is a significant need to support health professionals as well as patients and families on their journey from harm to healing. It is our hope that by taking this first step towards supporting health professionals through a PSI, we will contribute to system safety by providing tools and resources to everyone who makes up the system – patients, families, providers and healthcare leaders – that allow them to learn, collaborate and improve care for patients.

The following guiding principles underpin the development of this document:

1. It is important that health professionals have a psychologically safe environment that provides them with an opportunity to speak confidentially to a peer about their experience of a PSI because:
 - it will help them cope with what can be an 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, and to participate more effectively in PSI reviews and conversations with patients.
2. These support programs are not intended to affect transparency about the facts surrounding PSIs or withhold material facts surrounding PSIs from patients and families, but rather to provide a safe space to help health professionals cope with traumatic and stressful events. The emotional trauma, not the PSI, should be the primary focus of these programs. Practically, however, it will not always be possible to provide effective support if the events cannot be discussed at least in part. The balance between these interests requires careful consideration.
3. Those promoting peer-to-peer support programs 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 peer-to-peer support program for health professionals who experience a PSI does not in any way diminish the importance of reporting patient safety incidents for quality improvement efforts, disclosure of the facts around patient safety incidents to patients and families, and other incident management activities.

Background

Many efforts have been made in recent years to improve patient safety and decrease the number of patient safety incidents in the health system. These efforts have resulted in a vast number of quality improvement and patient safety initiatives and programs that have significantly raised awareness of the importance of patient safety and made a positive impact on patient care.

PSIs do continue to occur, however, with data showing that harmful PSIs range between 3% and 16% of all hospital admissions^{1,2,6,14}. It is the reality of a health professional's work environment that they are subject to ongoing risk for PSIs¹⁵. The nature of a health professional's work is that they are constantly making decisions – sometimes of extreme gravity – that affect patients' lives and where there are unfortunately risks for miscalculations, misdiagnoses, misinterpretations or missteps – sometimes with serious consequences¹⁶.

Emotional distress after PSIs

A significant number of studies conducted over the past few years confirm that health professionals feel emotionally distressed after a PSI¹⁻¹⁰, whether they are involved directly or indirectly. A systematic review by Seys et al¹ indicates that between 10% and 43% of health professionals are affected by PSIs, with one study reporting 40.8% of health professionals feel moderately severe harmful effects and 2.5% describe a severe impact on their personal lives.

Feelings health professionals describe include shame, humiliation, guilt and remorse. Their self-esteem is eroded, and they are filled with self-doubt, self-blame and feelings of inadequacy. They might fear punishment, job loss, patients' anger or colleagues' judgement. They can experience psychological symptoms such as panic, anxiety, grief and depression^{6,18,19}.

Sydney Dekker's book entitled *Second Victim: Error, Guilt, Trauma, and Resilience*¹¹ provides a comprehensive picture of the emotional reactions experienced by individuals who are involved in PSIs, and why they need support. He notes that the psychological journey some health professionals experience after a PSI can be traumatizing, and if they are not offered the help they need, this will erode his or her ability to cope with the experience. Dekker cautions that the trauma can even lead to posttraumatic stress disorder (PTSD) that leads to "emotional, social, behavioural, cognitive, and somatic consequences that can reverberate for a long time and that people are not well equipped to handle by themselves" (p. 17).

To understand why health professionals are so deeply affected by PSIs, it is helpful to understand who they are, and the environment in which they work.

The source of emotional distress

Health professionals are in the business of healing, and doing harm is the antithesis of what they aim to achieve. They feel pressure to be perfect in a situation where it is generally impossible to be perfect. It has been said that health professionals are trained in a culture of perfection²² where the expectation is that, once they are finished their training, the work they do will be flawless. Their expectations for error-free care are unrealistically high²².

Health professionals work within a highly complex and technical system under circumstances that are mentally and physically demanding. They are also often under incredible time pressures to make decisions without complete information, and they are working interdependently with others in systems that are not always effective all the while convinced that PSIs are always avoidable and that they are expected to be perfect. In actuality, health professionals work within a system full of ambiguity, uncertainty and morally complex choices, where PSIs are inevitable²³.

At the same time, PSIs are rarely considered inevitable – they are essentially considered anomalies in healthcare¹¹. Despite the inevitability of PSIs, where healthcare professionals are often simply inheritors of those PSIs and at the sharp end of a complex series of failures, there is a pervasive belief among health professionals that all PSIs are preventable^{24,25}.

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A note on the term “second victim”

Albert Wu coined the term “second victim”⁵ and many others, including Sydney Dekker^{11,15,22,23}, adopted the term to describe a health professional who experiences a PSI. The first victim is the patient and family / caregiver who was harmed, while the second victim is the health professional who is traumatized by the event.

Dekker and Wu’s work on exploring the nature of the emotions of individuals who experience a PSI has brought attention to the impact of PSIs on health professionals and has made a significant contribution to our understanding of these emotions. However, CPSI has chosen to avoid using this term, as this label often does not resonate with health professionals. Also, the label “victim” implies health professionals do not have a role to play in the incident, and that something has been done to them over which they had no control. Finally, calling the health professional a victim has the potential to demean the impact of the PSI on the patient.

Rather than adopting another term or label, which risks pathologizing health professionals and implying they are psychologically abnormal or unhealthy, we choose to refer to the effect rather than the individual: a health professional who experiences a PSI and who may be emotionally affected by it.

Just culture of safety and systems thinking: The ideal

Recognizing that PSIs should be an opportunity for learning and providing safer care for patients, many healthcare organizations and patient safety experts have explored how the healthcare system might create a more open and transparent environment. A number of efforts have been made to try to help health professionals understand that many of the PSIs that occur are often not due to any individual mistake, and very rarely because of negligence or incompetence. This has led to the development of just culture and systems thinking, where employees are encouraged to report and disclose PSIs without fear of inappropriate reprimand or punishment.

Disclosure of PSIs is a key building block of this just culture of safety and is a way of demonstrating to patients that they can trust healthcare professionals and organizations to be honest and open about harmful incidents, and to learn from these events to prevent them from recurring. It is also a health professional’s ethical duty and responsibility to tell the truth, promoting personal accountability and continuous learning²⁶.

A culture of silence and individual blame: The reality

Despite this attention to a just culture of safety and disclosure, creating an open and transparent environment and moderating shame and blame continues to be an enormous challenge^{3,4,20}. Health professionals continue to be unwilling to talk – and therefore learn – about harm or close calls.

Within this culture of blame, it is understandable why health professionals often choose to remain silent; they would likely hesitate to openly share information about PSIs because they fear punishment from their employers or judgment from their peers. This blame culture leads to underreporting of PSIs in healthcare; studies indicate that leadership is aware of less than 5% of the PSIs in their system, while front line staff members know about all of them¹.

Rise of support programs

As healthcare organizations continue work towards creating a just culture of safety, there is a growing recognition that health professionals can be emotionally traumatized after a PSI but might have difficulty seeking or finding help. There is also a recognition that unless health professionals are supported psychologically after a PSI, there is a risk that efforts to improve patient safety will be compromised^{12,13,28}. As de Wit et al.¹² note: “we cannot deliver the safest possible care unless we foster an environment in which healthcare workers have a safe place to grapple with the impact of their involvement in adverse events” (p. 858). White et al.¹³ note that the distress from PSIs has the potential to worsen productivity, quality, and safety. Van Gerven et al.²⁸ note that improving healthcare professionals’ work life wellness is considered a critical aspect of optimising health system performance. Finally, Pratt, Kenney, Scott and Wu²⁹ maintain that “failure to care for second victims could lead to a vicious cycle of adverse events, burnout, poor care, and more adverse events” (p. 238).

Seys et al.,¹⁷ also notes the following defensive changes after a PSI, which can have a negative effect on patient safety:

- More likely to keep error to themselves;
- Avoidance of similar patients;
- Feeling less confident with patient/family, getting more worried, less trusting of others’ capability;
- Avoiding further contact with patient/family;
- Thoughts about leaving practice;
- Change in health professional-patient relationship; and
- Ordering more tests, afraid of making another error.

There has recently been a growth of peer-to-peer support programs where health professionals can openly discuss PSIs in a safe, non-judgmental environment, thereby helping them deal with the emotional consequences of a PSI²⁶. There is evidence that, in the first moments after a PSI, health professionals may need to talk to a colleague and feel respect and empathy from others³⁰. These programs rely on volunteers from within the healthcare system who participate in training programs to provide support for their colleagues who are from similar professions and specialties as their own¹².

Many organizations offer assistance through some form of Employee Assistance Program (EAP), but the effectiveness of these programs for helping health professionals cope with their PSI experience is uncertain: “the low appeal of EAP may relate to a lack of tailoring to the needs of healthcare workers involved in adverse events, a lack of relevant training for EAP staff, or the use of non-clinician support providers who may lack credibility with healthcare workers”¹³ (p. 38). It is clear that it would be difficult, if not impossible, for non-clinicians to grasp the full extent of the physical, psychological and emotional impact of the experience of a PSI^{21,29}.

A few peer-to-peer support programs have been initiated in the US, such as the Resilience in Stressful Events (RISE) program at the Johns Hopkins Hospital, the Medically Induced Trauma Support Services (MITSS) program in Boston, the Centre for Professionalism and Peer Support at the Brigham and Women’s Hospital, and the forYou program at the University of Missouri Healthcare (MUHC).

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In Canada, there is much interest in exploring how best to support health professionals experiencing stressful events in the workplace. To-date, several organizations have developed support programs, including:

- Critical Incident Stress Program (CISP), British Columbia Emergency Health Services (BCEHS) and member of the BC First Responders' Mental Health Committee
- Occupational & Critical Incident Stress Management (OCISM) (Health Canada providing services to nurses working in First Nations communities across Canada)
- Peer Support and Trauma Response Program (The Toronto Hospital for Sick Children – SickKids)
- Peer Trauma Response Team Program (Alberta Health Services)
- Quebec Physicians' Health Program (QPHP)
- Second Victim Peer Support (Michael Garron Hospital)
- Second Victim Guidance Team (Central Health, Newfoundland and Labrador)

For more information on these programs and guidelines on how to set them up, refer to [CPSI Best practices](#) for workplace peer support programs in healthcare organizations.

Challenges of providing emotional support to health professionals

There are a number of challenges to providing support for health professionals who experience a PSI, not the least of which is their reticence to seek support. A large reason for this reticence is their shame, or their unwillingness to admit their fallibility; 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 (p.857). Further, some health professionals may not want to risk their credentialing bodies finding out that they sought mental health care¹³. Health professionals are also reticent to seek help because they fear being judged negatively by their colleagues, do not trust the confidentiality of the process, lack confidence in the value of the support, and worry about the implications for litigation.

The following table describes factors that impede disclosure of PSIs as described by Kaldjian et al.,³¹ providing an overall summary of reasons for helplessness – such as lack of control or confidentiality – and fears and anxieties including fear of legal liability or loss of reputation.

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Table 3.1: Factors that impede disclosure of PSIs

Helplessness	Fears and Anxieties
Lacking control of what happens to information once it is disclosed	Fearing legal or financial liability
Lacking institutional and collegial support after disclosure or a professional forum for discussion	Fearing professional discipline, loss of reputation, loss of position, or loss of advancement
Lacking confidentiality or immunity after disclosure	Fearing patient's or family's anger, anxiety, loss of confidence, or termination of physician-patient relationship
Believing error reporting systems penalize those who are honest	Fearing the need to admit actual negligence
Lacking feedback after reporting errors or a sense of ownership in the quality improvement process	Fearing the need to disclose an error that cannot be corrected
Lacking time to disclose PSIs	Fearing the possibility of looking foolish in front of junior colleagues or trainees
Feeling helpless about PSIs because one cannot control enough of the system of care	Fearing negative publicity
	Fearing the possibility of 'fallout' on colleagues
	Feeling a sense of personal failure, loss of self-esteem, or threat to one's identity as a healer

Because of these factors (explained further in Kaldjian et al.³¹), the existing culture of silence, and health professionals' reticence to acknowledge their fallibility, it is clear that if health professionals were to seek support, confidentiality would be of utmost importance.

In addition, because there is also a possibility that PSIs might lead to litigation, health professionals are also concerned that what they share with others – in this case with a colleague in a support program – might be used as evidence in a civil proceeding or in employment or college disciplinary proceedings. As noted by de Wit et al.¹² “this burgeoning movement faces an obstacle, though, given the uncertainty over whether discussions conducted as part of supporting Second Victims will be deemed admissible as evidence in malpractice litigation or other disciplinary proceedings” (p. 853).

Legal privilege and confidentiality for these communications is therefore important to explore, as health professionals giving and receiving support should understand whether and to what extent these communications can be legally protected, and how committed these programs and organizations will be to fostering that protection. With this knowledge, they can then be clear about what type of information should be shared, how best to support each other, and ensure that the support is appropriate and helpful.

Defining Confidentiality and privilege

Before examining whether communications shared within a peer-to-peer support program are protected, it is important to outline the difference between confidentiality and privilege.

Whereas confidentiality involves the ethical duty of an individual not to disclose information without consent (e.g. the right of a client to not have the information that was shared with the therapist disclosed without proper release), privilege is a type of legal protection that prevents the introduction of information or communications into evidence in a trial or other legal proceeding³². In other words, within a peer-to-peer support program, those providing the peer support might be bound by an ethical duty not to disclose information deemed confidential, but this information may not be privileged.

Privilege is the right to refuse to disclose evidence, which has the effect of denying a judge, jury, or other adjudicator information that might help find the truth; therefore, the law demands that privilege be justified by some compelling societal interest³³. If information is not privileged, then a plaintiff's lawyer could successfully seek to obtain access to the communications³³. Privileges can apply to a class or category (such as lawyer-client privilege) or can be applied on a case-by-case basis if certain criteria are met¹.

¹ For the case-by-case privilege to be applicable, a person wishing to claim the protection of the privilege bears the burden of establishing that four criteria (called the "Wigmore criteria") are satisfied:

- (1) the communication must originate in a confidence that it will not be disclosed;
- (2) the element of confidentiality must be essential to the full and satisfactory maintenance of the relationship between the parties;
- (3) the relationship must be one which should be sedulously fostered in the public good; and
- (4) if all these requirements are met, the court must consider whether the interests served by protecting the communication from disclosure outweigh the interest at getting at the truth and disposing correctly of the litigation^{33,34}.

Satisfaction of the final criterion is the most difficult to meet for any person claiming case-by-case privilege, as the judge must find that the benefit of disclosure for litigation is less than the damage that it would cause to the relationship³³. Since the aim of the litigation process is to find the truth, it is most likely that the courts will side with those seeking to disclose information from the court³³.

When communications about PSIs are protected

CPSI, along with all patient safety champions, encourages transparency and openness about PSIs, providing health professionals the opportunity to learn from PSIs, ensuring healthcare is improved and made safer. In fact, to reinforce this message, CPSI's Canadian Disclosure Guidelines²⁷ includes a set of "guiding principles" in the introduction.

Guiding Principles

The following guiding principles underpin the development and use of the Canadian Disclosure Guidelines:

Patient-centered healthcare: An environment of patient-centered healthcare fosters open, honest and ongoing communication between healthcare providers and patients. Healthcare services should be respectful, supportive and take into consideration the patient's expectations and needs at all times.

Patient autonomy: Patients have the right to know what has happened to them in order to facilitate their active involvement and decision-making in their ongoing healthcare.

Healthcare that is safe: Patients should have access to safe healthcare services of the highest possible quality. Lessons learned from patient safety incidents should be used to improve the practices, processes and systems of healthcare delivery.

Leadership support: Leaders and decision makers in the healthcare environment must be visible champions of disclosure as part of patient-centered healthcare.

Disclosure is the right thing to do: "Individuals involved at all levels of decision-making around disclosure must ask themselves what they would expect in a similar situation¹."

Honesty and transparency: When a harmful incident occurs, the patient should be told what happened. Disclosure acknowledges and informs the patient, which is critical in maintaining the patient's trust and confidence in the healthcare system.

The key takeaway from these principles is that disclosure is the right thing to do for patient safety, for the patient and for the health professional.

There are situations, however, when certain information about PSIs might be kept confidential or when it is protected by privilege. The reason for protecting this information is not to hide the truth; rather, it is to allow PSIs to be explored openly and transparently by the healthcare team so that the team may learn from the incident and improve patient safety. If these communications were not protected, or privileged, there would be a chilling effect on the robust discourse that must occur in order to improve care following a patient safety incident.

The following sections describe examples where information is protected.

Lawyer-client privilege

As with any lawyer-client relationship, information a health professional might share with his or her lawyer about a patient safety incident would be protected by this class or categorical privilege. Although this is an example of privileged communication, it would not apply to peer support programs because no legal advice is being sought from or provided by a lawyer.

Quality Assurance Committees

Throughout Canada in every common law province and territory, legislation protects information that is generated from certain quality assurance activities^{33,35}. This is generally referred to as “statutory privilege” or “statutory prohibition” which comes from legislation, not ‘common law’ (judge- or Court-made law) and not from the relationship of the parties sharing the information. Its scope is restricted to the circumstances intended by the legislation; it cannot be waived, as a privilege or confidentiality can be waived. It is widely accepted that without this guarantee of confidentiality, healthcare professionals would not freely participate in all quality assurance activities for fear of potential liability³⁶. Consequently, the quality assurance activities would not be as effective, and the quality and safety of patient care would be compromised³⁶.

The Canadian Medical Protective Association³⁷ explains that the quality assurance committees are not intended to preclude other patient safety initiatives:

“The reporting of critical incidents or adverse events to hospital quality assurance or peer review committees is generally part of a much broader initiative aimed at identifying and addressing systemic problems and improving patient safety. The ultimate goal of quality assurance activities is to critically review these incidents and to evaluate the effectiveness of the institution’s practices and procedures in order to improve patient safety overall. It is generally accepted that, in order for quality assurance programs to be successful and effective, physicians and other health professionals must have satisfactory assurances that the reporting and subsequent investigation of such information will not be used or disclosed outside of the quality assurance process (either to patients or to other hospital departments or committees). If physicians and other healthcare providers are not confident that quality assurance information and documentation will be protected, they may be reticent or even unwilling to participate in the process.”

While the specifics are different in each province/territory, the statutes generally follow the same model, keeping quality assurance proceedings, reports and investigations from being disclosed or used in court³⁴. For example, section 9 of the Alberta *Evidence Act*³⁸, which resembles legislation in other jurisdictions, reads as follows:

9 (2) A witness in an action, whether a party to it or not, is not liable to be asked, and shall not be permitted to answer, any question as to any proceedings before a quality assurance committee, and is not liable to be asked to produce and shall not be permitted to produce any quality assurance record in that person’s or the committee’s possession or under that person’s or the committee’s control.

Quality assurance committees are generally defined as committees appointed by regional health authorities or hospital boards, established under provincial legislation, or designated by ministerial order and prescribed in regulations³⁴.

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Protection of quality assurance activities is typically accompanied by a statutory prohibition against disclosure of quality assurance information in legal or professional proceedings.

It is interesting to note that recent changes to legislation in Ontario – the Quality of Care Information Protection Act (QCIPA) – could be considered indicative of a trend towards more openness for any investigations or activities around PSIs. In particular, the following statements³⁹ show clear support for using caution when invoking QCIPA:

- The intent of QCIPA remains valid, and a modified version of the legislation should be retained. However, the legislation should be amended to clearly indicate that when QCIPA is invoked, patients and families must be fully informed about the results of the investigation, including what happened, why it happened and what measures (if any) the organization intends to take to prevent future incidents. This should be done in a way that respects the confidentiality protections of QCIPA.
- The current variation in how QCIPA is used across Ontario hospitals needs to be addressed. QCIPA should only be invoked when the nature of the contributing causes to a critical incident is unclear and there is the need for considerable discussion and speculation about the causes of the incident. Ontario hospitals, with the help of Patients for Patient Safety, the Canadian Medical Protection Association, Health Quality Ontario and others, should learn from each other and develop clear guidance about the circumstances under which QCIPA should be invoked to investigate a critical incident, and when it should not be invoked.

QCIPA represents a more nuanced kind of legislative privilege/prohibition that could be adopted in other jurisdictions in the future.

Apology Act

Although the Apology Act is not directly related to privilege in a peer-to-peer support program, it is another instance where communications surrounding a PSI – an apology to a patient about a PSI – cannot be taken into account in determining fault or liability in a legal proceeding.

To date, eight Canadian provinces and one territory (British Columbia, Alberta, Saskatchewan, Manitoba, Ontario, Nova Scotia, Prince Edward Island, Newfoundland and Labrador, and Nunavut) have adopted “apology legislation,” either as stand-alone legislation or incorporated in Evidence Acts. In these provinces, an apology to a patient for an error is not admissible as evidence of liability in legal proceedings.

The main objective of apology legislation is to reduce health professionals’ concerns about the legal implications of expressions of sympathy, including apologies.

An apology is an expression of sympathy and regret and a statement that one is sorry. The words “I’m sorry” are known to foster increased respect and improved relationships between patients, families and healthcare professionals.

Legal privilege in a peer-to-peer support program

Considering the definition of legal privilege, along with the above scenarios where communications about PSIs would be privileged or otherwise protected, it is unclear whether communications that occur within a peer-to-peer support program could be privileged at present or subject to a statutory prohibition against disclosure at present, since:

- They do not occur within a client-lawyer relationship;
- They are typically not communications taking place or related to the activities of a quality assurance committee; and
- To date, there has not been a Canadian court decision to determine whether Wigmore would protect the confidentiality of peer support communications..

To date there has not been a court challenge to obtain access to peer support communications. The risk of a peer supporter being legally compelled to disclose is still therefore unknown. However, once it becomes known to patients, families and lawyers that these communications may be happening, it is reasonable to expect that there will be a curiosity about their relevance that could prompt inquiries. On the other hand, should anyone seek disclosure, they must have grounds for believing the information within the peer-to-peer support program is relevant or potentially relevant before a court will compel disclosure³⁴.

The fact that peer-to-peer support programs may not be protected by privilege does not necessarily mean organizations should be discouraged from implementing such an initiative – although it might make the implementation of a peer-to-peer support program more challenging. There are steps that organizations can take however to maintain confidentiality, if not privilege, so that health professionals might be free to discuss their emotions about traumatic events.

Recommendations for implementing a confidential peer-to-peer support program

All evidence gathered about the emotional impact of PSIs on health professionals' points to the importance of supporting them through what can be a traumatic experience. It is critical that leaders in healthcare organizations pay attention to the impact of PSIs, and initiate peer-to-peer support programs that will improve employee wellness and in doing so improve patient safety. Health professionals themselves need to understand the importance of seeking emotional support for the distress they experience so that they are better able to cope with their emotions in a timely manner, to offer themselves the opportunity for an earlier and fuller resolution of the physical and psychological trauma arising from the incident. In caring for themselves they will be able to provide better care to their patients and at the same time decrease the likelihood of a PSI.

The risk of peer support information being disclosed is unknown. The research conducted for these guidelines has demonstrated that there is no guarantee that the information shared within a peer-to-peer support program would be privileged; however, the benefit to the health care providers and their future patients may be more important than concerns about disclosure of conversations. In addition, the fact that these discussions may not be privileged does not mean they cannot be confidential, and every step should be taken to ensure this confidentiality.

There are a number of excellent resources available to help organizations implement a peer-to-peer support program:

- Hirschinger LE, Scott SD, Hahn-Cover K. Clinician support: Five years of lessons learned⁴⁰.
- Edrees H, Connors C, Paine L, Norvell M, Taylor H, Wu AW: Implementing the RISE second victim support programme at the Johns Hopkins Hospital: a case study⁴¹.
- Krzan KD, Merandi J, Morvay S, Mirtlallo J: Implementation of a “second victim” program in a pediatric hospital⁴².
- Pratt S, Kenney L, Scott SD, Wu AW: How to develop a second victim support program: A toolkit for Health Care Organizations²⁹.
- Seys D, Wu AW, Van Gerven E, Vleugels A, Euwema M, Panella M et al: Health care professionals as second victims after adverse events: A systematic review¹⁷.

To augment these resources, the following are a few recommendations for developing and implementing a peer-to-peer support program that will provide a psychologically safe environment for health professionals who experience a PSI and will mitigate risk of this information being used in a legal action.

Describing the program

Many health professionals are not aware of the psychological effect of a PSI until they experience it. It is therefore important to raise awareness about the traumatic emotional impact of PSIs through an education campaign that describes common reactions, behaviours and emotional consequences after a PSI, as well as ways to support the persons involved in the PSI^{30,39}.

Due to the challenges to implementing a peer-to-peer support program (as described above), not the least of which is a health professional's reluctance to seek help, it will be important for organizations to include the following messages in their description of the program:

- The program is confidential, and no documentation is maintained regarding the content of the discussion.
- The program aims to support health professionals through what is for many a traumatic experience.
- The program is an integral component of the organizational commitment to employee wellness and patient safety.
- The support offered by the program is not “therapy;” it is collegial support that comes from talking to someone who has “been there”^{21,44}.

It is normal to experience emotional and physical distress after a PSI, and it is critically important for individuals to seek support to cope with this distress.

Peer supporters are trained to offer emotional support, coaching and resources, not to review medical records or provide clinical feedback or opinions on the care provided¹³.

As an example, the Brigham and Women's Hospital created a Centre for Professionalism and Peer Support⁴³ and quote an article by Van Pelt⁴⁴ which serves to create an understanding for the vision and purpose of the peer-to-peer support program:

The Peer Support Service bypasses the stigmas that limit the utilization of formal support services and offers care providers a safe environment to share the emotional impact of adverse events while serving as a foundation for open communication and a renewal of compassion in the workplace. As the breadth of stressors impacting healthcare professionals is revealed, the Peer Support service is being recognized as a vital hospital-wide service. It also appears to offer an important leap forward in the critical areas of patient safety and quality of care⁴⁴.

Training peer supporters

As with any peer-to-peer support program, the peer supporters should receive training to ensure they are prepared to support their peers through an emotionally traumatic experience. This ought to include training for such skills as how to respond to distress calls, how to provide suicide first-aid, and how to give non-directive emotional support. Peer supporters must also be provided with training about what outside resources are available to peers in need.^{29,39,40}

As part of this training, it is important that the peer supporter understand their role in steering the conversation towards the emotional impact of the incident rather than opinions and speculations about what went wrong; the focus of the conversation should be on dealing with the emotional consequences of the

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incident³⁰. In other words, what happened happened: the conversations within a peer-to-peer support program do not change the facts. The purpose of peer-to-peer support programs should not be to analyze what went wrong or who is to blame; rather the purpose should be to support the health professional emotionally and to assist the caller in processing the emotion and connecting with professional resources where appropriate. White et al.,¹³ suggest that organizations can “minimize the risk of discoverability by assuming the clinician will discuss only their feelings as opposed to the facts surrounding the adverse event” (p. 38).

Peer supporter training should also include the practices and procedures for administering the confidential peer- to-peer support program including the logging of calls in a confidential manner (for statistical/cost evaluation purposes).

Other suggestions for maintaining confidentiality include ensuring:

- the organization establish Terms of Reference for the peer support program which incorporate confidentiality statements that parallel the first three Wigmore criteria (see footnote (i) on page 28 of this document);
- the organization establish the program under the umbrella of an existing privileged quality of care committee, or through the Risk Management office;
- peer supporters sign a confidentiality agreement;
- the identity of the peer supporters is not widely known;
- there is minimal documentation about those seeking support, and any documentation generated is marked “Confidential” and centrally stored in Risk Management or by the Quality of Care Committee;
- there is no record of telephone numbers;
- there is no documentation of the content of the conversations;
- health professionals are given the opportunity to make an anonymous telephone call; and
- there is a well-written policy documenting the purpose of the peer support program.

The challenge for organizations will be to provide effective services while maintaining confidentiality. It will be important for those developing the programs to find the right balance between confidentiality and personal support as the more confidentiality is maintained (with anonymous telephone calls, for example) the more difficult it will be to provide personal support that a health professional might need to cope with events.

Conclusion

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The psychological trauma that health professionals undergo when they are involved in a PSI can be overwhelming and complex. It can have a significantly negative effect on their wellbeing and on their ability to care effectively for their patients. It is therefore important that healthcare organizations explore how best to support their workforce through what can be a very distressing experience.

Organizations will face an uphill battle in de-stigmatizing psychological support and overcoming health professionals' reluctance to share their feelings about PSIs. A peer-to-peer support program is a long-term initiative which should be expected to take five to ten years to become recognized, accepted and well utilized.

When implementing a peer-to-peer support program, organizations will also be faced with the challenge of assuring health professionals that they will be in a psychologically safe environment, and that every effort will be made to keep the information confidential.

In light of the fact that the communications within the support programs are not privileged at present, health professionals may need to be persuaded that the benefits of emotional peer support outweigh the risk of the communications being disclosed.

At the same time, everyone involved in the care of patients – including patients and families – will need to be reassured that a peer-to-peer support program does not in any way diminish the importance of other quality and patient safety improvement efforts, including the reporting of PSIs, disclosure and other incident management activities. Facts are facts, and health professionals are ethically bound to disclose PSIs, and confidentiality does not imply freedom from accountability²⁶. There needs to be a clear message from everyone involved in the programs that they are not about keeping facts about patients' care from patients and others, but rather providing a safe space to help health professionals cope with traumatic and stressful events so that they might be in a healthier emotional state to care for their patients safely.

It is in the public's interest to support these peer-to-peer support programs because of their positive impact on the safety of subsequent patient care. Failing to provide this support might very well derail what could be one of the best paths to healing for health professionals who experience a PSI and obstruct what could be a valuable bridge to patient safety improvement⁴⁵.

Support for health professionals is an important component of a much larger incident management process that includes reporting, disclosure, analysis, learning, and quality improvement. Peer-to-peer support should be interwoven through this process. CPSI encourages organizations to design such programs with a commitment to confidentiality to the extent permitted by law.

CPSI promotes the disclosure of PSIs and continues to emphasize that these support programs are not about keeping facts about patients' care hidden, but rather helping health professionals cope with traumatic and stressful events so that they might be in a healthier emotional state to care for their patients safely in the future.

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Conclusion

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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].



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