National Learning Report
Support for staff following patient safety incidents

Independent report by the Healthcare Safety Investigation Branch I2020/015

January 2021
Providing feedback and comment on HSIB reports

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About HSIB

The Healthcare Safety Investigation Branch (HSIB) conducts independent investigations of patient safety concerns in NHS-funded care across England. Most harm in healthcare results from problems within the systems and processes that determine how care is delivered. Our investigations identify the contributory factors that have led to harm or the potential for harm to patients. The safety recommendations we make aim to improve healthcare systems and processes, to reduce risk and improve safety. Our organisation values independence, transparency, objectivity, expertise and learning for improvement. We work closely with patients, families and healthcare staff affected by patient safety incidents, and we never attribute blame or liability to individuals.

Considerations in light of coronavirus (COVID-19)

A number of national reports were in progress when the COVID-19 pandemic significantly affected the UK. Much of the work associated with developing the reports necessarily ceased as HSIB’s response was redirected. For this national learning report, while the learning described has not changed due to COVID-19, the processes by which HSIB engages with staff had to be adapted. These changes are acknowledged and described further in this report.

National learning reports

These reports offer insight and learning about recurrent patient safety risks in NHS healthcare that have been identified through HSIB investigations. The reports present a digest of relevant, previously investigated events, highlight recurring themes and, where appropriate, make safety recommendations. National learning reports can be used by healthcare leaders, policymakers and the public to aid their knowledge of systemic patient safety risks and the underlying contributory factors, and to inform decision making to improve patient safety.
Our investigations

Our team of investigators and analysts have diverse experience working in healthcare and other safety critical industries and are trained in human factors and safety science. We consult widely in England and internationally to ensure that our work is informed by appropriate clinical and other relevant expertise.

We undertake patient safety investigations through two programmes:

**National investigations**

Our national investigations can encompass any patient safety concern that occurred within NHS-funded care in England after 1 April 2017. We consider potential incidents or issues for investigation based on wide sources of information including that provided by healthcare organisations and our own research and analysis of NHS patient safety systems.

We decide what to investigate based on the scale of risk and harm, the impact on individuals involved and on public confidence in the healthcare system, and the learning potential to prevent future harm. We welcome information about patient safety concerns from the public, but we do not replace local investigations and cannot investigate on behalf of families, staff, organisations or regulators.

Our investigation reports identify opportunities for relevant organisations with power to make appropriate improvements through:

- ‘Safety recommendations’ made with the specific intention of preventing future, similar events; and
- ‘Safety observations’ with suggested actions for wider learning and improvement.

Our reports also identify ‘safety actions’ taken during an investigation to immediately improve patient safety.

We ask organisations subject to our safety recommendations to respond to us within 90 days. These responses are published on our website.

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A note of acknowledgement

HSIB would like to acknowledge the many healthcare staff who have engaged with its investigations and informed its outputs in support of improving patient safety. HSIB would also like to thank those who gave their time to share how their organisations offer support to staff.

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More information about our national investigations including in-depth explanations of our criteria, how we investigate, and how to refer a patient safety concern is available on our website.

**Maternity investigations**

From 1 April 2018, we have been responsible for all NHS patient safety investigations of maternity incidents which meet criteria for the [Each Baby Counts programme](https://www.royalcollege.org.uk/projects/each-baby-counts) (Royal College of Obstetricians and Gynaecologists, 2015) and also maternal deaths (excluding suicide). The purpose of this programme is to achieve learning and improvement in maternity services, and to identify common themes that offer opportunity for system-wide change. For these incidents, HSIB’s investigation replaces the local investigation, although the trust remains responsible for meeting the Duty of Candour and for referring the incident to us. We work closely with parents and families, healthcare staff and organisations during an investigation. Our reports are provided directly back to the families and to the trust. Our safety recommendations are based on the information derived from the investigations and other sources such as audit and safety studies, made with the intention of preventing future, similar events. These are for actions to be taken directly by the trust, local maternity network and national bodies.

Our reports also identify good practice and actions taken by the Trust to immediately improve patient safety.

Since 1 April 2019 we have been operating in all NHS Trusts in England.

We aim to make safety recommendations to local and national organisations for system-level improvements in maternity services. These are based on common themes arising from our trust-level investigations and where appropriate these themes will be put forward for investigation in the National Programme. More information about our maternity investigations is available on our website.
Executive Summary

The purpose of this national learning report is to inform the practice of supporting staff who are involved in and following patient safety incidents. Information has been drawn from the academic literature; from the knowledge and experience of HSIB’s staff, gained during their own previous careers and during HSIB investigations; and from case studies. The report brings these together to share findings that organisations may consider when developing their own programmes.

Following any incident, the first consideration must be for the support of the patients and families who have been affected. The academic literature and previous experiences of HSIB have shown that staff can also be affected by their involvement in an incident, and that this can have an impact on staff retention and performance, and therefore patient care. Most of the published literature describes this impact on staff and services rather than what can be done to minimise it.

HSIB’s scoping literature review (see section 4 and supplementary materials) found proposed models for staff support, but a limited range of evidence relating to their implementation and impact. Most programmes were in secondary care, in North America and included peer support as their main component. Some also had different tiers of interventions available. The accounts in the literature were descriptive and there was little formal evaluation. Potentially beneficial features of staff support programmes were also identified.

HSIB’s staff have experience in healthcare and other industries such as aviation and policing. In their work for HSIB, they interview staff from diverse healthcare organisations who have been directly or indirectly involved in patient safety incidents. Focus groups and interviews drew on these experiences and identified areas of good practice for supporting staff (see section 5 and supplementary materials).

Three case studies are included to illustrate staff support programmes in practice (see section 6). These describe the experiences of the organisations and factors which they consider have influenced their success.

This report concludes by bringing together the findings from the evidence sources and offers a summary that organisations may consider when developing programmes of support for their own staff who have been involved in patient safety incidents (see section 7). Factors identified as important for a staff support programme included:

- the context: for example, the culture and leadership of the organisation, and normalisation of the need for support
- individualisation: for example, identification of staff members or groups at particular risk, offering different routes for support
- delivery of the interventions: for example, accessibility out of hours, proactive delivery and resourcing of peer supporters
• investigations: for example, a clear focus on learning, clear timelines and communication and participation of individuals in resulting service improvements.

As a result of the findings, HSIB makes two safety observations:

**HSIB makes the following safety observations**

**Safety observation O/2021/091:**
It would be beneficial if the impact of programmes to support staff following patient safety incidents were subject to formal evaluation. This would assist understanding of what is good practice in terms of support delivered and resource required.

**Safety observation O/2021/092:**
It would be beneficial for organisations to implement programmes to support staff following patient safety incidents, taking into consideration the findings in this report relating to context, individualisation, delivery and investigation.
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1 Purpose of this report

1.1 Purpose

The purpose of this national learning report is to bring together available evidence and experience to aid in the development of support programmes for staff who have been involved in patient safety incidents. The findings will aid healthcare organisations when planning or developing their own staff support programmes and may encourage others to consider the development of programmes.

HSIB recognises the importance of supporting patients, families and staff following patient safety incidents to minimise harm. HSIB’s position in healthcare safety investigation allows for independent insights into how healthcare staff have been supported by their organisations after patient safety incidents.

1.2 Supplementary materials

Where this national learning report refers to supplementary materials, these are available via the HSIB website. The supplementary materials provide further information on methods used and findings of the scoping review.
2 Background

2.1 The impact of patient safety incidents

Patient safety incidents are ‘unintended or unexpected events which could have, or did, lead to harm to patients’ (NHS, 2017). The patient is the person most directly harmed following an incident, but harm can also occur to others. These include the patient’s family, healthcare staff who have cared for the patient, those who investigate the incident and the organisation where the patient was treated. Staff may experience emotional distress or wellbeing issues as a result of patient safety incidents. They may also sustain a moral injury which is ‘the psychological distress which results from actions, or the lack of them, which violate someone’s moral or ethical code’ (NHS Leadership Academy, 2020). Those harmed by patient safety incidents are often referred to as ‘victims’ in the literature, although this term is controversial.

The ‘third victim’ refers to the healthcare organisation that receives a ‘reputational wound’ that can be worsened or lessened by the behaviour of its leaders (Denham, 2007). The ‘third victim’ has also been used to refer to staff who suffer vicarious trauma from empathetically engaging with those who have been through incidents or trauma (British Medical Association, 2020a), such as healthcare staff responsible for incident investigations (Holden and Card, 2019).

2.1.1 Terminology

The term ‘second victim’ has been questioned, including by the original author (Wu et al, 2020). From the patient or family’s perspective the term ‘victim’ is thought to promote a belief that patient harm is not preventable and that as a victim, healthcare staff and organisations bear no responsibility (Clarkson et al, 2019). It may be perceived to ‘lessen the impact of the incident on the patient’ (Canadian Patient Safety Institute, 2019).

Wu et al (2020) suggest that the label of the ‘second victim’ should be used where leaders feel it appropriate. It may be a suitable term for policymakers, but different language may be
required when setting up support programmes or communicating with patients and their families.

HSIB has chosen to not use the term ‘victim’ in this report. It refers instead to the effect on and support of healthcare staff following patient safety incidents, as adopted by others (Canadian Patient Safety Institute, 2019).

2.1.2 Impact on healthcare staff

Profound effects on healthcare staff (Wu, 2000) may result from the actual events, subsequent investigations, media coverage and institutional treatment. Staff may respond to incidents ‘emotionally, socially, culturally, spiritually, cognitively and physically’ (Wolf, 2005). Examples include guilt, anxiety, fatigue, frustration, anger, self-doubt, and difficulty concentrating (Coughlan et al, 2017). Less commonly staff may develop severe mental health conditions, including post-traumatic stress disorder (PTSD) (Rassin et al, 2005). Responses may be considered from emotional, behavioural, cognitive and physical perspectives (see table 1).

Table 1 Examples of responses to traumatic situations (adapted from Coughlan et al, 2017; Rassin et al, 2005; Wolf, 2005)

<table>
<thead>
<tr>
<th>Emotional</th>
<th>Behavioural</th>
<th>Physical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anger</td>
<td>Hopelessness</td>
<td>Aches</td>
</tr>
<tr>
<td>Anxiety</td>
<td>Numbness</td>
<td>Dizziness</td>
</tr>
<tr>
<td>Depression</td>
<td>Resentment</td>
<td>Flushing</td>
</tr>
<tr>
<td>Fear</td>
<td>Sadness</td>
<td>Headaches</td>
</tr>
<tr>
<td>Guilt</td>
<td>Shame</td>
<td>Insomnia</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lump in throat</td>
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<tr>
<td></td>
<td></td>
<td>Nausea</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pains</td>
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<tr>
<td></td>
<td></td>
<td>Shortness of breath</td>
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<tr>
<td></td>
<td></td>
<td>Tiredness</td>
</tr>
</tbody>
</table>

Cognitive

Disbelief
Disorientation
Impaired judgement
Intrusive thoughts
Lack of concentration

Lack of motivation
Loss of control
Sensations
Smells
Vigilance

Avoidance
Aggression
Drugs and alcohol
Isolation
Over or under eating

Reduced functioning
Self-harm
Sleep disturbance
Violence
Withdrawal
The risk of a traumatic response is higher where the:

- outcome is poor for the patient
- perceived degree of responsibility for the event is high
- incident involves young, previously healthy or multiple patients
- staff member is female
- organisation has handled the error poorly
- organisation has a poor culture around safety and disclosure (Coughlan et al, 2017).

Symptoms last longer following incidents where permanent harm or death occurs. One study found staff were still affected after six months (Vanhaecht et al, 2019).

Staff develop coping strategies and behaviours in response to incidents. Analysis of such behaviours found that these may relate to tasks, emotions or avoidance (Busch et al, 2020) (see table 2). While these behaviours can be negative, they may also have positive implications. For example, Harrison et al (2014) found that 80.6% of doctors reported being determined to improve as an outcome after an adverse event or near miss.

### Table 2 Examples of coping strategies (adapted from Busch et al, 2020)

<table>
<thead>
<tr>
<th>Coping strategy</th>
<th>Examples</th>
</tr>
</thead>
</table>
| **Task**        | • Changing work attitude  
                 | • Following guidelines and policies more closely  
                 | • Paying more attention to detail  
                 | • Problem solving and concrete action planning |
| **Emotion**     | • Talking about or disclosing the error  
                 | • Apologising and doing something to make up  
                 | • Emotional self-control  
                 | • Positive reappraisal |
| **Avoidance**   | • Wishing the situation away  
                 | • Trusting others less  
                 | • Distancing  
                 | • Use of alcohol, drugs and medication |
In the longer term the psychological impact of patient safety incidents on staff can lead to significant effects on performance, health and wellbeing (Sirriyeh et al, 2010). Examples may include prolonged absences from work, ending of careers, self-harm, and suicide. Incidents can adversely affect promising and successful careers, relationships and lives. For organisations, the impact may be increased levels of sickness, increased turnover of staff and reduced morale, more conservative management of patients, and decreased discharges (Russ, 2017).

The narratives of staff provide insights into the significant impact incidents can have and the need for support. Figure 1 provides one junior doctor’s account given to HSIB.

2.1.3 Scale of the problem

Patient safety incidents have a significant impact on staff in the NHS:

“Staff also are requiring significant amount of support if they’re involved in incidents and we’re seeing quite a difference in the approach taken across the country.” (Health Service Journal, 2019)

Studies suggest that more than half of staff involved in patient safety incidents have been personally or professionally affected (Harrison et al, 2014; Edrees et al, 2011). Participants in those studies recall specific events where they were affected and had experienced problems such as anxiety, depression or concern about their ability to perform the job.

Support may be required as a result of an incident, or during subsequent events. These include the investigation, coronial inquests and legal processes. Support may also be required following disciplinary action, suspension and exclusions, although these are not specifically considered in this report. Levels of suspension and exclusion are a concern in the NHS (NHS Resolution, 2019). It has also been highlighted that there are disproportionate levels of disciplinary action against black, Asian and minority ethnic staff groups (Archibong et al, 2019; NHS Resolution, 2019).
I had been a doctor for two years. One day I returned to work to find that a patient I had assessed prior to finishing my shift the evening before had unexpectedly deteriorated and suffered a cardiac arrest. The patient died soon after. There had been concerns that his deterioration could have been prevented during multiple points of his care and I had been one of the last doctors to see him.

Whilst I was reassured by my senior colleagues that my actions were not of concern, I had an overwhelming feeling of shame due to a personal sense that I should have prevented this from happening. A significant feeling of self-doubt affected my confidence during my training over the months to come. I replayed my brief encounter with the patient over and over. I will never forget the joke I shared with the young, cheerful gentleman who I reassured would be fine and hopefully home tomorrow.

A serious incident investigation was launched by the hospital. My only interaction with this was a phone call during a ward round from the consultant leading the investigation. This occurred with no prior warning or offer of support. I was asked very specific questions about the case and given advice on how to manage a similar situation again in the future.

I felt angry that I was being partly blamed for a situation that was out of my control. I knew deep down that my actions were not responsible for this patient’s death, but the conduct of the interview cast severe self-doubt once again. At the time, I felt torn between seeking help and just keeping quiet. I felt that seeking support would be an admission of wrong-doing and inadequacy.

When I was asked to attend Her Majesty’s Coroner’s inquest almost three years later my anxieties were re-ignited. Whilst I fully appreciated the need for an inquest, the anticipation was difficult to deal with. My girlfriend took the brunt of my higher levels of stress.

I had moved onto a different hospital and sought the advice of a consultant I worked with. He took the time to sit and listen to my anxieties of what was to come. His advice and support was invaluable during a time where I felt out of my depth and alone. At no point did he attempt to re-examine the facts of the case to make judgement, but instead delivered practical guidance and the offer of support going forward. It was reassuring that such a well-respected consultant was taking the time to help me and as a result I felt much less anxious.

The aftermath of a patient safety incident quite rightly prioritises the patient affected and their family. It should be remembered though, that the staff involved in the incident will continue to care for others with a burden of emotion, as it was never their intention for things to go wrong.

This period in my life has undoubtedly affected me and shaped my current medical practice. However, I know that its impact on me has been incomparable to the impact on this patient’s family.

Junior doctor, NHS in England
2.2 Staff support

In this report, ‘support’ is considered as emotional and psychological assistance through talking, listening and practical engagement. Support for healthcare staff may be available through different avenues, formal and informal, which are discussed in this report.

The NHS Patient Safety Incident Response Framework recognises the need to identify, inform and support staff following patient safety incidents (NHS England and NHS Improvement, 2020a). However, nationally there is otherwise limited consideration of this need. The NHS People Plan 2020/21 pays considerable attention to staff support, but more specifically in relation to COVID-19 and health and wellbeing (NHS England and NHS Improvement, 2020b). This is further demonstrated by surveys from national bodies (General Medical Council, 2020; NHS Survey Coordination Centre, 2020; Nursing and Midwifery Council, 2019) where support is more often considered in general or related to training and development. The Care Quality Commission, in its key lines of enquiry, focuses on support and sharing for patients and families following incidents, but does not specifically describe the support of staff following incidents (Care Quality Commission, 2017).

The NHS People Plan and NHS Resolution acknowledge the need to support a just and learning culture for staff and patients following incidents in the NHS (NHS England and NHS Improvement, 2020b; NHS Resolution, 2019). A just culture is one that accepts mistakes happen and seeks to respond to incidents without inappropriate and punitive responses. The concept of restorative justice is an important component of a just culture and aims to ‘restore the status and heal relationships and injuries of victims and the wider community in the wake of an ethical breach’ (Dekker and Breakey, 2016). While not the focus of this national learning report, there is evidence of efforts to develop just and learning cultures with restorative justice, for example at Mersey Care NHS Foundation Trust (n.d.).

Organisations do not universally provide support to staff after patient safety incidents (Cabilan and Kynoch, 2017; Manser, 2011) and certain staff groups may be less likely to engage with available support, such as surgeons (Royal College of Surgeons of England, 2020). There may also be more formalised efforts to support staff in certain areas, such as secondary care, as demonstrated by the academic literature (see section 4). There is limited evidence of support in areas such as primary care (for example, Mira et al, 2015). This report discusses examples of support programmes in section 4.
2.3 The impact of COVID-19

During the development of this report the COVID-19 pandemic had a significant impact on healthcare staff across the world (Williamson et al, 2020). HSIB has heard about staff being redeployed to unfamiliar work environments, difficult working conditions and escalating death rates, and challenges to delivering the expected quality of care. Staff also reported having their own domestic pressures, resulting in a combination of work and home stressors with associated burnout and psychological harm. The ability of organisations to undertake the full range of patient safety investigations in a timely manner has also been affected (NHS, 2020a).

The COVID-19 pandemic has highlighted the importance of staff with evidence of increased access to support (NHS Employers, 2020; NHS, 2020b). Surveys such as those undertaken by the British Medical Association of doctors in England and Wales highlight the psychological impact of COVID-19 (British Medical Association, 2020b; 2020c). The surveys demonstrate variation, with around 50% of hospital doctors and 75% of GPs reporting a lack of support for their wellbeing.
3 Methods

The findings of this national learning report are drawn from a review of the published literature (see section 4) and interviews and focus groups (see section 5). Three case studies are presented (see section 6). An overview of the methods is presented in this section with further detail available in the supplementary materials.

3.1 Literature review

A previous published systematic review summarised the research around interventions to support healthcare staff following patient safety incidents and their impact, up to September 2010 (Seys et al, 2013). HSIB undertook a scoping review of the subsequent literature for this national learning report.

The scoping review followed a recognised approach (Arksey and O'Malley, 2005). A protocol was developed around the following question: ‘what interventions have been developed to provide support to healthcare staff following patient safety incidents and what has been the impact of these interventions?’

The bibliographic database Medline (Ovid) and the grey literature were searched. Grey literature refers to publications outside traditional academic publishing routes. All papers published from 2010 until March 2020 written in English and with full texts available were included. Papers were reviewed by three HSIB staff members. Further details are in the supplementary materials.

3.2 Interviews and focus groups

HSIB employees have diverse backgrounds in industries including healthcare, military, aviation and the police. Using qualitative research methods, HSIB employees in the national investigation programme were approached for interviews or focus groups. HSIB employees provided their observations, from HSIB investigations and prior experience, of good practice they had seen where staff had been supported by their own organisations following patient safety incidents.

Interviews and focus groups were semi-structured with an appreciative inquiry approach. This means that the focus was on good practice around staff support, rather than flaws (AI Commons, 2020). Interviews and focus groups were audio recorded, transcribed and thematically analysed.

A standard approach to thematic analysis (Braun and Clarke, 2006) was undertaken by two employees (the reviewers). A commonly used thematic analysis software programme was used (QSR, n.d.). Draft
3.3 Case studies

During review of the literature and from discussions in the interviews and focus groups, examples of local staff support programmes were identified. HSIB contacted a number of these to understand their programmes further. Three are described in section 6.
4 Literature review

This section provides a summary of the findings from the literature. The search strategy looked for interventions to support staff following patient safety incidents, and evaluation of their impact. Work concerned purely with the impact of incidents on staff, and with interventions designed to support staff after a traumatic event not related to a patient safety incident, were excluded.

Twenty-four research papers, reviews and editorials met the eligibility criteria and were included. A further 19 papers were included following a search of reference lists and websites, and a review of full texts and grey literature.

The final 43 papers included 33 original research studies, 6 reviews and 4 editorials, most commonly from North America. Most related to secondary care; only two papers specifically explored primary care contexts. A small number of papers looked at specialty areas including midwifery, paediatrics, surgery, pharmacy and radiotherapy.

Subsequent to HSIB’s review a further scoping review was published (Wade et al, 2020). The findings of that subsequent review are acknowledged in this national learning report due to similarities in some findings.

4.1 Summary of findings

An overview of the findings of the literature review is provided here, structured by the questions that were asked. Fuller details on the findings are available in the supplementary materials.

In brief, the review found that:

• most studies were descriptive only
• peer support was the most commonly described intervention
• several programmes exist which have multiple levels of support
• there is limited evidence of the impact of support programmes
• the investigation process itself also has the potential to be supportive.

4.1.1 What interventions are being used to support staff after patient safety incidents?

Many of the papers contained overlapping work so the range of interventions studied was small. There were various examples of interventions (see figure 2). Most included peer support, sometimes combined with other interventions. Studies were mainly descriptive, with few studies involving comparisons, randomisation or formal evaluation.
Peer support and programmes including peer support were the most commonly described approach. These were well received by most staff but acknowledged as not being suitable for all (Dukhanin et al, 2018; Edrees and Wu, 2017).

Papers acknowledged that ‘one size does not fit all’. For example, some studies found formal counselling (Mok et al, 2020; Burlison et al, 2017; Hu et al, 2012; Edrees et al, 2011) and employee assistance programmes (Hu et al, 2012) to be less desirable for some. There
were several programmes with multiple levels or tiers of support to adjust for the different needs of staff. The Medically Induced Trauma Support Service (MITSS) toolkit (Betsy Lehman Center for Medical Safety, 2018) and Scott et al’s (2010) model (see figure 3) were often cited.

Papers described features of support programmes that were thought to make them more effective, including emotional aid via discussion; reassurance and feedback from leaders; confidential and formal support; constructive learning processes; guidelines and education for staff; and commitment from leaders.

The concept of psychological or emotional first aid was discussed by a number of papers (for example, Gispen and Wu, 2018; Scott et al, 2010). First aid has been primarily used in developing countries after crisis events, but is thought to be applicable to healthcare (Gispen and Wu, 2018). It provides ‘humane, supportive, and practical help to support fellow human beings [immediately after] suffering serious crisis events’ (Snider et al, 2011) and can be delivered as part of a support programme. Snider et al (2011) with the World Health Organization suggests the core principles of first aid are look, listen, link and limits. Training is simple, efficient, and cost effective (Gispen and Wu, 2018).

The context within which programmes were implemented was felt to be important, with advocates for cultures that are non-punitive and aim for learning (Zhang et al, 2019; Edrees and Wu, 2017; Quillivan et al, 2016).

Wade et al’s (2020) review further identified that many support programmes were created with advice and oversight from the same panel of experts leading to a similar approach and few distinguishing features.
Scott et al (2010) described a three-tiered intervention model of support based on survey findings from their organisation.

The first tier promotes immediate emotional first aid at the departmental level. Staff receive basic awareness training. An estimated two thirds of staff involved in an incident may require support at this tier and will find it sufficient.

Tier 2 provides support for an estimated additional third of staff. This tier provides trained peer supporters. They are embedded clinically to allow continuous monitoring of colleagues and one-to-one support. Peer supporters access patient safety teams to help navigate investigation processes and are trained in leading group discussions.

Tier 3 provides professional and expert support services. This gives support beyond that given by peer supporters; some may need to be fast-tracked to this tier. Resources may include chaplains, employee assistance programmes and trained psychologists.
Individual debriefing of staff after patient safety incidents was considered by several papers (Blacklock, 2012; Edrees et al, 2011; Scott et al, 2010). While debriefing was not specifically searched for as part of this scoping review and this national learning report does not seek to draw conclusions on its role, it is important to acknowledge that the concept of psychological debriefing is controversial. Some claim it may be helpful, while others suggest it may lead to no benefit or further psychological harm (Rose et al, 2002; Wessely and Deahl, 2003). The term ‘debriefing’ may mean different things to different industries and people. The National Institute for Health and Care Excellence (NICE) refers to debriefing as a provision of single-session interventions to individuals that focus on a traumatic incident (National Institute for Health and Care Excellence, 2018). It concludes that psychologically focused debriefing is not recommended for the prevention or treatment of post-traumatic stress disorder (PTSD) because it ‘showed no benefit … and some suggestion of worse outcomes than having no treatment’. Instead, NICE recommend a range of psychological interventions.

### 4.1.2 What is the evidence of impact of these interventions?

Papers provided limited evidence of the impact of staff support programmes. One example of structured evaluation (Winning, 2018) demonstrated that peer support moderated the association between experiencing an event and anxiety and depression.

Conclusions citing the effectiveness of support were often extrapolated from the effect incidents have on staff where support programmes did not exist. For example, in one study the lack of support was described, with nurses observed to make poor recovery from incidents (Cabilan and Kynoch, 2017). Even when processes and protocols are in place, this does not necessarily mean they are effective (Kobe et al, 2019; van Gerven et al, 2016; White et al, 2015; van Gerven et al, 2014; Edrees et al, 2011) or that staff will access them (Edrees and Wu, 2017; Harrison et al, 2015).

Wade et al (2020) further highlighted the lack of robust evidence in this area, but suggested that support programmes organised by a quality improvement or patient safety department, rather than an employee assistance programme, might be associated with greater impact.
4.1.3 What is the role of the investigation process in support?

Many of the papers were concerned with the negative impact investigations had on staff. However, there were suggestions that the process of an investigation can itself have a beneficial effect. Papers described how investigations can be therapeutic by helping staff to get a sense of perspective and by being involved with safety improvements (Christoffersen et al, 2020; Ward Platt, 2018; Edrees et al, 2011). A supportive investigation process was described as timely, transparent, having feedback mechanisms, being undertaken within a just culture, and being explicitly for learning (Ullström et al, 2014). Investigations were also described as needing to be system focused and this is supported widely, for example by the Chartered Institute of Ergonomics and Human Factors (2020).

4.2 Limitations

The scoping review provided modest evidence of the benefit of support programmes and which support approaches are most effective after patient safety incidents. Many of the papers were concerned with secondary care, hospital-based staff; there is far less representation in the literature of staff support in other healthcare areas.

A focus on interventions in support of prevention of PTSD following traumatic situations other than patient safety incidents was out of scope for this review. Literature concerned with other traumatic situations will potentially offer further learning, for example POPPY, the programme for the prevention of post-traumatic stress disorder in midwifery (Slade et al, 2018).
5 Interviews and focus groups

This section provides a summary of the findings from the interviews and focus groups undertaken with HSIB employees. Ten interviews and three focus groups were undertaken during March to June 2020 involving 22 employees (referred to here as the participants). These included clinicians, safety scientists, human factors specialists and investigators with safety-critical industry backgrounds. They provided their observations and experience, from HSIB investigations and prior careers, of how staff had been supported by their own organisations following safety incidents.

5.1 Overview of themes

Following thematic analysis of transcripts and notes, five themes emerged, two of which had further subthemes (see figure 4). Each of the themes is briefly discussed in this section with illustrative quotes. Fuller details of the findings are available in the appendix.

Fig 4 Themes and subthemes from interviews and focus groups
5.1.1 What is support?

This theme considers what is meant by the term ‘support.’ Participants debated the definition of ‘support’ and there was a range of views.

“Support … but what does that mean? … Some people want to be listened to by someone who cares; for others it is practical. It is not a prescriptive definition, it is subjective.”

Support was felt to have many facets. Participants provided examples of support including: emotional and psychological; informational, such as advice around navigating the investigation process; and practical for particular tasks, such as telephoning family or arranging lifts home.

5.1.2 The case for staff support

This theme considers the need for staff support in healthcare and its effectiveness. Participants described positive examples of staff support they had seen or experienced in their careers and during investigations. These were contrasted with examples of psychological harm and moral injury sustained by staff who had not received support.

“… it’s brutal sometimes and it seems so wrong and we lose so many good staff, just because perhaps we’re not caring for them as we should do.”

Most participants’ accounts of support programmes in healthcare were of informal networks and individual peer support by colleagues. There were fewer examples describing formal support programmes. Support programmes were repeatedly described as being inconsistently provided. Contrasts were drawn with other safety-critical industries where formal programmes were more often available.

“I think most people don’t really think about it, they think it just happens…”

5.1.3 Providing support in healthcare

This theme considers examples of support programmes and interventions in healthcare settings. Participants described examples they had experienced or observed during investigations and in their previous roles in healthcare. While an appreciative inquiry approach was taken, participants often struggled to identify positive examples. Instead, they discussed factors that had led to limited or absent support. This theme therefore has two subthemes which explore positive examples of support from healthcare and negative cultures that impede staff support.

Positive examples from healthcare

Positive examples of effective support in practice were identified by participants. Examples included resources
to support wellbeing, such as Schwartz rounds, which are a structured way for staff to discuss the social and emotional aspects of health care (The Point of Care Foundation, n.d.); symbols of caring such as free food, free parking and wellbeing hubs; support immediately after incidents; and support through the subsequent investigations including during interviews.

“[For those] involved in an incident there was a set support package that was offered ... They would have an early debrief on the incident and make sure they were supported. Staff would then be followed up within 48 hours ... there were regular check-ins as they went through the incident investigation process and any coronial process and it’s a very well-structured service.”

Other examples of formal support described included telephone counselling services and access to mental health practitioners. Participants also described examples where staff sickness had been reduced through support programmes.

**Negative cultures impeding support in healthcare**

Culture represents ‘the shared ways of thinking, feeling and behaving’ (Mannion and Davies, 2018). Participants described negative cultures in organisations that led to punitive responses to incidents. Examples were given where individuals were labelled as being at fault and were prevented from undertaking tasks or were removed from usual work duties resulting in isolation and stigma. Participants also described their perceptions of different cultures across professions and specialties which influenced the way error was perceived and managed, and how support was provided and accepted.

“... when these things happen, the junior doctors just get spoken to and the nurses get it on their record ... [there is no] ... consistency between how people are treated ...”

**5.1.4 Providing support in other industries**

This theme considers examples of support programmes and interventions experienced outside healthcare. Participants discussed their experiences in professions such as the military, aviation, engineering and policing. Some of these organisations were felt to face similar challenges to healthcare when providing support, including the development of just cultures.

Participants described examples of support including preparation of staff for adverse events and the delivery of support after events. These may be routinely offered, so staff must opt-out, rather than opt-in. Police forces have recognised that certain groups are at higher risk of psychological harm due to the types of people and situations they deal with.
“... if you have a particular role that it’s known involves vicarious trauma, then you are deemed a high-risk group and you have monitoring, wellbeing surveillance.”

The ‘hot debrief’ (a discussion that takes place immediately after events) was commonly mentioned, particularly by those with a background in aviation and the military.

“... we used to say, it’s about sitting down, and having a quick chat … Some of the images you see, or things you hear, if they’re not talking about it, then you need to start worrying.”

Participants described that they perceived industries such as aviation and rail were in a better position to support staff because of their pre-existing no-blame culture and focus on systems. Those who had come to healthcare from other backgrounds reflected on the challenges they saw as different in health, such as the sheer number of incidents.

5.1.5 Principles of effective staff support

This theme considers the factors that may be associated with effective and impactful staff support. Participants discussed requirements for the development and implementation of staff support programmes following patient safety incidents.

Three subthemes were identified: culture and leadership; delivery and availability; and support during investigations and interviews.

Culture and leadership

This subtheme reflects participants’ views that organisations must value staff and ensure their support and wellbeing is a priority. Participants described a culture of support as one that provides resources for staff and ensures staff are treated fairly. Key to this was felt to be a just and learning culture, and the absence of stigma associated with being involved with an incident. HSIB staff felt that investigations must consider the systems within which incidents occur to move the focus away from individuals. They also felt that leadership was important to help normalise the need for and access to support. Leaders are well placed to role-model behaviours that seek out and accept support.

“My view is that [any changes] need to come from senior leadership ... to show the importance of it and it can’t be just a box-ticking exercise. It needs to be meaningful and actually led on and owned by the executives.”

Participants also discussed disciplinary action following incidents and how individual disciplinary action may be counterproductive to a just
culture, attributing harm to individual actions rather than system effects. HSIB staff gave examples of disparity in the way staff were treated following incidents depending on their healthcare profession or personal backgrounds.

**Delivery and availability of support services**

This subtheme reflects participants’ descriptions of how good examples of support programmes had been developed and what services were included. They described successful support as including the following: structure, independence, proactivity, consistent delivery and consistent availability. Participants felt support should be available via different avenues and include preparation of staff to deal with incidents before they occur. Support was described as needing to be specific to an individual’s requirements and therefore needed to be varied.

“It’s having a very individualised how can we help you, we appreciate this is a difficult time, what do you need from me, what will make this easier for you noting I can’t take the pain away.”

Participants recognised peer support as a desirable component of any support system. They felt that to be effective, peer supporters should be willing, able, trained and have the time to provide support.

**The role of investigation in supporting staff**

This subtheme reflects participants’ experiences of well-managed investigations providing support. Participants gave examples of where staff had been significantly distressed before and during investigations, particularly when revisiting previous events.

“Never ever underestimate how paranoid and fragile people are when they are part of an investigation; be immensely careful with your language and be supportive and nice.”

Staff participation in the form of providing information and helping to develop recommendations was regularly discussed and thought to be fundamental.

“... need greater involvement of staff in the process of investigation; they are not under investigation, rather they are part of it. They are the experts in the local environment and facilitate them to do their job, so they are more comfortable in sharing and see themselves as part of improvement rather than finger pointing.”

Participants felt that investigators should not be the same staff who are responsible for emotional support. It was felt that transparent processes and clear communication of plans and timeframes are necessary.
“… there is nothing worse than hanging around waiting … It’s about knowing what the process is, who’s doing what, when to expect to see anything, the confidence that you are going to see something come out of it, who else sees it, what the end result is …”

Participants described what they saw as the key principles for carrying out interviews with staff about patient safety incidents. This was provided from their perspectives as investigators and considered support before, during and after interviews. HSIB’s interview process is described further in the appendix. Participants described how interviews should be undertaken with advanced notice and in private environments, and interviewers should work to build a rapport with staff. Persons who accompany staff to provide support were thought to have a role in reassuring and empowering them during interviews.

“They would give an answer and look at [the accompanying person] for reassurance … [The accompanying person] let them get on with it … just that reassuring presence … and actually halfway through, they had clearly relaxed.”

Many participants felt the accompanying person should not be a senior member of the organisation or a line manager. It was felt that the presence of a hierarchy might stifle honest sharing of facts, and the interviewee might instead focus on what the organisation would want an investigator to hear.

Participants reflected that after an interview staff need ongoing support and need to know how to access it. They felt that consideration also needed to be given as to whether the staff member could go straight back to frontline work after the interview.

5.2 Limitations

The interviews and focus groups provided insights into the experiences of HSIB’s employees. These experiences are wide ranging but are recognised to be subjective and from a particular perspective. The backgrounds of staff were not representative of all safety-critical industries and most of those from healthcare had worked in secondary care.
6 Case studies of staff support

From the literature review and interviews and focus groups, HSIB identified several examples of staff support programmes being delivered in healthcare. Programmes often provided general support, but also included components to support staff following patient safety incidents. To explore examples further, authors and programme leads were approached with a request for an overview of their programmes and their insights. The selected examples in this section illustrate different settings: a trust-wide programme to support staff involved in patient safety incidents, a support programme developed for an intensive care unit team, and an international example of a well-established programme. These examples were chosen to reflect how certain organisations have developed programmes.

6.1 Supporting our Staff

Nottingham University Hospitals (NUH) NHS Trust, England: Supporting our Staff programme

The NUH Supporting our Staff (SoS) programme was identified from the scoping review (Jones et al, 2017) and an HSIB employee’s experience of working with the organisation. HSIB heard from the programme lead about how the programme was set up and is delivered.

SoS was launched in 2018 to support staff who have been involved in patient safety incidents. The content and structure were developed by stakeholders from patient safety, clinical psychology, medicine, nursing, learning and organisational development, occupational health, chaplaincy, and frontline staff. The programme lead described the importance of inclusion of a clinical psychologist, who had time allocated to the programme to offer their knowledge, expertise around psychological interventions and support for supporters.

The SoS programme is based on Scott et al’s (2010) three-tiered interventional model of support (see figure 5) and can be activated by an individual, their supervisor or through proactive identification of staff who might need support. The tiers include:

- Tier 0: resources to support general health and wellbeing with the intention of developing coping mechanisms before any incident occurs.
- Tier 1: following an incident, local manager, supervisor and colleague support. Educational resources are provided. The resources include a ‘demobilisation’ tool to ascertain whether staff are ‘FIT’ immediately after an incident (see figure 6).
- Tier 2: peer support programme offering support from trained individuals. Training was delivered by a consultant in psychological
Fig 5 Supporting our Staff model, Nottingham University Hospitals

- Tier 0: Health and wellbeing
- Tier 1: Emotional first aid
- Tier 2: Peer support
- Tier 3: Expert internal and external support including occupational health, chaplaincy and an employee assistance programme, provided 24 hours a day.

Fig 6 The FIT tool for demobilisation, Nottingham University Hospitals

Food: provide time for food, drink and collection of thoughts

Information: inform supervisors of the event and ensure information is shared about what has happened

Transport/telephone: consider practical arrangements for getting home and telephoning family/friends for support
The lead told HSIB that staff reported positive reactions to the programme, including beliefs that the support provided had been helpful and kept individuals at work. The lead also reported that since the programme’s launch the identification and support of staff by clinical areas had increased, suggesting to them a culture shift toward proactive support.

The peer supporters from SoS have more recently assisted in local wellbeing hubs throughout COVID-19. The SoS team now plans to increase engagement, increase support for peer supporters and provide routine staff support after coroner’s inquests.

The programme lead described what they perceived to be the key considerations for an effective staff support programme following patient safety incidents:

- recruitment of peer supporters with varied backgrounds to provide insights into the needs of staff across an organisation
- clinical psychologist support in development and delivery
- signposting to existing support mechanisms
- starting small and building up, rather than initially being too aspirational
- ensuring early conversations and support after incidents
- integrated care of the peer supporters
- showing the same compassion to colleagues as is shown to patients and their families.

### 6.2 Critical care support and wellbeing

**The Leeds Teaching Hospitals NHS Trust (LTHNT), England: support for staff in critical care**

The staff support service for adult critical care was set up in 2017 and is currently led by two of the Trust’s clinical psychologists. This followed the organisation’s recognition that critical care is a psychologically demanding work environment. The service provides support to more than 500 staff across the critical care areas. The service is voluntary and staff are given time within work hours to access it if required. It provides three approaches to support (see figure 7):

- Individual: one-to-one support to explore the impact of working in critical care and to identify any need for onward signposting, including for non-work matters.
- Group: team support, like peer support, providing multidisciplinary spaces to reflect. Some groups meet separately, such as new starters. Wellbeing training and reflective time are also included in study days.
- Service-wide: working with leaders in critical care to support initiatives
in department wellbeing, such as staff-led wellbeing huddles and developing content for ‘wellbeing Wednesdays’ via a closed social media forum. Psychologists act as a conduit between individuals and groups to leaders, suggesting initiatives and providing anonymous insights.

HSIB heard that the service proactively normalises and validates reactions to the stressful critical care environment. Reflective practice groups have been trialled, as have nurse-led wellbeing huddles at the end of each shift. The huddles include questions such as: ‘What has gone well?’, ‘Any lessons learned?’ and ‘What will you do to relax and switch off?’ The service also identifies gaps in wellbeing support and safeguards the needs of staff to have uninterrupted breaks and space to relax.

The service was described as having a role in supporting staff after critical incidents, which can include patient safety incidents. The psychologists are in regular contact with leaders and are informed about incidents. They can facilitate operational debriefs, including providing information on common stress reactions. They are available to staff for individual or group spaces to consider the emotional impact of their work. These spaces are sought out more by staff when relationships have already been developed with the psychologists. The clinical psychologist described how staff had responded positively to the service and reported feeling that it is changing the departmental culture of seeking support. A formal impact assessment is planned.

The clinical psychologist also outlined barriers to accessing the service. It was felt that not
all staff access the service for logistical reasons, because they have alternative support networks, or because they do not feel that they need support. It was felt that some may also see the need to access support as a challenge to their ability to cope, and perceive stigma associated with accessing a ‘psychologist’ for support.

The clinical psychologist described what they perceived to be the key considerations for an effective staff support programme:

• visibility and accessibility of the service and its facilitators; psychologists get to know staff, build relationships and are visible in the critical care departments

• clear boundaries for support; the service is for support in relation to work-related factors

• resources to deliver the programme

• finding champions for the service who encourage its use and role-model the need for all staff to access support from peers or formally

• getting feedback from users to see how it can be developed

• validation and normalisation; be genuine in the support delivered, acknowledge that it is ok to be affected by events and it is normal.

6.3 An international perspective

Peer support, USA: providing an international perspective

During the literature review for this report, HSIB identified extensive work focusing on peer support for the healthcare team developed at Brigham and Women’s Hospital, Boston, USA, led by their Center for Professionalism and Peer Support (CPPS) from 2008 to 2019 (Shapiro and Galowitz, 2016; Shapiro et al, 2014; van Pelt, 2008). Their peer support model, one of the first of its kind, has since been adopted by multiple national and international healthcare organisations. HSIB learned from the Center’s previous lead about how their peer support programme had developed and reflections on what makes it effective.

HSIB heard that the peer support programme is a formal initiative that supports discussions with staff after any type of serious, unanticipated adverse event. Shapiro and Galowitz (2016) describe the origin, structure and workings of the programme in their publication with information about their peer support conversation approach. The programme does not use the term ‘second victim’ because the term is known to be offensive to some patients and families (Wu et al, 2020).
Non-mental-health clinicians are trained to provide support to staff in one-to-one or group settings. A core tenant of the programme is that the support is offered proactively, reaching out to clinicians after known stressful events, rather than waiting for colleagues to exhibit signs of distress. Awareness of the programme is undertaken through conferences such as departmental meetings.

The lead described how the selection of peer supporters is critical for any support programme. They recommended that supporters are nominated, rather than volunteer. The supporters must be compassionate, respected clinically, able to communicate, and should represent diversity in sex, age, ethnicity, job role and specialty. Having peer supporters from varying backgrounds allows a degree of matching of supporter to peers.

HSIB heard how the peer supporters are trained and supported via a ‘support the supporters’ programme. Training includes:

- understanding common reactions to being involved in medical errors
- how to be helpful to colleagues without trying to ‘fix’ their emotions
- how to undertake a peer support conversation (Shapiro and Galowitz, 2016), using the principles of peer support such as empathetic listening, validation, non-judgmental curiosity and problem solving
- how to refer for further support such as professional mental health services
- knowing the boundaries of peer support.

The lead felt that a peer support programme should be available for all staff, but this may be challenging if resources are limited. Organisations might therefore need to prioritise staff groups or specialties where there is greater risk.

Regarding evaluation, HSIB heard that programmes must be honest from the beginning that they might not be able to demonstrate impact formally. Organisations might be able to measure some facets of impact using metrics such as surveying those who received peer support.

The lead described what they perceived to be the key considerations for an effective peer support programme:

- consistent model offering proactive support and taking referrals for one to one or team support; this includes triggers for proactively offering support instead of waiting for staff to exhibit signs of distress
- defined audience tailored to the available resource
- nominated, trained supporters from diverse backgrounds
• support for the supporters themselves

• easy access and the breaking down of professional, structural and cultural barriers to using the programme

• attempts to evaluate impact, acknowledging that the benefits of the programme are high and the associated risk low

• provision of resource and time for managing the programme.

6.4 Other case studies

The above three case studies are examples. Other programmes, both formal and informal, exist across the NHS. HSIB has heard of other programmes, particularly in secondary care, the ambulance service and mental health.

Beyond the individual programmes that NHS organisations have developed, NHS Employers offers a wide range of resources aimed at supporting the varying needs of staff (NHS Employers, 2020). While not focused on support following patient safety incidents, many of the resources consider staff wellbeing, which is particularly relevant during and in the aftermath of the COVID-19 pandemic. HSIB is also aware of a variety of commercially available peer support training programmes and employee assistance programmes.

Ongoing research and programmes of work around staff support have been identified. For example, Bournemouth University is undertaking a multi-site randomised control trial of a resilience training intervention with surgeons in training (Bournemouth University, n.d.). The research group has collaborated with the Royal College of Surgeons of England to publish a good practice guide to supporting surgeons after adverse events (Royal College of Surgeons of England, 2020).

Other programmes of work include The Yorkshire Quality and Safety Research Group and Improvement Academy, supported by the National Institute for Health Research Yorkshire and Humber Patient Safety Translational Research Centre. They have developed ‘a resource for clinicians who are involved in patient safety incidents, their colleagues and the organisations they work for’ (Yorkshire Quality and Safety Research Group and the Improvement Academy, 2019).
7 Summary of findings and observations

The following sections collate the learning from the evidence reviewed in this national learning report and make two associated safety observations. The evidence includes the scoping literature review, insights from HSIB’s employees and the case studies.

The evidence guiding the implementation of impactful staff support programmes following patient safety incidents is limited. The literature, interviews and focus groups demonstrate that many organisations are delivering support in some form. Much of the evidence for impact is descriptive, concerning gratitude from staff for the support given. As a result, HSIB makes the following safety observation.

HSIB makes the following safety observation

Safety observation O/2021/091:
It would be beneficial if the impact of programmes to support staff following patient safety incidents were subject to formal evaluation. This would assist understanding of what is good practice in terms of support delivered and resource required.

While there is limited evidence of the impact of current staff support programmes, all authors, interviewees and case study leads agreed with the need to implement support programmes for staff following patient safety incidents. The following sections present a summary of the findings from the evidence gathered. These findings are also informed by the experiences of HSIB’s employees in other industries. They aim to guide the development and implementation of staff support programmes in healthcare.

The findings are grouped into the overarching themes of context, individualisation, delivery and investigation. They are explored in turn and summarised in table 3. As a result of the findings and themes, HSIB makes the following safety observation.

HSIB makes the following safety observation

Safety observation O/2021/092:
It would be beneficial for organisations to implement programmes to support staff following patient safety incidents, taking into consideration the findings in this report relating to context, individualisation, delivery and investigation.

7.1 Overarching themes

7.1.1 Context

Context refers to the circumstances or settings within which staff support programmes are implemented. While this report is focused on support following patient safety incidents, the evidence suggests that any support for
staff after incidents must be part of a wider programme supporting health and wellbeing. Examples demonstrating this included Schwartz rounds (The Point of Care Foundation, n.d.) and symbols of caring, such as rest spaces and free food and drink.

Across the literature, interviews, focus groups and case studies reviewed for this report, it was suggested that organisational and professional cultures are fundamental in ensuring support is effective. Appropriate organisational cultures promote support and foster a just response to incidents, focused on learning (for example, Zhang et al, 2019).

HSIB heard about the influence of leaders in organisations and professional attitudes towards support following incidents. Interviews, focus groups and case study participants described their observations that organisation and profession leaders are crucial in developing supportive cultures by recognising that the mental health of staff matters, showing compassion, advocating for support programmes, and role-modelling access to support. Compassionate leadership has a key role in developing high-quality care through leaders ‘listening with fascination to those they lead, arriving at a shared (rather than imposed) understanding of the challenges they face, empathising with and caring for them, and taking action to help and support them’ (West and Bailey, 2019).

During interviews and focus groups, participants also described a perceived inequality around access to support services for all staff. They felt that support should be equitable and accessible to staff regardless of their professional background or role. For example, experiences were described where staff on rotational jobs or in locum positions had less access to support.

Participants with previous roles in other industries also described their perceptions that those industries face similar challenges to healthcare when developing and implementing support processes. They also acknowledged that healthcare has the added burden of more incidents. They felt the principles of just culture and system-based investigation may be more embedded in some safety-critical industries with constant reinforcement through training. A number of these industries have mandated support processes as part of their normal ways of working.

7.1.2 Individualisation

Individualisation refers to the provision of support that is individual to the needs of staff. Participants in interviews, focus groups and case studies discussed differing preferences about how to access support and the types of support that work for staff. This was supported by the literature,
suggesting that ‘one size does not fit all.’ For example, some studies found formal counselling (Mok et al, 2020; Burlison et al, 2017; Hu et al, 2012; Edrees et al, 2011) and employee assistance programmes (Hu et al, 2012) to be less desirable for some staff, and consideration should be given to cultural factors.

In support of tailoring support programmes to the needs of staff, toolkits are available which include the tiered structure as in figure 3 (Scott et al, 2010). These structures provide both formal and informal support options, provided within organisations and externally.

During the interviews and focus groups, HSIB also heard how other industries identify individual staff who may be in greater need of support. Examples included air traffic controllers and the vicarious trauma that might affect police officers who support families following loss. There may be similar benefit in identifying high-risk staff groups in healthcare. These groups could include those who deal with distressing clinical situations, such as safeguarding; those investigating and managing incidents; and those supporting patients, families and staff.

7.1.3 Delivery

Delivery refers to the structure and functioning of support programmes, and the types of support included. The evidence in this report highlights the forms of support in use (see figure 2). It acknowledges the need for support after an incident, but also that preparing staff to deal with challenging situations and develop coping strategies is important.

Despite the range of examples of support, HSIB heard about, and the literature describes a lack of support programmes for staff after patient safety incidents. Even when processes and protocols are in place, they are not necessarily effective (for example, van Gerven et al, 2016).

While delivery of a support programme should include multiple avenues of support to allow individualisation, peer support was discussed in the literature as being an important component. This was supported by the interviews, focus groups and case studies. HSIB also heard about how to ensure peer support programmes are successful, for example training of supporters, support and resources for supporters, confidentiality, and visibility of the programme. The literature provides examples of peer support programmes (for example, Shapiro et al, 2014) and information on how to deliver support sessions (for example, Ward Platt, 2018).

Delivery includes consideration of the barriers to implementation of a programme. The literature suggests that even when support services exist, staff might not
access them (Edrees and Wu, 2017; Harrison et al, 2015). HSIB heard from interview, focus group and case study participants of the need to identify the barriers and challenge them when setting up a programme and to make it sustainable.

A barrier regularly discussed was the reluctance of staff to access support. This was potentially because of pride, lack of self-recognition of the need, or stigma. The evidence suggests that proactive approaches may be more successful in overcoming such barriers and examples of this were discovered, for example, in the ambulance service and policing where an ‘opt-out’ process may be used.

A further barrier was ease of access to support. This included awareness of support options and the availability of support out of normal working hours. This was reinforced by the literature which described that staff work varying shifts (Trent et al, 2016; White et al, 2015) and may need support weeks, months or years after an incident.

The limited evaluation of support programmes was discussed. It was suggested, particularly by case study participants, that this was more likely to be due to difficulty with evaluation than lack of true impact. The literature review noted a tool to assist organisations to implement and track the performance of support resources, called the ‘Second Victim Experience and Support Tool’ (SVEST) (Burlison et al, 2017).

7.1.4 Investigation

Investigation refers to the formal processes of review following an incident. Well-designed investigation processes can themselves be supportive. Participants in interviews and focus groups described how a well-managed investigation, particularly the interview component, can be supportive by giving staff a sense of perspective on how the incident occurred and an opportunity to help implement safety improvements. This is supported by the literature (Christoffersen et al, 2020; Ward Platt, 2018; Edrees et al, 2011).

Most of the evidence about investigation processes came from HSIB’s employees’ experiences of their roles as investigators. They perceived that effective investigations should be open, have clear milestones, be system focused, be compassionate and have a clear focus on learning. The need for this is supported by publications such as the Chartered Institute of Ergonomics and Human Factors white paper which provides nine principles for learning investigations, one of which is to ‘adopt a systems approach’ (Chartered Institute of Ergonomics and Human Factors, 2020). Participants felt that consideration of staff support during investigations and interviews should be part of the investigation process, which includes separating investigators from those with line management or pastoral responsibilities.
Participants in the interviews and focus groups described the importance of the interview as part of the investigation process and that poorly managed interviews can be just as traumatic as the original incident. They provided various thoughts on how to conduct interviews in line with HSIB’s approach. An overview of HSIB’s approach to interviewing is provided in the appendix. HSIB has received positive feedback from staff on how it conducts its interviews.

Table 3 Summary of findings for support programmes for staff following patient safety incidents

<table>
<thead>
<tr>
<th>Theme</th>
<th>Summary of findings</th>
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| **Context**       | • Just, learning and supportive culture  
• Focus on the importance of staff mental health  
• Leaders and professional cultures that normalise and promote the need for support  
• Equitable access to support for those who need it |
| **Individualisation** | • Meet the needs of staff  
• Identify high-risk groups and situations for proactive support  
• Provide options for support – internal and external, formal and informal |
| **Delivery**      | • Develop coping strategies and prepare staff for an incident occurring  
• Structure with multiple avenues of support, including peer support  
• Provide resources for peer supporters and training  
• Break down barriers through clear advertising, out-of-hours provision and a proactive approach  
• Ensure the programme delivers for staff needs and preferences  
• Include provision to ‘support the supporters’ |
| **Investigation** | • Compassionate, focused on learning and systems based  
• Separate those supporting from those investigating  
• Interview with support in mind |
7.2 Aligning family and staff support

In September 2020 HSIB published its national learning report ‘Giving families a voice: HSIB’s approach to patient and family engagement during investigations’ (Healthcare Safety Investigation Branch, 2020). That report demonstrated the importance of patient and family engagement during investigations and set out HSIB’s principles (see figure 8). The findings in this national learning report suggest that there is less recognition of the importance of staff support following patient safety incidents and during investigations. Patient and staff support are equally important and this has also been recognised by others outside of HSIB:

“The most important thing to say is this isn’t something that’s different for staff and patients – it’s seeing staff and patients as equals in the same process and that we look to do whatever we can to support both to get some kind of resolution.” (Health Service Journal, 2019)

The considerations for providing patient and family engagement and support are like those described in this report for staff.

**Fig 8 HSIB’s principles for effective patient and family engagement and support**

- Personalised
- Open and transparent
- Accessible and inclusive
- Respectful
- Timely
8 Conclusions

This national learning report has described the impact of patient safety incidents on healthcare staff and how staff are supported following incidents and during subsequent investigations. It has drawn together the literature, HSIB employees’ observations of support in and outside of healthcare, and case studies.

HSIB has heard of situations where healthcare staff have been psychologically harmed following patient safety incidents. This is also clearly articulated in the literature. The evidence shows there are positive examples of individuals and organisations striving to support staff following patient safety incidents. The evidence also suggests this is appreciated by the staff involved, but impact is not well evaluated. However, the perception of all those consulted with during development of this report is that support systems are needed and are likely to have a positive impact.

The findings of this report are available to healthcare organisations to consider when developing and implementing their own support systems for staff following patient safety incidents. The findings include novel considerations, in part taken from other industries, such as the need to personalise care to individual staff and to identify staff groups who may be at an increased need of support.

The findings of this report suggest that healthcare needs to do more to support staff after patient safety incidents. Much like patients and families, everyone who has been harmed needs to be offered assistance. How to do this most effectively is still to be well evidenced, but based on current evidence, HSIB provides the findings in this report.

HSIB makes the following safety observations

Safety observation O/2021/091:
It would be beneficial if the impact of programmes to support staff following patient safety incidents were subject to formal evaluation. This would assist understanding of what is good practice in terms of support delivered and resource required.

Safety observation O/2021/092:
It would be beneficial for organisations to implement programmes to support staff following patient safety incidents, taking into consideration the findings in this report relating to context, individualisation, delivery and investigation.
9 Appendices

9.1 Themes from interviews and focus groups

This appendix provides a fuller summary of the findings from the interviews and focus groups as outlined in section 5.

9.1.1 The case for staff support

This theme explores the need for staff support programmes in healthcare. Participants felt that healthcare is inherently caring and described their experiences of informal support networks. However, they felt the success of those networks depended on the commitment of an organisation and individuals within that organisation. More formal support efforts were thought to often be lackadaisical.

“[Staff] found out in the course of their duties ... that a [patient] they had helped earlier in the day had died. They were not debriefed properly on the day, they just had to continue their job, they described very little support.”

There was disbelief and frustration among participants that staff were often not supported by their organisations. They had seen the results of inadequate support, including staff who had left their professions or continued suffering for many years with psychological distress.

“I've watched too many friends, colleagues; it's brutal sometimes and it seems so wrong and we lose so many good staff, just because perhaps we're not caring for them as we should do.”

Participants described negative examples of psychological distress caused to staff as a result of incidents. They felt that the many examples, such as the one below, evidenced the need for support programmes in organisations.

“[Staff] found out in the course of their duties ... that a [patient] they had helped earlier in the day had died. They were not debriefed properly on the day, they just had to continue their job, they described very little support.”

Participants all agreed with the need for staff support programmes after patient safety incidents. However, they felt that, to date, investment in such programmes had been limited. Participants had limited experience of the quantifiable benefits of support, but some examples were given.

“... they did some analysis on staff who had accessed support, [they] had an average of 15 days less absence from work than staff who didn’t access support from the stay well service.”
9.1.2 Defining support

This theme explores the concept of support. Participants debated the term ‘support.’ This evidenced variation in perceptions of what support is and what it offers.

“Support is a shocking word. We can offer support ... but what does that mean? What do you do, what can you do? ... some people want to be listened to by someone who cares; for others it is practical. It is not a prescriptive definition, it is subjective.”

Participants felt that ‘support’ needs a definition and clear purpose. It requires designated and committed staff who are aware of the purpose and what is within scope. Participants felt that both emotional and administrative support might be needed depending on the circumstances. Administrative support might include help with navigating the patient safety investigation process or preparing statements for the coroner.

9.1.3 Examples of support in healthcare

This theme explores examples of staff support experienced or observed by participants during investigations and in their previous roles. It provided insights into what is currently being delivered in healthcare. While this report aims to provide a positive exploration of how staff are and should be supported in practice, participants often struggled to identify positive examples. They instead discussed factors that had led to limited or absent support. These factors are acknowledged here as they can be reframed when later considering positive principles and values for staff support. This theme therefore comprises two subthemes that explore the negative cultures that impede staff support, and positive examples of staff support.

Negative cultures impeding staff support

This subtheme explores the values and norms of organisations, professions and leaders. Participants had experienced punitive responses to incidents and described their perceptions that some organisations prioritise their own protection over individual wellbeing. Individuals were described as being labelled as being at fault, both by organisations and colleagues.

“... there is a ‘leper colony’ aspect to being part of the team where the incident happened. They wear the lanyard of shame until it resolves. Lots of organisations try to move them away or hide them away.”

Participants described that following incidents, staff were often prevented from undertaking particular tasks or removed from work duties, resulting in isolation. Punitive responses were felt to
have led to fear, particularly of investigation processes. Even simple actions may be viewed with suspicion.

“Before they interviewed staff, they drew the blinds ... the word on the street was that was done to not let people see you cry. Interesting how the gesture is perceived.”

It was recognised by participants that while organisational leaders sometimes have the wrong attitude towards support, they are in a difficult position. For example, it may be difficult for leaders to know whether there is an ongoing risk to patient safety.

“... one of the things we have to deal with is that immediate risk of what do you do? Do you suspend somebody, do you support somebody? How do you support that person, and the knee-jerk reaction is to say right ok, your [operating] list is suspended?”

Participants felt that healthcare is more accepting of physical illness, as opposed to mental illness. This issue of cultural acceptance was felt to have led to an under acknowledgement of post-traumatic stress disorder in healthcare.

“I don’t ever remember it [signposting/staff support] being in place when I worked in healthcare services and I don’t see it there now ... it had to be a physical reason didn’t it, that was the nature people go off with physical.”

Observations on the different cultures across different professions and specialties were made by participants. These were felt to influence the way error is perceived and managed, and how support is provided and accepted. For example, ‘peer damning’ rather than support was described in certain professions. Although not all agreed, some participants felt that those from the medical profession are better protected and supported than those from a non-medical profession.

“... when these things happen, the junior doctors just get spoken to and the nurses get it on their record ... consistency between how people are treated...”

However, some participants also felt that individuals in the medical profession might be less likely to access support. This is possibly due to a culture of coping or the stigma of accessing support.

“... the [doctor] involved in that was clearly struggling and needed support. It wasn’t a trust issue it was their issue within. They wouldn’t broach the support issue because they thought they should just be getting on with it.”
Participants described reduced opportunities for support for staff who were not permanent members of a team or organisation, such as locum and bank staff, or doctors rotating through specialties.

Positive examples from healthcare

This subtheme explores examples of how staff had been effectively supported in practice. This was from the participants’ perspectives as investigators, but also from previous healthcare roles. Discussions included general resources to support wellbeing, such as Schwartz rounds.

“What was really good about it, was having a mix of people, we’d pick a topic, rather than an incident and you’d get a new doctor, a porter, somebody else, all talking about how something them feel and having permission to talk about how it made them feel.”

Participants described how organisations show how they value and support staff via symbols of caring. These were particularly evident during the response to COVID-19 and included examples such as increased peer support, free food, free parking, new staff relaxation areas, wellbeing hubs and ‘wobble rooms’.

Participants described effective support of staff immediately after incidents and through the subsequent investigations.

Examples of debriefing sessions were given ranging from ‘hot debriefs’ after each shift to specific debriefings following incidents. Debriefings need to consider who might have been involved in and affected by an incident, including those not delivering the immediate clinical care. As discussed in section 4, the role and impact of psychological debriefing is controversial and may mean different things to different industries and people.

“In my trust there were designated people who led those debriefs. We had a chaplain who was also a therapist who would come if there was a traumatic event. It was scheduled because the team was often disparate from other disciplines. It was about telling the story of the incident but seeing what people felt now and the emotional responses and how they were dealing with that.”

Beyond debriefings there were discussions about available formal support programmes, although these were less common. An example from the ambulance service was given as below.

“[For those] involved in an incident there was a set support package that was offered. Crews were immediately removed from duty for a period of time and returned to station where they would see a trained individual ... They would have an early
debrief on the incident and make sure they were supported. Staff would then be followed up within 48 hours ... there were regular check-ins as they went through the incident investigation process and any coronial process and it's a very well-structured service.”

Independent internal and external support services also existed. These included telephone counselling services and access to trained mental health practitioners such as psychologists.

Despite these examples of formal support services, informal support was thought to be more common in healthcare. Participants felt the benefit of informal support is that it does not have to rely on the formation and maintenance of formal organisational programmes.

“They said they didn’t get anything formal after ... but they had within their little group a good level of trust and they were able to talk together about it. So, there was nothing formal just that sort of localised care and support.”

With regards to interviews during investigations, participants shared multiple examples of effective support prior to and during the process. Key components included preparing staff for interviews and ensuring staff preferences had been accommodated, including how they would like to be interviewed and who they would like to attend the interview with.

“Two of the [staff] we saw together because on the day of the incident they were [working together]. We wouldn’t normally interview like that together, but they felt more comfortable that we did it that way and that seemed to work really well.”

During interviews, key steps were felt to be the initial introduction and ice breaking. Participants spoke of the need to frame interviews as an opportunity to explore learning in an honest and no-blame environment. Ice-breakers were useful to help alleviate some anxiety.

“We had a member of staff who would always start an interview with talking about something that had gone horribly wrong and it just made them a bit more human to that person, everyone makes mistakes and things don’t always go right.”

Participants felt that when ending an interview, consideration of immediate and longer-term ongoing support for staff is required. Examples were given where interviewers ensured staff were psychologically safe to return to work.
9.1.4 Examples of support outside healthcare

This theme explores how support is delivered in organisations outside of healthcare. Many participants were able to discuss their experiences from working in areas such as the military and policing. Discussions provided valuable insights, but also evidenced that other organisations face similar challenges to healthcare, including with the implementation of a just culture.

Examples of support in policing included preparation of staff before events and the delivery of support after events. Staff are given the skills to cope with traumatic events that they are likely to encounter. Suicides, for example, are acknowledged as an expected encounter. Policing has also recognised that certain groups are at higher risk of psychological harm and this is planned for.

In policing, family liaison is one of those high-risk groups. In healthcare there was thought to be under recognition of high-risk groups, which might include bereavement officers, family liaison officers, critical care staff and emergency department staff.

Policing was also described to use a defusing system where staff who have been involved in a traumatic event will be automatically invited to a meeting within 72 hours. This is an opportunity to explore how the event was for everyone and to offer further ongoing support.

In air accident investigations, both commercial and military, there are several support systems in place. Participants described that investigators aim to have a ‘hot debrief’ at the end of each day in the field.

“We always used to check in to see what their plans were for the rest of the day. Is it safe for you and your patients to be going to a clinical area after what was potentially an intense or difficult interview even if it wasn’t made difficult by the interviewer.”

“... if you have a particular role that is known involves vicarious trauma, then you are deemed a high-risk group and you have monitoring/wellbeing surveillance. You either got a face-to-face with a welfare officer or psychologist, and a psychological screening questionnaire for additional support if needed.”

“... if we didn’t have safe space, we would have blamey investigations in aviation and in truth there is an underlying blame about most things.”

“... we used to say, it’s about sitting down, and having a quick chat … Some of the images you see, or things you hear, if they’re not talking about it, then you need to start worrying.”
In air traffic control it was described how mandatory support processes are activated following certain events to provide support to controllers.

“One of the best examples is [air traffic services]. Air traffickers do this brilliantly ... the stress they're under if something happens. There’s a mandatory step away process, and going back to work process is brilliant ...”

Participants felt that some of the areas outside of healthcare, such as aviation and rail, were better placed to support staff because of their pre-existing no-blame culture and focus on systems. Just culture, for example, may be embedded in training at different levels of an organisation, regardless of seniority.

“... your very initial training you were taught about just culture and how that worked, when you went on supervisors’ course, you were taught about just culture and how that worked, and when you went on your management course you were taught about just culture ...”

Participants who had not previously worked in healthcare also reflected on the challenges faced when trying to deliver support in healthcare. These included having to deal with the sheer number of incidents occurring.

“That may be the difference in marine/air as they are sudden single events, no pre-empting it ... in healthcare there are so many incidents ... in air it was more sudden. You are suddenly thrown into it.”

9.1.5 Principles of effective staff support

This theme explores the fundamentals for the development and implementation of staff support programmes after patient safety incidents. Three subthemes were identified: culture and leadership, delivery and availability, and support during investigations and interviews.

Culture and leadership

This subtheme explores how organisations must value staff and ensure their support and wellbeing is a priority. A culture of support was seen by participants as not just providing resources for staff, but also ensuring staff are treated fairly after incidents occur.

“... we know that the majority of people come to work to do the job to the best of their ability in an imperfect system. What I would like to see is, gone are the days when a staff member involved in an incident is suspended or moved from an area because it was deemed that they were unsafe without any evidence or facts.”
Participants discussed the need for a functioning just culture that appropriately responds to incidents and supports staff. It was felt that support should be available in the immediate aftermath of an incident, and through the subsequent investigations and associated legal processes. Participants also discussed how a truly just culture can be difficult to implement as, while an investigation can consider the system influences on an incident, there is a risk that this can be seen as shifting responsibility.

“... we can shift the responsibility from the staff to the organisation, but it is a collection of people, so it is shifted onto someone else’s shoulders, who will then try to avoid being blamed ... It ends up on someone’s shoulders.”

A culture of support was also felt to be needed to ensure that incidents are seen as an opportunity to support and learn through transparent investigation. A systems-based approach to investigation was felt to be important to move the focus away from the individuals to identify how the system influenced the occurrence of the incident. The investigation was also felt to be useful in developing a supportive ‘being in it together’ team ethos where everyone is equal.

“... bringing everyone involved together, doing it as a team, team learning, team looking at the incident and making it really clear that we weren’t treating different people, differently from each other.”

Participants described how staff might feel isolated following an incident, which could limit their ability to access and be provided support, particularly from colleagues. By removing the stigma of being involved with an incident, it was felt that support can be effectively offered and received.

“... when someone goes off sick or gets suspended ... At that point they’ve lost all their contacts, because their immediate peers might have been involved. The only mechanism there is for that, your line manager checking in, and that is actually not the person you want.”

Leaders were felt to be well placed to role model behaviours of seeking out and accepting support. Examples included senior staff being accessible and
listening to more junior staff after incidents. Leaders as advocates were also thought to be needed to ensure support is a recognised priority for an organisation. This requires time, investment and resource to ensure it is effective.

“My view is that it [any changes] need to come from senior leadership ... to show the importance of it and it can’t be just a box-ticking exercise. It needs to be meaningful and actually led on and owned by the executives.”

Overall, participants felt that there needs to be commitment to support at all levels of an organisation and for all staff. This should include when staff have moved on from an organisation.

“[The organisation was] keen on supporting the staff member involved, the person was not in their trust anymore, but they still planned to provide support. They would have supported them through the inquest, even though no longer an employee, because it was under their employment at the time.”

Delivery and availability of support services

This subtheme explores how support services should be developed and what services should be included. Consideration of delivery included the structuring and provision of support programmes. Participants were surprised by the lack of consistent support available across healthcare when it is evidently required. It seemed that staff support had only recently become more of a priority, in part due to COVID-19.

“Consistency. I am surprised by the lack of central coordination ... If it is the right initiative, it is the right initiative no matter where you are. If people are looking at it, why has it not been cascaded, you need consistency across the support across the NHS.”

Participants felt that support programmes must be structured and consistently delivered. They discussed the need for consistent availability of support no matter what has occurred. They felt that there must be the same level of support available after any incident, even if it has resulted in no harm to the patient. Patients may not have been harmed, but the moral injury to staff may still occur.

Participants described the need for support to be available via different avenues, including prior preparation of staff to help them deal with incidents when they occur. Many examples were given of organisations delivering support via initiatives such as wellbeing hubs and employee assistance programmes. While these are important, they were not felt to be for everyone, and individualisation is needed dependent on needs.
“... we gave them everything we have got, but it may not be everything they need. It depends, they may just want a cup of tea. There is this notion of grand gestures in wellbeing hubs and safe spaces, the focus is on the resource to fix people ... rather than preventing breaking people in the first place.”

When providing support services, participants felt that organisations must ensure the services are confidential and independent of the various concurrent investigation processes. Many participants recognised occasions where staff were being supported by the same colleague who was undertaking the investigation, which they saw as a conflict of interest.

Participants described the need for support services to be accessible, whatever the time of day or day of the week. To do this requires absolute clarity on the avenues of support and how to access them. Out of hours, while a full service might not be available, it should still be clear who can be contacted if support is required.

Participants also discussed how support services should be proactive. They should not wait for the staff member to come to them, rather they should identify at-risk staff following incidents and approach them.

“Let’s have a process, let’s invite people and they choose to decline it rather than ask for it ...”

Peer support was recognised as a desirable component of any support system, but again may not be for everyone. Participants felt that for peer support to be delivered effectively, peer supporters must be willing, able, trained and have the time to provide support.

“It’s having a very individualised how can we help you, we appreciate this is a difficult time, what do you need from me, what will make this easier for you noting I can’t take the pain away.”

Beyond peer support, participants discussed other types of support available before incidents, in the immediate aftermath, during investigations and further ongoing support. It was recognised that support must start before an incident occurs by developing day-to-day staff wellbeing and coping mechanisms.

It was recognised that immediate responses are required following an event, but this rarely happens unless it has been a catastrophic incident.

“... it’s not about the person themselves taking the responsibility, it’s about the team or the line management taking the responsibility ... so someone’s just been through a serious incident, it takes five minutes to have a chat with them.”

‘Hot debriefings’ were discussed and felt by participants to be of value for certain events if done
in the right way, at the right time and in the right environment. Consideration should also be given to providing staff time and space away from work after incidents, although this might not be appropriate for all and may lead to isolation.

“I think most people preferred to stay at work because I think time away gave you time to think. Actually what they wanted was support and not to be away from work. It was a question we would ask as standard.”

Support during investigations is explored in the next section. However, participants reflected on how investigations and interviews may be therapeutic if undertaken from a systems perspective.

“… after we interviewed him he came and spoke to us the next morning … and said last night was the first night I’ve slept since the incident properly because I was able to describe things to you in a way that I wasn’t feeling judged and about how did the system allow this to happen …”

Other avenues of support beyond the immediate aftermath of the incident were discussed. These included peer support, counselling and external signposting. It was agreed that support needs to be available whenever staff need it, even months or years after an incident. It was felt that for support to be meaningful, organisations need to explore what is required by their staff rather than making assumptions.

“We’re kidding ourselves because there’s a 24-hour hotline that people will pick up and phone it. It’s a bit like the low-flying complaints thing. We’ll give you a telephone line so you can complain and phone up. It’s like two calls a year. But we have it, we shift the risk from ourselves to somebody else because we’ve got a telephone line …”

Support during the healthcare investigation

As participants worked for a healthcare investigation body, many discussions naturally considered support during investigations. Participants felt that support is not just emotional, but also provided through a well-managed investigation. For example, staff participation throughout the investigation was thought to be fundamental.

“… need greater involvement of staff in the process of investigation; they are not under investigation, rather they are part of it. They are the experts in the local environment and facilitate them to do their job, so they are more comfortable in sharing and see themselves as part of improvement rather than finger pointing.”
Participants described that an investigation must be undertaken by investigators who are trained to explore the various distressing events that have occurred. They cannot be the same staff who are delivering wider emotional support as these are conflicting roles. Participants also discussed the need for investigations to be transparent and provided examples of how some organisations had achieved this.

“...that’s why you do the icebreaking because you get them talking and people relax the more, they talk... ask them a few nothing questions at the beginning to get them into the flow of the interview and to relax.”

Examples of resources for preparation for interview were shared, including videos and leaflets. While leaflets were thought to provide useful information, they do not allow for human contact and mean investigators are faceless. Participants thought that investigators should speak directly to staff before the interviews to introduce themselves and the purpose of the interview.

Participants described what they saw as the key principles for delivering interviews. These considered the technique for interviewing and the practice of interviewees bringing an accompanying person to the interview. Interviewers need to ensure they conduct interviews in an appropriate environment and should work to build a rapport with staff. Generally, staff attending interviews will be feeling vulnerable so strategies are needed to help them relax.

“...that’s why you do the icebreaking because you get them talking and people relax the more, they talk... ask them a few nothing questions at the beginning to get them into the flow of the interview and to relax.”

Participants also spoke about tools to support the conducting of interviews. These included structured interview schedules and checklists to ensure required points are covered. These points included a standing item to explore what support staff have had and what they need.
The practice of having a person to accompany the staff member to provide support was encouraged by participants. Having the right accompanying person was thought to have a role in reassuring and empowering the staff member being interviewed. Many participants felt the accompanying person should not be a senior member of the organisation or a line manager because this might stifle honest discussion. Whoever the person is, they must be trusted by the staff member and allow them to openly discuss what happened and their concerns.

“They would give an answer and look at [the accompanying person] for reassurance and then [the accompanying person] might expand slightly but didn’t at any point try and take over the answering of questions. [The accompanying person] let them get on with it ... just that reassuring presence ... and actually, halfway through, they had clearly relaxed.”

Immediately following completion of an interview, participants felt that consideration should be given to whether the staff member has appropriate ongoing support or knows where to seek it should they need to. This might include time away from work.

“... from experience some people have found recounting the evidence difficult and would you want people going back into a clinical area from their safety point of view but also patients.”

Later following completion of an interview, it was felt that the staff member should be provided with feedback on the findings of the investigation with further opportunity for participation. Participants described the need to set timeframes within which the staff member might hear from the investigation team and how to access support in the meantime.

“... clarity about timetables, there is nothing worse than hanging around waiting with the sword of Damocles hanging over your head. It’s about knowing what the process is, who’s doing what, when to expect to see anything, the confidence that you are going to see something come out of it, who else sees it, what the end result is ...”

9.2 HSIB’s approach to interviewing staff

HSIB provides interview guidance and training to its investigators. This appendix provides a brief overview of some of the principles from that guidance that are specific to HSIB.
9.2.1 Preparing for interviews

- Where possible contact interviewees prior to their interview with information about the investigation and interview. For HSIB this includes explaining the process of independent, no-blame investigations.

- Conduct interviews with two investigators. More may look intimidating.

- Interviews should be recorded with consent.

- An interviewee may wish to bring a colleague to provide support. That person should not answer questions or make statements on the interviewee's behalf.

- Specific guidance is available for managing vulnerable individuals and where translation services are required.

9.2.2 Interview room set-up

- Interviews should be undertaken in a suitable room ideally located within the healthcare organisation or close by. The room should ideally be set up as below:
  - no barriers (for example tables) between the interviewer(s) and interviewees
  - interviewees should not be ‘caged in’ or facing a wall
  - the environment should be non-emotive (for example, emotive pictures or evidence should not be visible)
  - no hierarchy should be assumed in the seating arrangement
  - tissues (not in sight) and water should be available
  - quiet, relaxed, soundproofed and private
  - relevant documentation and notes should be on hand.

9.2.3 Conducting the interview

- Commencement of interviews should include:
  - informal hello
  - agreement to record
  - introduction of the team
  - explanation of the purpose, process and why the interviewee has been asked to attend
  - explanation of confidentiality.

- The interview then progresses and includes:
  - an easy, opening question, for example, ‘it would be really helpful if you could start by telling us a bit about your background/your role/how long you’ve worked at the trust’
- a set structure: HSIB uses the PEACE model (College of Policing, 2020) (see figure 9) or SE3R (Shepherd, 2015) for interviewing

- questioning using a ‘TED’ approach: Tell, Explain and Describe

- use of the second interviewer where appropriate.

• Closing interviews should include:

  - general closing statement, for example, ‘... is there anything that you would like to say that could help us with this safety investigation or anything you want to make us aware of?’

  - explanation of follow-up communication, for example, ‘if at any point you think of anything else that may help us please do not hesitate to contact me ... as more information is gathered, we may want to talk to you again, would you be content to speak to us again?’

  - guidance on support options

  - information on next steps and timeframes.

Fig 9 A brief overview of the PEACE interview technique

HSIB uses the PEACE model for investigative interviewing (College of Policing, 2020). PEACE stands for:

• Prepare and plan

• Engage and explain

• Account

• Closure

• Evaluate

A fundamental part of interviewing is gaining interviewee recollections. There are several approaches to assist recollection including:

• free recall: allows an interviewee to work through the event in a sequence best suited to them

• enhanced cognitive interview: techniques to help unpack memories
10 References


Further information

More information about HSIB – including its team, investigations and history – is available at www.hsib.org.uk

If you would like to request an investigation then please read our guidance before contacting us.

@hsib_org is our Twitter handle. We use this feed to raise awareness of our work and to direct followers to our publications, news and events.

Contact us

If you would like a response to a query or concern please contact us via email using enquiries@hsib.org.uk

We monitor this inbox during normal office hours - Monday to Friday (not bank holidays) from 09:00 hours to 17:00 hours. We aim to respond to enquiries within five working days.

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