

Learning From Incidents: An Insight into the Experience and Wellbeing of Healthcare Staff Involved in Patient Safety Incidents

Erika Carroll ¹, Adele Grazi ¹ & Samuel Cromie ¹

¹ Centre for Innovative Human Systems, Trinity College Dublin, Ireland

INTRODUCTION

With over 480,000 patient safety incidents reported within the Irish National Incident Management System since 2018¹, it is predicted that every clinician will be involved in an incident at some point of their career². Research proposes three pathways for clinicians following their involvement in an incident; Survive, Thrive or Drop-Out³. Approximately one third of staff involved in a patient safety incident meet the definition of a Second Victim⁴ due to the significant negative personal and professional implications they experience in the incident aftermath⁵. Factors that may affect coping and Second Victim likelihood include experience with the incident review process, gender, age, experience and role.

AIMS

1. Gain a fresh perspective on how Irish healthcare staff are coping in the aftermath of patient safety incidents.
2. Identify individual and organisational factors that predict Second Victim symptomology, coping and post-traumatic growth.
3. Identify if the Irish Healthcare System is sufficiently supporting staff through the two most important steps following an incident – the provision of emotional support and an opportunity to learn.
4. Compare Second Victim symptomatology across a general healthcare sample and a sample of Anaesthesiologists.
5. Gain insight into staff’s experience with the Incident Review Process – is it meeting the person-centred objectives of the Incident Management Framework?

METHOD

An explanatory sequential mixed-methods design was employed, conducted in two phases.126 participants who have previously been involved in a patient safety incident (56 Anaesthesiologists and 70 General Healthcare staff) completed an online survey containing the validated Second Victim Experience and Support Questionnaire (SVEST)⁷. 14 semi-structured interviews were conducted to extract more meaning from the quantitative data, identifying 4 key themes and 14 subthemes.

QUALITATIVE RESULTS

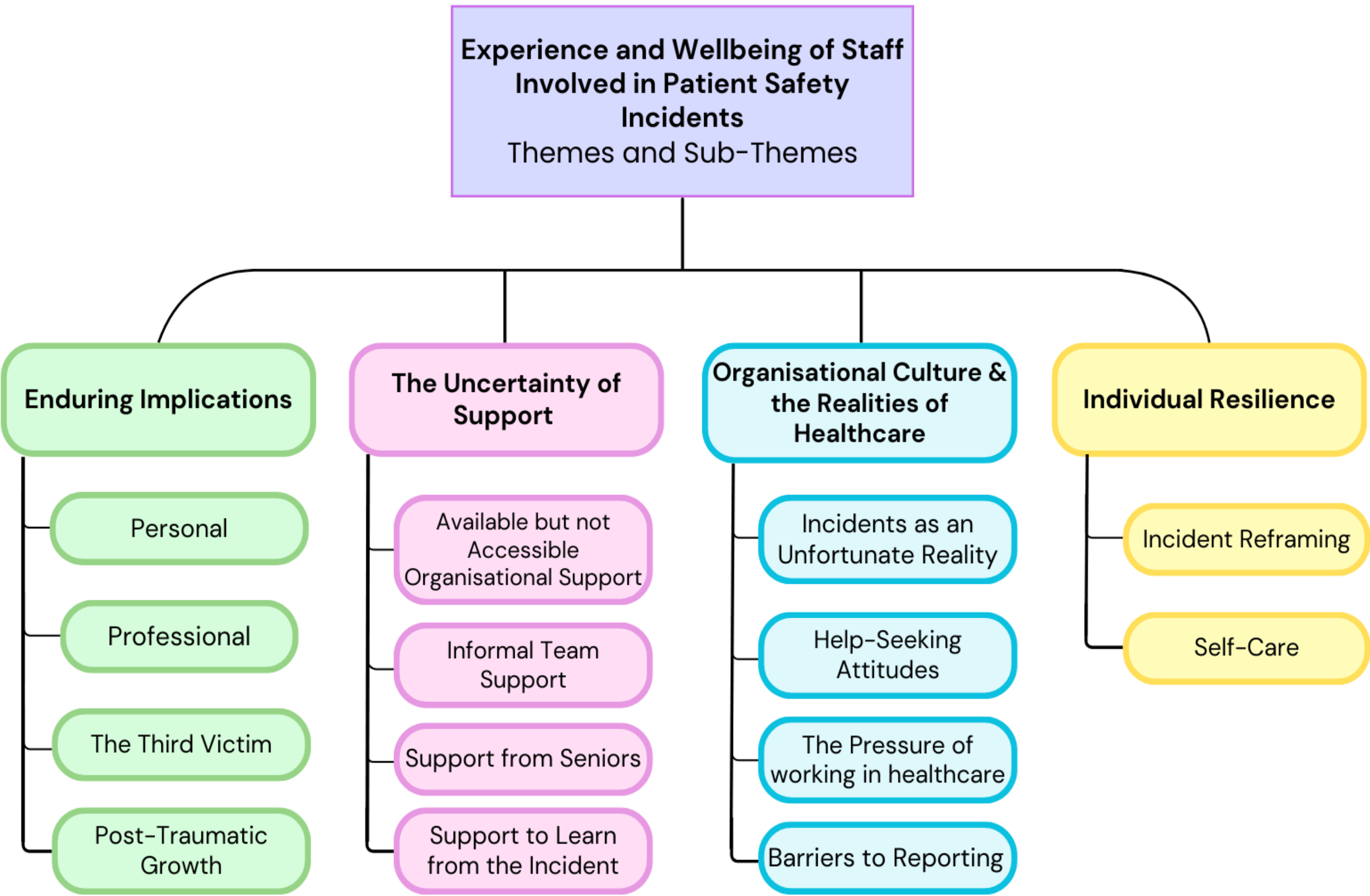


Figure 1. The 4 Themes and 14 Subthemes developed through Thematic Analysis



Figure 2. A sample of participant's quotations from the interviews

QUANTITATIVE RESULTS

Irish healthcare staff are experiencing significant Second Victim distress and negative work-related outcomes in the aftermath of patient safety incidents. Irish staff in this sample had significantly higher scores across all dimensions of the SVEST compared to the scale’s publishers⁷. These enduring personal and professional implications are significantly worse for anaesthesiology staff across all dimensions of the SVEST, with the exception of negative work outcomes (absenteeism & turnover).

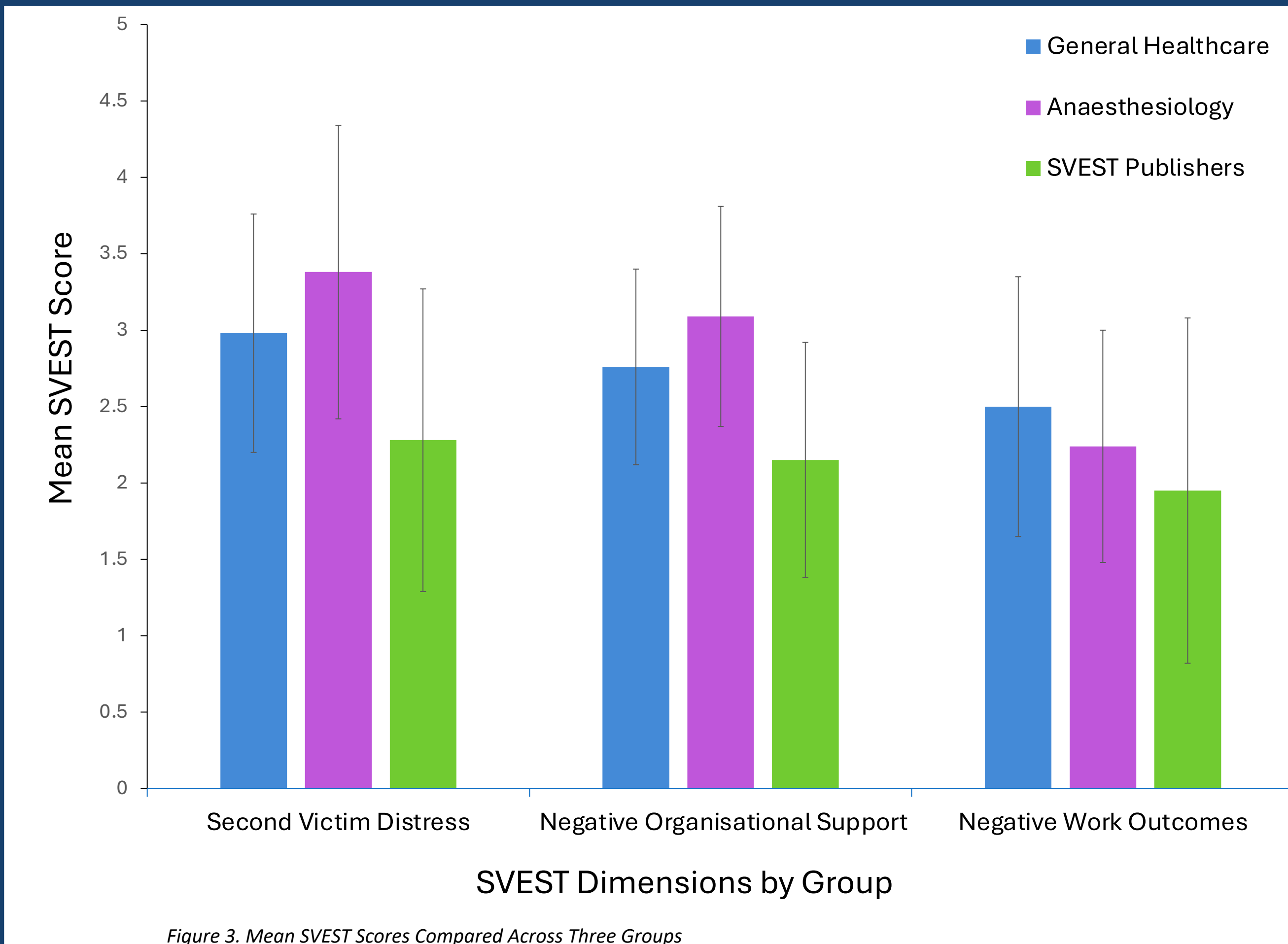


Figure 3. Mean SVEST Scores Compared Across Three Groups

Predictors of Second Victim Distress and Negative Work Outcomes:

- Negative Organisational Support
- Female Gender
- Role (Nursing & Social Care/ Psychology)
- Age (55-64 & 18-24)

Support

- In the aftermath of incidents, formal support options are available but not always accessible to Irish healthcare staff, leaving staff relying on peer, supervisor and non-work related supports to cope.
- Only 16.7% of staff agreed that they received the support they needed after the incident.
- The most desired form of support is from peers. This support is mostly informal in the way of “corridor chats” and “informal debriefing over coffee”. However, staff relationships may be negatively impacted by incident involvement (21.5%).
- Growing team and hospital sizes and the transitory nature of modern-day healthcare is making it more difficult for staff to stay connected, form relationships with colleagues and to adequately support peers after an incident.
- A “macho-culture” persists, leaving many staff feeling like they cannot be seen to require additional support. Help seeking attitudes require staff to “suck it up and just keep going”.

Incident Review Process

- The person-centred objectives of the incident review process are being inconsistently met.
- Staff reported experiencing insufficient communication (67.9%), re-traumatisation (58.5%) and a lack of respect, care and compassion throughout the incident review process (52.9%).
- Few staff believe that the incident review process will bring about meaningful change (33.9%).

Post Traumatic Growth

- Staff report developing closer relationships with their colleagues (25%) and increased vigilance to safety in clinical-practice (89.7%)

CONCLUSION

This study highlights the negative outcomes of patient safety incidents on Irish healthcare staff. Crucial systemic and cultural changes need to be made within the Irish healthcare system to make organisational support more accessible to staff, improve help-seeking culture and to increase incident reporting. More structured peer-support programmes such as the Danish “Buddy System”⁸ and the “forYOU” Team Intervention⁶ should be piloted within the Irish Healthcare System to create a more compassionate culture, increase attentiveness to colleague wellbeing, and in turn, reduce future patient safety incident involvement. As it is difficult to predict what incidents will most affect staff, there should be a protocol or system in place for staff to flag an incident that has caused them distress so that they can seamlessly and anonymously access additional supports. The principles of the Incident Management Framework need to be more consistently implemented to reduce the risk of retraumatisation and increased Second Victim distress throughout the Incident Review Process. In conclusion, recognising the complex challenges faced by staff delivering patient care, we must remember, protect and support the humans behind the healthcare system.

REFERENCES

1. Clancy, C., Shine, C., & Hennessy, M. (2023). Hospital Performance: An Analysis of HSE Key Performance Indicators. *Irish Government Economic and Evaluation Service Research Services & Policy Unit, Department of Health*
2. Von Laue, N., Schwappach, D., & Hochreutener, M. (2012). " Second Victim"- Error, Crises and how to get out of it. *Therapeutische Umschau. Revue Therapeutique*, 69(6), 367-370.
3. Jones, C., Robertson, N., Chamdal, V., Maltby, J., & Weger, S. (2019). Second victim support unit scoping project final Report. *AHSN network patient safety. England: NHS Improvement*, 1-19.
4. Wu, A. W. (2000). Medical error: the second victim: the doctor who makes the mistake needs help too. *Bmj*, 320(7237), 726-727.
5. Cobos-Vargas, A., Pérez-Pérez, P., Núñez-Núñez, M., Casado-Fernández, E., & Bueno-Cavanillas, A. (2022). Second Victim Support at the Core of Severe Adverse Event Investigation. *International Journal of Environmental Research and Public Health*, 19(24), 16850.
6. Scott, S. D., Hirschinger, L. E., Cox, K. R., McCoig, M., Hahn-Cover, K., Epperly, K. M., ... & Hall, L. W. (2010). Caring for our own: deploying a systemwide second victim rapid response team. *Joint Commission journal on quality and patient safety*, 36(5), 233-240.
7. Burlison, J. D., Scott, S. D., Browne, E. K., Thompson, S. G., & Hoffman, J. M. (2017). The second victim experience and support tool (SVEST): validation of an organizational resource for assessing second victim effects and the quality of support resources. *Journal of patient safety*, 13(2), 93.
8. Schröder, K., Bovil, T., Jørgensen, J. S., & Abrahamsen, C. (2022). Evaluation of the Buddy Study¹, a peer support program for second victims in healthcare: A survey in two Danish hospital departments. *BMC health services research*, 22(1), 566.

CONTACT INFORMATION

Name: Erika Carroll
Email: carroler@tcd.ie