Support for staff following patient safety incidents – Independent report by the Healthcare Safety Investigation Branch

Introduction

The latest report by the Healthcare Safety Investigation Branch (HSIB) seeks to inform the practice of supporting staff who are involved in and following patient safety incidents. It draws together research that trusts may find helpful when planning or developing local support programmes that are designed to provide emotional and psychological assistance, and practical help to staff. It also makes two safety observations.

This briefing summarises the key findings and recommendations from the report, and includes the NHS Providers media statement. To provide any comments on the report, please contact Catherine Harrison, policy advisor, at Catherine.Harrison@nhsproviders.org.

Key findings

- The first consideration after a safety incident should be support for the patient and any family affected. However, 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. The COVID-19 pandemic has further highlighted the importance of staff support in response to the increased challenges being faced both personally and professionally.
- The scale of the problem is significant, with some estimates suggesting that half of staff involved in safety incidents have been personally or professionally affected. Organisational responses can also disproportionately affect different staff groups, with disproportionate levels of disciplinary action against Black, Asian and minority ethnic staff groups.
- There is limited evidence guiding the implementation of effective staff support programmes to respond to this need. Although many organisations are delivering staff support in some form, the availability and extent of provision is variable. Patient and staff support after safety incidents are both important and require similar considerations: everyone who has been harmed needs to be offered assistance

- The factors identified as important for staff support programmes include:
  - the **context** (the circumstances or settings within which staff support programmes are implemented),
  - **individualisation** (the provision of support that is tailored to the needs of staff),
  - **delivery** (the structure and functioning of support programmes, and the types of support included) and
  - **investigation** (the formal processes of review following an incident).
- The report 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.

Impact of patient safety incidents

- The patient is the person most directly harmed by patient safety incidents, but it can also affect others including the patient's family, healthcare staff who have cared for the patient, those who investigate the incident and those working in the organisation where the patient was treated.

Harm experienced by staff can include emotional and psychological distress and wellbeing issues. The report sets out four types of responses to traumatic situations, summarised below:

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

Emotional		Behavioural	
Anger	Hopelessness	Avoidance	Reduced functioning
Anxiety	Numbness	Aggression	Self-harm
Depression	Resentment	Drugs and alcohol	Sleep disturbance
Fear	Sadness	Isolation	Violence
Guilt	Shame	Over or under eating	Withdrawal
Cognitive		**Physical**	
Disbelief	Lack of motivation	Aches	Lump in throat
Disorientation	Loss of control	Dizziness	Nausea
Impaired judgement	Sensations	Flushing	Pains
Intrusive thoughts	Smells	Headaches	Shortness of breath
Lack of concentration	Vigilance	Insomnia	Tiredness

- 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
- Examples of coping strategies that staff may adopts in the wake of an incident are outlined below:

Coping strategy	Examples (adapted from Busch et al, 2020)
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 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. This can increase levels of sickness, increased turnover of staff and reduced morale, more conservative management of patients, and decreased discharges.
- The scale of the problem is significant, with some estimates suggesting that half of staff involved in safety incidents have been personally or professionally affected. Organisational responses can also disproportionately affect different staff groups, with disproportionate levels of disciplinary action against Black, Asian and minority ethnic staff groups.

Current national resources

- Organisations do not universally provide support to staff after patient safety incidents. The current context of COVID-19 has highlighted the importance of staff needs, with some evidence of increased access to support. Relevant national resources and statements include:

- The introductory version of the NHS Patient Safety Incident Response Framework recognises the need to identify, inform and support staff following patient safety incidents. Beyond this, national policy support tends to be considered in general or related to training and development.
- The NHS People Plan 2020/21 pays considerable attention to staff support, but more specifically in relation to COVID-19 and health and wellbeing. It acknowledges the need to support a just and learning culture for staff in response to incidents.
- The CQC key lines of enquiry focus on support and sharing for patients and families following incidents, but does not specifically describe the support of staff following incidents.

Summary of findings from the evidence gathered

- There are positive examples of individuals and organisations striving to support staff following patient safety incidents, which is appreciated by the staff involved, but impact is not well evaluated. HSIB therefore make the following 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.
- The evidence also suggests that any support for staff after incidents must be part of a wider programme supporting health and wellbeing, such as Schwartz rounds (The Point of Care Foundation) and symbols of caring, such as rest spaces and free food and drink.
- There is a consensus that there is a need to implement support programmes for staff following patient safety incidents, and HSIB therefore make the following, second 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.
- Factors identified as important for a staff support programmes are summarised below:

Theme	Summary of findings
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

- The report makes it clear that support for patients and staff after patient safety incidents are of equal importance and require similar considerations. Everyone who has been harmed needs to be offered assistance. Further insight on the importance of patient and family engagement during investigations is set out in the September 2020 report, Giving families a voice: HSIB's approach to patient and family engagement during investigations.

NHS Providers view

Responding to HSIB's National learning report: Support for staff following patient safety incidents, the director of policy and strategy at NHS Providers, Miriam Deakin said:

"We welcome today's report, which provides much-needed guidance for organisations developing, or building on existing, support programmes for staff in the wake of patient safety incidents.

"It makes the case for proactive, structured, well-resourced and system-wide support both before and after safety incidents, and highlights the key role of learning and improvement as well as culture and leadership.

"Staff wellbeing is the top priority of trust leaders. In our recent survey, we found 99% of trust leaders are concerned, or very concerned, about staff burnout linked to current pressures.

"However, the report also makes clear the investment of time and resource needed to create a supportive environment for staff. The combination of increasing demand, reduced capacity and workforce shortages risks putting this work under strain, despite best efforts.

"While there has been steps taken to provide better mental health support for staff during the pandemic, in the long term we have to see more recognition of the ongoing importance of this, and the specific need in relation to safety events, as part of a wider approach to valuing staff.

"We also need to see investment in the NHS workforce to not only cover existing staffing gaps, but also to build in flexibility so that resilience can be improved. This is essential to ensure that expertise, time and resources are consistently available and protected within organisations."