Creating a safe space

Strategies to Address the Psychological Safety of Healthcare Workers
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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)\textsuperscript{1-4}, and there is an emerging recognition of the potential negative impact on both the health professionals’ health\textsuperscript{5-11} and on patient safety\textsuperscript{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
Introduction

Working in healthcare can be emotionally distressing. 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 and on patient safety. 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. 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. 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" and many others subsequently adopted the term to describe a health professional who makes a serious mistake. 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. 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. 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. 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. 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.”

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 mistakes on health professionals and set us on a path to recognize the traumatic experience of making a mistake 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 following15:

Table 1.0: Signs and Symptoms

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

Peer support programs 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. 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.” Further, some health professionals may not want to risk their credentialing bodies finding out that they sought mental health care. 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.
Creating a Safe Space
Strategies to Address the Psychological Safety of Healthcare Workers

References


8. Smetzer J. Don’t abandon the “second victims” of medical errors. *Nursing* 2012;42(2);54-58. doi:10.1097/01.NURSE.0000410310.38734.e0


10. Clancey CM. Alleviating “second victim” syndrome: how we should handle patient harm. *Journal of Nursing Care Quality* 2012;27(1), 1-5.doi: 10.1097/NCQ.0b013e3182366b53


Creating a safe space

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

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

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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).
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, 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. The SVEST is used to collect responses on psychological and physical symptoms after a PSI, and the quality of support resources available. The
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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 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)

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

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)

<table>
<thead>
<tr>
<th>Area of Practice</th>
<th>Number of Respondents</th>
<th>Response Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Care</td>
<td>270</td>
<td>69.2%</td>
</tr>
<tr>
<td>Primary Care</td>
<td>53</td>
<td>13.6%</td>
</tr>
<tr>
<td>Community Care</td>
<td>44</td>
<td>11.3%</td>
</tr>
<tr>
<td>Long-Term Care</td>
<td>14</td>
<td>3.6%</td>
</tr>
<tr>
<td>ALL*</td>
<td>5</td>
<td>1.3%</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>1.0%</td>
</tr>
</tbody>
</table>

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

*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>
<thead>
<tr>
<th>Years of Experience in Healthcare</th>
<th>Number of Respondents</th>
<th>Response Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 years or more</td>
<td>253</td>
<td>64.9%</td>
</tr>
<tr>
<td>6-8 years</td>
<td>43</td>
<td>11.0%</td>
</tr>
<tr>
<td>9-12 years</td>
<td>42</td>
<td>10.8%</td>
</tr>
<tr>
<td>3-5 years</td>
<td>35</td>
<td>9.0%</td>
</tr>
<tr>
<td>2 years or less</td>
<td>17</td>
<td>4.4%</td>
</tr>
</tbody>
</table>
Involvement in a Patient Safety Event

Of the 390 who responded, 58% indicated that they have been involved in a serious patient safety event\(^1\) 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

<table>
<thead>
<tr>
<th>Involvement in a Patient Safety Event</th>
<th>Number of Respondents</th>
<th>Response Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have been involved in a serious patient safety event impacting one of their patients</td>
<td>225</td>
<td>57.7%</td>
</tr>
<tr>
<td>A patient safety event caused them to experience anxiety, depression or wondering if they were able to continue to do their job</td>
<td>123</td>
<td>31.5%</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Involvement in a Patient Safety Event</th>
<th>Number of Respondents</th>
<th>Response Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have been involved in a serious patient safety event impacting one of their patients</td>
<td>106</td>
<td>46.3%</td>
</tr>
<tr>
<td>A patient safety event caused them to experience anxiety, depression or wondering if they were able to continue to do their job</td>
<td>57</td>
<td>24.9%</td>
</tr>
</tbody>
</table>

Table 1.7: Involvement in a Patient Safety Event – Nurses, Physicians, Pharmacists and Respiratory Therapists

<table>
<thead>
<tr>
<th>Involvement in a Patient Safety Event</th>
<th>Number of Respondents</th>
<th>Response Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have been involved in a serious patient safety event impacting one of their patients</td>
<td>97</td>
<td>73.5%</td>
</tr>
<tr>
<td>A patient safety event caused them to experience anxiety, depression or wondering if they were able to continue to do their job</td>
<td>53</td>
<td>40.2%</td>
</tr>
</tbody>
</table>

\(^1\) 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>
<thead>
<tr>
<th>Table 1.8: Psychological Distress - All respondents</th>
</tr>
</thead>
</table>

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

*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

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

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

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

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

*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

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

*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

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

*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

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

*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

<table>
<thead>
<tr>
<th>Experienced an incident in the last 12 months (N=123)</th>
<th>Receiving support in the last 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No (N=358)</td>
</tr>
<tr>
<td>No (N=267)</td>
<td>248 (92.9%)</td>
</tr>
<tr>
<td>Yes (N=123)</td>
<td>110 (89.4%)</td>
</tr>
</tbody>
</table>
Table 1.15: Experienced an incident in the last 12 months vs Received support in the last 12 months - MRTs

<table>
<thead>
<tr>
<th>Experiencing an incident in the last 12 months</th>
<th>Receiving support in the last 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>No (N=218)</td>
<td>Yes (N=3)</td>
</tr>
<tr>
<td>No (N=172)</td>
<td>166 (96.5%)</td>
</tr>
<tr>
<td>No (N=57)</td>
<td>52 (91.2%)</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Experiencing an incident in the last 12 months</th>
<th>Receiving support in the last 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>No (N=117)</td>
<td>Yes (N=8)</td>
</tr>
<tr>
<td>No (N=79)</td>
<td>68 (86%)</td>
</tr>
<tr>
<td>No (N=53)</td>
<td>49 (92.5%)</td>
</tr>
</tbody>
</table>

**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.
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- 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 ongoing 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**

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

*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 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.
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.
References


Creating a safe space

Section 2: Global environmental scan of peer to peer support programs
Acknowledgements

Section 2: Global Environmental Scan of Peer to Peer Support Programs

<table>
<thead>
<tr>
<th>Working Groups Members</th>
<th>Current Affiliations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Markirit Armutlu</td>
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<td>Diane Aubin Consulting</td>
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<td>Izaak Walton Killam (IWK) Health Centre</td>
</tr>
<tr>
<td>Katrina Hurley, MD.</td>
<td>Izaak Walton Killam (IWK) Health Centre</td>
</tr>
</tbody>
</table>

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).
Section 2: Global Environmental Scan of Peer to Peer Support Programs

Introduction

In an effort to learn from those who have already implemented Peer Support Programs (PSPs), The Canadian Patient Safety Institute (CPSI) determined that it would be valuable to conduct an environmental scan of national and international literature. In the meantime, researchers at IWK Health Centre were funded by an IWK Health Centre “Category A Research Grant” to conduct a scoping study to explore how health professionals are supported after a patient safety incident. The IWK researchers collaborated with CPSI to write this section about the findings from their study ii.

The IWK Health Centre study explored the range and context of interventions used in Canada and internationally to support health professionals emotionally in the workplace. The researchers considered qualitative and quantitative evidence, as well as policies, presentations, manuals and brochures. Specifically, the objectives were to:

- describe PSPs that address the impact of patient safety incidents (PSIs) on health professionals;
- describe the target audience of the intervention; and
- report the intervention outcomes for health professionals and the organization as a whole.

CPSI also collaborated with the IWK team to conduct an additional survey of healthcare organizations in Canada that were known to have established or were in the process of establishing a Peer Support Program.

Innovations in healthcare such as PSPs too often remain as isolated pockets of excellence. By sharing what was learned from the scoping study and survey, we aim to provide a broad overview of the variety of interventions used throughout the world. Our hope is that this will support healthcare organizations in their own program design and implementation, so that they might offer the best support possible for individuals in their organization who need emotional support.

ii The scientific findings from the IWK research, in an article entitled “Organizational interventions to support second victims in acute care settings: a scoping study” will be published in a peer-reviewed journal.
Methods

Scoping Study

The researchers performed a scoping study using the Arskey and O’Malley framework to characterize the range and context of interventions used to support health professionals emotionally.

The following scientific databases were searched:

- PubMed (November 2018);
- Embase via Elsevier (September 2017);
- Cumulative Index of Nursing and Allied Health (CINAHL) via EBSCOHost (September 2017);
- PsycINFO via EBSCOHost (September 2017);
- The Cochrane Central Register of Controlled Trials (CENTRAL) via Cochrane Library (September 2017); and,
- Web of Science Core Collection via Clarivate Analytics (September 2017).

All titles and abstracts that appeared relevant were selected for full text review. Two reviewers independently reviewed the full text articles to determine whether they described a program to support health professionals emotionally. During full-text screening, the text and reference lists of included papers were also screened for mentions of “second victim” support programs that were not found in the search. The researchers contacted authors of included studies to request further information about their programs.

Additionally, the following organizations were contacted to ask about documentation relating to any emotional support programs for health professionals of which they were aware, as well as additional contact information:

- Institute for Healthcare Improvement (IHI);
- Canadian provincial patient safety and quality councils;
- The Joint Commission;
- Agency for Healthcare Research and Quality (AHRQ);
- National Patient Safety Foundation;
- Canadian Medical Practice Association (CMPA);
- National Patient Safety Agency;
- Accreditation Canada;
- Royal College of Physicians and Surgeons of Canada;
- College of Nurses (Canadian provincial Colleges);
- Canadian Nurses Association;
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Section 2: Global Environmental Scan of Peer to Peer Support Programs

October 2019

The data were collated and summarized in a chart and programs were categorized and analyzed for common themes and characteristics. The search strategy for the scoping study favoured identifying PSPs that are published in peer reviewed journals. This field of study is growing rapidly, and we expect that there are many other programs that have yet to be published in the peer reviewed domain or are in the development phase. Some programs may be found exclusively on organizational intranets and protected access domains. The need to ensure confidentiality in this sensitive domain introduces a barrier to producing outcomes-oriented research.

Survey of Canadian Peer Support Programs

CPSI identified and surveyed a number of Canadian PSPs that have either been established or are in the process of being established. The organizations surveyed included:

- 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);
- Programme d’aide aux médecins du Québec (PAMQ)/Quebec Physicians’ Health Program (QPHP); and,
- Second Victim Peer Support (Michael Garron Hospital);
- St Michael’s Hospital, still in development phase;
- Chatham-Kent Health Alliance, still in development phase; and
- Second Victim Guidance Team (Central Health, Newfoundland and Labrador).

We do not expect that this is an exhaustive list of peer support programs in healthcare organizations in Canada. As we promote and expand our reach across the country, we will no doubt continue to discover other programs and organizations that support healthcare workers emotionally.

Through the survey and one-on-one interviews, we collected data about how and why the organizations implemented a PSP, details about the mandate, scope and policies, along with information about training, confidentiality and evaluation. Much of the information gathered in the survey and interviews is expanded on in the “Best Practices for Workplace Peer Support Programs in Healthcare Organizations” section of this
manuscript, but we include in this section an overall summary of the Canadian landscape. The survey questions are in Appendix 1.

**Findings**

**Scoping study**

After screening 5,634 titles and abstracts, the researchers identified 21 organizational programs that support health professionals emotionally. They identified two broad types of interventions: peer support programs and proactive education. Proactive education included curricula and toolkits intended to increase knowledge and awareness about the concept of the “second victim” (a term still widely used, but as we explain in the introduction to this manuscript, one CPSI has chosen to eschew) as well as coping strategies. Some programs included elements of both peer support and proactive education.

**Proactive education: toolkits, curricula and other resources**

Three programs described toolkits targeted toward managers and educators. The manager-targeted toolkits compiled resources for managers who may support second victims in the workplace such as mental health first aid. The educator toolkit was directed toward emergency medicine educators and included reading materials, slide decks and lesson plans.

Our search found three curricula directed toward specific audiences: nurse anesthetists, emergency medicine residents and medical educators and trainees. The latter program, called “When things go wrong” was based on a series of videos and vignettes that used real patient and family narratives, with role playing exercises and exploratory questions.

An educational program developed in Spain was a website that described patient safety incidents, second victims, crisis communication and disclosure. It included Spanish language videos demonstrating scenarios such as how to support a second victim in emotional distress.

In some instances, educational interventions were bundled with peer support programs to promote their peer support programs and raise awareness about the second victim phenomenon “to normalize the behaviour of seeking support after an adverse event”. For example, RISE used a website, promotional videos, internal publications, screensavers, presentations to targeted departments and unit-level champions to promote knowledge about second victims and the RISE peer support program. YOU Matter and forYOU educated staff to facilitate staff ability to identify and provide initial support to a second victim. The educational mandate of SWADDLE and CISM was broader than program awareness and initial staff support. SWADDLE promoted resilience through seminars and “resilience rounds” to discuss compassion fatigue and mindfulness.

Table 2.1 provides an overall summary of the proactive education found in the scan.
### Table 2.1: Summary of Proactive Education

<table>
<thead>
<tr>
<th>Location</th>
<th>Program Name</th>
<th>Short description</th>
<th>Clients/ Audience</th>
</tr>
</thead>
<tbody>
<tr>
<td>St. Luke’s Health System, Idaho, United States</td>
<td>After the Event Care Provider Recovery Toolkit 5</td>
<td>The toolkit is a resource for managers to supplement the EAP and CISM teams after an adverse event. Toolkit includes slides, talking points, and videos.</td>
<td>Health professionals</td>
</tr>
</tbody>
</table>
| Brigham and Women’s Hospital, Massachusetts, US | Medically Induced Trauma Support Services (MITSS) 20                           | MITSS produces programs that provide education to the healthcare community on medically induced trauma, the broad scope of its impact, and the crucial need for support services. Offers support to patients and family members. Programs include: Grand Rounds, Organizational Assessment, Speakers Bureau, Conferences and Symposia, Peer Support, Tool Box. Training includes: Peer Support Training, Post Event Support, One-on-One Phone Support and a 10-week Virtual Support group. Offers a 3-day workshop (train the trainer) to:  
  - Demonstrate peer support skills and how to effectively teach them to other health professionals  
  - Develop a work plan for implementation of clinician support at their institutions  
  - Share learning and experience with faculty and participants over three post-seminar conference calls | Clinicians               |
| Beth Israel Deaconess Medical Centre, Harvard Medical School, Massachusetts, US | When Things Go Wrong 8                                                      | Curriculum includes:  
  1. Baseline assessment of experiences, attitudes, and perceptions.  
  2. Interactive curriculum using filmed patient narratives  
  3. Implementation strategy for real-time disclosure.  

The curriculum was launched with separate tracks for staff physicians and residents. There is a 24-hour pager number for support and communication after a PSI. | Physicians & Residents |
<table>
<thead>
<tr>
<th>Location</th>
<th>Program Name</th>
<th>Short description</th>
<th>Clients/Audience</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017 Resident Wellness Consensus Summit in Las Vegas, Nevada, US</td>
<td>Resident Wellness Curriculum 9</td>
<td>The curriculum includes a two-module introduction to wellness; a seven-module “Self-Care Series” focusing on the appropriate structure of wellness activities and everyday necessities that promote physician wellness; a two-module section on physician suicide and self-help; a four-module “Clinical Care Series” focusing on delivering bad news, navigating difficult patient encounters, dealing with difficult consultants and staff members, and debriefing traumatic events in the emergency department; wellness in the workplace; and dealing with medical errors and shame.</td>
<td>Residents</td>
</tr>
<tr>
<td>2017 Resident Wellness Consensus Summit in Las Vegas, Nevada, US</td>
<td>Resident Educator Toolkit 10</td>
<td>Three educator toolkits were developed. The second victim syndrome toolkit has four modules, each with pre-reading material and a leader (educator) guide. In the mindfulness and meditation toolkit, there are three modules with a leader guide in addition to a longitudinal, guided meditation plan. The positive psychology toolkit has two modules, each with a leader guide and a PowerPoint slide set. These toolkits provide educators the necessary resources, reading materials, and lesson plans to implement didactic sessions in their residency curriculum.</td>
<td>Residents</td>
</tr>
<tr>
<td>Alicante-Sant Joan Health District Alicante, Spain</td>
<td>Mitigating Impact in Second Victims (MISE)12</td>
<td>The website was structured in two packages: demonstrative and informative. The informative package offers information about basic patient safety concepts including near misses, adverse events, and second victims. The demonstrative package included descriptions of the emotional consequences of PSIs as well as recommendations for actions following PSIs. This package had 15 videos to show what and what not to do in these situations. Information was also available through a mobile app.</td>
<td>Frontline hospital and primary care health professionals</td>
</tr>
<tr>
<td>Location</td>
<td>Program Name</td>
<td>Short description</td>
<td>Clients/ Audience</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>US International Critical Incident Stress Foundation (ICISF) Academy of Crisis Intervention</td>
<td>Critical Incident Stress Management (CISM)(^{21})</td>
<td>CISM is a comprehensive, integrative, multicomponent crisis intervention system. It includes multiple crisis intervention components, which functionally span the entire temporal spectrum of a crisis ranging from the pre-crisis phase through the acute crisis phase, and into the post-crisis phase. Applicable to individuals, small functional groups, large groups, families, organizations, and even communities. Aims to help law enforcement, firemen, paramedics, etc. deal with difficult situations and traumatic events.</td>
<td>First responders and emergency personnel and their families</td>
</tr>
<tr>
<td>Guidelines for the Practice and Training of Peer Support.</td>
<td>Mental Health Commission of Canada(^{22})</td>
<td>The Guidelines are intended to encourage the development of more peer support capacity in Canada and strengthen existing peer support initiatives. These Guidelines were developed in collaboration with peer support workers across the country. The document focuses on the empathetic and supportive role of a peer support worker in fostering hope, empowerment, and recovery. It is intended to provide direction to policy makers, decision makers, program leaders and the Canadian public about the practice of peer support.</td>
<td>Policy makers, decision makers, program leaders and the Canadian public</td>
</tr>
<tr>
<td>The Royal College of Emergency Medicine (RCEM), United Kingdom</td>
<td>The Safety Toolkit – Supporting the Second Victim(^{23})</td>
<td>The Safety Toolkit provides a framework for Emergency Departments to help them deliver safe, high quality care for patients. RCEM Learning: Supporting the second victim is the fourth of ten training modules related to patient safety.</td>
<td>Emergency physicians</td>
</tr>
<tr>
<td>Health PEI Prince Edward Island, Canada</td>
<td>Critical Incident Staff Support (CISS) Managers’ Toolkit(^{18})</td>
<td>The Toolkit outlines policies, articles, and checklists for managers responding to critical incidents. Information is listed as pre-incident, or post-incident (tier-based support).</td>
<td>Managers</td>
</tr>
</tbody>
</table>
Peer Support Programs

Peer support included a range of programs based on support from volunteer peers to structured multi-professional teams.

Twelve of the programs identified extended their mandate beyond the traditional definition of a “second victim” to include:

- “stressful, patient-related events”;
- difficult clinical outcomes or encounters;
- “difficult life events”;
- long term patient death or death/illness of staff or their family;
- targets of litigation or complaints;
- violence against staff;
- poor outcomes; and,
- self-care and wellness.

Peer support programs were administratively housed within a variety of organizational areas, such as patient safety programs, a quality improvement program, hospital-based risk management programs, or an occupational health program.

Some programs reached out to health professionals automatically in response to a specific event in the organization, while other programs depended on self-referral or referral by a colleague or administrator. One program, the Clinician Peer Support Program, described multiple paths by which it was activated: self-referral, referral by a peer supporter or referral by patient safety or risk management staff. In the Physicians Insurance Peer Support Program, clinicians are contacted by peers who are trained by the claims department to provide support before or during litigation.

All but one program did not mandate participation in the program. Participation in Healing Beyond Today was mandatory for staff, as it was created in response to a specific significant PSI.

Table 2.2 provides an overall summary of the peer support programs found in the scan.
### Table 2.2: Summary of Peer Support Programs

<table>
<thead>
<tr>
<th>Location</th>
<th>Program Name</th>
<th>Short description</th>
<th>Mandate/ Scope of support</th>
<th>Clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cleveland Clinic, Ohio, US</td>
<td>Code Lavender: Holistic Rapid Response 4</td>
<td>Provides emotional support to patients, family members, and hospital personnel (clinical and non-clinical) via an interdisciplinary rapid response team. Triggers include unexpected death, death or illness of staff or long-term patients. First response is within 30 minutes, with repeated check ins over the next 72 hours. Services offered include massage, spiritual care, Reiki, Healing Touch, aromatherapy, and access to EAP.</td>
<td>Emotional support</td>
<td>Patients, families, hospital personnel (clinical and non-clinical)</td>
</tr>
<tr>
<td>Methodist Hospital of Indiana, US</td>
<td>Healing Beyond Today 2</td>
<td>The “Healing Beyond Today” program was launched after a response to a PSI in the NICU to help transition those involved with return to work. It was a Critical Incident Stress Debriefing (CISD)-based program. Attendance was mandatory for all unit staff, and invitations were extended to ancillary personnel. Sessions included sharing of feelings and grief to assist with self-forgiveness, return to work, and creating a vision for the future. Sessions were held off-site.</td>
<td>Post critical Incident (transition back to work)</td>
<td>“Second victims” of one particular PSI</td>
</tr>
<tr>
<td>US Brigham and Women’s Hospital, Mass., US</td>
<td>Center for Professionalism and Peer Support (CPPS) (formerly Clinician Peer Support Service) 3,24</td>
<td>PSS is a rapid response model that is available to access 24 hours a day, seven (7) days a week. The program is voluntary and separate from hospital quality assurance (self-referral, or by EAP, Risk Management or colleagues). There is no record keeping or documentation. 1:1 support is available for individual clinicians and group peer support for healthcare teams, and may be provided over the phone. The program is not meant to replace formal counselling, and has a list of resources for those who require these services.</td>
<td>Support after significant emotionally stressful events</td>
<td>Clinicians (physicians and nurses)</td>
</tr>
<tr>
<td>Location</td>
<td>Program Name</td>
<td>Short description</td>
<td>Mandate/ Scope of support</td>
<td>Clients</td>
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<tr>
<td>Grup SAGESSA Tarragona, Spain</td>
<td>USVIC (Unidad de Soporte a las Segundas Victimas del Incidente Critico)⁶</td>
<td>The support unit is comprised of a bioethicist, two nurses, a psychologist, and a lawyer. Provides psychological and medical support to second victims, as well as legal guidance. The unit can be activated through self-referral, or by colleagues or management. Once activated, a rapid response team will appear on scene as soon as possible. If required, more visits/phone calls can be arranged. A root cause analysis is carried out simultaneously, and a report is made available to staff.</td>
<td>“Second Victims” (psych, medical and legal assistance)</td>
<td>Staff</td>
</tr>
<tr>
<td>Barnes Jewish Hospital, St. Louis, Missouri, US</td>
<td>We Care⁷</td>
<td>Debriefings may be individual or group-based. The We Care team is available 24 hours/day seven (7) days/week. They pro-actively contact potential “second victims” or accept referrals from HCPs. We Care team meetings are scheduled monthly to discuss encounters and support other team members. All support is confidential and no personal or situational details are recorded.</td>
<td>“Second victims”</td>
<td>Clinicians</td>
</tr>
<tr>
<td>The Everett Clinic, Washington US</td>
<td>Provider Support Group⁵</td>
<td>Dedicated to supporting health professionals who are involved in PSIs, potential claims or lawsuits, or the litigation process. Healthcare professionals are matched with mentors who have been involved in similar types of events (PSI/claim/lawsuit). Mentors meet monthly to address barriers. Post mentor/mentee surveys are distributed once the partnership has ended.</td>
<td>After PSI</td>
<td>Health professionals</td>
</tr>
<tr>
<td>Physicians Insurance, Washington US</td>
<td>Physicians Insurance Peer Support Program⁵</td>
<td>Program is administered by volunteer clinician members retained as consultants to the Claims Department. They contact members by telephone to offer short-term, confidential, emotional support and resources after a PSI is reported to the Claims Department in anticipation of litigation.</td>
<td>After PSI</td>
<td>Physicians</td>
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<td>Location</td>
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<tr>
<td>Providence Everett Regional Medical Centre, Washington, US</td>
<td>Care for the Caregiver: Providence Peer Support Team[^5]</td>
<td>A peer support program to support health professionals who are involved in a PSI or “other difficult situation.” An eight-hour educational program occurs twice annually. Created in collaboration with EAP, who are involved in the education.</td>
<td>After PSI or “other difficult situation”</td>
<td>Health professional staff</td>
</tr>
<tr>
<td>University of Missouri Health Care (MUHC), Missouri, US</td>
<td>forYOU[^16, ^25, ^26]</td>
<td>Rapid Response system available 24/7 to clinicians. Three-tiered model of support[^16] where Tier 1 represents local or departmental support and response to promote identification and awareness of second victims, Tier 2 represents guidance and nurturing of identified second victims by specially trained peer supporters, and Tier 3 represents access to professional services: chaplaincy, EAP, social work, and clinical health psychologists. Training in crisis support and stress management includes 18 hours of didactic lectures, small group work, and simulation.</td>
<td>Emotional first-aid after unanticipated or stressful/traumatic events</td>
<td>Clinicians (and their family members)</td>
</tr>
<tr>
<td>Johns Hopkins Hospital Maryland, US</td>
<td>Resilience in Stressful Events[^17, ^27] (RISE)</td>
<td>Multidisciplinary team of peer supporters who can be activated through the paging system. It is available 24/7. The RISE team will page back within 30 minutes and arrange a meeting within the next 12 hours. Group or individual support is possible. In this encounter, the RISE team member provides psychological first aid and provides a list of resources that may be helpful to the caller. All interactions are confidential. After the encounter, the peer supporter activates a debriefing, where the supporter receives support from other RISE members. Training is a two-day workshop.</td>
<td>Unanticipated patient event, stressful situation, or patient-related injury</td>
<td>Health professionals</td>
</tr>
<tr>
<td>Location</td>
<td>Program Name</td>
<td>Short description</td>
<td>Mandate/ Scope of support</td>
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<tr>
<td>Scott &amp; White Medical Center, Texas US</td>
<td>Staff Well-being Assistance During Difficult Life Events (SWADDLE)</td>
<td>1:1 ongoing peer support provided with psychological first aid, and referral to outside resources if needed. Based on the Scott three-tiered model of staff support. Program provides prevention education for compassion fatigue, secondary traumatic stress, and burnout. Resilience Rounds are scheduled bi-monthly; these have both a didactic educational component, as well as a facilitated, confidential 20-30 minute group discussion. Also train in “high-risk” areas in psychological first aid. A licensed behavioural health clinician was also hired to assess escalating psychological crises and fast-track psychiatric referrals.</td>
<td>“Second victims,” and after claims, litigation, and board complaints/ disciplinary action.</td>
<td>Health professionals</td>
</tr>
<tr>
<td>Washington University School of Medicine, US</td>
<td>Washington University School of Medicine Clinician Peer Support Program</td>
<td>Trained peers provide support to clinicians (defined as physicians, residents, fellows, physician assistants, nurse practitioners, and certified registered nurse anesthetists) after PSIs. Self-referral, referral by a peer supporter, or by patient safety staff or risk management staff. Training program provides evidence-based information on the emotional and functional impact of PSIs, information on positive coping mechanisms and clinician resiliency, and on established warning signs/known risk factors for depression and/or suicide.</td>
<td>After PSI</td>
<td>Clinicians</td>
</tr>
<tr>
<td>Nationwide Children’s Hospital Ohio, US</td>
<td>YOU Matter</td>
<td>Coverage for the program is provided 24 hours/day, seven (7) days/week. Interventions are based upon the Scott 3-Tiered model of Staff Support. Encounter forms can be accessed through SharePoint, and include only non-identifying data. This website also contains meeting minutes, lists of resources, and promotional materials. The program was managed through SharePoint (an online platform), and information was distributed through SharePoint as well. Initial peer support training consisted of eight (8) hours of</td>
<td>“Second victims”</td>
<td>Health professionals</td>
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Survey of Canadian Peer Support Programs

To develop the Best Practices Guidelines for Peer to Peer Support Programs, CPSI sought out healthcare organizations in Canada that already had extensive experience developing and implementing a PSP. Representatives from the organizations participated in a working group to develop the document, took part in group and individual discussions, and filled out a survey (see Appendix 1). For this reason, much of the knowledge from these Canadian organizations is collated in the Best Practices Guidelines for Peer to Peer Support Programs.

The following points summarize some of the common themes that emerged from the Best Practices Guidelines for Peer to Peer Support Programs working group:

- A peer support program includes any program that uses peers to provide 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. For a fuller definition, see the PSP definition in the introduction to manuscript.

- The main driver for initiating a PSP in these organizations was the recognition of the importance of mental health and wellness for individuals in their workplace, and a commitment to improve it. However, the catalyst for initiating a program in a healthcare organization varied somewhat among organizations.

- Although PSPs in healthcare are becoming recognized as a crucial service, it is still a worthwhile endeavour to establish the need for a PSP in the organization.

- However the idea for a PSP was initiated, it is important to assemble a strong organizational planning team to carry it through to implementation.

- Establishing a clear goal for the PSP is a key contributor to the success of a program.

- It is imperative that the PSP has foundational support from those in the organization who will contribute to its success.

- The process of implementing a PSP is often underestimated by people who are keen and have good intentions to help their colleagues. However, if this team of individuals with good intentions has a conviction that a PSP is crucial to the well-being of their colleagues, uses an informed selection, recruitment and training process for peer supporters, and is willing to work through some of the steps described in the Best Practices Guidelines for Peer to Peer Support Programs, they will have an excellent chance of success.
- One of the most important steps in establishing a PSP is to institute a policy that outlines exactly what the program is, how it is structured, and how it will be implemented.

- PSPs should, if possible, be inclusive rather than exclusive, that is, be open to all levels and all groups of clinical or non-clinical staff, and also include volunteers, students, trainees or anyone who might be affected by a critical incident, experiencing stress or affected by emotional trauma in the workplace.

- Three key decisions need to be made in operationalizing the PSP: How is a worker connected to the PSP? What types of issues are supported? What is the process once the PSP is activated?

- It is important to clearly outline the responsibilities of managers and supervisors, who often have an important role in encouraging an individual to seek support, or referring them to the PSP.

- Confidentiality is the cornerstone of the policy and of the PSP. [See the Confidentiality section]

- The peer supporters of a PSP are an integral component of the program, and the most important factor for its success. As such it is crucial that those implementing a PSP pay close attention to selecting, training and supporting them.

Table 2.3 provides an overall summary of the peer support programs known to CPSI as of publication. Note that many of the tools and resources from these Canadian programs are available in the Creating a Safe Space Toolkit.
Table 2.3: Canadian Peer Support Programs

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<thead>
<tr>
<th>Institution / province or territory</th>
<th>Program name</th>
<th>Established</th>
<th>Short description / Links</th>
<th>Clients</th>
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</table>
| Michael Garron Hospital, ON        | Second Victim Peer Support | 2014        | As part of its wellness strategic plan to foster a healthy workplace environment, the MGH began developing a Second Victim Peer Support Program to provide strong support to individuals who have experienced traumatic situations. Their program aims to provide 24-hour care to staff and physicians who are experiencing a normal reaction to a stressful event or outcome. The goal is to help healthcare team members understand what is known about this phenomenon and help them quickly return to work. Toolkit Resources:  
  - Providing Care and Support for our Staff (Brochure)  
  - Learning to Care for our Own (Training Slide deck) | All staff (both clinical and non-clinical), physicians and volunteers, or anyone who is directly involved or witnesses an incident, or anyone who experiences a long period of high-stress or repeated exposure to emotional trauma. |
### Institution / province or territory

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<tr>
<th>Program name</th>
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<tbody>
<tr>
<td>Province of Quebec</td>
<td>Programme d’aide aux médecins du Québec/ Quebec Physicians’ Health Program</td>
<td>1990</td>
<td>In the 1970’s, firmly convinced that physicians experiencing problems should not be ostracized but rather given peer support to help them find solutions, the then secretary general of the Collège des Médecins du Québec (the Québec College of Physicians), began providing peer-to-peer support to colleagues grappling with health problems. From these beginnings in 1990, an independent peer support program, the PAMQ/QPHP, was introduced in Quebec. The PAMQ/QPHP is an independent, not-for-profit organization, where physician advisors provide assistance on a confidential basis to colleagues affected by any type of situation or illness. All the situations observed by the PAMQ/QPHP are deemed as having the potential to cause psychological impacts to physicians which could ultimately jeopardize the quality of care provided to patients. Toolkit Resources:  - Analysis of the Effectiveness of Employee Assistance Programs: The Case of the QPHP  - Quebec Physicians’ Health Program  - Annual Report of the PANG Program - Rapport Annuel 2017-2019 (French Only)  - During a workplace crisis - is it possible not to react  - <a href="http://www.pamq.org">www.pamq.org</a></td>
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<td>Program name</td>
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| British Columbia Emergency Health Services (BCEHS). BC | Critical Incident Stress (CIS) Program | 2015 | BCEHS implemented a Critical Incident Stress peer support program for employees. The peer team approach is based on the Mitchell Model but modified for the reality of 4000 employees spread across the 944,735 km of the province of BC. The program is activated on average four times a day. Peer support is the central pillar of a five-pillar approach that includes Readiness, Resilience, Response, Recovery, Reentry on a Research/Standards base. Peers are the key to organizational culture change, stigma reduction, listening and linking too early and occupationally appropriate, community-based psychological intervention. Toolkit Resources:  
- BCEHS CIS Program Logic Model  
- Psychological Supports for Employees (FAQ)  
- Tackling Occupational Stress Injuries – The BCEHS Experience (Slide deck)  
- Critical Incident Stress Program Policy  
- Critical Incident Stress Program – Volunteer Peer Team Orientation Manual | All current employees of BCEHS are eligible for the program. Students are offered initial support and referred to community resources. |
<p>| The Toronto Hospital for Sick Children – SickKids ON | SickKids Peer Support and Trauma Response Program | 2018 | Acknowledging that compassion fatigue, burnout, second victim distress and traumatic stress are common issues that affect healthcare professionals, SickKids launched the Peer Support and Trauma Response Program. The aim of the program is to improve the psychological health and safety of staff and penetrate the cycle of silence around the topic of mental health. | Available to anyone who holds a SickKids badge. |</p>
<table>
<thead>
<tr>
<th>Institution / province or territory</th>
<th>Program name</th>
<th>Established</th>
<th>Short description / Links</th>
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<tbody>
<tr>
<td>Chatham-Kent Health Alliance, Ontario</td>
<td>Peer Support Group</td>
<td>2019</td>
<td>The decision to develop a program was in response to an organizational goal of providing a psychologically safe workplace. The program is situated within occupational health and can be triggered by the affected individual, a concerned co-worker or by leadership. Peer-supporters are staff members who were nominated by their managers, and then volunteered to be trained supporters in the program.</td>
<td>Staff, physicians, volunteers and students</td>
</tr>
</tbody>
</table>

The program offers hospital-wide interpersonal 1:1 peer support as well as CISM (Critical Incident Stress Management) response following distressing and traumatic events. The aim is to promote prevention, staff resiliency and effective coping strategies. Peers consist of physicians as well as clinical and non-clinical staff whose role is to provide confidential support, to listen, inspire, gently challenge and encourage while helping colleagues deal with stress and personal concerns. There are currently over 85 active peers on the team.

Toolkit Resources:
- [Trauma Response and Peer Support Policy](#)
- [Scope of Manager, Peer Support Program Role](#)
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<th>Institution / province or territory</th>
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<tr>
<td>Central Health, NL</td>
<td>Second Victim Guidance Team</td>
<td>2020 (expected)</td>
<td>Still in development at publication. The program was initiated because caring for the second victim is considered an important part of an integrated system for managing adverse events and establishing a just culture. As of publication, the program is still in development, but they have completed the following: • Pilot training in two high risk areas 2016 • Guidance team established 2017 • Management competency training 2018 • Training and Peer Support program TBD</td>
<td>All employees, physicians, volunteers (directly), patients and families (indirectly)</td>
</tr>
<tr>
<td>Alberta Health Services AB</td>
<td>Peer Trauma Response Team Program</td>
<td>2001</td>
<td>The program was initiated to help mitigate the burnout employees were experiencing as a result of critical incidents occurring in the workplace. The goal is to provide an opportunity to normalize the group or individual who experienced a critical incident, or who encounter traumatic events in the workplace that may cause physical or mental stress. The program objectives are to lessen the impact of a critical incident and to accelerate recovery, and includes education regarding prevention, recognizing signs and symptoms of critical incident stress and understanding how to access the support. Toolkit Resources: • Peer Trauma Response Team Logic Model • Peer Trauma Response Team Network Committee - Terms of</td>
<td>Alberta Health Services employees</td>
</tr>
<tr>
<td>Institution / province or territory</td>
<td>Program name</td>
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<tr>
<td>St Michael’s Hospital ON</td>
<td>TBD</td>
<td>2019</td>
<td>Still in development at publication. The hospital undertook a multi-phase, user-centered approach to create an organization-wide second victim support program. The next step is to develop an organizational response that will support individuals experiencing stress from patient-care encounters either immediately, or shortly after the event. The organizational program will supplement existing debriefing and support programs developed at the unit level, and enhances the existing the EAP and OMA physician health programs.</td>
<td>TBD</td>
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</table>
| Health Canada                      | Occupational & Critical Incident Stress Management (OCISM) | 1991 | The program provides services to nurses working in First Nations communities (nursing stations, health centres, home and community care) and zone/ regional offices, including FNIHB / Transferred / Band-employed / Agency / student nurses. OCISM is specialized for nurses only. The goal of the program is to safeguard nurses’ wellbeing after a critical incident, to help them maintain/return to health, to prevent/ reduce occupational stress injuries, promote nurses’ resilience, accelerate normal recovery, and minimize absenteeism. Toolkit resources:  
- OCISM Tips for coping for individuals directly involved in a traumatic event  
- OCISM Tips for coping for individuals involved in sustained, high intensity work | Nurses working in First Nations communities across Canada |
## Institution / province or territory

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<th>Short description / Links</th>
<th>Clients</th>
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<tr>
<td><strong>OCISM Tips for Family, Friends and Co-workers of individuals involved in a traumatic event</strong></td>
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<tr>
<td><strong>OCISM Tips for supervisors and managers of employees involved in a traumatic event</strong></td>
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<tr>
<td><strong>OCISM Tips on Coping following a traumatic Event</strong></td>
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<tr>
<td><strong>OCISM Brochure</strong></td>
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## Conclusion

The challenge of synthesizing findings from the scan and survey is that there are many ways to define, implement and assess PSPs. It is clear that there is a broad impetus internationally to improve the mental health and well-being of health professionals and others who work and train in healthcare organizations, and a recognition that there is a need to train peers to support one another emotionally.

We hope this document provides those seeking to establish or improve on their own PSP with ideas and inspiration to create a successful program that is tailored to the specific needs of their healthcare organization.
References


20. Tobin WN. MITSS: Supporting patients and families for more than a decade 2013.

21. The International Critical Incident Stress Foundation.


Creating a safe space

Section 3: Confidentiality of Peer to Peer Support Programs in Healthcare Organizations
Acknowledgements

Section 3: Confidentiality of Peer to Peer Support Programs in Healthcare organizations

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Deborah Prowse | Patient Representative
Brent Windwick | Field Law

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

Introduction

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 we have 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.

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 making mistakes that lead to PSIs\(^15\). 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 consequences\(^16\).
Emotional distress after PSIs

A significant number of studies conducted over the past few years confirm that health professionals feel emotionally distressed after a PSI\(^1\text{-}^{10}\), whether they are involved directly or indirectly. A systematic review by Seys et al\(^1\) 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 (2013) 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 perfection\(^22\) 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 high\(^22\).

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 inevitable\(^23\).

At the same time, PSIs are rarely considered inevitable – they are essentially considered anomalies in healthcare\(^11\). 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\(^24,25\).
A note on the term “second victim”

Albert Wu coined the term “second victim”5 and many others, including Sydney Dekker11,15,22,23, adopted the term to describe a health professional who makes a serious mistake. 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 make mistakes has brought attention to the impact of mistakes 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 mistake 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 challenge3,4,20. Health professionals continue to be unwilling to talk – and therefore learn – about mistakes 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. As de Wit et al. 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. note that the distress from PSIs has the potential to worsen productivity, quality, and safety. Van Gerven et al. note that improving healthcare professionals' work life wellness is considered a critical aspect of optimising health system performance. Finally, Pratt, Kenney, Scott and Wu 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. 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 PSI. 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 others. 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 own.

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” (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.

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). Although no
official support programs have been developed in Canada as of the writing of these guidelines, there is much interest in exploring how best to support health professionals experiencing a PSI.

**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. 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” (p. 857). Further, some health professionals may not want to risk their credentialing bodies finding out that they sought mental health care. 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., 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.

**Table 3.1: Factors that impede disclosure of PSIs**

<table>
<thead>
<tr>
<th>Helplessness</th>
<th>Fears and Anxieties</th>
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<tr>
<td>Lacking control of what happens to information once it is disclosed</td>
<td>Fearing legal or financial liability</td>
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<tr>
<td>Lacking confidentiality or immunity after disclosure</td>
<td>Fearing professional discipline, loss of reputation, loss of position, or loss of advancement</td>
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<tr>
<td>Lacking institutional and collegial support after disclosure or a professional forum for discussion</td>
<td>Fearing patient’s or family’s anger, anxiety, loss of confidence, or termination of physician-patient relationship</td>
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<tr>
<td>Believing error reporting systems penalize those who are honest</td>
<td>Fearing the need to admit actual negligence</td>
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<tr>
<td>Lacking feedback after reporting errors or a sense of ownership in the quality improvement process</td>
<td>Fearing the need to disclose an error that cannot be corrected</td>
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<tr>
<td>Lacking time to disclose errors</td>
<td>Fearing the possibility of looking foolish in front of junior colleagues or trainees</td>
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<tr>
<td>Feeling helpless about errors because one cannot control enough of the system of care</td>
<td>Fearing negative publicity</td>
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<td></td>
<td>Fearing the possibility of ‘fallout’ on colleagues</td>
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<tr>
<td></td>
<td>Feeling a sense of personal failure, loss of self-esteem, or threat to one’s identity as a healer</td>
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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 proceeding. 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 interest. If information is not privileged, then a plaintiff's lawyer could successfully seek to obtain access to the communications. 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 met.

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iii 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.

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 relationship. 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 court.
When communications about PSIs are protected

PSI, 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 Guidelines\textsuperscript{27} 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 situation\textsuperscript{1}.”

- **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 activities33,35. 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 Act38, 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.
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 statements\textsuperscript{39} 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 not likely to meet the criteria for recognition of a by case-by-case privilege; and
- They are not communications taking place within a quality assurance committee.

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 disclosure.34

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 reassurance 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 are not 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 learned\textsuperscript{40}.
- 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 study\textsuperscript{41}.
- Krzan KD, Merandi J, Morvay S, Mirtlallo J: Implementation of a “second victim” program in a pediatric hospital\textsuperscript{42},
- Pratt S, Kenney L, Scott SD, Wu AW: How to develop a second victim support program: A toolkit for Health Care Organizations\textsuperscript{29},
- 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 review\textsuperscript{17},

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\textsuperscript{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\textsuperscript{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 provided\(^{13}\).

As an example, the Brigham and Women’s Hospital created a Centre for Professionalism and Peer Support\(^{43}\) and quote an article by Van Pelt\(^{44}\) 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 care*\(^{44}\).

**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 incident\(^{30}\). 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 71 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

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 destigmatizing 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 accountability.26 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 improvement.

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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Creating a safe space

Section 4: Canadian Best Practice Guidelines for Peer to Peer Support Programs
## Acknowledgements

### Section 4: Canadian Best Practice Guidelines for Peer to Peer Support Programs

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<td>Brenda Roos</td>
<td>Health Canada</td>
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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).*
Section 4: Canadian Best Practice Guidelines for Peer to Peer Support Programs

Introduction

It is clear from the results of the survey [see Section 1] and scoping review [see Section 2] that there is a great need for establishing peer support programs in healthcare organizations in Canada. The current literature [see Section 2] on mental health and wellness for health professionals also supports these findings, leading the Canadian Patient Safety Institute (CPSI) to make a strong recommendation to healthcare organizations to establish peer support programs for individuals in their organization who may be experiencing emotional distress.

Along with this recommendation, CPSI aims to support healthcare organizations that intend to establish a Peer Support Program (PSP). For this reason, we worked with Canadian experts in the field to develop this Best Practices section of the Creating a Safe Space: Strategies to Address the Psychological Safety of Healthcare Workers. These experts were recruited to be members of this working group because of their expertise in establishing their own peer support programs. Their collective wisdom shaped the direction and content of this manual; the members gave advice on important elements to include in our document, shared with us a multitude of resources and tools, outlined tips and lessons learned, and worked closely with us to develop key messages and recommendations to help organizations succeed with their PSPs.

The following are the program names (in various stages of development) and organizations of the working group members:

- 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);
- Programme d’aide aux médecins du Québec (PAMQ)/Quebec Physicians’ Health Program (QPHP);
- Second Victim Peer Support (Michael Garron Hospital);
- St Michael’s Hospital, still in development;
- Chatham-Kent Health Alliance, still in development; and
- Second Victim Guidance Team (Central Health, Newfoundland and Labrador).
This is not an exhaustive list of peer support programs in healthcare organizations in Canada. There are other programs and organizations that support healthcare workers. For example, there are a number of health professional associations that offer peer support, and burgeoning initiatives such as the Schwartz Rounds™ that is now active in six centres in Canada. We uncovered a number of programs in our survey of peer support in Canada [see Section 2] and will no doubt continue to discover others as we continue our work in this area. We hope that this document will help bring together a community of practice where we can collaborate and learn from each other’s experience.

It is important to note that these are guidelines only, not a definitive step-by-step script; each organization will necessarily customize their PSP according to their own policies, culture and vision.

Purpose of the Best Practices section

The aim of this section is to provide a roadmap for healthcare organizations that are contemplating or are in the process of implementing a structured and formal workplace-based PSP program where employees, some with lived experience, are selected and prepared to provide peer support to other employees within their workplace (see definition p. 12 of the manual). This document was created to offer practical advice and outline key recommendations on how to develop the core elements for developing a comprehensive and sustainable approach to peer support. We aim for it to be beneficial to whoever initiates the program at any level: from the individual who identifies the need for peer support and wants to know how to get started, to organizational leaders who recognize the importance of supporting their staff and who need information to guide their process. It is important to note that these are guidelines only, not a definitive step-by-step script; each organization will necessarily customize their PSP according to their own policies, culture and vision.

There are valuable resources available already that provide guidance for the fundamentals of peer support programs in general. For example, Peer Support Canada provides certification for peer support, along with a number of resources on such topics as peer support competencies, training, code of conduct and core values.

In particular, the Mental Health Commission of Canada (MHCC)’s Guidelines for the Practice and Training of Peer Support (2013) provide comprehensive advice on a number of relevant topics, including:

- the value of peer support;
- guiding values and principles for peer supporters;
- skills, abilities and personal attributes of peer supporters; and
- guidelines for training peer supporters.
The British Columbia Emergency Health Services (BCEHS) adapted a great deal of this information, along with materials from the Critical Incident Stress Foundation, for their own program, and informed much of the content for the BC First Responders’ Mental Health website. We will be referring to both the MHCC and the BC materials frequently throughout the text.

There is also knowledge to be gained from peer support programs for healthcare professionals that have been established for a number of years. The following programs, based in the United States, have several particularly useful documents and other resources that informed our work:

- **Resilience in Stressful Events (RISE) second victim support programme** at the Johns Hopkins Hospital;
- **ForYOU team** at the University of Missouri Health Care (MU Health Care);
- **Medically Induced Trauma Support Services (MITSS)** in Massachusetts; and
- **The Center for Professionalism and Peer Support** at Brigham and Women’s Hospital in Massachusetts.

We do not intend to re-create such knowledge in this document; rather, our intention is to focus on fundamental considerations for establishing a peer support program within healthcare organizations, using examples and best practices gleaned from our experts and from other organizations with well-established peer support programs.

Throughout this text, we will be referring to two other sections of this manual that complement and reinforce the information here:

- **Tools and Resources for Peer Support Programs**: A comprehensive list of tools and resources that will help organizations implement a peer support program.
- **Addressing Confidentiality for Peer-To-Peer Support Programs for Health Professionals**: Clarifies the legal privilege and professional confidentiality considerations for a PSP.

**Definition of Peer Support**

As we have seen from the scoping review [see Section 1], there are many variations in the meaning and/or composition of a PSP. 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, the working group members agreed on the definition of a PSP as stated in the introduction to this manual, which is repeated on the next page for convenience (Box 4.1):
“Peer support is an important addition to SickKids as it gives staff an opportunity to connect with colleagues that “get it”. It is not counselling or therapy. It is a chance to get some extra support. There is such value in talking through difficult moments. I enjoy being part of the Peer team as it always reminds me what dedicated and passionate professionals I am privileged to work with here at SickKids. This is not an easy place to work yet people come day after day and year after year to help (through whatever profession they are part of). Peer helps me connect with staff from all over as people not just professionals. I think that is important.”

(Shaindy A. Child Life Specialist, Peer Supporter, SickKids)
Box 4.1: Definition of a Peer Support Program

A peer support program (PSP) includes any program that provides non-clinical emotional support to health professionals (and in some cases other individuals who work, volunteer or train at an organization) who is 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.
Guiding values and principles of a peer support program

A valuable framework for those who are implementing a PSP is the MHCC’s description of the primary values and principles of practice to which organizations should adhere. Below is an abridged version of those values and principles, as summarized by the BC First Responders’ Mental Health.

Primary values

- Self-determination, self-resiliency and equality: the belief that each person knows the path towards recovery that is most suitable for them and that it is the peer’s choice to engage in a peer support relationship.

- Self-compassion: the belief that empathy increases self-compassion, minimizes moral injury and reduces stigma around seeking help.

- Mutuality and empathy: the belief that all involved in the peer support relationship can benefit from the reciprocity and understanding that comes from lived experience.

- Recovery, hope and empowerment: the belief that there is power in hope and positivity and that these can aid in recovery.

Principles of peer practice

- Respect where each individual is in their journey towards empowerment and/or recovery and recognize that while peer supporters may have lived experience, the beliefs and healing paths of peers may not be the same as their own.

- Help peers normalize or destigmatize their distress, and encourage resilience through compassion and self-compassion.

- Help peers to determine their own direction. Work with peers to identify and explore options, and support them to take steps forward on their own rather than “helping” by doing it for them.

- Create a peer relationship that is open and flexible and maintain the focus on the peers and their needs. Ask yourself: “Are we in a safe place in the client’s eyes?”

- Focus on positivity and on the peer’s journey to a more hopeful, healthy and full life, rather than focusing on symptoms, diagnoses or objectives set by someone other than the peer.

- Share aspects of lived experience in a manner that is helpful to the client, demonstrating compassionate understanding and inspiring hope for recovery.

- Self-care is essential to the well-being of the peer supporter. Take care to recognize the need for health, personal growth, and resiliency when working as a peer supporter.

- Use communication skills and strategies to foster an open, honest, non-judgmental relationship that validates the peer’s feelings and cultivates trust.

- Empower peers to find their path towards a healthier outcome, and encourage them to disengage from the peer support relationship when the time is right for the peer.
Respect professional boundaries with the peer and with other professionals should they become involved. It might be useful to establish whether the relationship is a short term or long term one.

Collaborate with others (community partners, mental health practitioners, leadership, other stakeholders) whenever appropriate.

Know personal limits during crises and other times, and seek assistance when appropriate. Peer support work can be intense and experiences very challenging and as such, peer supporters need to understand the importance of taking care of themselves.

Maintain high ethics and personal boundaries to avoid harming the peer or the reputation of peer support.

Participate in continuing education and personal development to learn skills and strategies to assist in peer support work.

Building a program

The working group members for this section of the manual committed to offer practical advice and make concrete recommendations that would be valuable for individuals in healthcare organizations who were in the process of implementing a peer support program. We hope that by sharing their experience on how they developed their own peer support programs, and gleaning the most useful information from other key resources, we will help others who are establishing a peer support program.

Initiating the program

The main driver for initiating a PSP in the organizations is the recognition of the importance of mental health and wellness for individuals in their workplace, and a commitment to improve it. However, the catalyst for initiating a program in a healthcare organization varied somewhat among organizations.

For some organizations, the catalyst was a specific critical incident or trauma that had a significant emotional impact on staff, prompting the organization to take action so as to be prepared for future incidents and enhance the organization’s response to them. In fact, more than one organization noted that the need for the PSP was driven by a critical incident.

For others, organizational leaders officially acknowledged that stresses and traumas were affecting the workplace – with one organization calling it a “trauma-infused environment” for example – and identified the need for emotional support for their staff and committed to promoting wellness. As an example, the RISE second victim programme at the Johns Hopkins Hospital was initiated because: “… patient safety leaders recognized a gap in the ability of the institution to provide consistent and timely support to second victims”\(^1\). The genesis of the peer support program at the Brigham and Women’s Hospital was simply their “observation that clinical staff were suffering following adverse events”\(^2\).

Some organizations implemented a PSP because they identified a rise in reports related to mental health such as the number of workplace violence incidents, absenteeism due to mental health illness, or the number of staff members accessing the Employee Assistance Program. In some cases, a PSP is initiated because of legislation; for example, many provinces are instituting presumptive legislation for paramedic
services related to occupational stress injuries. This change enables workers to access treatment more readily without have to prove their mental injuries were work related. The expectation of employers is that they are being proactive in managing occupational stress injuries through mitigation and early identification.

Other PSPs were created to support health and safety standards, organizational policies or national standards for a psychologically safe workplace, such as the National Standard for Psychological Health and Safety in Canadian Workplaces. Still others were prompted by unions requiring more mental health support for their members.

In whatever manner the need was recognized, the PSPs mostly grew organically without a clearly outlined process. Step-by-step, each organization put together the building blocks needed to establish a PSP. The following outlines the main building blocks.

**Establishing the need**

Although PSPs in healthcare are becoming recognized as a crucial service, it is still a worthwhile endeavour to establish the need for a PSP in the organization. Not only does it serve the purpose of substantiating the need for the program to organizational leaders and/or policy makers, but it will also provide valuable information about how best to deliver the program and identify the clients’ needs.

The following are some of the tools and methods organizations use to assess needs:

- **Questionnaires or “pulse” surveys**, giving insight into potential clients’ perspective of organizational support for their mental health (these were sometimes given out after a presentation about mental health). The MITSS program has a survey tool for clinicians and staff.
- **Interviews and focus groups** with frontline staff and with managers.
- **Management forum** where a presentation was made to all managers and senior executives, followed by a survey of management.
- **External review** of psychological health and safety.
- **Engagement survey** that assesses, for example, how staff rate the stress levels of their jobs, and how their emotional well-being and mental health are supported.
- **Environmental scan/gap analysis** of internal supports already in place (both formal and informal). The MITSS recommends that organizations include in the scan such resources as chaplaincy, social work, psychiatry, employee assistance programs. They also have an organizational assessment tool for clinician support. See Box 4.2 for an example of internal resources to assess.
- **Assessment of current response processes** for responding to critical incidents.
- **Assessment of key performance indicators** for short- and long-term illness should be examined, especially since mental health injuries can result in higher absenteeism and relapse.
• **Helping leadership recognize that early intervention is important**, and that if mental health is not recognized as a priority, this can result in moral injury, stigmatization and poor organizational morale.

• **Unit walkabouts and huddles** in identified high-risk areas, such as the emergency department and ICUs.

• **Review of data** in such areas as workplace violence and harassment, absences due to mental illness, referrals to the EAP or psychological interventions.

• **Pilot projects** to assess feasibility and value of PSP (for example, in one department or unit).

• **Review of standards** for mental health support (e.g. CSA Occupational Health and Safety, Mental Health Commission of Canada, Accreditation Canada, International Critical Incident Stress Foundation).

• **Literature reviews and background research** to gather knowledge on the importance of peer to support for health professionals.
Box 4.2: SickKids Hospital

Example overview of current services that support staff mental health:

- Occupational Health Clinic;
- Health Absence Management Program (HAMP);
- Wellness Program;
- Peer Support and Trauma Response Program;
- SickKids Mental Health Strategy;
- Peer Support and Risk Management Serious Safety Event Protocol;
- Customized mental health training during new nurse orientation period;
- SickKids Mental Health Resources for Staff website;
- Consultation with the Centre for Addiction and Mental Health (CAMH) Work, Stress and Health Program;
- Employee Assistance Program (EAP);
- Psychologist coverage in benefits plan;
- Incapacity in the Workplace policy;
- Prevention of Workplace Violence and Harassment policy;
- Other Human Resources programs and policies including the Engagement Survey;
- SickKids’ Mental Health Management Model; and
- Classroom training for people managers on managing health, conduct and performance.

“There are not a lot of places to go for support, so it is very appreciated when it is offered.”

(PAMQ/QPHP)
Assembling a team

Wherever the idea was initiated, it is important to assemble a strong organizational planning team to carry it through to implementation, in the form of a steering committee or working group. Members might include organizational leaders, managers and frontline staff from various clinical departments, as well representatives from human resources, occupational health and safety, patient safety/risk management teams, employee wellness teams, spiritual care teams, critical incident management teams, unions or provincial health authorities. Alberta Health Services suggests that team members might be nominated by their peers because they have certain skills or are seen as credible and respected. [See AHS Information for Leaders newsletter, Workplace Peer Support]

These teams – in the form of a working group or steering committee – are responsible for establishing the foundation of the PSP, including goals, policies, procedures and business plan. They might also be engaged in needs assessment/gap analysis, creating a work plan, strategic planning, and implementing, championing and evaluating the program.

“The best thing is feeling that I’m making a difference for my colleagues in a way that is in tune with my values.”

(PAMQ/QPHP)
Identifying the goals

Establishing a clear goal for the PSP is a key contributor to the success of a program. This goal ensures that all levels of the organization understand the purpose and value of the PSP, and stay focused on what they are trying to accomplish.

The following are sample elements that might be embedded in the goals for a PSP, drawn from a selection of goals of established PSPs:

- safeguard the well-being of individuals at the organization;
- allow individuals time to collect themselves and reflect immediately following an incident;
- assist in the recovery of individuals who experience critical incident stress;
- help individuals maintain and/or return to health;
- prevent more serious occupational stress injuries and illness;
- provide reassurance and reduce the stigma of mental illness;
- promote resilience;

Box 4.3: Examples of a PSP team

**SickKids**
A steering committee was convened to develop a proposal for the implementation of a sustainable hospital-wide workplace peer support program. The working group included representatives from Occupational Health and Safety, Risk Management, Quality and Safety, Human Resources, Social Work, Facilities, Clinical Programs, Physicians and the Caring Safely project team and steering committee.

**Johns Hopkins Hospital’s RISE program**
The PSP team included leaders in patient safety, risk management and clinical departments, who gathered to discuss “the magnitude and importance of the problem, current infrastructure to support healthcare providers, stories and experiences, and strategies to improve the system”\(^1\). They then put together a multidisciplinary “Programme Development Team” – including the director of patient safety, a physician faculty member, a risk manager, a patient safety researcher, a nurse manager and a hospital chaplain. to lead the strategic planning and implementation.

**St. Michael’s Hospital**
An interdisciplinary group of healthcare and non-healthcare staff and trainees (i.e. physicians, nurses, social workers, clerical staff, security personnel) participated in two iterative design workshops facilitated by a design specialist. They and worked together to identify a program framework and prototypes, then test-drive and explore the feasibility of the design team’s prototypes.
• provide referrals, resources and links to other support services, and activate appropriate psychological interventions as required;

• help individuals understand that their reactions are normal and expected;

• enable health professionals to continue to function effectively in the workplace; and

• reduce absenteeism.

Box 4.4: Sample Goals

**PAMQ/QPHP**

To prevent mental health problems among physicians, foster early identification and appropriate treatment of their problems, and help them stay in their job, or enter or re-enter the labour market.

**RISE second victim support programme**

To foster a culture in which all employees are resilient and mutually supportive before, during and after stressful events. To provide timely access to support employees’ immediate needs to complement the services being offered by the existing employee assistance programme*.

**Brigham and Women’s Hospital**

To provide a safe way for clinicians impacted by events to talk about their experience and emotions with someone who has empathy from having “been there”*. [see Brigham’s FAQs]

**MITSS**

To assist affected individuals to process adverse medical events in a positive manner in order to move forward both personally and professionally*.

**St. Michael’s Hospital**

To provide immediate response to staff (medical and non-medical) and trainees who may be having emotional distress from being involved in a negative patient care interaction.

The goal of the program can be tied to long term outcomes for the organization, such as one that fosters a just culture of transparency or a resilient workforce, or to outcomes more specific to the program – such as one that provides emotional support to health professionals after a critical incident. They can also be linked with the “five rights of second victims” outlined by Denham*: treatment, respect, understand and compassion, supportive care and transparency and opportunity to contribute to enhancing the systems of care.
Partnering with leadership

It is imperative that the PSP has foundational support from those in the organization who will contribute to its success. This means getting buy-in from the organizational leadership, managers and those who will be served by the PSP.

Getting buy-in from senior leaders is not always as big a challenge as expected; in fact, our working group members often noted that “there was no argument” from senior leaders, as many already recognized that the need for a PSP was significant. In the same way, most managers also supported the PSP and were on board right away.

Still, there may well be resistance from leadership or management within the organization. Even the current climate of promoting the well-being of health professionals in the workplace does not mobilize senior leaders as much as it should. The RISE program at Johns Hopkins Hospital noted that one of the biggest challenges was the “limited awareness of the magnitude and importance” of the issues.

Some of the tactics used to bring senior leadership on board included:

- Providing evidence from a needs assessment or staff survey that clearly demonstrates the need for better emotional support as a result of workplace critical incidents.
- Clearly stated goals that demonstrated the benefits of the program to the organization (e.g. more resilient workforce, decreased absenteeism, improved patient safety).
Creating a Safe Space  
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- Assembling a team that was representative of relevant and various areas and levels of the organization.
- Sharing a video of a champion of mental health after a critical incident, thus humanizing an experience. [CPSI’s provider experience videos](#) are powerful examples of such testimonials.
- Committing to clear lines of communications to senior leadership throughout the initial stages of the development of the program, and ongoing reporting to keep them apprised of its progress.
- Collaborating with the union(s) if applicable, ensuring they understand the purpose and benefits of the program.
- Educating leadership about the benefits of peer support whenever the opportunity arises (e.g. regular meetings, workshops, training sessions, manager and director forums, townhalls, HR community quarterly meetings, etc.).
- Creating a roadmap to take the organization from “we’ve never thought about having a peer support program” to a fully implemented and sustainable program.
- Provide a case study or story of a critical incident where staff were not supported (with a less than ideal outcome) and one where staff were supported (with a more positive outcome).
- Demonstrating return on investment (ROI) with data and statistics such as absenteeism due to mental health illness.
- Explain the importance of adhering to standards for mental health in the workplace.

The [MITSS Clinician Support Tool Kit for Healthcare](#) also provides a list of several resources under the headings “Internal Culture of Safety,” “Organizational Awareness” and “Leadership Buy-in” that might help change the mindset of some more resistant leaders and staff, and prepare the organization for the establishment of a peer support program.

Once some of these steps have been taken, it is a good idea to take the time to assess leadership understanding and readiness before moving forward.

**Operational policies and structures**

Once the kernel of an idea begins to grow – whether it starts with an informal conversation, a reaction to a serious critical incident, or a formal organizational response to growing mental health issues among staff – it is time for the team to begin to formulate a strategic and/or organizational plan and implement the policies and build the structures required to build the foundation of a PSP.

A cautionary note expressed by our experts was that it is likely to take more time than expected to implement a PSP. Even the well-known RISE program at Johns Hopkins Hospital noted “there were relatively few calls in the first year of operation” and “the greatest challenge was getting staff members who could benefit from the programme to use it”. Their suggestion is to “start slow and steady, and start with where people were at” and expect a few challenges along the way.
There are many questions to answer, and decisions to be made about such issues as who should own the program, how the program will be set up, how to recruit, train and compensate peer supporters, how staff will be connected or referred to the program, and how will the program be staffed and/or resourced.

The process of implementing a PSP is often underestimated by people who are keen and have good intentions to help their colleagues. However, if this team of individuals with good intentions has a conviction that a PSP is crucial to the well-being of their colleagues, uses an informed selection, recruitment and training process for peer supporters, and is willing to work through some of the steps described in this manual, they will have an excellent chance for success.

**Instituting a policy**

One of the most important steps in establishing a PSP is to institute a policy that outlines exactly what the program is, how it is structured, and how it will be implemented.

Some organizations began with existing policies – such as policies for employee wellness, just culture, occupational health and safety – and adapted them to include a PSP. These policies might include elements of peer support that are not yet formalized.

Others created a policy that was specific to the PSP. This process could be lengthy, with many iterations of the policy, especially as the concept of peer support or critical incident management might be new to those creating the policy, and many decisions have to be made about the mechanics of the program.

Below are suggestions for both the foundational and operational elements that might be included in an effective PSP policy, which was informed by the B.C. First Responders Mental Health Committee Developing a Peer Support Policy and the SickKids Trauma Response and Peer Support Policy, both available in our Tools and Resources section:

**Foundational elements:**

1. **Policy statement:** The policy statement should outline the purpose, goal and scope of the PSP, who is served by it and how it will benefit the organization.

2. **Definitions:** Provide a clear definition of peer support, how it will operate in your organization, and how it can assist health professionals who have mental health challenges. There might also be other terms you need to define, such as “peer supporters,” “critical incident” or “mental health and well-being.”

3. **Interventions:** Provide details of what type of interventions and services are available through the PSP (and what is not available, if this provides further clarification).

4. **Fit within organizational structure:** Clarify how the PSP is related to existing supports for staff and under what department or group will it be housed (e.g. employee assistance programs, human resources, wellness programs, occupational health and safety). The MITSS Clinician Support Tool Kit for Healthcare provides a number of examples for where the support program could be anchored, under the heading “Operational” on page 7. Wherever it is housed, our working group recommends that, to be most effective, peer support needs to operate autonomously (i.e. that it is a confidential safe space away from the operational arms of the organization) and be a core component of an organization’s mental health system.
5. **Resources**: Outline how the organization will commit to developing and maintaining a peer support program, including such elements as support for peer support members (including regular and ongoing training, and psychological oversight to gauge their health and resiliency), salaries for staff running the program, promotional materials, appropriate benefit resources, or secure privacy and communication equipment.

6. **Evaluation**: Determine the timeline for reviewing the policy, and for ensuring the PSP is achieving its purpose in supporting the mental health and wellness of health professionals. Identify the metrics that will be tracked to assess utilization and quality of programming.

7. **Communication** strategy both within the program and how program interfaces with hospital.

**Operational elements:**

1. **Clients**: Outline who will be supported, identifying precisely to whom and in what circumstances the policy will apply.

2. **Process**: Outline how the PSP will be activated, or how and when a worker will be connected or referred to a peer supporter.

3. **Responsibilities**: Explain the responsibilities of managers and supervisors as well as staff, peer supporters and peer program managers or coordinators.

4. **Confidentiality and documentation**: Provide details on how the PSP will maintain confidentiality.

It is important to put in place a plan to inform those who work at the organization about the policy, so that all are aware of the implementation of the PSP. This could be done through presentations or written literature on the program. Depending on the scope of peer support being offered, consider what training will be provided to raise awareness and understanding of peer support among all those in the organization who may access it (see section below on "Training").

The B.C. First Responders Mental Health Committee provides a [template](#) for creating a policy that is specific to first responders, but can effectively be adapted to PSP for other health professionals.

The operational elements of the program will now be explored further.

**Implementing the program**

**Clients: Who will be supported**

There was clear consensus among our experts that a PSP should, if possible, be one that is inclusive rather than exclusive. This is to say that we suggest that PSPs be open to all levels and all groups of clinical or non-clinical staff, and also include volunteers, students, trainees or anyone who might be affected by a critical incident, experiencing stress or affected by emotional trauma in the workplace – as long as there are appropriate peer supporters available. As noted by one working group member, “our peer support program is open to anyone who wears a SickKids badge” or anyone who is identified as officially working at the organization.

Some of the organizations were targeted to a specific audience, but their PSPs were more inclusive than exclusive, and aimed to reach the broadest client base within their parameters. For example, the OCISM
notes that support is offered to all nurses working in First Nations communities including those employed by FNHB, Band, agency, and nursing students.

Whatever the organization decides, a clear statement within the policy explaining who will be supported by the PSP is essential.

**Process: How will the PSP be activated and followed through?**
The process to determine how the need for support is identified or the PSP is activated can be challenging, but is a key element of establishing the structure and procedures for the program. Decisions will need to be made that are related to three key questions:

1. **How is a worker connected to the PSP?**
2. **What types of issues are supported?**
3. **What is the process once the PSP is activated?**

The following sections will provide advice and examples to help make those decisions.

**How is a worker connected to the PSP?**
There are many mechanisms that can connect a worker to a PSP. The most common mechanism is self-referral, where an individual calls a telephone number to reach the PSP directly. Some programs also have an email address for an individual to connect with the program, or have set up a paging system.

It is sometimes the case that a supervisor – such as a program director, manager, team lead or preceptor– will recognize that one of their staff members is in need of support. (see sections below on “Responsibilities of Managers and Supervisors” (p. 106) and “Other Training Considerations” (p. 124). Managers and supervisors can call the PSP themselves to alert them to the issue with the individual. In this case, some PSPs will arrange for a peer supporter to get in touch with the individual, at which point he or she will have the opportunity to accept or decline the service. In other PSPs, the peer supporters do not reach out to individuals when a call comes in from a concerned third party because of confidentiality issues or because the individual might not be open to talking when they have not been advised. In this case, the PSP will more likely assist the third party with their concerns regarding the colleague they are calling about and support them in helping the colleague access the PSP.

SickKids follows a process in the event that there is a referral for their PSP, as per their Peer Outreach flowchart.
The Center for Professionalism and Peer Support suggests that in cases where an individual is referred by someone other than themselves, the peer support call the individual and state: “I am calling as a peer supporter. I heard things didn’t go well yesterday, and I’m calling to find out how you are doing. Would it be helpful to talk about your experience?”

Counsellors or therapists associated with the EAP or OH&S programs might also refer individuals to the PSP, or contact the PSP themselves to identify an individual who might benefit from their services. It is usually the case that the PSP will not be engaged unless the staff person has asked the individual if they can be referred.

A colleague of an individual might also call the PSP to talk about someone they are concerned about. The peer supporter might then give advice on how to talk to the colleague, or how to encourage them to contact the PSP themselves.

Another circumstance in which the PSP is activated is where there are many involved in an event who are traumatized or emotionally distressed. This might be a suicide by a staff member, an unexpected patient death or, in the case of first responders, during a disaster (such as wildfires or mass casualties, for example). Chiefs of staff, managers, supervisors or others involved in the management of such an event, and even sometimes staff who identify that many of their colleagues have been impacted by an event, decide to proactively activate the PSP. The PSP is therefore activated for a group of individuals, and results in a group intervention.

SickKids follows a clear process when a traumatic event occurs, as per their Peer Trauma Response flowchart.

Some organizations use proactive methods for engaging the PSP. For example, the PSP at one organization (SickKids) coordinates a morning safety call to capture what has occurred overnight as well as an evening safety call to get a pulse on what has transpired during the day to know how to intervene overnight. They look for out-of-the-ordinary outcomes that may have led to emotional distress, then check in with any individuals involved to make sure they are alright, refer them to appropriate resources such as the EAP or spiritual care team and/or activate a group intervention with the team involved. These proactive steps help mitigate risk of critical event by anticipating resource needs and deploying appropriate resources.

“Once the program was established and proved its worth, we were able to focus on delivering excellent program services rather than justifying why it was needed.”

(OCISM)
BCEHS uses the standard International Critical Incident Stress Foundation (ICISF) list:

**Figure 4.1: Top 9 CIS Triggers**

<table>
<thead>
<tr>
<th>Top 9 CIS Triggers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicide of a colleague</td>
</tr>
<tr>
<td>Line of duty death</td>
</tr>
<tr>
<td>Disaster or multi-casualty incident</td>
</tr>
<tr>
<td>Significant events involving children</td>
</tr>
<tr>
<td>Prolonged incidents ending in loss</td>
</tr>
<tr>
<td>Excessive media interest</td>
</tr>
<tr>
<td>Event with threat to staff safety</td>
</tr>
<tr>
<td>Serious on the job injury</td>
</tr>
<tr>
<td>Work on relatives or known victims</td>
</tr>
</tbody>
</table>

**What types of issues are supported?**

Individuals seeking support might be experiencing distress in the form of anxiety, depression, PTSD, burnout or compassion fatigue, which can result from a variety of emotional issues as described in the definition of a PSP [p. 12 of this manual]. It is important to be clear about what emotional issues will be supported by the PSP. The most effective way to determine this is to build from the definition of a PSP. It is especially important to be clear as to whether the PSP is for patient safety incidents only (as are many of the established programs in the US) or for other issues such as critical incidents/traumas and other work-related stress as outlined in our definition of a PSP.

**Box 4.7: OCISM**

Example of proactive method for engaging the PSP:

**OCISM**

In the OCISM program, peer supporters review occurrence reports and proactively follow up to see how nurses are doing. They provide advice on self-care, and allow them an opportunity to discuss the event, with the purpose of averting a more serious response to a critical incident.
What is the process once the PSP is activated?

Once a call is made to the PSP, the next step is to assign a peer supporter to the case. Whether the call is channeled to a staff member of the PSP or to the peer supporter on call, these individuals are responsible for connecting a peer supporter to the individual in need. They will gather enough information about the individual and the incident so that they can create an action plan.

An important part of the plan for proceeding is identifying the most appropriate individual to match with the person in need. This might mean matching for profession or role, license level, years of experience, rural vs urban, work experience or gender, for example. In some cases, however, organizations have found that it is a peer supporter who knows little of the work of the affected group or individual who is a more objective – and helpful – resource. The assignment of a peer is therefore often managed on a case-by-case basis; what is important is that the peer matching creates a “safe place” for the individuals seeking help.

In some organizations, individuals with formal mental health credentials – such as psychiatrists or psychologists or social workers – are assigned to clients with evidence of severe trauma.

Depending on the structure of the PSP, there may only be one or two peer supporters on call at the time, or the availability of peer supporters might depend on those who happen to be currently in the workplace.

It is also decided on a case-by-case basis when the intervention takes place. In a study done by the RISE program, the researchers found that the preference expressed by participants ranged from as soon as the event happened (12.7%) to within a few hours after the event (25.4%) to within a couple of days (48.2%) and after a week (8.1%)\(^1\). Most organizations try to get back to the individual in a timely manner, at least to connect and find out how urgent the need is.

Peer support is mostly provided in-person – or by telephone if the client prefers – in a suitable environment that is quiet and private.
It is recommended that support be rendered immediately, or as soon as possible after the PSP is activated\(^5\). Some peer support interventions might be a one-time support, and some might include follow-up or ongoing support if this is indicated or requested. It is also sometimes the case that peer supporters are there to provide immediate and urgent support, then connect the clients to other resources or supports as appropriate. Scott et al\(^6\) suggests that there are three tiers of emotional support for a health professional: tier 1 is immediate emotional first aid to make sure the individual is okay; tier 2 is support from peer supporters; tier 3 is expedited referral to professional counselling.

### Box 4.9: Sample process to activate PSP

**Chatham-Kent Health Alliance**

The following process is written into the Chatham-Kent Health Alliance policy, and is a useful example of the steps in a PSP once it is activated:

- When a need arises, a message is sent to all peer supporters through WhatsApp.
- Preference will be given to activating supporters who are currently in the workplace (i.e. before calling in team support who are not working)
- The on-call Peer Support Group member shall immediately upon request of services assess the nature of the incident, the needs of those involved, and the 5 T’s (themes, targets, types, timing, team) so that appropriate action may be initiated.
- The on-call Peer Support Group member will begin a plan of action based on the 5 T’s that may include scheduling a date and time with the individual(s) involved for various Peer Support Group services, or immediate referral.
- Periodically, the member(s) providing services will speak with fellow Peer Support Group team member(s) for a personal debrief to evaluate the services rendered and discuss any positive and negative feedback methods for improvement and anything that can help.
- No notes shall be taken during any intervention, but basic records should be attempted following the intervention.

### Responsibilities of managers and supervisors

In the policy for the PSP, it is important to clearly outline the responsibilities of managers and supervisors, who often have an important role in encouraging an individual to seek support, or referring them to the PSP. They should not be left out of the organizational response to critical incidents.

Managers and supervisors need to be trained to recognize the signs of distress, and given clear instructions on how and when to refer their staff to the PSP (see the section on “Other training considerations”). The following is the BCEHS list of signs and symptoms of critical incident stress (CIS) to look for in a staff member [www.bcehs.ca/health-info/support-for-bcehs-family-members/critical-incident-stress/signs-and-symptoms-of-critical-incident-stress](http://www.bcehs.ca/health-info/support-for-bcehs-family-members/critical-incident-stress/signs-and-symptoms-of-critical-incident-stress), which complements their leadership training about...
the mental health and identifying when management responsibilities decrease and health care supports increase.

Figure 4.2: Top 10 CIS Signs & Symptoms

Managers and supervisors might encourage their staff member to call the PSP, provide details on how to do so and reassure them that it is a confidential service that is fully supported by the organization. They can also support their staff member by reassuring them that they continue to have complete trust in their professional abilities, and that they are important to the team\(^5\). The OCISM’s “Tips for Supervisors and Managers of Employees Involved in a Traumatic Event” are a useful resource.

The following are examples of leadership steps for managers and supervisors help support their staff:

- Connect with the individuals as soon as possible, in private, and express your concern. Let them know you care.
- Reaffirm confidence in them.
- Normalize their response to the situation, and self-disclose (briefly) if possible or appropriate.
- Explain what services are available to them, including the PSP, and how to access them.
- Reassure them of confidentiality of your interaction and the available services.
- Notify staff of next steps, and keep them informed.
Assess the individual’s fitness for duty (physical and mental). Direct them to supports such as an Occupational Health Clinic, a family physician, a walk-in clinic or an ER (if after hours).

If an individual needs to leave work, take steps to ensure their safety and ensure the individual is okay for travel or being at home.

Consider calling in replacement staff.

Monitor and check in with the individual regularly.

“We have a new group of peer supporters that started up in the summer. The group was so committed they’ve since been able to gain the trust of their team. That is success.”

(Alberta Health Services)

Central Health proposes Denham’s five human rights\(^4\) for those involved in a critical incident, which all staff can easily remember with the acronym TRUST:

Figure 4.3: Five Human Rights

<table>
<thead>
<tr>
<th>Five Human Rights</th>
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</thead>
<tbody>
<tr>
<td>Treatment that is just</td>
</tr>
<tr>
<td>Respect</td>
</tr>
<tr>
<td>Understanding and compassion</td>
</tr>
<tr>
<td>Supportive care</td>
</tr>
<tr>
<td>Transparency</td>
</tr>
</tbody>
</table>
“Within 2 or 3 months of creating awareness about emotional distress after a critical incident, we had a critical incident. It paid off because rather than leadership swooping in, we helped leadership be accountable and step through the helping process. The client who was most affected said ‘this is the first time in 25 years that a manager called to see how I was doing.”

(Central Health)

There are a number of key phrases and key actions managers and supervisors can use to support their staff members.

Key phrases:

- “This had to have been difficult. Are you okay?”
- “I believe in you.”
- “I cannot imagine what that must have been like for you. Can we talk about it?”
- “I can see this case hit you – it happens to us all sooner or later.”
- “I need you to [suggest a very simple action] now. Can you do that?”
- “When we get through this situation, we will help you come to terms with what has happened…and get you support.”
- “You are a good nurse/ doctor/ pharmacist/ volunteer/ student working in a very complex environment.”
- “It’s human to make errors.”
- “It’s common to think about it and lose sleep.”
- “The fact that you are upset shows that you are a caring, committed health professional.”
- “Over time, the feelings gradually lessen.”
- “Remember all the good you have done.”
Confidentiality and Documentation

It is generally acknowledged that confidentiality is the cornerstone of the policy and of the PSP. Confidentiality is especially important to health professionals who fear being perceived as vulnerable or weak for seeking mental health support and, particularly with respect to patient safety incidents where they fear exposure to legal or disciplinary actions. It is therefore important to be clear in the policy – and to the health professionals – that the organization will make every effort to maintain confidentiality within the PSP. It is also important that peer supporters make clear the limits of confidentiality to those they are supporting.

A detailed explanation of how best to maintain confidentiality and what is protected by legal privilege is provided in the section in the manual entitled “Addressing Confidentiality for Peer-to-Peer Support Programs for Health Professionals.” [see Section 3]

One of the key recommendations about confidentiality coming out of this work is that PSPs should maintain minimal documentation about those seeking support. If any information about the clients is collected, then there are strict protocols for maintaining the confidentiality of the records such as keeping them in secured shared files on secured computers, accessible only to the coordinators of the program. The data collected should be kept for statistical and evaluation purposes only such as to help those responsible for the PSP review their processes, evaluate trends in the workplace, and determine whether there are proactive solutions to prevent critical incidents from adversely affecting their staff.
Regulated health professionals who are providing the support (such as physician-counsellors, social workers, or psychologists) should consult the appropriate legal resources concerning regulations about documentation. This not only protects confidentiality of the clients, but also protects peer supporters who are using their credentials to provide the support.

As noted in Section 3 [of the manual on Confidentiality], there are exceptions to confidentiality, such as when there is a risk for self-harm or harm to others.

“Peer support means providing a safe and non-judgmental space for another to be heard, understood, and helped in a kind and compassionate way. It also means to be of service to another by being present moment by moment, empathetic, curious and trusting that the person I'm supporting is resourceful and whole internally despite their external circumstances.”

(Karen W., Pharmacist, Peer Supporter, SickKids)

Peer supporters

The peer supporters of a PSP are an integral component of the program, and the most important factor for its success. As such it is crucial that those implementing a PSP pay much attention to selecting, training and supporting them. The peer support role is typically voluntary and needs to be fully supported by management.

Role

It is the responsibility of peer supporters to understand their role and its boundaries and to be committed to the values and principles of the program.

Peer supporters also need to embrace their role as someone who helps their peers to leverage their own resilience, allowing them to heal themselves. It is also important that peer supporters avoid pathologizing what are normal reactions to stressful situations, and help normalize the emotions and feelings their peers are having.

Most importantly, peer supporters must recognize that they are not providing professional psychological support – they are not clinical therapists, nor are they providing psychological or psychiatric counselling.
The role of the peer supporter is to listen and coach. This means that they avoid diagnosing or providing psychological treatment to the clients, or determining solutions or directing their decisions. Peer supporters provide non-clinical emotional support to individuals in the form of empathetic support, active listening, encouragement and information about resources and other supports available to them. Although peer support can be offered on its own or as a complement to clinical care, a peer supporter does not take the place of a clinician and should not aim to “fix” a fellow employee.

It is also important to establish and maintain boundaries within peer support relationships between a professional and personal relationship. The BC First Responders’ Mental Health PSP notes the following points that are worth considering when determining boundaries:

- Communicating boundaries early in the peer support relationship can be helpful in managing expectations. This might include setting limits on time or location — for instance, agreeing that peers may contact peer supporters only up to a specific time of day or that they cannot approach peer supporters while they are on a call.

- Those offering peer support should be friendly and compassionate but maintain a professional relationship. There can be a fine line between a helping relationship and a friendship. When the relationship becomes too personal, the peer support relationship should be ended.

- Establishing a back-up peer, or having oversight from a peer support coordinator or a psychologist, can assist when the boundaries appear to shift. If the relationship becomes close or inappropriate (if it becomes too intimate or sexual in nature, for instance), being able to hand off the file and extricate oneself from the relationship helps to keep peer support ethical and ensures that the peer who is need of support has someone else who can take over with an understanding of that person’s needs.

- Peer support training should be provided on how to recognize when the peer supporter is becoming too involved or when the peer seeking help is becoming too dependent.

Another key distinction to establish is that the discussions between the peer supporter and the client should be primarily emotion-focused rather than problem-focused. A problem-focused conversation is one that pays attention to facts (e.g. learning from mistakes, seeking information, determining what transpired, dealing with the problem itself) whereas an emotion-focused interaction addresses feelings and actions to help the individual move forward. The peer supporters are also there to provide referrals and/or identify resources as part of a constructive helping process.

For a fulsome description of the scope of the role of a peer supporter and their code of conduct, the SickKids “Scope of the Peer Role” and the Peer Support Program Code of Conduct, along with the BCEHS CISP peer support manual (Appendix C) are excellent resources.
Attributes

Certain characteristics contribute to the effectiveness and quality of a peer supporter. The following are some of the key attributes that have been inspired by both the MITSS, MHCC and BC First Responders Mental Health:

- empathetic, respectful, and non-judgmental;
- skilled at communicating and active listening to encourage openness and honesty;
- capable of critical thinking to assist the peer to discuss concerns, determine the peer’s true needs, and detect when a peer is nearing or in crisis;
- emotional maturity;
- ability to gain trust of clients;
- culturally aware/sensitive;
- keen to learn and build peer support skills and accessible for team activities;
- committed to confidentiality (within legal limits); and,
- ability to work within established guidelines.
“There will always be that feeling of uncertainty....will I be able to help? Will I say the right things? How will I know what to do? What if I miss something? Being a peer is not about having the right answers and knowing exactly what to do or say because reality is you won’t always be on point and no one expects you to be. Being a peer is about realizing you have been given an opportunity to step into someone’s life. Recognizing the difficulty and courage it takes to seek out for help and express one’s vulnerabilities. Realizing they are seeking for support/guidance, resources and a steer in a direction to help them through a challenging time. It’s about being sincere, honest, offering practical suggestions, actively listening, checking in/following up, being genuine and being in the moment with them as best as you know how to be. For me being a peer is knowing small sincere efforts can go a long way.

It is a challenging yet humbling experience. Every time I willingly step into a peer’s life a part of their journey stays with me. Each experience is unique and motivates me to continue learning and growing both professionally and personally.”

(Neelam W., RN, Peer Supporter, SickKids)
Another key attribute for a peer supporter is that they share lived experience similar to the clients who will be seeking help. In other words, they are health professionals who themselves have experienced emotional distress related to their work in healthcare, or who have had mental health challenges. This enables them to have empathy towards the clients, and been seen as non-threatening by the clients. It is important to point out, however, that peer supporters should be recovered from this distress or have overcome their mental health challenges, to the point where they are able and ready to support a peer.

Peer supporters should also ideally be aligned with the values and principles of peer support. Box 4.12 provides a number of examples of values that define peer supporters.

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**Box 4.11: Requirements for peer supporters**

**Alberta Health Services**

Peer supporters are those who are:

- respected by co-workers and would go to for non-judgmental support;
- considered trustworthy by co-workers;
- have good communication skills, i.e. listening, eye contact, body language;
- shows concern and cares for co-workers’ well-being;
- a mature individual, responsible, good work habits and a minimum two years with AHS;
- is working a position of at least .8 to full-time equivalent (negotiable) and days/ nights, for easy accessibility as a peer supporter;
- is elected by his/her peers (with references from manager and peers on application);
- demonstrates good coping skills and a positive attitude;
- is committed to being available to assist with crisis intervention;
- is interested in the Peer Trauma Response Team and is interested in supporting his or her peers; and
- is able to leave their workplace to respond to an incident when necessary.
Box 4.12: Core values expected of peer supporters

MHCC

[https://www.mentalhealthcommission.ca/English/document/18291/peer-support-guidelines]

- **Hope and recovery**: acknowledging the power of hope and the positive impact that comes from a recovery approach.
- **Self-determination**: having faith that each person intrinsically knows which path towards recovery is most suitable for them and their needs, noting that it is the peer’s choice whether to become involved in a peer support relationship.
- **Empathetic and equal relationships**: noting that the peer support relationship and all involved can benefit from the reciprocity and better understanding that comes from a similar lived experience.
- **Dignity, respect and social inclusion**: acknowledging the intrinsic worth of all individuals, whatever their background, preferences or situation.
- **Integrity, authenticity and trust**: noting that confidentiality, reliability and ethical behaviour are honoured in each and every interaction.
- **Health and wellness**: acknowledging all aspects of a healthy and full life.
- **Lifelong learning and personal growth**: acknowledging the value of learning, changing and developing new perspectives for all individuals.

PAMQ/QPHP
(from the website http://www.pamq.org/en)

- **Confidentiality**: Maintain the highest standards of confidentiality and discretion to protect our clients’ identity and privacy.
- **Respect**: Empathy and consideration. Being open and non-judgmental when faced with a situation, its consequences and the emotions it triggers. Impartiality.
- **Integrity**: Our actions are guided by the observance of our organizational values. Decency, honesty toward clients, colleagues and partners.
- **Knowledge sharing**: Sharing knowledge with a view to improving physicians’ health. Sharing innovative intervention methods aimed at broadening the scope of action taken to foster physicians’ well-being.
- **Teamwork**: Show respect for others’ skills by working cooperatively and pooling knowledge (regarding resources, partners and colleagues).
As a final note, peer supporters are held to a high standard when it comes to conducting themselves in a professional manner, whether they are acting as a peer supporter or are in their regular role in the workplace. Any confidentiality breaches or ethics violations on their part reflects poorly on the team, and the organization needs to be clear that peer supporters should not behave in a manner that will discredit or erode trust in the PSP.

**Recruitment**

The recruitment and selection process for peer supporters is critical. Some organizations use an elaborate process that includes nominations, references, psychological screening and panel interviews to select peer supporters; for others, the process is less formal. Whatever the process, it is important to ensure the PSP has the right people on board or the right cohort of peer supporters; if not the PSP will not be successful. If an organization does not recruit the people with the right personalities and qualities, then this will impact the credibility, sustainability, optics and implementation of the program.

In some cases, potential peer supporters are recruited through management, who nominate staff they determine meet the criteria established by the organization (as per above attributes) although this may not be suitable in an organization with low trust in management. Alternatively, as the Centre for Professionalism and Peer Support notes, they ask departments to “nominate colleagues who they would want to go to for support.”

**Figure 4.4** outlines the process used by the former Trauma Prevention and Peer Support Training (TEMA) program used to recruit and select their peer supporters, which demonstrates a thorough selection process for selecting appropriate individuals for this important role.

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**Box 4.12 (continued): Core values expected of peer supporters**

**Peer Support Canada**

- hope and recovery;
- empathetic and equal relationships;
- self-determination;
- dignity, respect and social inclusion;
- integrity, authenticity and trust;
- health and wellness; and
- lifelong learning and personal growth.
Some organizations also invite staff members to nominate themselves. The following is an example of a process organizations might use in this case [see the **ForYOU Activation policy**.]

1. Invitation for expression of interest is posted.

2. Potential peer supporter sends expression of interest or fills out an application form (see [Applicant Package and application form for AHS](#) and [sample application for the ForYOU program](#), including two peer references and one manager reference.

3. Psychologist interviews potential peer supporter for mental fitness.

4. Potential peer supporter is interviewed and assessed against criteria such as listening skills, empathic approach, and demonstration of understanding of confidentiality.

5. If accepted, the peer supporter signs a confidentiality and performance agreement.

For an example of the type of information to consider for the recruitment of peer supporters, see the [Alberta Health Services’ Applicant Package](#).

Some organizations find it easier at the outset to focus on leveraging internal experts, or staff members who are already trained in counselling or specialized therapeutic knowledge. It is important, however, to make sure that these internal experts are clear on the limits of this role as support and not counselling.
Supporting the supporters

Organizations need to safeguard the mental health of the peer supporters themselves. It is important to recognize that there is a possibility that peer supporters will also experience emotional distress from their work in the PSP, and that they may well need ongoing support. Because of the emotional nature of peer support, even the most resilient peer supporter could be prone to burnout or a mental health challenge.

Monitoring through supervision, mentoring of peer supporters, communities of practice for peer supporters, regular meetings for the cohort and ongoing training are all valuable methods to support peer supporters. As an example, after every encounter within the RISE program, “the peer responder activates a debriefing, in which he/she facilitates a session to receive support from the other members of the RISE team and to provide a learning opportunity for other members”1.

In addition, it is important to be clear that a peer supporter’s commitment is always voluntary, enabling them to step away when they feel they need to — if they find that the work triggers mental health concerns in themselves or if they are simply in need of a break.

The MITSS Clinician Support Tool Kit for Healthcare recommends that the organization provide a “tool box” for each peer supporter to ensure they have all the tools they need to succeed. This tool box could include:

- clear concise description for a peer supporter;
- list of recommended support for referral (if needed);
- list of active listening techniques;
- the do’s and don’ts of listening;
- contact list for immediate escalation;
- training; and
- support services available to them.

“Each year we have managed to get actively suicidal employees into hospital. We have helped employees with substance use disorder (SUD) move into treatment, but we still have a long way to go.”

(BCEHS)
Remuneration

It is usually the case that the role of peer supporters is a voluntary one. However, there are a number of details an organization must work out so that they might develop clear guidelines for when the peer supporter provides support during their working hours, or when they are called in to provide support. One clear recommendation from those who have developed a PSP is that organizations should consider the importance of allowing peer supporters time away from their regular work duties to provide the support or to attending PSP meetings. Peer supporters are also entitled to funded training and retraining, travel and other expenses, and appropriate recognition for the volunteer work they do.

Box 4.13: Example of a remuneration policy

Alberta Health Services

Following a critical event, peer supporters will be asked to go to the unit to offer support. The cost of replacing the peer, if they are called to a critical incident while on shift, is the responsibility of the unit the peer comes from and this time will NOT exceed four hours. If peer supporters on shift are unavailable to be deployed to the unit, peers may be called in from home. In the event that this happens these peers will be paid four hours callback pay. The Peer Supporter will submit to the PTRT Administrator a reimbursement form signed by the unit manager. Each peer will not be used as a peer supporter more than twice a month to prevent over-use and burnout. This will also help keep the replacement cost to all the units involved the same. Peer supporters will be responsible for attending team meetings and education sessions as covered under their roles and responsibilities. This may mean rescheduling shifts and will be the responsibility of the employee and their manager.

There are cases, however, when the role is an officially paid position, such as with the PAMQ/QPHP- an independent non-profit organization where physician advisors are hired to provide peer support in a structured manner. This is also the case with the OCISM program, where staff members are hired for this role or for a coordination role.

A number of organizations have salaried staff positions to coordinate and direct the program. A good example of a description of the role of a program manager for a PSP is the SickKids program.[see the Scope of Manager, Peer Support Program in the Tools and Resources section.

“We get a lot of feedback about the difference that we make.”

(PAMQ/QPHP)
Training

Training is an integral component of the PSP. Not only should there be a comprehensive training program for the peer supporters, but it is also important that organizations provide specific training to leaders, managers & supervisors, as well as to all staff in the workplace.

Peer supporters training

Once peer supporters are selected and before they provide any services, they should be provided with training that will prepare them to support their peers who are experiencing psychological distress.

There are a number of external providers who provide training for peer support. Many of these are not focused directly on health services, but might be a valuable starting point for organizations that do not have the internal resources for such training. Some organizations used the following external providers:

- International Critical Incident Stress Foundation training;
- The Institute for Healthcare Improvement’s “Building a Clinician Peer Support Program” which is conducted by the Medically Induced Trauma Support Services);
- The MHCC’s The Working Mind program;
- Critical Incident Stress Management program; and
- Canadian Mental Health Association (CMHA).

The RISE program at Johns Hopkins Hospital offered psychological first aid (RAPID-PFA) training to their peer supporters; RAPID stands for Reflective listening, Assessment, Prioritization, Intervention and Disposition.

If an organization does have the internal resources and can draw on members of staff such as risk managers, counsellors, EAP provider, wellness team members, spiritual counsellors, or PSP staff, they might choose to develop their own custom-made training program that aligns with their vision and needs for a PSP.

Whether it is provided by an external company, through internal expertise or a combination of both, the training is usually for at least three full days.
Box 4.14: A note on adult learning

Ontario Tech University

PSP training should be a collaborative learning experience where adult learners and instructors learn with, from and about each other’s perspectives and related work experience. This relationship requires respect and trust for each other’s abilities and challenges. Central to this approach is placing learners at the centre of the learning process.

This approach requires ongoing self-reflection on the part of the instructor to better adapt their teaching and evaluations to meet the changing and different learning styles of learners. To that end, the instructor should strive to provide learners with the relevant tools, frameworks, concepts and materials that inform the subject area. They should also use a variety of teaching strategies in an interactive and respectful environment, such as traditional lecture-based learning, problem-based learning, experiential learning and appreciative inquiry learning. The methodologies used should combine both the cognitive (i.e., knowledge), psychomotor (i.e., skills), and affective (i.e., attitudes) domains of learning (i.e., Bloom’s Taxonomy). The learning environment should be a safe, fun environment designed to exchange, share and explore new ideas between both learner(s) and instructor.

Continuing education such as PSP training can be conceptualized as an interactive activity involving three phases:

1. Exposure: the introduction of the knowledge in the classroom (note the classroom can be online or in the traditional classroom).

2. Immersion: introduces learners to interaction with other professions in the classroom and during a simulated training experience to engage in the learning experience.

3. Mastery: the incorporation of the knowledge, skills and attitudes into daily professional practice.

To ensure learners have a good understanding of the application of knowledge and skills, evaluation is needed that includes a variety of activities (e.g., group work, presentations, interactive structured class discussion and written reports).


Building on the MHCC’s list of fundamental topics that should be required learning for peer supporters, we suggest the following basic curriculum.

- Fundamental principles, values, and ethics of peer support, including rules of confidentiality.
- Role and responsibilities of a peer supporter, including knowledge about limits and boundaries.
- Value of leveraging resilience and avoiding pathologizing normal reactions to stressful incidents.
- Cause and variety of common mental health issues for health professionals (compassion fatigue, vicarious trauma, stress, anxiety, burnout, depression, moral distress, post-traumatic stress disorder, serious safety events).
- Explanation of the Mental Health Continuum Model
- Recognizing and overcoming the stigma associated with mental health issues.
- Interpersonal communications and building supportive relationships.
- Crisis management training, to provide knowledge of how to identify and safely manage a crisis situation including:
  - the effect of crisis, trauma, and operational stress on well-being;
  - understanding human stress response;
  - stress management and resiliency;
  - process of recovery and change;
  - self-determination and how to foster it;
  - suicide awareness and intervention (BC peer manual Appendix G); and
  - difference between PTS and PTSD, along with signs of traumatic stress.
- Knowledge of available resources for referral.
- The importance of self-awareness and self-care to maintain one’s own wellness and resilience.
- Preparing with the peer for the end of the peer support relationship.
- Review of internal organizational policies and legislation impacting peer interactions.
- Operational aspects of the PSP – mobilization, triage and any tools developed to arm peers with opportunity to assess for risk or to indicate peer engagement.

This training can be adapted to the needs of the PSP in each organization, and expanded as the scope of the program grows. For example, further peer supporter training could be about interpersonal conflicts at work, managing workload stress, grief counselling, or organizational topics such as HR procedures, policies and organizational alignment with other supports.
Peer supporters also need opportunities for continuous learning and development. As noted by BC First Responders’ Mental Health, “in addition to ensuring that peer supporters have the skills and knowledge to do the work, training can be re-energizing and help build morale, camaraderie, and a sense of shared purpose and value among the peer support team.”

The MITSS program recommends that there should be ongoing meetings with the supporters to review the cases and discuss what is working, what is not working and where they can improve.

**Other training considerations**

Although the training of peer supporters is the most significant training, others in the organization should also have the opportunity to learn about peer support.

To be successful, PSPs must be supported in principle by leadership and management, so it is important to provide them with a basic understanding of why peer support is important, and how best to support their workforce when there is a critical incident. The RISE program at Johns Hopkins Hospital made sure to train “several directors from units at increased risk for death and adverse events… an action that also corresponded to more calls originating from those units.”

Supervisors and managers need to be trained to ensure they identify individuals who might benefit from peer support, so they need to understand what the PSP does and how it can support their staff. The BCEHS developed a list of “What to look for – Any change in four areas of normal behaviour” including changes in physical, psychological, behavioural and cognitive behaviour, available in their Volunteer Peer Team Orientation Manual. The OCISM developed tips sheets including Tips on Coping Following a Traumatic Event and Tips for Supervisors and Managers of Employees Involved in a Traumatic Event to help managers know when there would be a need for a peer, along with a “do’s and don’t’s” flyer.

It is also a good idea to provide basic training to everyone in the workplace including such topics as what mental health issues might arise as a result of work, what symptoms to look out for in themselves and their colleagues, how the PSP can help and how to access it. The MITSS program suggests that organizations consider writing a crisis communication plan that all staff have been educated about that can be accessed at any time. They provide examples of how some organizations have implemented this in their Clinician Support Tool Kit for Healthcare “Policies, Procedures and Practices” section.

Organizations need to break the stigma that exists regarding access and use of mental health services, as a way of breaking through the shame and blame culture. This goes a long way to reducing the stigma around mental health conditions and laying the foundation for the success of peer support.
How to ensure spread and sustainability of the program

Only once the PSP is in place, and peer supporters are trained and prepared to be on call to assist clients is it time to launch the program. By this time, the organization may have already announced plans for a PSP and built awareness and energy around the program, and also involved a number of workers in the needs assessment and planning. With the launch, however, when the PSP is ready to take on clients, then it is time for a promotional campaign.

What to promote

Key to the success of the program is promoting not only the services provided, but the values and principles behind the PSP. In particular, fully describing how the program will maintain confidentiality, including any limitations on this confidentiality, is key to reassuring staff that the PSP is a safe place for them to seek support.

It is also vital to promote the PSP as a non-judgmental inclusive space that is open to anyone regardless of their profession, sex, gender, culture, or levels. The MITSS program also recommends that the organization normalize the emotional impact to staff, for example by spreading the word that the PSP is about “normal people, having normal responses, to abnormal events”\(^9\).

It is also important to emphasize to the potential clients that the organization’s leadership and management are fully supportive of the program, and endorse its vision and values. The leadership and management should be fully on board to create a just culture where all those who work at their organization feel psychologically safe to seek help when they are emotionally distressed. This culture – where the organization is seen as supportive of mutual criticism and constructive feedback – plays a key role in the success of the program\(^5\).

Edrees and Wu\(^10\) list a number of barriers to developing a support program, among which are those can inform what might have to be countered in a promotional program (Table 4.1):

“We have one quarter of the work force connected with peer supporters in four years.”

(BCEHS)
Table 4.1: Potential barriers to developing a support program

<table>
<thead>
<tr>
<th>Potential barriers (Edress and Wu)</th>
<th>How to counter</th>
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<tr>
<td>Trust and concerns about confidentiality or fear of hindering career advancement</td>
<td>Fully describe how the program will maintain confidentiality (see Box 19 for example)</td>
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<tr>
<td>Lack of interest on the part of staff</td>
<td>Identify reason for lack of interest, and train leaders, managers and supervisors to explain the importance and value of the PSP at every opportunity.</td>
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<tr>
<td>Novelty of concept</td>
<td>Be clear about what the PSP is and aims to accomplish. Begin with a pilot project on one or two units to familiarize staff with the idea of a PSP.</td>
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</table>

Publicizing and maintaining the values behind the PSP will inspire its growth and sustainability. As an example, the PAMQ/QPHP highlights the importance of their values with a rich and straightforward description of each one on their [website](http://mitss.org/) (see Box 4.15).

“A peer support program is likely to be an evolving structure... a dynamic process that adjusts to identified needs and is not necessarily static.”

(PAMQ/QPHP)
How to spread the word

The RISE program at Johns Hopkins Hospital recommends “a sustained, multipronged campaign” to increase awareness and trust among staff. There are numerous methods to promote the PSP in an organization. The following are some suggestions:

Orientation of new staff: Many organizations include descriptions and information on how to access the PSP in their orientation to new staff, ensuring the messaging around just culture, psychological safety and leadership support is ingrained from the beginning.

Education sessions: Training sessions about the PSP and related topics (such as resilience training and, mental health awareness), which can be given as a stand-alone in-person workshop, as a web conference, or as part of regular inservice training or staff meetings.

Testimonials: Reassuring testimonials from those who have used the services of the PSP can be a powerful inspiration to encourage staff to seek support. The PAMQ/QPHP has several short videos of physicians who encourage others to reach out when they need help, thus humanizing the experience for everyone. There are also several provider experience videos available on CPSI's website that might also be a useful resource to organizations implementing a PSP, especially those that are focused on patient safety incidents.

Box 4.15: Core values expected of peer supports

PAMQ/QPHP (from the website)

- Confidentiality: Maintain the highest standards of confidentiality and discretion to protect our clients’ identity and privacy.
- Respect: Empathy and consideration. Being open and non-judgmental when faced with a situation, its consequences and the emotions it triggers. Impartiality.
- Integrity: Our actions are guided by the observance of our organizational values. Decency, honesty toward clients, colleagues and partners.
- Knowledge sharing: Sharing knowledge with a view to improving physicians’ health. Sharing innovative intervention methods aimed at broadening the scope of action taken to foster physicians’ well-being.
- Teamwork: Show respect for others’ skills by working cooperatively and pooling knowledge (regarding resources, partners and colleagues).
“Elevator speech”: The forYOU program created a short description of the PSP that leaders, managers, peer supporters and any staff can use to quickly tell someone about the program and give them a brief overview of why it is important and what support it includes (Box 4.16).

Box 4.16: Elevator Speech

The forYOU team is a peer-support team developed to address the needs of staff when they have been involved in a difficult case which impacts them emotionally. The event does not have to be related to a medical error. This could be a case in which staff relate to the patient on a personal level and there is an unexpected patient outcome or it is just difficult to understand the outcome.

This is important because:

- Staff may feel guilty for the patient outcome, and are unable to share their feeling with others.
- Staff can begin to second-guess their clinical skills and knowledge base, if they are unable to confide in a trusted peer.
- In extreme cases staff may experience a professional crisis, leading to a potential change in career.

Available support includes:

- Over 300 clinicians (MDs, nurses, RT, and managers) have been specifically trained to assist staff in this type of situation.
- ForYOU brochures are available for staff and family members to help them better understand what the staff member may be experiencing.
- Additional resources include Risk management, Chaplains, EAP and additional professional counseling from a clinical psychologist when peer support is not sufficient.

The ultimate goal of the forYOU team is to help healthcare professionals at UMHC return to a ‘pre-event baseline’ level of performance following a traumatic patient event.

Presentations: Any opportunity where groups are gathered at the workplace, such as conferences, staff meetings, workshops, grand rounds, M&M rounds, faculty orientations, OH&S meetings, committee meetings, joint OH&S committees, medical staff association meetings, in-service training, nursing week, or lunch & learn sessions, where a short presentation or toolkit can be made or a booth set up to remind staff about the PSP is also a useful way to spread the word.

Promotional materials: Organizations have developed a variety of promotional materials such as brochures, advertisements in internal newsletters, or such items as computer stickers, screen savers, business cards, magnets or pens that have the telephone number imprinted on them for easy access.
Social media: Information about the PSP on the organization’s external or, if applicable, internal website, Facebook page, Twitter account or other means of marketing the PSP through social media can be useful to spread the word about the program more widely, especially if the PSP is a provincial or national program.

Evaluating the program

One of the most significant challenges of evaluating the PSP is that, because of confidentiality, not much data is recorded and even less is accessible to anyone other than those who are responsible for storing it securely.

However, with the data that is collected – such as number of peer supporters, leaders and staff trained, number of clients who contact the PSP and/or who are served, number of staff available for peer support, number of hours of staff volunteer time, cost of the program – the organization can at least determine such elements as utilization rates, return on investment and human resource costs. If other data is collected – such as type of incident or health issue, referrals made or follow up required, for example – then this data can also be used to evaluate the effectiveness of the PSP.

Although it might be difficult to ask clients who are seeking help to then evaluate the program, this might be offered as an opportunity, where appropriate, to seek feedback through a satisfaction survey about the support received. There is also a tool called the “Second Victim Experience and Support Tool” (SVEST) that evaluates the critical incident experiences of staff members and the quality of support services. The SVEST can be used to evaluate staff perceptions before and after the implementation of a peer support program.

Managers and supervisors might also be approached to evaluate the program, by providing feedback from their perspective about its usefulness for their staff.

It might also be useful to survey all staff to find out if they are aware of the PSP, if they have used it and if so, were they satisfied or do they have any suggestions for improving the program.

One of the most effective evaluations might be through the peer supporters, who can provide valuable feedback about their experiences, and exchange lessons learned with the other peer supporters and program directors.

It is also important that those responsible for the program connect with leadership and management to ensure they are meeting the goals they set for themselves, and still on course with their vision and mission.
Testimonial from a Staff Member Who Used Peer Support Program

“There are so many parts of nursing life that are incredibly challenging. There can be difficult moments where you find yourself in the middle of work chaos- the stress, the constant battle with time, the innate pressure to deliver the highest quality of care on your 11th hour. The journey we go through has many layers and all of those complex feelings we experience can take a toll. We are only but human. Having the awareness of when work life puts insurmountable pressure on your mental health and the foresight to actively seek the support you need are two things I think healthcare professionals constantly battle with….

This is where The Peer Support Program comes in. The day I met K., she provided that one-on-one support for me. It was at a time when I wasn't even aware of how much I needed it. I was emotionally and physically drained and I didn't know where to look for support. She called me. I think vulnerability can be a scary thing but the support I got that day and over the next month was probably was the sole largest contributor to rebuilding my strength and resilience. K. made herself available for face-to-face support as well as group debriefs. The encouragement I got from this program was confidential, non-judgmental and helped to remove some of the stigma that still exists around mental health. As nurses, we need to be honest and authentic with how trying our careers can be. By doing so, we all discover how important self-care is to having a healthy work life…

Peer support gave me concrete help and initiated the need to process a very difficult part of my career. This in turn made me feel strong enough to support other people as a CSN. When it comes to working with our team, confidence in a peer-based support system can be one of the most powerful ways to build each other up.” (Clinical Charge Nurse, SickKids)
Conclusion

There are many hurdles to overcome, many decisions to make and many steps to take in the process of implementing a PSP, but those who have been through it attest to the fact that it is worth the time and effort required.

Key to the success of any program is that the leadership and management of the organization fully back the program and that this is visible to those who work, volunteer or are being trained at the workplace, which creates a psychologically safe environment for the PSP to gain momentum and succeed. The organization has to be seen to be “walking and talking the talk” where the PSP is part of a greater wellness portfolio, and where everyone feels comfortable seeking help.

Those who initiate the idea of a peer support program, or the champions of the PSP, need to understand that the process is long, but if they have clear goals and believe in the value of PSP, the program will take shape and eventually flourish.

Another important element to the growth and sustainability of the PSP is that all efforts are made to maintain confidentiality for those seeking support. As we have seen, it is difficult for health professionals to come forward for support if they think they will be perceived as vulnerable or weak for seeking mental health support.

If an organization makes the effort to work with their employees to find out what their needs are and what kind of peer support they are looking for, they will also have a much better chance of success.

Peer support is only one link in the chain of assistance for emotional distress, but it might be the most crucial link for individuals who would otherwise endure their psychological pain alone. CPSI urges all healthcare organizations to thoroughly investigate the value and benefits of a PSP for their workforce and, if they determine that such a program will help their workers through the many critical incidents and emotional distress they are likely to experience, then we also urge them to implement a PSP adapting the best practices outlined in this manual and using the many tools and resources we collected. [See the Creating a Safe Space Toolkit]
References


Creating a safe space

Section 5: Peer Support Toolkit
Acknowledgements

Section 5: Creating a Safe Space: Peer Support Toolkit

Working Groups Members | Current Affiliations
--- | ---
Markirit Armutlu | Canadian Patient Safety Institute
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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).
# Creating a Safe Space Peer Support Toolkit

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<td><strong>Health Canada - Occupational &amp; Critical Incident Stress Management (OCISM)</strong></td>
<td>OCISM Tips for coping for individuals directly involved in a traumatic event</td>
<td>Coping tips for an individual involved in a traumatic event</td>
<td>PDF</td>
<td></td>
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<tr>
<td>Organization</td>
<td>Title</td>
<td>Category</td>
<td>Description</td>
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<tr>
<td>OCISM Tips for coping</td>
<td>OCISM Tips for individuals involved in sustained, high intensity work</td>
<td>Promotional material</td>
<td>Coping tips for individuals exposed to ongoing trauma as a part of their work</td>
<td>PDF</td>
</tr>
<tr>
<td>OCISM Tips for Family, Friends</td>
<td>OCISM Tips for Family, Friends and Co-workers of individuals involved in a traumatic event</td>
<td>Promotional material</td>
<td>Tips for family members on how to support their loved one who has experienced a trauma at work</td>
<td>PDF</td>
</tr>
<tr>
<td>OCISM Tips for supervisors and</td>
<td>OCISM Tips for supervisors and managers of employees involved in a traumatic event</td>
<td>Promotional material</td>
<td>Tips for managers to support an employee who has been through a traumatic event</td>
<td>PDF</td>
</tr>
<tr>
<td>OCISM Tips on Coping</td>
<td>OCISM Tips on Coping following a traumatic Event</td>
<td>Promotional material</td>
<td>Lists signs and symptoms following a traumatic event.</td>
<td>PDF</td>
</tr>
<tr>
<td>OCISM Brochure</td>
<td>OCISM Brochure</td>
<td>Promotional material</td>
<td>Brochure on the background, purpose and actions of the OCISM Program</td>
<td>PDF</td>
</tr>
<tr>
<td>IHI - Institute for Healthcare</td>
<td>Leadership Response to a Sentinel Event: Respectful, Effective</td>
<td>Background</td>
<td>IHI's website of resources to support individuals and organizations after an adverse event</td>
<td>Webpage</td>
</tr>
<tr>
<td>Improvement</td>
<td>Crisis Management</td>
<td></td>
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<tr>
<td></td>
<td>Why Is Psychological Safety So Important in Health Care?</td>
<td>Background</td>
<td>Short video on the importance of psychological health and safety in healthcare</td>
<td>Video</td>
</tr>
<tr>
<td></td>
<td>Online Training - Responding to Adverse Events</td>
<td>Training resources</td>
<td>Online training on responding to an adverse event. One module focuses specifically on the second victim. Note: The training is free, however you must create an account to access it</td>
<td>Webpage</td>
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<tr>
<td>Organization</td>
<td>Title</td>
<td>Category</td>
<td>Description</td>
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<tr>
<td>International Critical Incident Stress Foundation Inc.</td>
<td>ICISF Academy of Crisis Intervention</td>
<td>Training resources</td>
<td>ICISF offers a variety of online and in-person training courses on crisis intervention</td>
<td>Webpage</td>
</tr>
<tr>
<td>Living Works</td>
<td>Applied Suicide Intervention Skills Training (ASIST)</td>
<td>Training resources</td>
<td>Applied Suicide Intervention Skills Training (ASIST) is a two-day interactive session on how to intervene and help prevent the immediate risk of suicide</td>
<td>Webpage</td>
</tr>
<tr>
<td></td>
<td>SafeTALK</td>
<td>Training resources</td>
<td>safeTALK is a half-day alertness training course that helps people recognize signs of a potential suicide and how to intervene</td>
<td>Webpage</td>
</tr>
<tr>
<td>Medically Induced Trauma Support Services (MITSS)</td>
<td>MITSS Homepage</td>
<td>Program description</td>
<td>Homepage of Medically Induced Trauma Support Services Program</td>
<td>Webpage</td>
</tr>
<tr>
<td></td>
<td>Clinician Support Tool Kit for Healthcare</td>
<td>Program development tool</td>
<td>Toolkit of resources and templates collated by the MITSS team to support other organizations to develop their own support programs</td>
<td>PDF</td>
</tr>
<tr>
<td></td>
<td>MITSS Organizational Assessment Tool for Clinician Support</td>
<td>Program development tool</td>
<td>Organizational self-assessment on key actions required to develop a peer support program</td>
<td>PDF</td>
</tr>
<tr>
<td></td>
<td>MITSS Staff Support Assessment Tool</td>
<td>Evaluation tool</td>
<td>Staff survey on organizational supports available to them following a serious adverse patient event</td>
<td>PDF</td>
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</table>
### Mental Health Commission of Canada

<table>
<thead>
<tr>
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<th>Category</th>
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<tbody>
<tr>
<td></td>
<td>Advancing Psychological Health and Safety within Healthcare Settings</td>
<td>Background</td>
<td>Homepage highlighting the MHCC's work in psychological health and safety in the healthcare sector</td>
<td>Webpage</td>
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<tr>
<td></td>
<td>Guidelines for the Practice and Training of Peer Support</td>
<td>Background</td>
<td>National guidelines on the practice and training of peer supporters</td>
<td>PDF</td>
</tr>
<tr>
<td></td>
<td>Implementing the National Standard in the Canadian Health Sector: A Cross Case Analysis</td>
<td>Background</td>
<td>This report shows the findings from 19 healthcare organizations who implemented the National Standard for Psychological Health and Safety in the Workplace over three years - their facilitators and barriers to creating a mentally healthy workplace</td>
<td>PDF</td>
</tr>
<tr>
<td></td>
<td>Issue Brief - Workplace Mental Health</td>
<td>Background</td>
<td>Background brief on the issue and importance of psychological health and safety in the healthcare sector</td>
<td>PDF</td>
</tr>
<tr>
<td></td>
<td>Join the Movement Video</td>
<td>Background</td>
<td>Short video on the importance of psychological health and safety in healthcare</td>
<td>Video</td>
</tr>
<tr>
<td></td>
<td>Making the Case for Peer Support</td>
<td>Background</td>
<td>Comprehensive report evaluating the state of peer support in Canada</td>
<td>PDF</td>
</tr>
<tr>
<td></td>
<td>Webinar - Taking care of those providing care: Psychological health and safety in Canadian healthcare settings</td>
<td>Background</td>
<td>Webinar on the importance of psychological health and safety in the healthcare sector</td>
<td>Video</td>
</tr>
<tr>
<td></td>
<td>Webinar - Proactive Peer Support: Protecting and promoting the</td>
<td>Program description</td>
<td>Webinar on the York Region Paramedic Services peer support program</td>
<td>Video</td>
</tr>
<tr>
<td>Organization</td>
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<td>wellbeing of first responders</td>
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<tr>
<td>MHCC - Philippe Larivière, Paramedic Instructor</td>
<td>Stories of Recovery - First Responders</td>
<td>Testimonial</td>
<td>Philippe (Paramedic Instructor, Manitoba) shares his experience of living in recovery with mental illness incited by a particularly difficult call</td>
<td>Video</td>
</tr>
<tr>
<td>Mental Health First Aid</td>
<td>Training resources</td>
<td></td>
<td>Mental Health First Aid is a training course designed to give members of the public the skills to help someone who is developing a mental health problem or experiencing a mental health crisis</td>
<td>Webpage</td>
</tr>
<tr>
<td>The Working Mind - First Responders</td>
<td>Training resources</td>
<td></td>
<td>The Working Mind First Responders (TWMFR), formerly known as Road to Mental Readiness, is an education-based program designed to address and promote mental health and reduce the stigma of mental illness in a first-responder setting</td>
<td>Webpage</td>
</tr>
<tr>
<td>Michael Garron Hospital</td>
<td>Providing Care and Support for our Staff - Brochure</td>
<td>Promotional material</td>
<td>This brochure describes Michael Garron Hospital's Emergency Department care and support team program that is available for staff</td>
<td>PDF</td>
</tr>
<tr>
<td></td>
<td>Training Slide deck - Learning to Care for our Own</td>
<td>Training resources</td>
<td>Training slide deck on the background of second victim, survey results from staff about available supports and the program design at Michael Garron Hospital</td>
<td>PDF</td>
</tr>
<tr>
<td>Quebec Physician's Health Program</td>
<td>Analysis of the Effectiveness of Employee Assistance Programs: The Case of the QPHP</td>
<td>Program description</td>
<td>Report on the effectiveness of the Quebec EAP program in supporting physicians</td>
<td>PDF</td>
</tr>
<tr>
<td></td>
<td>Program Homepage</td>
<td>Program description</td>
<td>Homepage of the Quebec Physician's Health Program</td>
<td>Webpage</td>
</tr>
<tr>
<td>Organization</td>
<td>Title</td>
<td>Category</td>
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<tr>
<td>Rapport Annuel 2017-2018 (French Only)</td>
<td>Program description</td>
<td></td>
<td>Annual report of the PAMQ program.</td>
<td>PDF</td>
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<tr>
<td>During a workplace crisis - is it possible not to react</td>
<td>Promotional material</td>
<td></td>
<td>Two-pager on responding to difficult situations at work.</td>
<td>PDF</td>
</tr>
<tr>
<td>Caring for the Caregiver - Introduction</td>
<td>Program description</td>
<td></td>
<td>Video on overview of the Caring for the Caregiver program</td>
<td>Video</td>
</tr>
<tr>
<td>Caring for the Caregiver: Peer Support for Caregivers in Distress</td>
<td>Program description</td>
<td></td>
<td>One-pager overview of the Caring for the Caregiver program</td>
<td>PDF</td>
</tr>
<tr>
<td>Hospital peer-to-peer support</td>
<td>Program description</td>
<td></td>
<td>Homepage of the Caring for the Caregiver: Implementing RISE (Resilience in Stressful Events) Program. Provides an overview of the issue and their program</td>
<td>Webpage</td>
</tr>
<tr>
<td>Trauma Response and Peer Support policy</td>
<td>Policy document</td>
<td></td>
<td>SickKids policy statement on trauma response and peer support.</td>
<td>PDF</td>
</tr>
<tr>
<td>Scope of Manager, Peer Support Program Role</td>
<td>Recruitment</td>
<td></td>
<td>Document explaining the scope, roles and responsibilities of the Manager, peer supporter program role</td>
<td>PDF</td>
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<tr>
<td>Ted Talk - Dr. Brian Goldman</td>
<td>Testimonial</td>
<td></td>
<td>Canadian physician, Dr. Brian Goldman, shares his experience following a medical error</td>
<td>Video</td>
</tr>
<tr>
<td>The Safety Toolkit – Supporting the Second Victim</td>
<td>Program Development tool</td>
<td></td>
<td>Toolkit of document and resources collated by the Royal College of Emergency Medicine to support the second victim</td>
<td>PDF</td>
</tr>
</tbody>
</table>
## Creating a Safe Space

### Strategies to Address the Psychological Safety of Healthcare Workers

**Section 5: Creating a Safe Space Peer Support Toolkit October 2019**

<table>
<thead>
<tr>
<th>Organization</th>
<th>Title</th>
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<tbody>
<tr>
<td>Washington Patient Safety Coalition</td>
<td>Supporting the Second Victim Recommendations</td>
<td>Promotional material</td>
<td>One-pager of recommended actions for individuals and leadership teams to support the second victim</td>
<td>PDF</td>
</tr>
<tr>
<td></td>
<td>WEBINAR - Care for the Colleague: Bringing Encouragement and Support in Difficult Events</td>
<td>Program description</td>
<td>Recording of webinar presented by Kit Hoffman on the experience setting up a Care for the Colleague program at Confluence Health</td>
<td>Video</td>
</tr>
<tr>
<td></td>
<td>PODCAST: The New Wave of Healthcare - Episode 2: How can large hospital systems offer care to its caregivers after an adverse event?</td>
<td>Testimonial</td>
<td>Podcast of healthcare professionals discussing their experiences following an adverse event</td>
<td>Podcast</td>
</tr>
<tr>
<td>Workplace Strategies for Mental Health</td>
<td>Peer support Programs</td>
<td>Program development tool</td>
<td>Overview of setting up a workplace peer support program</td>
<td>Webpage</td>
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</table>
Creating a safe space

Conclusion
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)
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
Creating a Safe Space
Strategies to Address the Psychological Safety of Healthcare Workers

☐ 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

<table>
<thead>
<tr>
<th></th>
<th>1 Strongly Disagree</th>
<th>2 Disagree</th>
<th>3 Neither Agree or Disagree</th>
<th>4 Agree</th>
<th>5 Strongly Agree</th>
<th>6 Not Applicable</th>
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<tbody>
<tr>
<td>I have experienced embarrassment from these instances.</td>
<td></td>
<td></td>
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<tr>
<td>My involvement in these types of instances has made me fearful of future occurrences.</td>
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<tr>
<td>My experiences have made me feel miserable.</td>
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<tr>
<td>I feel deep remorse for my past involvements in these types of events.</td>
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9. Physical Distress

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

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

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]
Creating a Safe Space
Strategies to Address the Psychological Safety of Healthcare Workers

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