

**Supporting healthcare staff after patient safety incidents:
An exploration of policy, practice, and terminology**

“There’s no point having a rhetoric of concern if nothing will be done”

A thesis submitted in fulfilment of the requirements for the degree of
Doctor of Philosophy

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Declaration

I declare that this thesis is my own work and has not been submitted
for the award of a higher degree elsewhere

ABSTRACT

Background and objectives: This project investigates the policies informing emotional and psychological support for healthcare staff after involvement in patient safety incidents, the support provided in practice, and the terminology used to describe those involved.

Method: In a qualitative study design, semi-structured interviews were conducted with 27 healthcare professionals in England, with management, supervisory, or policy responsibility, to answer two research questions: 1) the policies, protocols, and practices they were aware of that aim to support healthcare personnel in their organisation who have experienced unanticipated adverse or near miss medical events, and 2) their views about the term “second victim”. Thematic analysis was chosen to analyse the interview data.

Findings: Four themes were developed: 1) Severe and enduring impact; 2) Absence of policies; 3) No certainty of support; 4) Language undermines support. A notable gap exists between rhetoric about staff wellbeing, including in national and international healthcare policy reports, and the rarity of structured support after patient safety incidents (PSI). Staff are impacted both by the incidents and by the way their organisation treats them. Informal support depends upon the goodwill of close colleagues, and may not be available. There is an imbalance between the high expectations placed on staff and the support resources they can access. Routine language usage in healthcare negatively impacts support provision. The established “second victim” concept accurately reflects the feelings of staff affected by PSI, but is not a stable construct, has unwelcome connotations, and causes offence to some patient representatives.

Conclusions: There are many national and international policy recommendations to support staff emotionally and psychologically after PSI. A small number of policies require support provision, without stipulating how. Support programmes known to exist are mostly in North America. In the UK, support is lacking, and necessary components of structured support are identified.

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Glossary

Term	Definition
Adverse event	An incident which resulted in harm to a patient, in contrast to complications of disease
Adverse reaction	The unexpected harm resulting from a justified action where the correct process was followed for the context in which the event occurred
Ameliorating action	An action taken or circumstances altered to make better or compensate any harm after an incident, including open disclosure and apology to affected patients
Balint Group	A Balint group is formed of clinicians who meet regularly to present clinical cases to improve their understanding of the emotional factors impacting the clinician-patient relationship
Clinical Supervisor	A senior medical, nursing, or psychological professional, responsible for ensuring that the professionals they supervise are not expected to take responsibility for, or perform, any clinical activity if they do not have the appropriate experience and expertise, and for providing feedback to the supervisee
Complication	An unfavourable result of a disease, health condition, or treatment, including any deviation from the normal post-operative course after surgery
Critical incident	1) A situation where pressure on services means that local health management are concerned they cannot provide critical services for patients, and a hospital will not be able to function as usual 2) An incident resulting in serious harm to the patient, when there is an evident need for immediate investigation and response
Deanery	Organisations responsible for the management and delivery of postgraduate medical education and for the continuing professional development of all doctors and dentists
Duty of Candour	Healthcare professionals have a legal duty in the UK to be open and honest with patients in their care when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress (see also: open disclosure)
Educational supervisor	A trainer who is selected and appropriately trained to be responsible for the overall supervision and management of a specified trainee doctor's educational progress during a clinical training placement
Employee Assistance Programme (EAP)	A contracted, external service provided to organisations that offers assessments and short-term counselling to employees who have personal or work-related problems, and who are referred by their institution or who self-refer
Foundation doctor	A newly qualified doctor (UK) undertaking a two-year clinical training programme
Healthcare-associated harm	Harm arising from or associated with plans or actions taken during the provision of healthcare, rather than an underlying disease or injury

Glossary (continued)

Healthcare manager or supervisor	Any healthcare personnel, including clinical staff with policy, managerial, or supervisory responsibility, at any level within their healthcare organisation
Healthcare professional	A person associated with a healthcare discipline who is qualified and allowed by regulatory bodies to provide a healthcare service to patients
Healthcare staff	Any personnel working in a healthcare organisation
Junior doctor	A qualified doctor practising at any stage between graduation and completion of specialist postgraduate clinical training
Medical error	The failure of a planned medical action to be completed as intended or the use of a wrong plan to achieve an aim
Medication error	A preventable event in medication prescription or administration that may cause or lead to patient harm
Mental health	A person's condition with regard to his or her psychological and emotional wellbeing
Near miss	An event not causing harm because it did not reach the patient, but which had the potential to cause injury or ill health
Never event	A serious patient safety incident that is wholly preventable because of existing guidance or safety recommendations
Never event list	16 specified incidents, including: wrong site surgery; wrong implant or prosthesis; retained foreign object post procedure; administration of medication by the wrong route; misplaced naso- or oro-gastric tubes; scalding of patients; and certain incorrect uses of medications
NHS Practitioner Health Programme	A free, confidential service for doctors and dentists in England with mental illness or addiction problems
No harm incident	An incident which reached a patient but no discernible harm resulted
Occupational Health	A specialist branch of medicine focusing on the health of staff in the workplace
Open disclosure	An open discussion with a patient (or family/carer) about an incident that resulted in harm to that patient while they were receiving healthcare
Patient safety	The reduction of harm associated with healthcare to an acceptable minimum
Patient safety incident	An event or circumstance arising from either unintended or intended acts that could have resulted, or did result, in unnecessary harm to a patient receiving healthcare
Policy	A high-level overall plan, course, or method of action about what to do in particular situations, agreed and formally documented within an organisation, including governments, to guide and determine present and future decisions
Primary care	Includes NHS general practice, community pharmacy, dental, and optometry services
Quality improvement	Actions to improve outcomes for healthcare service users and to develop the workforce that supports them using systematic methods

Glossary (continued)

Reportable circumstance	A healthcare situation in which there was significant potential for harm, such as serious understaffing, or a faulty piece of equipment, but no incident occurred
Root cause analysis	A systematic iterative process whereby the factors which contribute to an incident are identified by reconstructing the sequence of events and repeatedly asking why, until the underlying root causes have been elucidated
Schwartz Round	A facilitated group reflective practice forum giving staff from all disciplines an opportunity to reflect on the emotional and social aspects of working in healthcare
Second victim	A healthcare professional who is involved in an unanticipated adverse patient event, in a medical error and/or a patient related injury and become victimised in the sense that the provider is traumatised by the event
Secondary care	Healthcare services (hospital and community) which generally will need a referral from a General Practitioner
Sentinel event	A patient safety incident that reaches a patient and results in death, permanent harm, or severe temporary harm, and where intervention is required to sustain life
Serious incident	Acts or omissions in care that result in unexpected or avoidable death, or unexpected or avoidable injury resulting in serious harm to the patient where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified
Serious untoward incident	An event where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified
Trauma	1) A deeply distressing or disturbing experience 2) Physical wounds or injuries
Vicarious liability	The imposition of liability on employers for the wrongdoings of their employees, holding the employer liable for any wrongful act committed while an employee is conducting their duties

CHAPTER 1: INTRODUCTION AND BACKGROUND

1.1 [Introduction to the chapter](#)

The context for this thesis is the incidence of unintended medical error and other unintended harm either caused, or nearly caused, to patients by healthcare professionals, and the consequential negative emotional and psychological impact that involvement in such incidents can have on the staff involved.

The structure of the thesis and the rationale for the research are set out in this chapter. This rationale includes an exploration of the characteristics of patient safety incidents (PSI), defined below, and the known impacts of such incidents on patients and their families. It then considers the effects of these events on the healthcare professionals involved, illuminating the types of incidents that have been examined, and the contexts of the studies undertaken. The concepts that are associated with PSI and their impacts are explored; the concepts forming the focus of this thesis are identified, and their importance and relevance are explained. This chapter also includes reflexive consideration of my background and its effect on my choices as researcher in this project.

1.2 [The characteristics of patient safety incidents and associated concepts](#)

The World Health Organization (WHO)¹ describes how medical practices and risks associated with healthcare provision can contribute substantially to patient harm as a result of unsafe care (WHO, 2019). The degree of patient harm caused ranges from none, where the harm remained potential not actual, to severe and even fatal outcomes. The WHO identifies an extensive list of specific types of patient safety situations that can cause harm to varying degrees. These include medication errors made at the point of prescription or administration; surgical errors, including wrong site or wrong patient procedures; healthcare-associated infections acquired during hospital stays; diagnostic errors and delays leading to the advancement of disease that might have been prevented; and any unsafe or incorrect treatment or practice. Key concepts associated with patient safety incidents and their definitions are included in the Glossary, and explored below where there has either been debate or potential for confusion or ambiguity.

¹ The WHO is the healthcare organisation within the United Nations, which has 194 member countries

A widely used concept in patient safety is that of adverse events. The WHO (2005) defined an adverse event in healthcare as “an injury related to medical management, in contrast to complications of disease” (p. 8). In its subsequent Conceptual Framework for the International Classification for Patient Safety (ICPS) (WHO, 2009), 48 concepts relevant to patient safety were identified and included, and definitions and preferred terms agreed. Adverse events were reframed as a “harmful incident (adverse event)” and defined as “an incident which resulted in harm to a patient” (p.22). A patient safety incident (PSI) was defined as “an event or circumstance that could have resulted, or did result, in unnecessary harm to a patient” (p. 15), encompassing both harmful, no harm, and near miss events. This is the term that will be used throughout this thesis, clarifying as appropriate where reference is being made to a near miss (which in the ICPS means did not reach a patient, either because of chance or because it was detected and intercepted in time), or no harm incidents (which reached the patient but did not cause harm).

The concept of “complications” is not included in the 48 selected concepts of the ICPS, although it is frequently used in healthcare research literature, where it appears to cover preventable and non-preventable negative healthcare outcomes for patients, often during or following surgery (for example in Higgins et al., 2021; Pinto et al., 2013 and 2014; Siddaiah-Subramanya et al., 2021). Dindo et al. (2004) define complications very broadly as “any deviation from the normal post-operative course” ranging from outcomes requiring no further intervention or treatment, to the death of the patient (p. 206). The ICPS considered the “complication” concept, but elected not to adopt it within the final classification, perhaps because of the imprecise nature of the term’s connotations; the fact that there is no clear or consistent definition of a complication in the surgical literature (Rampersaud et al., 2006), suggests lack of clarity or specificity. This potential for terminology to be used in general and imprecise ways, covering harmful outcomes that either could have been avoided (such as medical errors), or that were unavoidable or could not have been anticipated, means that the causes of harm could be obscured. Except where there is an exploration of research that uses the term “complications”, the preferred term used in this thesis will be PSI.

Some of the concepts used in healthcare are employed within certain jurisdictions only, or used differently in different locations. In the ICPS, a “critical incident” is not one of the 48 concepts selected for inclusion. It is, however, referenced in the list of considered

terms, and a definition is reported from the Canadian Patient Safety Dictionary: “an incident resulting in serious harm to the patient, when there is an evident need for immediate investigation and response” (p. 111), which other healthcare authorities may term a serious incident. “Critical incident” is sometimes used in a very different way in UK healthcare, to describe when a hospital no longer has the capacity to accept admissions to provide patient care, due to extreme pressures across the organisation, and where patients may have to be diverted to other facilities. Within the UK, healthcare policy and practice include the concept of a “Never Event”, defined as “serious incidents that are wholly preventable” (NHS Improvement, 2018) and that require investigation under the Serious Incident Framework (NHS England, 2015b). There is a published Never Events List (NHS Improvement, 2018) that contains 16 specific items. There is no equivalent concept in the ICPS, but these events would all be captured under the definition of PSI.

There is potential for confusion where terms are used not only to cover different situations, but may also be used interchangeably, such as “serious incident requiring investigation”, “serious incident”, and “serious untoward incident”, all used in UK healthcare. These descriptors all refer to “adverse events, where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified” (NHS England, 2015b, p. 6). In the United States (US), the broadly equivalent term is “sentinel event” is used to describe PSI that reach a patient and result in death, permanent harm, or severe temporary harm, and where intervention is required to sustain life (The Joint Commission, 2017).

It is problematic to understand or evaluate impacts clearly and unambiguously where the norms of different healthcare systems make use of different terms to describe incidents that cause patient harm. It is nonetheless incontrovertible that PSI of all types can have disastrous effects for those who experience them, and the available evidence about patient harm is explored below.

[1.3 Harmful, no-harm, and near miss incidents: the impact on patients, families, and carers](#)

The impact on patients of healthcare going wrong is known to be substantial. Globally, the WHO (2019) estimates that in high-income countries, one in every ten patients is

harmed while receiving hospital care, with almost 50% of the PSI that lead to this harm being preventable, and millions of patients suffering injuries or dying every year, because of unsafe and poor-quality healthcare. In a systematic review of the incidence and nature of in-hospital adverse events, reported in a total of 74,485 patient records, de Vries et al. (2008) found that the median overall incidence of documented in-hospital adverse events was 9.2%, with a 43.5% median percentage of preventability. 56.3% of patients experienced no or minor disability as a result of a PSI, but 7.4% of PSI were fatal.

Operation-related (39.6%) and medication-related (15.1%) incidents constituted the majority. The WHO reports that unsafe surgical care procedures cause harm in up to 25% of patients, meaning that almost seven million surgical patients suffer serious harmful events annually, one million of whom die during or immediately following surgery (WHO, 2019). Blood clots (venous thromboembolism) are described as one of the most common and preventable causes of patient harm during hospitalisation. An estimated 3.9 million cases occur annually in high-income countries, with six million cases in low- and middle-income countries (Raskob et al., 2014).

Unsafe injection practices in healthcare settings account for a burden of harm estimated at 9.2 million years of life lost to disability and death worldwide (Jha et al., 2013). Patient harm can also result from unsafe transfusion practices, exposing patients to the risk of adverse reactions and the transmission of infections (WHO, 2010a). Data on adverse transfusion reactions from a group of 21 countries show an average incidence of 8.7 serious reactions per 100,000 distributed blood components (Janssen & Rautmann, 2016). Radiation errors can involve overexposure to radiation and cases of wrong-patient and wrong-site identification (Boadu & Rehani, 2009), and a review of radiotherapy safety data estimates the overall incidence of radiation errors at 15 per 10,000 courses of treatment (Shafiq et al., 2009).

Diagnostic errors are estimated to occur in approximately 5% of adults in outpatient care settings, more than half of which have the potential to cause severe harm (Singh et al., 2014). Late diagnosis can also lead to patient harm. Serious infections can be diagnosed too late to save a patient's life, and sepsis infections are reported to affect an estimated 31 million people worldwide, causing over five million deaths per year (Fleischmann et al., 2016). Healthcare-associated infections in general are reported to

occur in seven out of every 100 hospitalised patients in high-income countries, and more frequently in low- and middle-income countries (Allegranzi et al., 2011).

Two decades ago, the incidence of medical error in the US was estimated to be up to 98,000 preventable deaths of hospital patients per year, amounting to the fourth most common cause of death in the US out of all possible causes (Kohn et al., 2000). Subsequent research (Classen et al., 2011; James, 2013; Makary & Daniel, 2016) found that these numbers were likely to be a significant underestimate. Makary and Daniel calculated that medical error amounted to the third leading cause of death in the US, although the methodological foundation to these reported estimates has been questioned (Shojania & Dixon-Woods, 2017). The WHO's Regional Office for Europe reported that reducing the rate of PSI in the European Union would lead to the prevention of more than 750,000 harm-inflicting medical errors per year, leading in turn to over 3.2 million fewer days of patient hospitalisation, 260,000 fewer incidents of permanent disability, and 95,000 fewer deaths annually (WHO, 2010a).

The very considerable physical and psychological impact of PSI on patients and their families, caused by the incident and by the subsequent handling, was also acknowledged in a UK government report on learning from adverse events in the NHS (Donaldson, 2000):

Adverse events involve a huge personal cost to the people involved, both patients and staff. Many patients suffer increased pain, disability, and psychological trauma. On occasions, when the incident is insensitively handled, patients and their families may be further traumatised when their experience is ignored, or where explanations or apologies are not forthcoming. The psychological impact of the event may be further compounded by a protracted, adversarial legal process. (pp. 15-16)

The report argued that the effect of incidents on patients, their families, and staff was not sufficiently appreciated, and that more attention should be given to ways of minimising the impact of PSI on all those involved.

However, the potentially severe consequences of PSI on patients observed twenty years ago, including death, permanent disability, post-traumatic stress, and financial hardship, were still in evidence fifteen years later. In a systematic review of patients' experiences of harm during healthcare, Harrison, Walton et al. (2015) reported that

“patient-defined harm was physical, financial and/or psychological. Physical effects were often reported as short term in comparison with psychological harms” (p. 439). Physical harm sustained during healthcare by US patients and their families (Southwick et al., 2015) has been found to result from diagnostic and therapeutic errors, surgical or procedural complications, and hospital-associated infections. The incidents also had psychological consequences, which led to a loss of patients’ and families’ trust in both the health system generally and medical professionals as individuals.

Ongoing patient harm has been reported in the healthcare systems of developed and developing countries, where medication errors have been found to be a leading cause of injury, avoidable harm, and avoidable costs (Aitken & Gorokhovich, 2012). In 2018, the UK Secretary of State for Health publicised data reporting that medication mistakes may cause 1,700 patient deaths a year in the NHS, at a total cost of £1.6bn, and that 4.8 million errors with the potential to cause severe harm occurred in England per annum. These data resulted from a study by Elliott et al. (2021), estimating the total number of avoidable adverse medication errors in NHS England to be 237 million annually, with 66 million having the potential to cause some degree of patient harm.

This evidence relating to the impact of harmful PSI on patients and their families or carers together shows that the negative effects remain substantial, and that they are not only physical in nature in terms of ongoing illness, disability, or death, but that they can also cause considerable financial, emotional, or psychological hardship that can endure well beyond the incident itself.

[1.4 Patient safety concepts which are the focus of this thesis](#)

There are many concepts in the patient safety arena, not all of which fall within the scope of this thesis. (See Glossary for definitions.) This thesis is not exploring concepts such as “reportable circumstances” which relate to organisational failings in the design or running of healthcare systems, or “critical incidents” where this means organisations or services being overwhelmed and unable to continue because of insufficient resources. Nor is this research about harmful events in healthcare where harm is deliberately carried out by individuals with malicious or criminal intent, or unexpected adverse reactions to medications that were correctly prescribed. “Ameliorating actions” with respect to patient recovery or disclosing incidents to colleagues and patients are also not where the focus of this research lies.

The patient safety-related concepts which do form the focus of this thesis are unintended, preventable or avoidable harmful incidents, clinical errors, and no harm-, and near miss events that had the potential to cause patient harm but which did not do so, and which occurred in hospital or community care (known in the UK as secondary care). These events are all defined in the ICPS and captured by the umbrella term “patient safety incident”, but they are described in the literature using various terms. Patient safety incident is also the term used in the draft Patient Safety Incident Response Framework (NHS England and NHS Improvement, 2020) that updates the Serious Incident Framework (NHS England, 2015b), and was intended for rollout in 2022 in NHS Trusts². Concepts that have been selected as the focus of this thesis are those where individual healthcare professionals have had responsibility for patient care either going wrong or having had the potential to do so, or where they have been involved as part of the clinical team where this has happened, and where any such event resulted in a negative emotional or psychological impact on healthcare professionals present. No harm- and near miss events may give rise to no impact at all on patients or their families, but they may nonetheless have a substantial impact on the emotional or psychological wellbeing of the professional who was involved in the incident (Harrison et al., 2014; HSE Quality and Patient Safety Directorate, 2013; Quillivan et al., 2016; Waterman et al., 2007). These emotional and psychological impacts of involvement in PSI on healthcare professionals are the focus of this thesis, and concepts specifically related to these impacts are addressed in more detail below.

1.5 The impact on healthcare professionals of involvement in patient safety incidents

The high incidence of actual or possible patient harm outlined above means that considerable numbers of healthcare professionals will experience being involved in PSI during their careers, and this creates the potential for widespread emotional, psychological, and professional impacts. In the last two decades, attention has been drawn to the additional impact of such events not only on patients, but on the healthcare professionals involved: how the staff member may feel, how this can affect that individual’s immediate and longer-term psychological and emotional wellbeing, and professional consequences, including the subsequent provision of safe patient care.

² An NHS Trust is an organisational unit within the UK National Health Service, generally serving either a geographical area or a specialised function. A Trust may run several hospitals.

The negative impact on healthcare professionals of being involved in a PSI has been explored in over two hundred research studies. The most prevalent negative symptoms, covering physical, emotional, and cognitive effects, were found to be troubling memories (reported by 81% of affected healthcare professionals), anxiety/concern, anger toward themselves, regret/remorse, distress, fear of future errors, embarrassment, guilt, and sleeping difficulties (Busch et al. (2020b).

Many healthcare professionals have reported experiencing a negative and at times traumatic impact after being involved in a harmful PSI, and exposure to traumatic events is known to be a specific risk factor for many psychiatric disorders, particularly anxiety, depression, post-traumatic stress disorder (PTSD) and self-harm (Pietrzak et al., 2011). Among studies covering various professions, Wolf et al. (2000) found that 43.3% of 402 healthcare professionals, including nurses, pharmacists, and physicians, experienced a moderate or severe impact that included feelings of guilt and anxiety following involvement in a medication error that they judged to be serious. The respondents' fears related to the safety of their patient, and to the professional consequences they anticipated, such as disciplinary action, and punishment. Other evidence has found that 30% of 898 survey respondents among four healthcare professional groups experienced anxiety, depression, or concerns about their ability to perform their jobs as a result of a PSI (Scott et al., 2010), and in a smaller survey 66% had similar emotional and psychological outcomes (Edrees et al., 2011).

It is important to note that these studies are among many carried out in the US, which is where much of the research into this topic has taken place. Explorations of the impact of a PSI on involved professionals elsewhere in the world are far fewer in number, but they also report emotional and psychological effects experienced by staff, arising from both the incident and the handling by their healthcare organisation. Impacts of PSI have been reported on UK doctors (Harrison et al., 2014), with 76% of respondents affected personally or professionally. Negative effects included stress (74%); anxiety (68%); lower professional confidence (63%), and sleep disturbance (60%). Evidence from elsewhere in the world (Harrison et al., 2019), found that 77% of Vietnamese healthcare professionals were affected professionally or personally, with 84% experiencing negative impacts to their psychological health. Surveys of other populations have reported similar emotional and psychological responses, including nurses in Argentina who made a medication error (Brunelli et al., 2018), and nurses in Korea, who

experienced distress arising mostly from fear of blame and negative professional consequences (Kim et al., 2022). These studies demonstrate that the emotional or psychological impact on healthcare professionals of involvement in a PSI is substantial, widespread, and not isolated to one geographical location.

Some studies have investigated the impacts in a single professional group. While different professions and populations are reported to be affected to differing degrees, negative emotional and psychological impacts are considerable, ranging from 10.4% of 2,500 otolaryngologists (Lander et al., 2006), to 82.4% of family physicians and their staff (O’Beirne et al., 2012). Psychological distress was experienced by 42% of paediatric critical care providers after PSI, and one-third of respondents questioned their self-efficacy as a healthcare provider (Wolf et al., 2021). In the specialism of obstetrics and gynaecology, 63.3% of professionals surveyed experienced distress after involvement in a PSI (Santana-Domínguez et al., 2022). The traumatic nature of clinical work-related events in this field has been found to lead to PTSD (Baas et al., 2018).

The data gathered forms an evidence base across healthcare professions and locations of serious emotional and psychological responses and impacts experienced by staff after PSI, with additional fears about negative professional consequences.

[1.6 Patient safety investigation processes and impact](#)

This thesis is not focused specifically on patient safety investigations, but it is known that involvement in these processes can be challenging for patients, their families or carers, and for the healthcare professionals involved in the incident under investigation (Healthcare Safety Investigation Branch, 2020). As such they have a role in the impact experienced after PSI, and there follows below an outline of the multi-layered investigation processes that can happen in the UK, and their potential impacts.

[1.6.1 Investigation processes](#)

“Root cause analysis” (RCA) is a collective term employed internationally that describes a wide range of approaches used to uncover the causes of problems. The concept is used in healthcare (see Glossary) to capture the systematic process by which PSI are investigated to establish the sequence of events, underlying causes, and contributory factors (WHO, 2009). In the UK healthcare system, an RCA is the application of a recognised method for conducting incident investigations, as a

mechanism intended to drive patient safety improvements. In the NHS, there are three levels of RCA currently specified within the Serious Incident Framework (NHS England, 2015b). According to the Framework, the level of investigation selected (set out in Table 1 below) should be proportionate to the incident; each level has its own template, timeframe, and guidance.

Table 1
Root cause analysis levels (NHS England)

RCA Level	Intended focus	Timeframe for completion
Concise	Less complex incidents which can be managed at a local level	Within 60 days
Comprehensive	Complex issues that should be managed by a multi-disciplinary team involving experts or specialist investigators	Within 60 days
Independent	Where it will be difficult for an organisation to conduct an objective investigation internally, or where the integrity of the internal investigation is likely to be challenged, due to the size of organisation, or the capacity/ capability of the available individuals and/or number of organisations involved	Within six months

The Healthcare Safety Investigation Branch (HSIB), set up in 2017, is the UK organisation tasked with conducting the independent investigations of patient safety concerns in NHS-funded care across England, where these are required. Their investigatory role is to identify the contributory factors that have led to potential or actual harm to patients, without attributing blame or liability to individuals, and they issue safety recommendations aimed at improving healthcare systems and processes, to reduce future risk and improve patient safety. Since 2018, they have been responsible for all NHS patient safety investigations of maternity incidents which meet criteria for the Each Baby Counts programme (Royal College of Obstetricians and Gynaecologists, 2017) and for maternal deaths (excluding suicide). For these incidents HSIB's investigation replaces the local NHS Trust investigation.

In the UK, public inquiries into failings and serious concerns about healthcare organisations, such as the Mid-Staffordshire Hospital inquiries (Francis, 2010; 2013), do not investigate individuals, but they have led to national changes including the legal

Duty of Candour³, and reforms to protect whistle-blowers (Freedom to Speak Up⁴). These inquiries can, however, make recommendations that the General Medical Council (GMC)⁵ and the Nursing and Midwifery Council (NMC)⁶ should consider investigating the conduct of the staff involved. This occurred, for example, following the Morecambe Bay inquiry (Kirkup, 2015), which was established because of concerns over serious incidents in the maternity department at one hospital. The report concluded that serious failures of clinical care led to the avoidable deaths of mothers and babies. The GMC (for doctors) and the NMC (for nurses and midwives) can investigate serious concerns raised about individual healthcare professionals, with the aim of protecting the public and establishing whether the professional is fit to practise. A question of fitness to practise can arise if a healthcare professional's performance has caused harm to patients, put patients at risk of harm, or if he or she has shown a deliberate or reckless disregard of clinical responsibilities towards patients.

Where there has been a patient fatality, investigation processes can lead to attendance by UK healthcare professionals at inquests and the Coroner's Court, or the need to provide official statements about events to the authorities. NHS Trusts can offer staff legal support at Coroner's Court in the form of vicarious liability⁷. However, this type of support can be withdrawn at the Trust's discretion, for example if the member of staff does not accept responsibility for the patient outcome. Incident investigations can lead to UK healthcare professionals who are considered responsible for a patient death, even where no harm was intended, being charged with manslaughter by gross negligence, which carries a potential legal sentence of life imprisonment.

The impact of these investigation processes is explored below.

³ The statutory Duty of Candour, introduced in 2014, requires that UK healthcare professionals must be open and honest with patients and their representatives, employers, and other relevant organisations when something that goes wrong with treatment or care causes, or has the potential to cause, harm or distress.

⁴ The Freedom to Speak Up review into whistleblowing in the NHS in England was published 2015. It aimed to ensure that NHS staff would feel safe to raise concerns, confident that they would be listened to and the concerns acted upon.

⁵ The GMC has a statutory role to protect patients and improve medical education and practice across the UK. It decides which doctors are qualified to work in the UK; oversees UK medical education and training; and sets the standards UK doctors must follow.

⁶ The NMC has a statutory role to regulate the nursing and midwifery professions. It maintains the register of professionals eligible to practise, and sets professional practice standards.

⁷ Vicarious liability refers to NHS bodies taking on legal liability for the acts and omissions of employees and others acting under their direction and control, that lead to harm or losses during the performance of NHS activity.

1.6.2 The impact of investigation processes on those involved

Investigations into patient safety incidents can have substantial negative impacts on all parties involved. Patients and families can be impacted not only by the health consequences of an incident, but also by not being given a voice in the process, being kept in the dark about timeframes or other aspects, or by not being treated in a collaborative or sensitive way (HSIB, 2020). Conducting investigations respectfully and compassionately, acknowledging the effects and impact an event may have had on a family, and providing or signposting support throughout the process is explicitly advised by the HSIB (2020) in its report about family engagement in national patient safety investigation processes. This report indicates that greater importance is being attached to making investigations more supportive to the participants, especially patients and families, but that this approach is in its early stages of development.

Placing emphasis on supporting and being respectful to all the parties involved in investigations, including patients, families, and staff, is also an element of the draft NHS Patient Safety Incident Response Framework or PSIRF (NHS England and NHS Improvement, 2020). While identifying and responding to the clinical needs of patients affected by an incident is the explicit priority, the PSIRF states that investigations should be “people focused” and that patients, families, carers, and staff are to be involved as “active and supported participants” (p. 33). The PSIRF also stipulates that all involved should be able to say they were treated with honesty and clarity in response to all queries and concerns, and that any challenges to the organisation should not inhibit its efforts to engage with the involved parties (pp. 34-35). Managers are explicitly required to “understand the potential impact of patient safety incidents on staff” (p. 36), but it is not clear how this understanding is to be ensured or its intended effects monitored. These official calls for engagement with patients, families, and staff in an open, understanding, and supportive way (NHS England and NHS Improvement, 2020) suggests that to date this has not been the usual approach.

Other investigative processes and their consequences can directly impact the psychological wellbeing of healthcare staff. The impact of fitness to practise (FTP) processes⁸ on doctors can exacerbate underlying mental health disorders such as

⁸ Fitness to practise rules set out the standards of competence, care and conduct expected of regulated healthcare professionals. A question of fitness to practise can arise if a healthcare professional’s performance has harmed patients or put patients at risk of harm.

depression, bipolar, and personality disorders, as indicated in an independent report commissioned by the GMC (Horsfall, 2014). The potentially severe negative psychological impact on the health and wellbeing of those involved in FTP processes, including feelings of confusion, powerlessness, vulnerability, and the threat of professional ruin, was also reported by Maben et al. (2021) with respect to healthcare professionals generally. The risk of deteriorating mental health in both nurses and doctors being assessed for FTP has also been identified (Baker-Glen et al., 2015; Bourne et al., 2015; 2016; Casey and Choong, 2016), and can in some cases lead to professionals dying by suicide (Jones-Berry, 2016; Hawton et al., 2015).

Being subject to a patient complaint can also cause adverse health impacts, mainly mental health related, on the involved healthcare practitioners (Biggar et al., 2020), including a higher risk compared to their peers of suicidal thoughts, anxiety and depression, anger, guilt, and shame. Serious negative effects on physicians have been found to arise from the complaint itself and also from the associated investigation processes (Hanganu & Ioan, 2022), resulting in insomnia, nightmares, stress, fear and anxiety, professional doubts about their medical decisions, and a tendency to avoid patients with serious illnesses. The authors concluded that there was a need for change in the legal and medical systems to create mechanisms to support doctors during investigation processes.

This recent evidence presents a picture of healthcare investigation processes having the potential to impact negatively on all involved parties including staff. There is no available evidence that calls for current investigation approaches to be made more understanding and supportive have been implemented by Trusts in practice.

[1.7 Concepts related to the impact on healthcare professionals of involvement in patient safety incidents](#)

There are a number of concepts that have been used within the literature to describe the emotional or psychological impact on healthcare professionals who have been involved in patient care going wrong. These concepts are explored below, with reasons presented as to whether they have been selected for inclusion as a prime focus of this thesis.

1.7.1 Second victim

Healthcare professionals can be negatively affected, sometimes gravely, following their involvement in incidents where patient safety has been compromised, or where patient harm could have occurred. There is an extensive evidence base describing how the psychological and emotional effects can be long lasting and can have substantial professional and personal impact. The “second victim” concept, its evolution, and views about it are explored fully in Chapter 3; it is very widely used in this research field as a way of exploring the impacts of PSI on healthcare staff, but its validity as a construct has been called into question (Harrison et al., 2015), and it has opponents who question its appropriateness (Clarkson et al., 2019).

Although these impacts had previously been described and researched, it was a US medical professional who was instrumental in bringing this issue to prominence. From his perspective as a clinician, Wu (2000) coined a term to reflect the emotional and psychological impact experienced by staff in a BMJ editorial, entitled “Medical Error: The Second Victim” and subtitled “The doctor who makes the mistake needs help too”. The context was the US Institute of Medicine’s report of the same year, highlighting the extent of medical mistakes (Kohn et al., 2000), but noting that blaming individuals, which was the prevailing approach in healthcare organisations, did little to make the system safer or prevent future harm to patients. Calls began for clinicians, made vulnerable by their involvement in an error, to receive emotional support from their colleagues. Doctors were the main focus, but other healthcare team members including nurses and pharmacists were also acknowledged to be affected (Wu, 2000), although patients were “the first and obvious victims” (p. 726). The support said to be needed, but rarely forthcoming, included empathy and reassurance from colleagues.

The “second victim” concept was taken up and subsequently defined and elaborated by a group of experts led by a clinician (Scott et al., 2009), broadening its coverage with regard both to the types of relevant experience of healthcare staff and the groups of personnel included. However, it has recently acquired some very vocal detractors and there is now controversy and sensitivity surrounding use of the term, particularly the word “victim”. Use of this word to describe clinicians involved in patient harm has been deemed unacceptable by some patient representatives and advocates (Clarkson et al.,

2019), because they perceive this to undermine the status those harmed and their families.

While the term is considered by some to be flawed or offensive, it nonetheless remains an important reference point in the development of attempts to consider in a more compassionate light those healthcare professionals who have caused or risked causing patient harm, to encourage those professionals to seek support if they are negatively affected by being involved in a PSI, and to provide access to support within healthcare organisations. This is not only for the professionals' own benefit, but to reduce the likelihood and risk of further patient harm, as set out in section 1.8 below. The "second victim" concept thus warrants further investigation, because much of the research literature and evidence base uses this terminology, and it is the only concept that expressly describes the emotional or psychological impact experienced by healthcare professionals as a result of their involvement in challenging clinical events involving actual or potential patient harm. This thesis expressly aims to explore views about the relevance and appropriateness of this concept.

Other concepts that have been used to describe negative impact on healthcare professionals' wellbeing, but which are not the primary focus of this research, are presented and analysed below.

[1.7.2 Vicarious traumatisation](#)

In 1966, Jung stated that "The doctor...quite literally 'takes over' the sufferings of his patient and shares them with him. For this reason he runs a risk and must run it in the nature of things" (pp. 171-172). In his practice as a psychological therapist, Jung believed it was to be expected that the patient's emotional burdens could become those of the practitioner. A later review of the enduring psychological impact on professionals who work with victims of previous traumatic incidents (McCann and Pearlman, 1990) included a theoretical conceptualisation of the effects of being exposed to the traumatic experiences of victim clients via client accounts, that the authors termed vicarious traumatisation (VT). Empathic engagement with clients' or patients' traumatic experiences was found to have the potential to negatively affect practitioners' thoughts and feelings about safety, trust, esteem, intimacy, and control (Pearlman & Saakvitne, 1995), creating a change in cognitions that could relate to others or to oneself. However, there was no reference to the professional being involved in the traumatising event.

The concept of VT is used in some recent research to describe the impact on healthcare professionals of being involved in events that are traumatic or fatal for their patients, including an exploration of operating room clinicians' experience of VT when their patients died (Hartley et al., 2019). The authors noted that VT originally described the harm caused to clinicians by virtue of witnessing the consequences of another's prior trauma. However, the line between the patient's trauma and the professional's has started to blur in recent studies and reviews, moving the VT concept away from its original conceptualisation, and reducing or entirely eliminating the "vicarious" element, as in the meta-synthesis of the VT experienced by healthcare providers involved in traumatic childbirths (Shorey & Wong, 2021). The authors found that healthcare professionals experienced negative emotional impacts after PSI, including being powerless to advocate for women, and consequent feelings of guilt and self-blame. Inadequate support from their colleagues and organisations also negatively influenced their ability to cope with the aftermath of traumatic experiences or to stay in the profession. It seems that the patient's traumatic experience can lead to specific emotional, psychological, and professional impacts on the staff involved in the incident at the time, which suggests that in fact these effects are not vicarious.

An investigation into health professionals' exposure and responses to perinatal incidents, when serious harm was caused to the mother or baby, has used the term "indirect trauma" (Sheen et al., 2014, p. 729), which may be a more accurate descriptor for some scenarios than VT. Referring to indirect trauma having been addressed in frameworks including PTSD and VT, the authors acknowledged that PTSD could also occur as a response to the direct experience of trauma. However, their approach still appears to suggest that the trauma in a PSI is the patient's, rather than that of the involved healthcare professionals, who remain witnesses to events. Being a witness or bystander, either passive or at one remove, is not how many healthcare professionals have described or perceived their own experiences of involvement in PSI, and this approach removes any sense of the professional being a contributor to or having any responsibility for the incident or outcome, which can be an important factor in the impact experienced. (See for example Delacroix, 2017; Luu et al., 2012; Schwappach & Boluarte, 2009; Sirriyeh et al., 2010; Waterman et al., 2007.)

The VT concept, which does not only apply to healthcare workers, is being used in ways that appear to describe the patient's physically traumatic outcome impacting the

healthcare professional's emotional or psychological state, including where the professional was directly and contemporaneously involved in the patient's negative experience. The VT concept was not intended to describe being present at or participating in the traumatic event, and it does not include the idea of feeling some degree of responsibility or accountability for the traumatic incident. Therefore, although VT is now used in ways that blur the boundaries with other concepts explored below, it is about responses to accounts of previous harm experienced by the patient, not about being involved in the incident. As such it is not included as a concept for central focus in this thesis.

1.7.3 Secondary traumatic stress

Secondary traumatic stress (STS) is another concept that has begun to be used in ways that extend it beyond its original intended meaning and scope, including as a way of describing the impact on healthcare professionals of being involved in PSI. However, it is another concept that relates to trauma experienced by the patient, and was introduced to describe behaviours and emotions resulting from helping, or wanting to help, a traumatised person and alleviate another's suffering (Figley, 1995). Figley equated this concept to compassion fatigue, first identified by Joinson (1992), although it can be argued that STS is a possible antecedent to, rather than the equivalent of compassion fatigue. Figley (1995) considered that psychological therapists and other professionals were vulnerable to secondary stress disorders, and suggested that "Knowing and especially treating someone who is traumatized is the systemic connector that links the traumatic feelings and emotions of the primary to the secondary 'victims'" (p. xvi). The language used in this reference to other professionals foreshadows the "second victim" concept (Wu, 2000) but, like VT, the STS concept was not intended to entail clinician involvement in the original experience of the trauma.

STS was subsequently conceptualised as a cluster of reactions resembling PTSD (Bride et al., 2004), indicating the potential for overlap between these concepts. Bride and colleagues described STS symptoms such as unwelcome re-experiencing of traumatic material (intrusive thoughts, memories, and images), avoidance of trauma triggers and emotions, and increased physical arousal. However, these effects result from knowledge about a traumatising event that has been experienced by another suffering

person, and are associated with indirect exposure to the events via professional relationships with previously traumatised individuals. The latter are considered the trauma victims, and the trauma is understood to be psychological, not primarily physical. Similar symptoms have also been experienced by healthcare professionals who have been involved in harmful patient safety incidents (Busch et al., 2020b; Harrison et al., 2014), but in these cases the exposure to and involvement in the PSI has been direct or immediate.

Trauma is often understood by healthcare professionals to mean the patient's physical injuries or wounds, and the implications of this connotation are explored further in chapters 6 and 7. STS has been studied in nurses who primarily cared for critically ill and injured trauma patients, where trauma had this physical meaning (Von Rueden et al., 2010). The authors summarised the definition of STS as "the emotions and behaviours that a person experiences as a result of being exposed to another person's traumatic experience" (p. 191). They categorised the various factors that could influence the development of STS in nurses who were exposed to a variety of traumatic stimuli because of their hospital patients' medical conditions and injuries that necessitated the care, not because of anything going wrong during their care. Again equating PTSD symptoms with STS reactions, Von Rueden and colleagues suggested that support from others, and relationships with co-workers, could prevent or limit STS. However, none of the factors mentioned that contributed to STS included a PSI occurring as part of unsafe or incorrect treatment.

Recent studies of the negative psychological impact of traumatic births on the obstetricians and midwives involved, as well as on the patient and family, have begun to suggest the traumatic experience for the patient (which may be physical and psychological) may also be felt as a psychologically traumatic experience for the healthcare professional (Schrøder, Larsen et al., 2016). The STS concept is now explicitly being used in this way, overlapping the experiences of patients with those of obstetrics and gynaecology physicians following PSI (Krupey et al., 2021). The authors noted that healthcare workers could experience cognitive, psychological, emotional, and behavioural consequences from either direct or indirect involvement in a traumatic patient injury event, taking the STS concept beyond its original scope.

While researchers are clearly beginning to use STS in a way that overlaps with other concepts, this thesis is not about witnessing traumatic patient events without having had any involvement; it is about being negatively affected by participation in the care that ultimately results in the negative outcome. This means that STS as a concept is not a primary focus of this thesis.

1.7.4 Moral distress

The concept of moral distress among healthcare professionals has been found to give rise to depression, anxiety, emotional withdrawal, frustration, anger, and a variety of physical symptoms (Leggett et al., 2013), many of which are described in the experiences of healthcare professionals following involvement in PSI. It has been described as an inability to act morally, producing in nurses “Painful feelings and psychological disequilibrium” (Wilkinson, 1989, p. 516). However, as originally identified by Jameton (1984; 2013; 2017), moral distress is a phenomenon occurring when the healthcare practitioner knows the professionally and ethically appropriate action to take, but is not able to follow through with this approach in practice because of organisational constraints. It is described as: “Doctors feeling unable to give the standard of care they were trained to or that patients want” (Oliver, 2018, p. 1), arising from deteriorating NHS morale and engagement, short staffing, underfunding, or worsening access and waiting times, which placed pressure on clinicians.

Moral distress is not, however, about the experience of PSI, unless patient harm were to arise because of inadequate resources. The concept offers a sense of healthcare staff being prevented from acting in an ethical way, or feeling forced to act in a way that runs counter to their personal and professional values. The concept of moral distress may engender similar negative emotions in healthcare practitioners to those that can occur following a PSI, but moral distress differs in its principal cause, namely organisational constraints on the healthcare professional, who does not have the requisite resources to carry out tasks, or who feels obliged to go against what he or she considers the appropriate course of action in treating a patient. There may be no patient harm or near miss incident. As such this concept is not central to this research project.

1.7.5 Burnout

Burnout is a concept that is frequently mentioned in studies and commentary about the wellbeing of healthcare professionals, including the negative impact resulting from

patient safety incidents (Dalton, 2021; Fahrenkopf et al., 2008; Gibby & McKimm, 2021; Gupta et al., 2022; Heiss & Clifton, 2019; Lewis et al., 2015). However, burnout describes the effects of chronic emotional and interpersonal workplace stressors, not just in healthcare, and is characterised by emotional exhaustion, depersonalisation, and reduced personal accomplishment or increased ineffectiveness (Maslach et al., 2001) that develop over time. While healthcare professionals may experience burnout and be involved in a PSI, they are distinct concepts, and burnout is not a central focus of this research.

1.7.6 Third victim

The impact of PSI on healthcare organisations has been the subject of reports and comment for over two decades, and it is the organisation which is considered to be the potential “third victim” following a PSI, because it “sustains a wound” (Denham, 2007). This impact can be made worse by the leadership’s response to the incident. Hiding systems failures and covering up mistakes could create worse outcomes for the organisation, including “distrust that may prove to be an overwhelming sepsis” (Denham, 2007, p. 116). This can lead to the organisation suffering financial or reputational damage, potentially producing long-term business difficulties (Liukka et al., 2020). In the UK, the very substantial financial implications resulting from clinical litigation settlements made by the NHS each year, a large proportion of which arise from obstetric incidents causing serious disabilities, have been acknowledged by the government (Donaldson, 2000). This considerable financial impact on healthcare organisations, in addition to the negative impact on patients, families, and public confidence, may explain why maternity services have been made a special focus of HSIB investigation processes in the UK, as noted above.

Not caring for involved healthcare staff by offering them support after a PSI is also considered an error that would put the organisation “at risk for becoming a third victim and sustaining irreparable harm as an institution” (Denham, 2007, p. 118). The concept of the third victim was recently extended to capture not only the organisation as an umbrella entity, but also individual healthcare personnel “with indirect exposure to an adverse event” (Holden & Card, 2019, p.166). This extension includes patient safety professionals responsible for incident investigation and patient safety improvement, risk managers, and whistle-blowers. The authors argue that these “third victims” could

experience acute stress disorder or PTSD, loss of confidence, economic harm, and could even leave the profession.

Although links have been made between the concepts of the second and third victim, the “third victim” is not a concept that is part of the focus of this thesis, because it extends beyond the healthcare professionals who have been negatively affected by their direct involvement in PSI and is principally about the impact on the organisation as a whole.

1.8 Why support for healthcare professionals matters after PSI

Research has described the potential physical, emotional, and cognitive impact on staff of being involved in PSI (Busch et al., 2020b), the coping strategies staff employ (Busch et al., 2020a), and the relationship between severity of harm caused and the severity and duration of the symptoms experienced by those healthcare personnel (Vanhaecht et al., 2019), with potentially long-standing adverse psychological and physical disruptions to the personal and professional lives of affected healthcare staff if the emotional trauma is not effectively addressed (McDaniel and Morris, 2020). Some staff support programmes and their origins are described in the literature (including Edrees et al., 2016; El Hechi et al., 2019; Krzan et al., 2015; Lane et al., 2018; Scott et al., 2010), and some schemes have been evaluated (including Merandi et al., 2018; Moran et al., 2020). Chapter 4 investigates these existing programmes in more detail.

Since 2020, the ongoing COVID-19 pandemic has brought the burden carried by healthcare staff to greater public prominence (Scott, 2021), and it has resulted in recommendations that mental health support should be offered to healthcare personnel to support their recovery from emotionally difficult patient care experiences (Greenberg, Cooke et al., 2020; Greenberg & Rafferty, 2021). These experiences extend beyond PSI and harm being caused by healthcare staff, with the proposed support aiming to protect the mental health of healthcare workers who have to make morally challenging decisions when resources are overstretched (Greenberg, Docherty et al., 2020). This thesis is not about the impact of the pandemic on healthcare staff, although the data collection took place at this time. The objective of the pandemic staff support plan, informed by research into the mental health impact of disasters and traumatic events, including military approaches (Greenberg, Cooke et al., 2020), was not only to assist individuals, but to increase general resilience among the workforce,

and minimise the number of staff needing to be absent on sick leave when their skills were so urgently needed.

1.8.1 Benefits to staff of support after PSI

Calls for emotional and psychological support to be made available to healthcare professionals following their involvement in unintended PSI have now been made for over two decades. These calls include compassionate and empathic responses to the potentially severe negative emotional and psychological impacts on staff, and a desire to promote recovery and the restoration of functioning. There is evidence that showing compassion to healthcare professionals not only assists the affected individuals, but also makes economic sense for their organisations (Trzeciak & Mazzei, 2019).

Arguments have been advanced that organisations have an ethical duty to support all those impacted by PSI, including involved healthcare professionals (Coughlan et al., 2017), and that support for healthcare professionals negatively affected by involvement in PSI forms a key component of an ethical safety culture (Monteverde and Schiess, 2017). The authors argue that the organisational duty of care not only to patients, but also to employees requires organisations to provide the necessary staff support resources, including evidence-based ethical guidelines and standardised procedures. All UK employers have an existing legal duty of care⁹ to their employees, which is mentioned in some national policies (Chapter 2), and explored further in Chapter 7. This duty covers physical and psychological health, safety and welfare (Health and Safety Executive, 1999), but it is not clear whether or how this is applied in practice in the area of PSI.

Staff support is also argued to be a necessary component of a “just culture” (Reason, 1997), whereby PSI are viewed as opportunities for learning and improvement within systems, rather than deflecting from or avoiding organisational accountability for patient outcomes by blaming staff. There is growing understanding that many medical errors are the result of system failures, rather than being attributable to one individual (Reason, 1995; 2000). This suggests that responding in a punitive way is both unhelpful and inappropriate (White & Delacroix, 2020). Recent studies have nonetheless found

⁹ The Management of Health and Safety at Work Regulations (1999) require that UK employers protect the health, safety and welfare of their employees and other people who might be affected by their work activities. Employers must do whatever is reasonably practicable to achieve this.

that blame is still experienced by healthcare professionals, and a culture of blame, inadequate support, and lack of a clear and transparent investigative process appeared to worsen the impact on operating theatre staff following surgical incidents (Serou, Slight et al., 2021).

Evidence has shown that being involved in a medical error can lead to serious emotional distress that has the potential to “imprint a permanent emotional scar” (Schwappach & Boluarte, 2008, p. 9). The authors argued that to mitigate the substantial burden these responses placed on physicians’ health, wellbeing, and subsequent work performance, healthcare institutions and clinical leaders needed to accept accountability “and provide staff with formal and informal systems of support” (p.9). Evidence from Korea has also confirmed that less organisational support was associated with nurses having more severe symptoms after a PSI (Choi et al., 2022), and that having support was essential for nurses’ recovery (Chan et al., 2017).

1.8.2 Benefit for patients and organisations of staff support after PSI

Given that involvement in PSI has been shown to give rise to stress and other negative emotional or psychological consequences among healthcare staff, and evidence outlined below demonstrates the risk to patient safety from worker stress, it follows that staff support is not only for the benefit of the affected individual, but that it would foster better patient outcomes.

The experience of strain is associated with more medical errors amongst healthcare workers (Firth-Cozens & Gerrity, 2001), and there is evidence that stress and strain impair doctors’ decision-making, productivity, and patient safety (Trzeciak & Mazzairelli, 2019; West & Coia, 2019). A link between doctors’ work-related stress and patient outcomes was found by Firth-Cozens and Greenhalgh (1997), with 82 out of 225 doctors reporting incidents where they considered that symptoms of stress had negatively affected their patient care. This had led to lowered standards in half of the cases, serious mistakes in 7% of cases, and two reports of patient death. In a study of 7,905 surgeons, highly stressed professionals were found to be three times more likely to make a major surgical error than those with low stress levels (Shanafelt et al., 2010). Worse physical and mental health among nurses has also been found to relate to a greater number of reported medical errors, with depression the leading predictor of mistakes (Melnik et al., 2018).

This evidence of the link between the wellbeing of healthcare professionals and that of their patients explains why supporting healthcare professionals to manage the effects of PSI and restore their ability to function safely and effectively is of prime importance, not simply for their own benefit, but for that of their patients. Healthcare professionals who are working while experiencing emotional, psychological, physical, or cognitive impairment may not be functioning at their optimum level, and may pose a risk to the safe care of their subsequent patients. Involvement in medical errors without subsequent support can also lead to defensive medicine practices and choices, negatively impacting patients (Cankaya et al., 2021; Panella et al., 2014). Providing support immediately after the incident as well as on a medium- and long-term basis would improve the quality of care for these patients and reduce or remove risk (Seys et al., 2013), and having an accessible support programme would improve clinician recovery and ensure higher quality, safer patient care (Harrison, Lawton et al., 2015).

Lack of support can have a negative impact on nurses' decisions whether to disclose an error and on the recovery process (Cabilan & Kynoch, 2017). Support is thus an important element of a psychologically safe climate in which staff can disclose PSI and speak up when patient care goes wrong, which in turn supports organisational priorities to improve healthcare quality and safety for patients (Joesten et al., 2015; Wu et al., 2013). Psychological support after PSI can also assist the return to work of healthcare professionals who have taken sick leave, and can encourage staff considering leaving the profession to stay in their jobs, avoiding turnover costs for the organisation (Kable & Spigelman, 2018; Moran et al., 2020; Shorey & Wong, 2021).

[1.8.3 Lack of staff support after PSI](#)

In spite of the numerous calls for staff support after PSI, there have been many observations that support is often lacking, or piecemeal and unreliable (including Canadian Patient Safety Institute, 2019; Ferrús et al., 2017; Harrison et al., 2014; Lee et al., 2019; Pinto et al., 2013; Quillivan et al., 2016; Reiser Crelier et al., 2020; Rodriguez & Scott, 2018; Scott et al., 2009; Sirriyeh et al., 2010; Ullström et al., 2014; Waterman et al., 2007; White et al., 2008). The relatively small number of support programmes for healthcare professionals negatively affected by PSI involvement that are described in the research literature are explored in Chapter 4. The apparent lack of widely accessible support gives rise to a key question for this thesis, namely whether

support provided in practice is informal and ad hoc, or whether there are policies in place at the national or international level that recommend or require the provision of specific support approaches or resources within healthcare organisations to address these circumstances.

1.9 Policies about support for healthcare professionals after PSI

Whether there are known national or international policies either calling for or stipulating the implementation of healthcare staff support after PSI is the subject of detailed consideration in Chapter 2. This includes the recommendations for supporting staff after PSI set out in the UK's draft Patient Safety Incident Response Framework (NHS England & NHS Improvement, 2020), mentioned above. Within the research literature about emotional and psychological support for staff who are negatively affected after involvement in PSI, there has been very little consideration of the policies that underpin or inform staff support, and no consensus has been identified about the elements to include when designing post-PSI support (Seys et al., 2013). Most of the studies that have reported support interventions have described the content of these programmes, rather than the policies on which they were based (Wade et al., 2020).

It has nonetheless been argued that the implementation of guidelines regarding support after work-related traumatic events could be beneficial for healthcare professionals and would be likely to improve their satisfaction with the support received (Kerkman et al., 2019). Some studies have considered the frameworks for support practices within specific local organisations, and a small number of Belgian hospitals reported having organisational-level support systems for the healthcare professionals involved in incidents (Van Gerven et al., 2014). The authors evaluated the protocols provided by these hospitals using the White paper by the US Institute for Healthcare Improvement (Conway et al., 2010) and the model of staff support proposed by Scott et al. (2010). They found that only a minority of Belgian hospitals followed part of this available US guidance. In Swiss hospitals, support for staff traumatised after PSI was generally said by Quality Managers and hospital Chief Executive Officers to be available in theory, but often in an unstructured way, risking inadequate provision of support in terms of quantity and quality (Reiser Crelier et al., 2020). The guidelines relating to support that were identified were not always implemented in practice, suggesting that even where

policy guidelines exist at the local level, they may not lead to the provision of support for affected staff.

1.10 Rationale for the thesis

Some recommendations for supporting healthcare professionals when they have been negatively affected by involvement in PSI are known to exist, particularly in the US. What is not clear is the extent to which any structured organisational support that is currently provided after PSI is underpinned by a specific reference to a healthcare policy, requirement, or set of guidelines, which would make access to provision transparent and consistent. This requires identification and analysis of relevant policy, and investigation into the support programmes described in the literature, and their policy bases.

An initial literature search found no investigations into the overarching national or international policies used as the basis of emotional or psychological support provision for healthcare professionals who have been involved in PSI. The extensive body of research that has been carried out into the emotional and psychological impact of PSI on these professionals focuses mostly on the experiences of healthcare staff. No studies have been identified that explore the views and perceptions of healthcare professionals who hold policy, management, or supervisory positions within their organisation (referred to as “healthcare managers” throughout this research) about the policies that exist in relation to emotional or psychological staff support following PSI, their knowledge of the support that is offered in practice within their organisation, and the terminology used to describe the professionals involved in these situations.

The purpose of this project, therefore, is to shed light upon existing national and international policies and guidelines that either require the provision of emotional or psychological support for healthcare staff after PSI, or that could be drawn upon when creating organisational policies and practices. The research will aim to identify whether policies that exist are sufficient to bring about the implementation of support, or whether there is a gap between policy and practice. It will explore the support programmes that have been reported in the literature, and identify where these are located. It will then investigate in an interview study whether healthcare managers are aware of policies about staff support after PSI, and whether structured support is available in practice to their staff.

The project will also explore views about the terminology used to describe healthcare professionals who have been distressed and in need of psychological or emotional support following involvement in PSI, and specifically the evolution of the “second victim” concept. This is necessary, because while some healthcare professionals believe this term accurately describes the plight of negatively affected staff, a number of patient representatives have recently been vocal in arguing that the word “victim” is only appropriate for patients and their families, and not for describing healthcare workers. If the most widely used term has detractors, including about its validity as a construct (Harrison, Lawton et al., 2015), this could have a negative impact on the willingness of organisations to offer support to their staff after PSI (Wu et al., 2020).

The structure of the thesis is set out in section 1.12.

1.10.1 Research questions

To address these aims, the research questions identified for this thesis and the qualitative study are:

- 1) What policies, protocols, and practices are healthcare policymakers, managers, or supervisors aware of that aim to support healthcare personnel in their organisation who have experienced unanticipated adverse medical events or near misses in UK healthcare settings?
- 2) What are the views of healthcare policymakers, managers, or supervisors about the term “second victim”?

1.11 The personal and reflexive

This research originated as a funded project with a general theme of “second victims in healthcare”. While exploring the existing research and identifying possible gaps for further work, I was initially shocked at the statistics about medical error, and started to question the “second victim” concept, which was included in a large proportion of research in this field, without an apparent analysis of its use or evolution. I then found that the majority of the work undertaken to date in this area focused on the impact of PSI involvement for healthcare professionals, without investigating or describing available support mechanisms. I started to explore what was available by way of support and to discuss this informally with healthcare professional friends and acquaintances. It became clear that in the UK, support for healthcare staff in these circumstances was

not routine, and certainly not formalised or structured. As the project began (in 2018), a preliminary exploration suggested that there were some specific guidelines and policies for support available in the US (without any corresponding governmental or legal requirement or obligation on healthcare organisations), yet none that were evident in the UK. This led me to focus on support in practice, and to investigate any underpinning policies. Focusing on healthcare staff with management, supervisory, or policy responsibility became a way of narrowing the focus of the research, and also identifying a population that would be most likely to have awareness of and experience with supporting colleagues after they had been involved in PSI.

My own professional background played a part in drawing together the focus of this work. My perspective and knowledge as a practising psychotherapist informed my own views about the value of emotional and psychological support in the workplace, about healthcare organisations, and about the benefits of fostering psychological wellbeing for staff as well as patients. However, I did not want to focus on the experience of psychotherapists, who are trained in understanding and managing their own and others' psychological responses to negative events, and also have supportive structures such as supervision as part of required professional standards. I was equally aware that healthcare professionals outside my specialism could hold very different or entirely opposing views about whether the provision of support to staff in distress after PSI was needed or desirable.

My professional background as a former UK Government policymaker (outside the healthcare arena), and as a trained linguist and teacher, together contributed to my interest in policy and its implementation, and to the emphasis I place both on the importance of language use and terminology, and on potential assumptions about shared understanding and meanings. I am aware that in the UK public sector, the development of a policy, and the language used in its formulation, together form a key part of introducing or changing what happens in practice on a uniform or widely accessible basis, in a way that is acceptable to stakeholders. For organisations other than government to institute policies or practices within their organisations that have potential resource implications, a legal or government policy guideline or requirement may be the essential impetus that sparks change.

Throughout this research project I have endeavoured to remain aware of the assumptions, preferences, and presuppositions that I may be bringing to the research topic, and to be vigilant about any deductive thinking or desire to lead the process or the interpretation of data (Finlay, 2002). It has been my intention to stay alert to the possibility of ignoring or obstructing any ideas that do not fit with my own potential preconceptions about what may be uncovered (Levitt et al., 2015). I do not consider it possible or desirable to remove traces of myself entirely from the research process, but I have striven to be watchful about any impact my preconceptions and beliefs about significance could have at each stage of the research process. To aid transparency about my own assumptions before and during the research process, I kept a reflective research journal and timeline, to track and help illuminate my developing perspective, preferences, and decisions (Ortlipp, 2008). An extract of my journal is included at Appendix A, and issues of positionality and the choices I made are explored further in Chapter 5 (Methodology).

1.12 Structure of the thesis

The thesis is divided into eight chapters, including this introductory chapter in which I have set out the background and context to this research project. In the following chapter, I investigate the international and national policies that healthcare and patient safety bodies and organisations have developed to address the impact on healthcare professionals of involvement in PSI. In the third chapter, I investigate the concept of the “second victim” in healthcare, which has been central to much of the research undertaken in this field to date, and I present an analysis of the concept and the controversy that now surrounds it. In the fourth chapter, I review the literature relating to structured organisational support programmes for healthcare staff after experience of PSI, highlighting the policies that informed those programmes where these are reported.

In the fifth chapter, I set out the methodological approach taken, detailing my epistemological positioning, choices made, and the qualitative methods used, with reference to appropriate standards of quality for qualitative research (Morse, 2015; Spencer et al., 2003), and relevant ethical considerations and requirements. Within the sixth chapter, I report the findings of the project in relation to the research questions posed, including the codes and themes I identified and developed, and supporting quotations from participants in the qualitative interview study. In the Discussion

chapter, I reflect on those findings and contextualise them within extant theory and previous literature. I endeavour to answer the research questions and I reflect on the limitations of the research. In the eighth and final chapter, I review the new knowledge gained, and set out the contributions of the research to the field of healthcare staff support following involvement in PSI. I suggest avenues for future research to explore. Finally, I engage in personal reflections on the project.

1.13 Chapter summary

In this first chapter I have aimed to give a broad introduction to this research, which sets out to investigate the knowledge and views of healthcare managers, supervisors, and policymakers about the policies that underpin the emotional or psychological support available to healthcare professionals when they have been involved in harmful, no harm, or near miss PSI, their knowledge of support in practice, and views about the terminology used to refer to the staff involved who have been negatively affected by these experiences.

I have described the context in which the research has taken place, explored the patient safety concepts that are used in this research field, and considered what is known about the impact of PSI and investigation processes on involved staff. I have explored the concepts that relate to the potential emotional and psychological impact of PSI on staff, and clarified concepts which are the focus of this project. I have selected the concept of the “second victim” for inclusion in this thesis, because of its widespread use in research studies about the topic, and the important debate to which it has given rise. I acknowledge that many concepts relating to the impact of PSI on healthcare professionals’ emotional and psychological wellbeing are now used in ways that overlap. I set out the benefits to healthcare staff, patients, and healthcare organisations of staff having access to support after PSI, and the risks inherent in their not receiving support.

I have outlined my own background and motivation for undertaking this work, as a former policymaker and current psychological healthcare provider. I aim to make an original contribution to the literature by advancing understanding of the policies that underpin emotional and psychological support interventions offered in practice to healthcare professionals when they are involved in and negatively affected by patient safety incidents.

CHAPTER 2: POLICIES ON SUPPORT FOR HEALTHCARE STAFF INVOLVED IN PATIENT SAFETY INCIDENTS

2.1 Introduction to the chapter

This chapter provides an analysis of existing policies about the provision of emotional and psychological support for healthcare professionals after their involvement in patient safety incidents (PSI), to demonstrate how the negative experiences of those healthcare professionals may have been addressed by the development of relevant national or international policy. It explores what is known about the countries, settings, and the remit of organisations where national or international policies have been identified. The chapter considers whether the type of healthcare system may influence the development of perspectives about healthcare professionals' experiences and possible responses. Using documentary analysis methodology, the analysis explores the nature of the identified policies that refer to staff support, and whether they are standalone, or form part of policies about other related issues. The analysis considers the status and function of the policies: whether they constitute mandatory or otherwise binding requirements for support to be provided, or simply amount to advisory policy statements and recommendations, and what this means.

The rationale for this policy analysis arises from the fact that no existing explorations have been identified of the policy bases underpinning the emotional or psychological support provided to healthcare professionals who are negatively affected by involvement in PSI. The aim of this research project, as set out in Chapter 1, is to shed light upon known national and international policies and guidelines that are, or could be drawn upon when creating organisational approaches to the provision of such support to affected healthcare staff in practice. Identifying whether such policies already exist forms a foundation to investigating the first research question, namely: What policies, protocols, and practices are healthcare policymakers, managers, or supervisors aware of that aim to support healthcare personnel in their organisation who have experienced unanticipated adverse medical events or near misses in UK healthcare settings? If relevant policies are found to have been formulated at the international or national level, it will then be instructive to investigate if the research study participants have knowledge of these policies being applied in practice, or if any identified interventions relating to the support of healthcare professionals have a specific policy basis.

2.2 What is policy and why it matters

The Cambridge Dictionary defines “policy” as a set of ideas or a plan of what to do in particular situations that has been agreed officially by a group of people, an organisation, or a government. The Irish Health Information and Quality Authority (HIQA) describes policy as “a written statement that clearly indicates the position and values of the organisation on a given subject” (HIQA, 2008, p. 61). Policy formulation derives from a perceived need to manage a problem or set of circumstances, or pressure from interested parties to introduce change in the way things are done, within one organisation or an entire sector (Adelle & Weiland, 2012). Policies can indicate priorities, intentions, and goals, and usually form the basis of procedures or practices to achieve these, but they can equally stand alone and serve as a starting point, identifying values and aspirations rather than specifying or requiring practice.

In healthcare, the word “policy” can have a different connotation, meaning a clinical treatment protocol or the agreed, uniform approach to a specific medication use, sometimes called a Standard Operating Procedure (SOP). This is not the way in which the word is employed in this chapter. Here “policy” is:

- a high-level overall objective, plan, recommendation, or call for action, aimed at supporting healthcare professionals involved in PSI
- formally documented within a healthcare regulatory, supervisory, or investigatory authority, or other official healthcare body with either a national or international remit

National and international policies matter, particularly in a highly regulated area such as healthcare, because accepted or required practices are intended or expected to flow from them. A policy forms the underpinning architecture to frame and guide decisions and future actions of the healthcare organisations that fall within the scope of the originating body. Such bodies may include health ministries, national quality and standards organisations, and international organisations that aim to direct and advise their member countries with respect to healthcare policy and activity. An important part of analysing policies is to consider the agendas that lie behind them, and whether policy statements and recommendations have practical effect. This is explored further in section 2.9 below.

2.3 The need for organisational support for healthcare professionals after patient safety incidents

As set out in Chapter 1, the potentially serious negative impact on involved healthcare professionals of being involved in a PSI can include emotional and psychological harm, across healthcare professions and disciplines (Edrees et al., 2016; Quillivan et al., 2016; Ullström et al., 2014). There are several important reasons for aiming to avoid or mitigate such outcomes. Workplace health and safety regulation across employment sectors in the UK, for example, already makes it the legal duty of all employers to protect the health, safety, and welfare of their employees, and to do whatever is reasonably practicable to achieve this, including providing employees with information about risks in the workplace and how they are protected (Health and Safety Executive, 1999). Healthcare services are recognised to entail a higher degree of risk than many other organisations have to manage, with higher levels of work-related stress than many other professions (European Commission, 2021), potentially placing staff members in a more precarious situation for their own health, safety, and welfare, and giving rise to a need to account for and address this risk.

The psychosocial risks workers may experience within their work life is gaining more attention internationally, and the need to address them is increasingly recognised. The recently published ISO Standard 45003 (ISO, 2021)¹⁰ entitled “Occupational health and safety management — Psychological health and safety at work — Guidelines for managing psychosocial risks” is not specific to the healthcare field and does not address patient safety, but it has relevance to this topic. This voluntary international standard provides guidance on the management of psychological risks and promoting well-being at work, as part of an occupational health and safety management system. Its recent development shows that there is growing international awareness of the need to “prevent work-related injury and ill health to workers, and to provide safe and healthy workplaces” (p. 1) across all sectors. The standard makes explicit that for organisations “the impact of psychosocial risks includes increased costs due to absence from work, turnover, reduced product or service quality, recruitment and training, workplace investigations and litigation, as well as damage to the organisation’s reputation” (p. 2).

¹⁰ The ISO is an independent, non-governmental international organisation with a membership of 167 national standards bodies. It shares knowledge and develops voluntary, consensus-based international standards to address global challenges.

All of these factors are relevant to healthcare workplaces and form part of the rationale for staff psychological support provision after PSI.

As well as ensuring compliance with existing health and safety rules and standards, a second key reason for supporting healthcare professionals involved in PSI, highlighted in Chapter 1, is that not managing any negative emotional or psychological effects may incur further risks to patient safety. This could arise if a professional's distressed state leads to further mistakes being made, or to defensive clinical choices being taken that are not in the patient's best interests (Bari et al., 2016; Panella et al., 2014; Robertson & Long, 2018). The link between patient safety and healthcare worker productivity and safety can create risks for the organisation economically and with respect to quality of care generally, as well as for individual patients to whom it provides services (West & Coia, 2019).

Third is the opportunity that provision of psychological or emotional support affords to organisations to treat their workers with care, compassion, and empathy. In Chapter 1 the ethical reasons for compassionate care of and concern for staff were outlined. Such an approach supporting professionals' recovery after negative impacts from PSI involvement may also foster staff loyalty and encourage retention (Trzeciak & Mazzarelli, 2019). Fourth is that being negatively affected after a PSI, not receiving support to recover, and feeling unable to continue has led to healthcare professionals taking absences or leaving their jobs (Cho et al., 2022; Finney, Torbensen et al., 2021; Mok et al., 2020; The Joint Commission, 2012), potentially wasting years of training, and resulting in the economic loss to their employer of their skills and years of experience, which are expensive to replace (House of Commons Health and Social Care Committee, 2021).

[2.4 Healthcare systems and settings where evidence is focused](#)

As discussed in the Introduction to this thesis, most of the evidence that has emerged about the impact on healthcare professionals of being involved in PSI, and explorations of the ways in which organisations could consider supporting their workers after such events, has originated in the US (Busch et al., 2021). Other countries where these impacts have been investigated, or supportive solutions for healthcare professionals are reported to have been introduced (explored further in Chapter 4), include some

European countries and other OECD nations including Australia and Canada (De Bienassis et al., 2021).

Healthcare systems are based on a variety of economic models for provision and, in contrast to economically advanced nations, low-income or middle-income countries may struggle to attain basic standards for safe clinical work (WHO, 2021), and may have insufficient resources to provide support for healthcare professionals after PSI. This means that health worker safety or support will inevitably feature very low down in the order of priorities of some nations' policies, in spite of WHO recommendations to all member countries to make healthcare worker physical and psychological safety a key consideration (WHO, 2020a).

2.4.1 The influence of context on policy perspectives

A key factor underpinning choices about whether and how to develop policies concerning the provision of emotional or psychological support to healthcare professionals after PSI is that healthcare services within all systems have several layers of delegation and supervisory oversight. Health ministries create policies with respect to their public health goals and priorities, such as ensuring access to healthcare, improving the quality of healthcare and outcomes, and balancing this with available resources and judgements about cost-effectiveness. They also delegate powers and functions to regional authorities, care quality bodies, and service provider organisations who manage the day-to-day delivery of healthcare. The multiplicity of actors and stakeholders within healthcare systems can result in overlap, gaps, or differences in the priorities of the various organisations and agencies involved in regulation and provision, including limiting the allocation of resources to activities that are not mandatory or directly supervised (Sabik & Lie, 2008).

Current evidence about healthcare professionals' experiences of PSI and the support that is offered to assist recovery, as set out in the Introduction to this thesis, is not evenly distributed across countries and healthcare systems. Even in developed and high-income countries, the degree of focus on the issue of healthcare professional support has varied, in terms of both regulatory system attention and research output (Seys et al., 2013). While there were a number of early investigations into the experience of distress on the part of healthcare professionals after medical errors or other traumatic patient outcomes in the UK (Firth-Cozens, 1987; Kirby, 2003), the majority of published

studies have taken place in the US, where the issue of supporting healthcare professionals who have experienced a negative impact in these situations was originally raised and actively taken up (Christensen et al., 1992; Hilfiker, 1984; Newman 1991; Wu, 2000; Zeidenstein, 1995).

The US focus on this work may derive in part from the fact that the US healthcare system is based on varying types of insurance entitlement, and that the US devotes twice as much of its national income to healthcare relative to other OECD countries as a proportion of GDP (OECD, 2021), making it a very costly system. For those citizens who do have insurance cover, it ranks number one worldwide on responsiveness (Bolnick, 2003; WHO, 2000). This is arguably because the financial constraints upon it are not those of public health systems, and because US healthcare organisations need to compete for patients. Moreover, health services in the US also compete for workers, which may make the need to be responsive and offer supportive resources and benefits more important for attracting and retaining staff than within publicly funded health settings. Litigation and claims resulting from medical errors and other PSI have also long been a feature of the US insurance-driven healthcare system (Kavic, 2004; Mohr et al., 2000), which may have brought the impact on healthcare professionals of involvement in incidents to greater prominence at an earlier point.

By contrast, many healthcare systems around the world are publicly financed by means of funding from national, regional, or local taxes, and many aim to offer universal coverage to their citizens. This means that their healthcare organisations may not need to compete in the same way for their workers, if conditions are on more standardised footings. It is also important to note that public health systems will be subject to more financial constraints than their private counterparts, and this may shape perspectives about organisational priorities, and impact the allocation of resources to services aimed at supporting staff (Harrison & Wu, 2017), particularly if such provision is not required by regulators and supervisory authorities. Public healthcare systems may choose to develop policies that are supportive of staff where staff illness or retention becomes a concern, or where research evidence supports their introduction.

[2.5 Healthcare sectors and disciplines where evidence is focused](#)

Much of the evidence that has emerged about the impact on healthcare professionals after their involvement in PSI has come from secondary (hospital and community) care.

There are relatively few studies about the impact on professionals in primary care (Cebrian-Cuenca et al., 2021; Müller et al., 2020; Tan & Chen, 2018; Venus et al., 2012), or those containing at least some primary care participants (Ferrús et al., 2021; Kerkman et al., 2019; Mira et al., 2015), suggesting perhaps that less importance has been attached to this part of the healthcare system, or that assumptions are made about there being fewer serious PSI in the primary care sector. An important factor is that the far higher number of healthcare staff in hospital and community services (Rolewicz & Palmer, 2020) has led to a greater focus on this sector because of the larger potential impact. This project is not focused on any single specialism and aims to investigate emotional and psychological support for healthcare staff after PSI as it applies to all the professions.

However, within the secondary care sector there has been a notable research focus on maternity services and the experiences of obstetricians and midwives involved in traumatic births. (See, for example, Cankaya et al., 2021; Cauldwell et al., 2015; Christoffersen et al., 2020; Hajiesmaello et al., 2022; Javid et al., 2019; McCarthy et al., 2021; McNamara et al., 2017; Minooee et al., 2021; Rivera-Chiauzzi, Finney et al., 2022; Schrøder, Edrees et al., 2019; Schrøder, Larsen et al., 2016; Schrøder, Jørgensen et al., 2016; Schrøder et al., 2017; Slade et al., 2020; Wahlberg et al., 2017; Wahlberg et al., 2019; Wahlberg et al., 2020). These studies and several literature reviews specific to the maternity care field (Aydin & Aktas, 2021; Buhlmann et al., 2021; Coughlan et al., 2017; McDaniel & Morris, 2020; Nydoo et al., 2020; Shorey & Wong, 2021) focus on the physical trauma of the mothers and their babies, and on the consequent experience of traumatic stress by the involved healthcare professionals (Kerkman et al., 2019; Winning et al., 2018), although it is not always clear what these traumatising incidents have entailed, and whether they could have been avoided by professional interventions. Given that a PSI is defined as “an event or circumstance that could have resulted, or did result, in *unnecessary* harm to a patient” (WHO, 2009, p. 15, italics mine), the traumatic stress experienced by obstetric professionals may, by contrast, result from unexpected and unavoidable outcomes, including situations in the environment such as violence (Wahlberg et al., 2020), that are unrelated to the birth itself. The focus on the maternity sector may also arise because high rates of childbirth-related trauma in mothers have been found to correspond to the levels of traumatic response in the involved healthcare professionals (Kendall-Tackett & Beck, 2022). A

further factor that may have led to a focus on this sector is that deaths related to childbirth are considered an important marker of a society's well-being (Morton et al., 2021), and maternal mortality is still an issue of concern in technically and economically advanced countries, with a large proportion of litigation and clinical negligence claims in healthcare arising following negative outcomes to mothers and babies during birth (HSIB, 2021a; NHS Litigation Authority, 2012), the costs of which can incentivise regulatory authorities to make changes.

These legal and financial factors related to patient safety outcomes may be central to the agendas behind the development of healthcare policy, including about staff support. This is explored further in section 2.9 below.

2.6 Search for policies

Policies that form the focus of this analysis are those from international or national healthcare bodies that describe, advise, recommend, or require the provision of psychological or emotional support to healthcare professionals who have been negatively impacted by their involvement in PSI. Policies published by healthcare trade union bodies have not been included, because while these organisations may call for, or choose to provide emotional or psychological support for their own professional groups and membership, they cannot stipulate that support be provided for non-members, or for other professions. The scope of national records is limited to OECD countries on the basis that OECD members are mostly high-income economies considered to be developed countries; this makes it more likely that they will have produced policies or guidelines regarding patient safety, including potentially support for healthcare professionals after PSI. Most of the known research studies about support provision for healthcare professionals who have been involved in a PSI (explored further in Chapter 4) have been undertaken within OECD member countries.

2.6.1 Search strategy

To identify policies about emotional or psychological support for healthcare professionals who have been involved in PSI, advice was sought from a subject specialist librarian. The search strategy involved an initial PubMed search using the terms "healthcare professional*" AND support AND ("adverse event*" OR "patient safety incident*" OR "medical error*") AND (guideline* OR framework OR policy).

The records retrieved were reviewed for references to national and international policies or guidelines about support for healthcare professionals following PSI.

International policies were sought by handsearching the WHO's list of publications on the topic of patient safety; the OECD iLibrary in the area of "Health, Patient safety"; including health working papers and reports in their Economics of Patient Safety series; and European Commission publications on patient safety.

It was recognised that national policies were very likely to be located within the grey literature, and the databases TripPro, Policy Commons, Overton, and the National Grey Collection were searched using the same terms, with the addition of "psychological support" to focus the search. Relevant national policies were also sought within OECD reviews of individual health systems, publications from the European Observatory on Health Systems and Policies, Commonwealth Fund Health Care System Profiles, and the WHO Regional Office for Europe. The health ministries and patient safety authorities of OECD member countries were located and individually searched to identify available national policies on support for healthcare staff, including references made within policies on patient safety and open disclosure of PSI. Results accessible in English, French, Italian, or Spanish were scrutinised for any included reference to psychological or emotional support for staff after PSI or adverse events. The citations of all documents retrieved were also scanned.

[2.6.2 Eligibility for inclusion](#)

The inclusion criteria were as follows:

- policy documents or reports from international bodies (WHO, OECD, European Commission), or individual OECD member countries, that describe, advise, recommend, or require the provision of psychological or emotional support to healthcare professionals who have been negatively impacted by involvement in PSI / adverse events. Descriptions of support as caring, empathic, or related to healthcare professional wellbeing were included as types of emotional support
- accessible in English, French, Italian, or Spanish

[2.6.3 Exclusion criteria](#)

Records were excluded as follows:

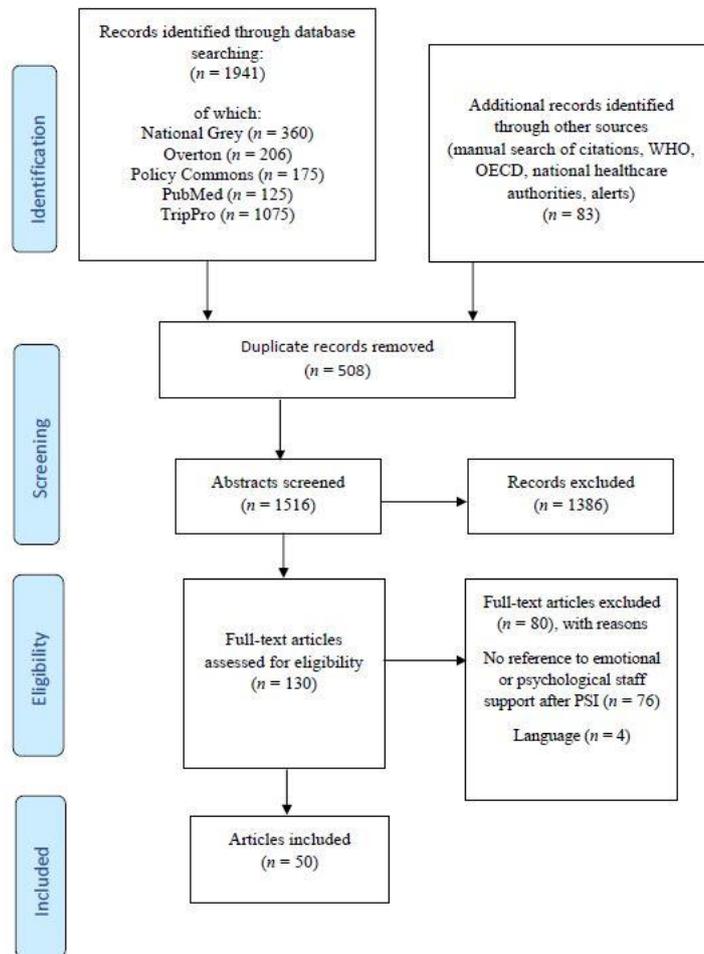
- not in English, French, Italian, or Spanish
- no reference to psychological or emotional support for healthcare staff after PSI / adverse events
- relating to moral distress or ethical decision support, or support (encouragement) to learn, improve knowledge or skills, or to disclose incidents
- relating to health worker mental health not in connection with PSI
- regional or local, rather than national or international in scope
- about non-OECD country healthcare systems
- only about clinical treatment protocols, patient care, or patient and family support

A total of 1941 records were retrieved from the database searches, with an additional 83 identified from other sources. Duplicates were removed and the remaining 1516 records were initially screened by title and abstract. 130 potentially relevant documents were assessed in full text, of which 80 were excluded by virtue of mismatch with the inclusion criteria. Of the 50 included records, eight were from international bodies, and 42 from national organisations.

Figure 1 sets out the process of record inclusion, exclusion, and final selection.

Figure 1

Flow chart of literature search and selection process



Note. Adapted from: Moher et al. (2009). Preferred reporting items for systematic reviews and meta-analyses

2.7 Results

2.7.1 International policies identified

The eight identified records originating in international organisations are included in Table 2 below. The status of all these records is non-compulsory (the document uses the terms guidance, guidelines, recommendation, or description). The status of the documents is explored in the analysis (section 2.9). The records are ordered by descending membership size of the international body, and then by date. Five documents are from WHO reports (WHO, 2008; 2010c; 2020a; 2020c; 2021). Two are OECD reports (2018, 2021). One originated in the European Union (EU Expert Group on Health System Performance Assessment, 2020).

Table 2*Characteristics of the included records by international organisation*

International Body / Date	Document title	Policy status	Reference to psychological or emotional support for staff after PSI
WHO (2008)	Patient safety workshop: Learning from error	Non-compulsory	Health-care workers may be personally affected after involvement in care which has resulted in error. Understanding this and providing support to health-care workers is challenging, but vitally important (p. 13)
WHO (2010c)	Patient safety workshop: Learning from error	Non-compulsory	Health-care workers may be personally affected after involvement in care which has resulted in error. Understanding this and providing support to health-care workers is challenging, and necessary (p. 13)
WHO (2020a)	Charter on health worker safety: A priority for patient safety	Non-compulsory	Health workers should be assured of access to psychological support and able to report safety concerns without fear of retaliation (p. 5)
WHO (2020c)	Patient safety incident reporting and learning systems: Technical report and guidance	Non-compulsory	Proper counselling and support is provided for staff who have been involved in serious incidents (the “second victims”) (p. 47)
WHO (2021)	Global Patient Safety Action Plan 2021-2030 (final report)	Non-compulsory	Strategy 4.4 (Actions for health care facilities and services) Ensure that patients, families, and health workers are given ongoing psychological and other support in the aftermath of a serious patient safety incident (p. 45)

Table 2 (continued)*Characteristics of the included records by international organisation*

International Body / Date	Document title	Policy status	Reference to psychological or emotional support for staff after PSI
OECD / Hasegawa & Fujita (2018)	Patient Safety Global Ministerial Summit. Patient safety policies: Experiences, effects, and priorities; lessons from OECD member states	Non-compulsory	More than half of states make efforts to provide emotional support to staff involved in adverse events. Most of them are voluntary efforts in each hospital ... Second victims may be able to use the scheme easily if there is a standardized program (p. 55)
OECD / De Bienassis et al. (2021)	Health Working Papers No. 130: The economics of patient safety Part IV: Safety in the workplace: Occupational safety as the bedrock of resilient health systems	Non-compulsory	The health workforce needs to be supported through concrete policy actions and appropriate resources. This includes ... access to psychological support, and services to promote employee well-being (p. 6) An overarching policy and governance framework is needed ... for organisations to keep their staff safe and healthy (p. 68)
EU Expert Group on Health System Performance Assessment (2020)	Assessing the resilience of health systems in Europe	Non-compulsory	Evaluate the quality of emergency care services' crisis management system and related protocols, including the capacity to provide adequate psychological support to patients and staff in the event of a crisis (p. 26)

2.7.2 National policies identified by country

Forty-two relevant records were identified that provide evidence of a national policy, covering 13 of the 38 OECD member countries. The records are included in Table 3, in alphabetical order by country, and then by date. The data includes the status of the document as either non-compulsory (where the policy refers to a guidance, guidelines, recommendation, or description) or as a requirement. Only three out of 42 of the policy documents constitute a requirement; these records are colour coded green. Sixteen of the records originated in the UK and eight in the US. The UK is counted as one member country within the OECD, but the separate UK nations of Northern Ireland, Scotland, and Wales have different regulatory authorities for health, and this is shown in the records identified.

No records containing a reference to the need for psychological or emotional support for staff after PSI within national policy were located for the following OECD countries: Austria, Colombia, Costa Rica, Czech Republic, Estonia, Greece, Hungary, Iceland, Japan, Korea, Latvia, Lithuania, Luxembourg, Mexico, Poland, Portugal, Slovak Republic, Slovenia, Spain, Sweden, or Turkey. Potentially relevant records were located for Denmark, Finland, Norway, and the Netherlands, but were not accessible in the included languages, and thus excluded.

Table 3*Characteristics of the included records by country*

Country / Body	Report / Date	Policy status	Reference to psychological or emotional support for staff after PSI
Australia			
Commission on Safety and Quality in Health Care (2020)	Review: Implementation of the Australian Open Disclosure Framework	Non-compulsory	The Commissioners also recognised the important role of staff support, as the open disclosure process can be emotional and stressful for the healthcare providers and managers involved. For the healthcare provider this can become more stressful if they are referred to Australian Health Practitioner Regulation Agency (AHPRA) (p. 34)
Commission on Safety and Quality in Health Care (2021)	Incident Management Guide	Non-compulsory	Ongoing support should be offered to patients, carers, families, and members of the workforce who are involved in the incident (p. 6)
Belgium			
Platform for Continuous Improvement of Quality of Care and Patient Safety (2021)	Website: https://www.paqs.be/en-GB/Ressources/Partage-d-evenements-indesirables	Non-compulsory	Healthcare institutions must ensure that supporting professionals following an adverse event becomes a core part of staff management and that such support is integrated into clinical risk management
Canada			
Canadian Patient Safety Institute (2019)	Creating a safe space: Strategies to address the psychological safety of healthcare workers	Non-compulsory	The psychological trauma that health professionals undergo when they are involved in a PSI can be overwhelming and complex. It can have a significantly negative effect on their wellbeing and on their ability to care effectively for their patients. It is therefore important that healthcare organisations explore how best to support their workforce through what can be a very distressing experience (p. 78)

Table 3 (continued)*Characteristics of the included records by country*

Country / Body	Report / Date	Policy status	Reference to psychological or emotional support for staff after PSI
Chile			
Patient Safety Foundation (2020)	Revista Chilena de seguridad del paciente [Chilean Journal of patient safety]	Non-compulsory	Organisations should support healthcare professionals involved in PSI
France			
Haute Autorité de Santé (2011)	Annonce d'un dommage associé aux soins [Disclosure of care-related harm]	Non-compulsory	Healthcare professionals need support following an adverse event, and cannot be expected to seek support themselves. Specific resources should be signposted or external referrals made to meet their needs (p. 36)
Haute Autorité de Santé (2016)	Cadre général d'évaluation des démarches d'analyse des EIAS [General framework of adverse events analysis steps]	Non-compulsory	The organisation offers psychological support to professionals involved in adverse events (idea of second victim) (p. 31)

Table 3 (continued)*Characteristics of the included records by country*

Country / Body	Report / Date	Policy status	Reference to psychological or emotional support for staff after PSI
Haute Autorité de Santé (2017)	Risques psychosociaux des internes, chefs de clinique et assistants (médecine, pharmacie et odontologie) [Psychosocial risks for newly qualified practitioners, clinical leads, and assistants (medicine, pharmacy, and dentistry)]	Non-compulsory	Recognition of second victim concept and empathetic and non-judgemental debriefing of healthcare personnel involved in adverse medical events (p. 17)
Germany			
Strametz et al. / German Coalition for Patient Safety (2020)	Maintaining capacity in the healthcare system during the COVID-19 pandemic by reinforcing clinicians' resilience and supporting second victims	Non-compulsory	Second victims need fast, personal and confidential support within a comprehensive, easily accessible, stratified system (p. 4)

Table 3 (continued)*Characteristics of the included records by country*

Country / Body	Report / Date	Policy status	Reference to psychological or emotional support for staff after PSI
Ireland			
HSE Quality Assurance and Verification Division (2018)	Incident Management Framework – Patient and staff stories	Non-compulsory	The first and most important source of support to staff who are involved in an incident is the person’s line manager and their colleagues. They need not to feel isolated and alone, rather they need to feel a sense of empathy and support ... following this up with an offer of more formal support options to staff (such as employee assistance programs [EAPs], social workers, clinical psychologists, or counsellors) (p. 14) In the same way as the Incident Management Framework places emphasis on the need to support service users and their families, it must also seek to support staff (p. 15)
HSE Quality Assurance and Verification Division (2020)	Incident Management Framework	Non-compulsory	It is therefore critical that the first response of services when an incident occurs is one of ‘leaning in’ to support those affected with what is called psychological first aid (p. 22)
HSE National Quality Improvement Team (2021)	ASSIST ME A model of staff support following patient safety incidents in healthcare	Non-compulsory	Recommended model and list of resources. Part of the national Open Disclosure programme
Israel			
Sigler-Harcavi, A. / Ministry of Health Quality and Patient Safety Executive Division (2020)	The third circle of victims, following a sentinel event - the ripple effect	Non-compulsory	Following the occurrence of a sentinel event, caring for the second and third circle of victims is an integral part of forward-facing risk management (p. 13)

Table 3 (continued)*Characteristics of the included records by country*

Country / Body	Report / Date	Policy status	Reference to psychological or emotional support for staff after PSI
Italy			
Ministry of Health Department of Quality (2011)	Linee guida per gestire e comunicare gli Eventi Avversi in sanità [Guidelines for managing and disclosing adverse events in healthcare]	Non-compulsory	Healthcare organisations should evaluate the psychological state of professionals involved in an adverse event with a view to providing appropriate psychological and personal support (p. 35)
New Zealand			
Health Quality & Safety Commission (2017)	National Adverse Events Reporting Policy	Requirement	All health and disability service providers obliged to comply and those who voluntarily agree to comply with this policy are expected to have processes to support staff involved in adverse events and subsequent review (p. 5)
Health Quality & Safety Commission (2017)	A guide to the National Adverse Events Reporting Policy	Non-compulsory	The Commission has provided a link to [the Irish] ASSIST ME guidance on how to support staff involved in an adverse event – on its website (p. 9)
Switzerland			
Vincent & Staines / Federal Office of Public Health (2019)	Enhancing the quality and safety of Swiss healthcare	Non- compulsory	That an evidence-based toolkit is developed to assist Swiss health care organisations in developing and implementing a systematic support programme, and that organisations financially invest in these support programs for both ethical and financial reasons (p. 185)

Table 3 (continued)*Characteristics of the included records by country*

Country / Body	Report / Date	Policy status	Reference to psychological or emotional support for staff after PSI
UK (England)			
NHS National Patient Safety Agency (2010)	Medical error. What to do if things go wrong: A guide for junior doctors	Non-compulsory	Being open involves ... providing support for those involved to cope with the physical and psychological consequences of what happened (p. 20) [It is not clear if this refers to patients alone or patients and staff]
NHS England (2015)	Serious Incident Framework: Supporting learning to prevent recurrence	Non- compulsory	Serious incidents can have a significant impact on staff who were involved or who may have witnessed the incident. Staff involved in the investigation process should have the opportunity to access professional advice from their relevant professional body or union, staff counselling services and occupational health services (p. 39)
Cumberlege / National Maternity Review (2016)	National Maternity Review: Better Births	Non-compulsory	When things go wrong, there should be a rapid investigation, support for staff involved (p. 50) Recognise the impact on staff and have appropriate support structures in place to support them to report adverse events and to deal with their own emotional reaction to the incident (p. 68)
Care Quality Commission (2016)	Briefing: Learning from serious incidents in NHS acute hospitals: A review of the quality of investigation reports	Non-compulsory	When an incident has serious consequences for a patient and their family it can also have a profound effect on the staff involved and the teams in which they work. While it is clearly a priority to manage the immediate needs of the patient and their family, it is also important to support members of staff who may be affected by the incident (p. 3)

Table 3 (continued)*Characteristics of the included records by country*

Country / Body	Report / Date	Policy status	Reference to psychological or emotional support for staff after PSI
NHS England (2018)	Towards commissioning for workplace compassion: Support guide	Non-compulsory	The term “second victim” is sometimes used to describe the impact on the workforce when harm occurs to patients in the receipt of healthcare services. The Point of Care Foundation publication <i>Behind Closed Doors</i> stresses that: “delivering high quality care is only possible if staff get the practical and emotional support they need... staff experience should be given equal priority to patient experience at all levels of the healthcare system (p. 11)
NHS (2018)	Workforce health and wellbeing framework	Non-compulsory	Risks to the mental health of staff are identified and managed, for example having an effective procedure in place to support staff following a traumatic incident (p. 47)
NHS Resolution (2019)	The Early Notification Scheme progress report: Collaboration and improved experience for families	Non-compulsory	It is imperative that action is taken to join up support services, and with NHS Trusts recognising and committing to their duty of care to staff. This is vital not only for an individual health professional’s wellbeing and ability to provide safe, empathic care but also for the state of the national workforce going forward (p. 33) Appendix II provides a list of supportive services for NHS staff provided by professional organisations, social media and charities, as well as those available to the public (p. 62)
NHS Health Education England (2019)	NHS staff and learners’ mental wellbeing commission	Non-compulsory	For staff that experience the emotional or psychological impact of a specific clinical incident, organisations should ensure access to debriefing and support in timely and confidential fashion (p. 83) NHS service managers should develop incident protocols for when staff are placed in a situation that would disproportionately impact on their wellbeing (p. 84)

Table 3 (continued)*Characteristics of the included records by country*

Country / Body	Report / Date	Policy status	Reference to psychological or emotional support for staff after PSI
NHS England and NHS Improvement (2019)	The NHS patient safety strategy	Non-compulsory	The new Patient Safety Response Framework sets expectations for informing, involving and supporting patients, families, carers and staff affected by patient safety incidents (p. 23)
NHS England (2019)	A practical guide for responding to concerns about medical practice	Non-compulsory	There is published literature about the risks posed to professional health and wellbeing by medical error – the so-called second victim phenomenon (Appendix D). Whilst the safety of patients is paramount, the duty of care to the professional is also important and in turn can have a bearing on safety in itself (p. 14)
NHS England & NHS Improvement (2020)	Patient safety incident response framework	Requirement	Requires providers of NHS-funded care to develop ... procedures to support staff affected by patient safety incidents (p. 23) Staff should be supported throughout the PSII [Patient Safety Incident Investigation] process because they too may have been traumatised by their involvement (p. 65)
Health & Safety Investigation Branch (2021)	National Learning Report: Support for staff following patient safety incidents	Non-compulsory	It would be beneficial for organisations to implement programmes to support staff following patient safety incidents (p. 8)
NICE (2022)	Mental health support at work	Non-compulsory	Recommendations 1.8.1 to 1.8.3: Employees in high-risk occupations [police / healthcare] are offered support after a traumatic event ... All high-risk occupations should already have policies and procedures in place on how to deal with predictable and stressful occupational events (p. 40) Risks to the mental health of staff are identified and managed, for example having an effective procedure in place to support staff following a traumatic incident (p. 47)

Table 3 (continued)*Characteristics of the included records by country*

Country / Body	Report / Date	Policy status	Reference to psychological or emotional support for staff after PSI
UK (Scotland)			
Healthcare Improvement Scotland (2015)	Being Open in NHS Scotland: Guidance on implementing the Being Open principles	Non-compulsory	Staff should feel supported through the adverse event review process because they too may have been traumatised by being involved (p. 6)
Healthcare Improvement Scotland (2019)	Learning from adverse events through reporting and review: A national framework for Scotland	Non-compulsory	This national framework is intended to provide an overarching approach developed from best practice to support care providers effectively manage adverse events (p. 6) The organisation should give early consideration to the provision of information and support to patients, service users, families, carers, and staff involved in the adverse event, including details on available support systems (p. 14) The support needs of staff involved in the adverse event must be considered and information leaflets should be provided (p. 27)
UK (Northern Ireland)			
Northern Ireland Department of Health (2017)	Quality strategy (q2020) steering group meeting	Non-compulsory	Statement by CMO: For generations, staff and second victims have not been supported well and it is a very important area of work

Table 3 (continued)*Characteristics of the included records by country*

Country / Body	Report / Date	Policy status	Reference to psychological or emotional support for staff after PSI
US			
Conway et al. / Institute for Healthcare Improvement (2010)	Respectful management of serious clinical adverse events	Non-compulsory	Is there ongoing support to the clinicians and team at the front line of the harm? Are they at risk of personal harm? When are they safely able to return to providing care? Appoint a trained staff member who staff involved in the event can contact 24 hours a day, 7 days a week. Offer support through Employee Assistance Programs, peer support groups, and other professionals (p. 12) Has the organization expressed empathy [to frontline staff] and been visible? (p. 21)
National Quality Forum (2010)	Safe practices for better healthcare – 2010 update: A consensus report	Non-compulsory	Safe Practice 8: Care of the Caregiver Following serious unintentional harm due to systems failures and/or errors that resulted from human performance failures, the involved caregivers (clinical providers, staff, and administrators) should receive timely and systematic care to include: treatment that is just, respect, compassion, supportive medical care (p. vii) Caregivers, staff, and administrators directly involved in serious unintentional harm as defined above must be considered patients requiring immediate and ongoing care (p. 25)

Table 3*Characteristics of the included records by country*

Country / Body	Report / Date	Policy status	Reference to psychological or emotional support for staff after PSI
The Joint Commission (2012)	Improving patient and worker safety: opportunities for synergy, collaboration, and innovation	Non-compulsory	Attending quickly to the emotional needs of health care professionals involved in events benefits their recovery and ability to return to optimum job performance (p. 118) Each organization will need to ensure that management of safety events reflects core organizational safety values by protecting patients and providers both medically and emotionally (p. 119)
Agency for Healthcare Research and Quality (2016)	Communication and optimal resolution (CANDOR) toolkit. Module 6: Care for the caregiver	Non-compulsory	Care for the caregiver programme implementation guide. Three tiers of support for the caregiver are set out: local/ department (reassurance); trained peer support (crisis intervention/debriefing); expedited external referral, including to psychologists (p. 1)
Perlo et al. / Institute for Healthcare Improvement (2017)	IHI framework for improving joy in work	Non-compulsory	(As part of psychological safety) “the organization provides full support for the staff involved in an adverse event (often referred to as the second victim)” (p. 17) “Offer one-on-one, group, and peer support for second victims of adverse events, particularly events involving harm” (p. 27)
The Joint Commission (2017)	Leadership standard LD.04.04.05, in Sentinel Event policy	Requirement	Leaders make support systems available for staff who have been involved in an adverse or sentinel event. Note: Support systems recognize that conscientious health care workers who are involved in sentinel events are themselves victims of the event and require support (p. 18)

Table 3*Characteristics of the included records by country*

Country / Body	Report / Date	Policy status	Reference to psychological or emotional support for staff after PSI
The Joint Commission (2018)	Quick Safety Issue 39: Supporting Second Victims	Non-compulsory	Provide guidance on how staff can support each other during an adverse event (ie how to offer immediate peer-to-peer emotional support or buddy programs). If the EAP is the sole source of support for second victims, consider creating supplemental programs after evaluating the EAP’s structure and performance (p. 2)
National Steering Committee for Patient Safety/ Institute for Healthcare Improvement (2020)	National action plan to advance patient safety	Non-compulsory	<p>Calls on US healthcare organisations to “identify, mitigate, and address system problems that contribute to physical, psychological, and emotional workforce harm ... and provide appropriate resources” (p. 18)</p> <p>Commit to workforce physical, psychological, and emotional safety and wellness, and full and equitable support of workers (p. 22)</p> <p>Identify solutions that address and mitigate the impact of traumatic events and crisis on the physical and mental health and well-being of the health care workforce (p. 28)</p>

2.8 Policy analysis methodology

The methodology selected to analyse the records identified is documentary analysis, set out by Shaw and colleagues (2004). There is little specific guidance available for analysing documents in the health policy field (Dalglish et al., 2020), but without offering a step-by-step method, Shaw et al. offer an approach that goes beyond accepting policy documents at face value, to include an interpretive element that aligns with qualitative research. This is important because policy documents do not necessarily provide researchers with facts relating to what organisations are currently doing (Atkinson & Coffey, 1997), and may be partial or superficial (Shaw et al., 2004). Shaw and colleagues observe that documents offer material for study even when the policy being studied is very new, or where there is limited evidence for change in practice. Rather than necessarily offering detailed prescriptions for required approaches, policy documents may illuminate aspirations and objectives for future action, and provide insights into ideas and values that national or international organisations wish publicly to espouse and promulgate, with the possible aim of testing the water of stakeholder opinion, or of influencing other bodies to take action. They may also simply be trying to appear supportive of a certain perspective, without requiring action.

The documentary analysis approach aims to identify what is overtly and explicitly conveyed on the surface of policy documents, and what agendas may lie beneath. There could be an overarching objective of the document requiring action by healthcare staff (for example open disclosure of errors) that appears to have a different emphasis to any included policy statement about emotional or psychological support for staff. It could also be the case that lack of precision in the way policy statements are articulated or defined is expressly designed to accommodate potential tensions between high-level policy statements and the specifics of implementation that is expected of healthcare organisations on the ground. The generality of high-level statements could also derive from a need to synthesise the views of different contributors, particularly in the case of international (multilateral) organisations, or from lack of legal or political locus to require change to be introduced in practice.

This analysis will thus explore what the existence of the identified policy documents in the international and national arenas contributes to the topic of psychological or emotional support for healthcare professionals following involvement in PSI. It will consider the status of the documents that have been identified, and whether they constitute non-compulsory recommendations, or binding requirements for member countries or organisations to adhere to, which has implications for the reach and impact of these policies in practice. The analysis will consider the primary remit of the policies, to assess whether their objectives are focused closely on the provision of support, or directed more widely to achieve other aims or agendas within the policy process (McConnell, 2018). The type of language used to persuade and influence, particularly within the non-compulsory documents, will also be considered.

2.8.1 Positionality

Chapter 1 included a statement about my professional background as a former UK Government policymaker, and this experience includes an awareness gained of national and international policy processes and of the relevance of the language used in policy formulation. This includes the resonance of certain words that may sound mandatory, such as “must” and “should”, but which may in fact only amount to recommendations. Working in the field of international trade gave me direct experience of and insight into the workings of multilateral organisations including the WHO, the OECD, and the EU, and the ways in which they seek to shape the policies of their member countries by seeking consensus and making policy statements, often without having the authority to impose requirements.

2.9 Documentary analysis

2.9.1 The nature and status of international policies

The international documents identified from the WHO, OECD, and EU all call for healthcare organisations to provide psychological or emotional support for their staff as part of worker safety, including following involvement in PSI, but without making it a requirement, nor setting out precisely how to implement the recommendations.

There are several important factors that lie behind the approach of recommending rather than requiring policy and practice changes. First among these is that international organisations need the agreement of all members to introduce policy requirements that

stipulate uniform practice standards or specific approaches. This is challenging in a sector where members are at different stages of economic development, as in the WHO, and may have differing approaches to the delivery of healthcare and to staff support within their systems, as in the OECD and EU. This leads to policy statements and recommendations, with which member countries are not obliged to comply, rather than the setting of mandatory requirements about procedures.

2.9.2 Interpretation of international policy agendas

The “soft norms” produced in the form of non-compulsory recommendations by international bodies (Gostin et al., 2015) are nonetheless potentially influential at the national level, because they can focus attention on issues, highlight best practice, shape priorities, recommend change, and eventually be incorporated into national regulation or guidelines. Changes may, however, take many years, and the agendas lying behind recommending support for healthcare workers involved in PSI are several.

The connection that has been made explicit between patient safety and healthcare staff wellbeing (for example, West & Coia, 2019; IHI, 2020; Maben, 2013; NHS, 2019; Torijano et al., 2021) means that the promotion of worker safety forms part of improving safety and quality of care for patients, which is a primary focus for international bodies in the healthcare field. The WHO argues that “the health, safety and well-being of health workers is a legal and moral responsibility of governments” (WHO, 2020a, p. 2), and it calls for the establishment of “synergies between health worker safety and patient safety policies and strategies” (p. 3). In the WHO’s Global Patient Safety Action Plan (WHO, 2021) they set a strategic objective to engage and empower patients and families to help achieve safer health care (p. 42), and it is within this objective that they include a recommendation for healthcare facilities and services to “ensure that patients, families and health workers are given ongoing psychological and other support in the aftermath of a serious patient safety incident” (p. 45). Situating this staff support as a subset of engaging and empowering patients and families suggests either that support for staff after PSI was considered a lower priority that did not warrant its own objective, or that there was sensitivity among member countries about according it individual strategic status.

Improved occupational safety has benefits for organisations if fewer PSI occur as a consequence, in terms of cost savings and reputational enhancement (ISO, 2021). The latter is particularly relevant in systems where patients can choose their healthcare provider. Where staff can continue working safely in their posts following incidents, this may lead to improved staff morale, staff retention and decreased turnover (Burlison et al., 2017; Moran et al., 2020).

The WHO's calls for healthcare worker support following PSI, identified in the records in Table 2 (WHO 2008; 2010c; 2020a; 2020c; 2021), were issued in the context of its role in advocating for improving health and safety for health workers, and encouraging countries to develop and implement their own national occupational health programmes for healthcare staff. The WHO has stated that "protection of the health and safety of health workers should be part of the core business of the health sector" (WHO, 2022, p. 7). However, this recent report (entitled *Caring For Those Who Care*), while calling for the "organization and provision, as appropriate, of services for mental health and psychosocial support and follow-up, and support to victims of workplace violence and harassment" (p. 29, italics mine), contains no references to support for staff following PSI. This suggests that support for staff after PSI has been moved down the policy priorities since the publication of the earlier documents.

The OECD's stated role is to shape policies that foster prosperity, equality, opportunity, and wellbeing, by presenting economic arguments, evidence, and best practice for policy and practice change, rather than by regulating to achieve such changes. OECD recommendations represent a political commitment to the principles they contain and entail an expectation that member countries will do their best to implement them, but they are not mandatory or otherwise binding. One OECD document (De Bienassis et al., 2021) contains a recommendation that the health workforce be supported through concrete policy actions and appropriate resources, including access to psychological support. A key factor to note about this document is that it was authored by the Secretariat, and not by member states. OECD working papers always carry a careful disclaimer that the views expressed within them are those of the authors and "should not be reported as representing the official views of the OECD or of its member countries" (De Bienassis et al., 2021, p. 3), although they are nonetheless expressly authorised for publication by the relevant OECD directorate. A second document, reporting a Patient Safety Global Ministerial Summit (OECD, 2018), describes how

some member countries make efforts to provide emotional support to staff involved in adverse events, without offering any comment on or value judgements about this practice. This neutral, descriptive approach can be understood as an attempt to influence and shape the policies of the member countries, without having the locus to require such developments, while needing to be mindful of the sensitivities of members who are not following this type of approach for economic or policy reasons.

The single relevant European Union report identified (European Union Expert Group on Health System Performance Assessment, 2020) refers to psychological support for healthcare staff as part of emergency care services' crisis management systems, and recommends that member states "evaluate the capacity to provide adequate psychological support to patients and staff in the event of a crisis" (p. 26). This is a very tentative proposal, in one specialist area of healthcare service provision. As with the WHO and OECD records, this document identifies needs and signals possible ways forward, but it does not go beyond urging action to evaluate capacity for support provision (for patients as well as staff). This is in part because the organisation's remit at the working level is advisory, and does not permit setting requirements. It is also likely that member state representatives declined to agree jointly to a stronger commitment.

Within the international policies that make mention of psychological or emotional support for staff following PSI, there appears to be an overarching consensus about the importance of this issue. However, these international policy statements constitute recommendations and proposals that cannot require, and have not achieved the introduction of national policies across their member countries. They also link any development of staff support to improvements in services for patients, and it is unclear whether the staff support element is considered a priority. The documents have thus not yet resulted in widespread development of policy that requires the implementation of staff emotional or psychological support in practice within national healthcare systems, although it is possible that they have served and will serve in the future as encouragement for some member countries and national organisations to do this.

[2.9.3 The nature and status of national policies](#)

The national policy documents that have been found to exist in this arena fall, with one exception (Healthcare Safety Investigation Branch, 2021b), under the umbrella context

of patient safety more broadly, and form part of other policies about approaches to the management of PSI, including adverse event reporting requirements, and open disclosure of incidents. The link between improving patient safety and supporting staff after PSI is firmly and explicitly made. It is not clear if referring to support for staff within broader policy aims is intended to raise the priority placed on staff support, or as a sweetener to encourage staff adherence to other policies that assist organisations in their monitoring of PSI and improving care quality.

The majority of the 42 national policies identified constitute guidance or recommendations, not requirements, about support for staff following PSI. There are two healthcare systems that have referred in national policies to a requirement or an expectation of compliance placed on the healthcare organisations within their oversight, and one standards accreditation body that sets a requirement for its members. The New Zealand Health Quality & Safety Commission's National Adverse Event Reporting Policy (2017) contains an expectation that organisations will have processes in place to support staff involved in adverse events and subsequent review. However, there is no detail about what the processes must involve, and it is not clear what the consequences might be for not complying. The NHS England's Patient Safety Incident Response Framework (NHS England and NHS Improvement, 2020) "requires providers of NHS-funded care to develop ... procedures to support staff affected by patient safety incidents" (p. 23), but without specifying approaches:

For staff to be appropriately supported, all organisations must have systems and structures that ensure managers and wider staff ... understand the potential impact of patient safety incidents on staff; can recognise and help to manage the signs and symptoms of stress (including those associated with post-traumatic stress disorder) in themselves and colleagues; have access to support following patient safety incidents. (pp. 36-37)

The third policy that constitutes a requirement is The Joint Commission's Leadership Standard LD.04.04.05 that forms part of the Sentinel Event policy (The Joint Commission (2017), applicable to those US healthcare organisations and facilities accredited by the Commission. This potentially covers all of the US, but healthcare organisations can voluntarily pursue accreditation; it is not an obligation. The policy, which is about how to manage incidents requires that: "Leaders make support systems

available for staff who have been involved in an adverse or sentinel event” (p. 18). There is no detail about what this support would entail, although the Standard mentions “the human resources function or an employee assistance program” (p. 18). Similar to the PSIRF, the nature of this requirement is thus imprecise, and the type of support is left to organisations to decide.

All of the other 39 policies about support for staff after PSI are framed as recommendations or guidance that urge healthcare organisations to take action. Some include toolkits, templates, or ideas for support provision, but many simply make calls for support provision without specifying how, and there is a degree of vagueness in the detail. The Joint Commission’s Quick Safety Issue 39: Supporting Second Victims, includes “Safety actions to consider” (The Joint Commission, 2018, p. 2), for use if organisations decide to implement a support programme. The suggestions mention peer support or “professional resources for external intervention to ensure that the unique needs of each clinician are met” (p. 3), but there is no set model proposed. In its National Action Plan to Advance Patient Safety, the Institute for Healthcare Improvement (2020) calls on US healthcare organisations to “identify, mitigate, and address system problems that contribute to physical, psychological, and emotional workforce harm ... and provide appropriate resources” (p. 18), again without specifying how. This generality within the policy recommendations certainly affords organisations the opportunity to individualise support and to identify the needs of the workforce in an autonomous way, but it also leaves scope for inaction.

There is some cross-referencing of policy documents, as a way of providing suggestions for possible approaches, which may also serve as a way of not requiring a specific template of support. Within its section on support for staff after incidents, the Patient Safety Incident Response Framework (NHS England & NHS Improvement, 2020), which does set a requirement for staff support after PSI across England, signposts a midwifery supervision model named A-EQUIP (“Advocating for education and quality improvement”). The name of this model suggests that it is aimed at improving midwifery practice, and an exploration of its contents reveals that it describes a continuous improvement process for midwives to build their own personal and professional resilience, and improve the quality of patient care. It is not in any respect about offering support to staff after PSI, and it is unclear why organisations would be directed to consider this model to underpin staff emotional and psychological support,

unless support is being conflated with the idea of expectations on staff to be resilient and cope on their own.

The Irish ASSIST ME model of staff support (HSE Quality and Patient Safety Directorate, 2013) is also cross-referenced in the Patient Safety Incident Response Framework (NHS England & NHS Improvement, 2020) as a potential approach to follow. The Irish model is more relevant to emotional and psychological support for staff after PSI. It acknowledges the impact on staff from near misses through to major incidents, and observes that any level of incident could cause “traumatic stress” (HSE Quality and Patient Safety Directorate, 2013, p. 1). The framework, updated in 2021 (HSE National Quality Improvement Team, 2021), emphasises the importance of line managers and colleagues communicating supportively with staff involved in an adverse event. However, some of its elements are imprecise: it suggests prompt debriefing for the individual or team, but it is not clear if this means clinical or emotional debriefing. It advises provision of a designated support contact, and information on the existing emotional and practical support available via the existing Occupational Health department or Employee Assistance Programme, which may not have the capacity or expertise to offer emotional or psychological support after PSI (Klatt et al., 2021). While it makes some general suggestions, this policy is more about recommending empathic communication and offering information and signposting, rather than establishing a precise support pathway to targeted resources.

The one policy document that is entirely focused on staff support after PSI (HSIB, 2021b) is based on a review of the literature and primary research. It makes recommendations, termed “safety observations”, and offers detailed proposals for organisations to consider. Acknowledging that there has been limited evaluation to date of the impact of existing staff support programmes, the report nonetheless states that “all authors, interviewees and case study leads agreed with the need to implement support programmes for staff following patient safety incidents” (p. 39), and it extends this argument beyond the usual HSIB remit of national PSI investigations. The policy document strongly advocates for support to be framed in precise, context- and delivery-focused ways that meet the identified needs of staff within their organisations, and that provide “equitable access to support for those who need it” (p.43). The document provides recommendations about the importance of creating multiple options and avenues for support, including “internal and external, formal and informal”, identifying

“high-risk groups and situations”, and providing “proactive support” (p. 43). However, the HSIB has no powers to require healthcare organisations to support their staff, and its proposals are advisory.

2.9.4 Interpretation of national policy agendas

The developments in policies that either recommend or require staff psychological or emotional support after PSI, apart from the recent HSIB report (2021b), are grounded in agendas that aim to bolster patient safety and quality of healthcare, rather than focusing on staff support per se. The Canadian Patient Safety Institute’s report about addressing the psychological safety of healthcare workers (2019) is introduced within the context that “Patient safety incidents are the third highest cause of deaths in Canada” (p. 7). The Joint Commission (2012) argues that health systems aiming to reduce patient harm must seek to improve both patient and worker safety. The Irish ASSIST ME model of staff support was adapted from the Medical Protection Society’s framework for helping staff to communicate about adverse healthcare events with patients and families, in order to manage complaints more effectively, which indicates the origin and dual agenda of this policy. Other national policies focus principally on encouraging the reporting and disclosure of adverse events (Australia’s Commission on Safety and Quality in Health Care, 2020; France’s Haute Autorité de Santé, 2011); care quality improvement and risk management (Belgium’s Platform for Continuous Improvement of Quality of Care and Patient Safety, 2021; Israeli Ministry of Health Quality and Patient Safety Executive Division, 2020); incident management processes (HSE Ireland National Quality Improvement Team, 2018); and maintaining capacity in the healthcare system (German Coalition for Patient Safety, 2020).

For the NHS, the stated agenda behind the recent requirement to provide support to staff after PSI arises from an understanding that “the wellbeing of staff involved is often overlooked but can leave staff lacking confidence, unable to perform their job, requiring time off or leaving their profession” (NHS England and NHS Improvement, 2020, p. 78), thus focusing on the risks to the organisation of inadequate performance, and staff sickness absence or turnover. There is also express acknowledgement of an intention to enhance patient experience: “There is existing evidence on the importance and effectiveness of support programmes for such staff and their potential to counter the

negative impact outlined above to result in more positive impact for staff and patients alike” (p. 78).

It is evident that publishing recommendations or developing guidelines on the approach to take after PSI, including recommendations for supporting staff negatively affected by their involvement, does not necessarily mean they will be utilised, implemented, or accessible in practice (Edrees & Wu, 2017; Harrison et al, 2015; Mira et al., 2020; Van Gerven et al., 2014), either uniformly or at all. There seems a marked dislocation between policies that set out an awareness of the impact of PSI and acknowledge a need for staff support, and any robust willingness to require organisations to take specific action to institute support for staff. The ongoing calls for access to emotional or psychological support suggest that general recommendations and guidelines without precision or binding effect have been insufficient to bring about the widespread implementation of provision. It is clearly not simply that such recommendations have only recently been made and have not had time to follow through into practice, although this may be relevant for more recent policy statements. The Italian Guidelines for managing and disclosing adverse events in healthcare (Ministry of Health, 2011) were published over a decade ago, and yet there remains concern that Italian healthcare professionals are still experiencing negative consequences after PSI, without access to emotional or psychological support (Rinaldi et al., 2016). Moreover, the policies that do exist fail to stipulate where precisely accountability for implementation lies within organisations, and where exactly to focus the responsibility for ensuring support provision. Much of the detail is left entirely to healthcare organisations at the service facility level to establish, which may mean it does not happen, as the evidence still suggests.

The HSIB policy document (HSIB, 2021b) aims to identify specific ways in which support should be provided, and argues that organisations need to go beyond a tick-box exercise of simply stating that support is available, such as having a helpline that is not used, or through merely signposting external resources such as an Employee Assistance Programme. This is a stance that is obliquely critical of general calls to make staff support available, and it is possible that this evidenced policy may serve to influence NHS England or healthcare provider organisations over time. While the absence or vagueness of policies about support does not preclude organisations from instituting their own arrangements (Akkermans & Laarman, 2016; Laarman et al., 2019), the lack

of precise, directive, and transparent requirements, means that for those healthcare professionals negatively affected by involvement in PSI, consistent and beneficial emotional and psychological support may not become available or accessible in practice, even in countries where such support is reported to be expected or required by the relevant authorities.

2.9.5 The language of persuasion and influence

The language used in many of these policy documents contains strongly worded terms such as “must” or “should” (Belgian Platform for Continuous Improvement of Quality of Care and Patient Safety, 2021; France’s Haute Autorité de Santé, 2011; Healthcare Improvement Scotland, 2019; HSE Ireland National Quality Improvement Team, 2018; National Quality Forum, 2010). This language suggests a high degree of intention to influence and persuade, but without always having the underpinning powers to require implementation.

Within UK policy development, the words “must” and “should” represent firm exhortations, but they do not carry the legal force of an explicitly mandated requirement. The NHS England’s Patient Safety Incident Response Framework (NHS England and NHS Improvement, 2020) contains the first use of the words “must” and “requires” in an NHS document about staff support. However, it is not clear exactly what the nature of the requirement is, or when it will officially be in force. This framework is still in the process of being trialled with some NHS Trusts and Clinical Commissioning Groups¹¹ and has not been implemented in the envisaged timeframe nor rolled out to all healthcare organisations. It is not known if this is because of the COVID-19 pandemic or for other operational or policy reasons. Moreover, the framework does not set out any specific template for support provision, and simply signposts some information and resources for organisations to consult and consider. There is no specific reference to how provision will be ensured or monitored, nor to any sanctions for non-compliance. This means that even the inclusion of a formal requirement may leave room for limited or no support in practice.

¹¹ A Clinical Commissioning Group is a group of general practices in one area which come together to commission health services for their patients, including hospital and community care services.

2.10 Chapter summary

Policies have been identified at the international level, and at the national level in a small number of countries, mostly recommending rather than requiring access to psychological or emotional support for healthcare professionals involved in PSI. The few policies that do set an expectation or requirement of such support do not specify how this should be achieved, nor precisely by whom, nor how the availability of provision will be monitored or ensured. The context for all but one of the policies is the overarching policy aim of promoting improvements in patient safety and quality of healthcare, and they are in many cases linked expressly to the management of PSI that includes open disclosure of incidents and support for patients. In other words, support for staff is an adjunct to different policy targets and priorities, principally intended to benefit patients and organisations, not the involved professionals.

Links between patient safety and the psychological wellbeing of healthcare workers are increasingly being made explicit in international and national policy reports, which creates the impression that emotional and psychological support for staff is considered important. However, the lack of widespread and consistent availability of support policies at the national healthcare system level, and the apparent lack of specific and binding requirements on healthcare organisations, together indicate that this linkage is not universally accepted or remains theoretical and vague.

Two international and ten national policies identified include the term “second victim” to describe the staff negatively impacted by their involvement in a PSI, but some of the most recent policy documents choose not to use this terminology. Much of the large body of research that calls for emotional or psychological support for staff after PSI also uses this term, and the next chapter of this thesis will explore the origin and evolution of the “second victim” concept, views that have been expressed about it, and its contribution to and place in this field.

CHAPTER 3: THE “SECOND VICTIM” IN HEALTHCARE: A CONCEPT ANALYSIS

3.1 [Introduction to the chapter](#)

It is known that healthcare staff can be negatively affected, sometimes gravely, following their involvement in incidents where patient safety has been compromised, or where patient harm has almost occurred, known as a near miss. There is an extensive evidence base describing how the psychological and emotional effects can be long lasting (Vanhaecht et al., 2019) and have considerable professional and personal impact. The term “second victim” was coined by a clinician to describe healthcare professionals who are negatively affected after making an unintended medical error. Patients were acknowledged to be “the first and obvious victims” of medical mistakes, but a second layer of negative impact was identified: “Doctors are wounded by the same errors: they are the second victims” (Wu, 2000, p. 726). The aim was to highlight that the staff involved, including “nurses, pharmacists, and other members of the healthcare team are also susceptible to error and vulnerable to its fallout” (p. 727) and needed emotional support. However, it was not the norm for emotionally and psychologically affected staff to receive the sympathy Wu believed they needed.

This chapter will explore the context within which the “second victim” concept was introduced. It will outline the concept analysis methodology selected, undertake a systematic search of records, and explore the concept’s development from its inception in 2000 to its later definition and elaboration by a group of experts (Scott et al., 2009). The broadening of the concept’s coverage over time with regard to different staff experiences, and the groups of personnel included will be illuminated, clarifying what “second victim” now captures and describes, 20 years on. The chapter will also explore the views that have been expressed about use of the term, and will analyse the implications of the controversy that has arisen.

3.2 [Rationale for investigating the second victim concept](#)

The “second victim” concept, which was intended to be supportive of healthcare staff, has divided opinion, been criticised, and caused controversy. These doubts encompass its validity as a construct (Harrison, Lawton, et al., 2015), its breadth of coverage, and its potential insensitivity to patients who have been harmed or to their families, when used as a label for distressed staff (Clarkson et al., 2019). As highlighted in the

Introduction to this thesis, “second victim” is now used to describe the impact on healthcare staff of work-related incidents from a wide range of scenarios. These include the original idea of staff experiencing negative feelings following unintended medical error, but it has since been extended to cover a broad range of distressing work-related events, including patient injury or death without any mistakes in care, or violence to staff from patients and their families. This means that “second victim” suggests a distressing work-related experience that may or may not include fault on the part of the healthcare professional, and is also used as a term to label affected individuals.

The controversy that surrounds the term’s broad use and potential insensitivity is explored further in section 3.8.4 below. Notwithstanding its detractors, the term has continued to be used over two decades in many research studies that evidence the potentially negative impact of patient safety incidents (PSI) on healthcare professionals, and in calls for emotional support to be provided to affected staff. The question for this analysis to explore is what the concept of the “second victim” now encompasses and describes, whether it is sufficiently clear, and whether there is perceived value or purpose in its ongoing use.

3.3 Context: Concern about safety in healthcare

The term “second victim” was introduced at a time of growing concern about the prevalence of clinical incidents resulting in harm to patients, and the need to improve the quality and safety of healthcare. A report by the US Institute of Medicine highlighting the extent of medical mistakes stated starkly that “Preventable medical errors in hospitals exceed attributable deaths to such feared threats as motor-vehicle wrecks, breast cancer, and AIDS” (Kohn et al., 2000, p. 1). The authors noted that blaming individual professionals, which was the prevailing approach in healthcare organisations, did little to make the system safer and prevent someone else from committing the same error. In the last 20 years, medical mistakes and other PSI have continued to occur in high numbers, and improving healthcare quality and patient safety is still of vital concern, as outlined in the Introduction to this thesis.

Given the frequency of medical errors, many healthcare professionals are likely to experience being involved in unintended PSI during their careers, and thus risk experiencing negative psychological and professional consequences. This raises the question of whether healthcare organisations should aim to address the negative effects

on staff, and to support them to recover from the impacts they experience, partly to enable them to care safely for subsequent patients. Since having processes and systems of staff support require high-level organisational decisions and resource allocation, it further prompts investigation into whether and how affected professionals are identified, and whether the terminology of “second victim” is both clear and appropriate.

As a prelude to seeking the views of NHS England healthcare managers, supervisors, and policymakers about the term “second victim”, it was important to clarify the evolution of the concept over time to its current usage. The concept is still widely used in research studies, but the analysis of policies in Chapter 2 identified that the concept is included in some policy documents only. This chapter will investigate why some commentators and researchers now choose not to refer to “second victims”, and what this means for the concept’s contribution to this research field.

3.4 Concept analysis method

The Walker and Avant (2011) eight-step concept analysis methodology was used to examine the “second victim” concept within healthcare. The steps are depicted in Figure 2, and were followed in order. Once the concept has been selected, the steps involve explaining the aim and purpose of the analysis, identifying all uses of the concept, and establishing its defining attributes. Exemplar cases are created, which for Walker and Avant can be fictitious, to illustrate the concept (a “model case”), a related concept that has some overlapping characteristics (a “borderline case”), and a “contrary case” that does not share the attributes of the concept under investigation. In this analysis, the anonymised cases were taken from case studies or other empirical evidence described in the research literature. The antecedents and consequences (what happens before and after an occurrence of the concept) and any established measurement tools, termed “empirical referents” are also identified within the methodology, to provide a complete picture of contemporary use.

The Walker and Avant approach was selected because it was developed specifically for use in healthcare, comprises clear elements, including a formal, systematic search of the literature, and aims to clarify how concepts are interpreted and how they have changed over time, which is relevant for a concept that is over 20 years old. An adaptation of this methodology (Rodgers, 1989; 1991), was considered but not adopted,

because it invites researchers to select the sources they prefer, and then employs a random selection process for the included records, which could result in key uses of the concept being omitted (Penrod and Hupcey, 2005).

The search was originally undertaken in September 2019 and updated in February 2021. In consultation with a subject specialist librarian, four databases were selected for the search: MEDLINE Complete, CINAHL, PsycINFO, and EMBASE, using the term “second* victim*” in the title, OR abstract, OR full text, including citation only, from the inception of the databases; no further date restriction was applied. The inclusion of citation only records was to capture relevant records where the specific term was not explicitly used in the title, abstract or main body of the text, and yet the article’s content was about the same topic of healthcare professionals experiencing distress after involvement in PSI. Truncation was used to capture linguistic variations, such as “secondary victimisation”.

The findings of the search are recorded in section 3.6 and Table 4, and the eight concept analysis steps are described in Figure 2 below.

Figure 2

Steps for Undertaking a Concept Analysis (Walker and Avant, 2011)

- | |
|--|
| <ol style="list-style-type: none">1 Select a concept2 Determine the aim and purpose of the analysis3 Identify all uses of the concept4 Determine the defining attributes of the concept5 Construct a model case6 Construct borderline and contrary cases7 Identify antecedents and consequences8 Define the empirical referents |
|--|

[3.4.1 Quality assessment](#)

Walker and Avant do not include explicit reference to quality criteria for including or excluding records in the analysis, because the aim is to identify all uses of the selected

concept, including in articles, letters, and commentary that are not necessarily primary research and may not have an epistemological or methodological basis. The inclusion criteria are specified in section 3.6.2; they seek to capture the ways in which the “second victim” concept has been employed since its inception, with included records explicitly or implicitly offering different meanings and interpretations. Extensions and critiques of the concept’s use are also identified.

The goal of concept analysis is to establish the state of the science surrounding the chosen concept, and to identify the concept’s strengths and limitations (Penrod and Hupcey, 2005). It aims to illuminate how the concept is used, and whether it represents a robust and clearly delineated idea. The analysis thus evaluates the clarity and usefulness of the concept, and Morse et al. (1996) propose a set of four principles against which a concept should be assessed. These comprise that the concept should be clearly defined and well differentiated from other concepts; coherently and systematically related to other concepts; “applicable to the world” and operationalised; and appropriate to its use in context (p. 257). These principles were used as a guiding framework to assess the quality of the concept itself within this analysis.

3.5 Concept selection and aim

The selected concept is “second victim” and is a description of healthcare workers involved in the provision of medical treatment to patients, in formal healthcare settings in primary care, hospitals, community nursing, and ambulance services, where a PSI or near miss has occurred, and the staff are negatively affected. It is also used as a compound adjective to highlight a characteristic of the impact or outcome, such as “second victim experience”. There is an extensive body of literature about “second victims” and their experiences that use or cite the term, including reviews of the literature, empirical studies, and many editorial articles and commentaries. Preliminary reading revealed that the “second victim” concept was used in various and sometimes unclear ways in the literature, covering multiple situations. It was found to overlap or be used interchangeably with the concepts of vicarious traumatisation (Hartley, 2018), secondary traumatic stress (Kruper et al., 2021), and moral injury (Stovall et al. 2020), although these concepts only share some of the same elements. The “second victim” concept has not been systematically explored, and no comprehensive evaluation of its uses, attributes, or the consensus definition (Scott et al., 2009) has been identified.

The idea of healthcare professionals experiencing negative emotional impact from involvement in PSI predates use of the term “second victim” (Dornette & Orth, 1956; Hilfiker, 1984; Johnson & Kirby, 1954; Newman, 1991; Zeidenstein, 1995). The objective of this analysis is to explicate the meaning of “second victim”, exploring the linguistic connotations, identifying the ways in which the concept is understood and used, and to use sample cases from existing research to define its core attributes and distinguish it from other concepts with which it is at times confounded. The analysis will aim to clarify what the “second victim” concept describes and contributes.

3.6 Findings

3.6.1 Linguistic connotations

Merriam-Webster Online, Merriam-Webster Medical, and Cambridge online dictionaries were searched with the aim of identifying available definitions of the term “second victim”, but none were found. Merriam-Webster’s online dictionary was then consulted to consider the linguistic connotations of the concept’s elements:

Second: number two in a series; next to the first in place or time; next to the first in value, excellence, or degree; inferior, subordinate; next after the first in rank, position, authority, or precedence.

Victim: one that is acted on and usually adversely affected by a force or agent; one that is injured, destroyed, or sacrificed under any of various conditions; one that is subjected to oppression, hardship, or mistreatment.

The language components of the “second victim” concept evoke an impression of individuals suffering as a consequence of their involvement in a distressing event or situation, with the “victim” element suggesting that those affected had no control over the experience, although this may not be the case if the individual made an avoidable error. The implications are that the concept describes psychological or emotional injury to a healthcare worker, following involvement in harm being caused or nearly caused, unintentionally, to his or her patient. The word “second” may also suggest that the harm to the worker is not only chronologically second, but also of second order importance as compared to that suffered by the patient. This may also be inaccurate, because in a near miss there may be no effect on the patient, and yet considerable distress experienced by the professional. Linguistically, therefore, the concept is not a wholly accurate or comprehensive descriptor of all possible scenarios it is used to capture.

3.6.2 Uses of the concept

A total of 1467 records were originally retrieved from the database search in 2019, including 24 literature reviews and 94 studies; this increased to 1954 records in the 2021 updated search, using the same criteria (see section 3.4), and included 46 literature reviews and 180 studies, demonstrating the extensive ongoing interest in the “second victim” topic, and in use of the term. A hand search of citations and an online search of grey literature was also undertaken, including publications by the World Health Organization (WHO), UK NHS bodies, and the US Institute of Medicine (since 2015 called the National Academy of Medicine), National Quality Forum (NQF), and The Joint Commission, using the “second victim” term applied to healthcare professionals involved in PSI. Research studies, literature reviews, editorial comment, articles and letters in professional healthcare and academic journals, and policy documents using the term were all considered. The WHO website search resulted in the retrieval of one record, in a Patients for Patient Safety newsletter (WHO, 2016). This newsletter reported on conference proceedings where physician wellbeing was linked to patient safety and quality of care, referring to medical practitioners who had been psychologically harmed as “second victims”, but without offering a definition. In total, this part of the search yielded 312 potentially relevant records.

In the updated search, following the removal of duplicates in Endnote ($n = 539$), 1727 records remained. The titles and abstracts of all records were reviewed, and where the setting, context, or focus was not clear, the full text was reviewed. The terms second victim, secondary victim, and secondary victimisation were found to be used in cases of abuse, assault, witnessing non-medical disasters, bullying, criminal injury or liability cases, and in data processing and storage. These records ($n = 886$) were excluded. The total number of relevant records identified in this database search, using the “second victim” term to refer to healthcare staff being involved in a PSI in their healthcare workplace, was 841, all of which were reviewed in full text to establish their use of or comment on the concept, and to identify any changes and developments in the defining attributes.

The following inclusion criteria were applied:

- published in English, French, or Spanish, **and**

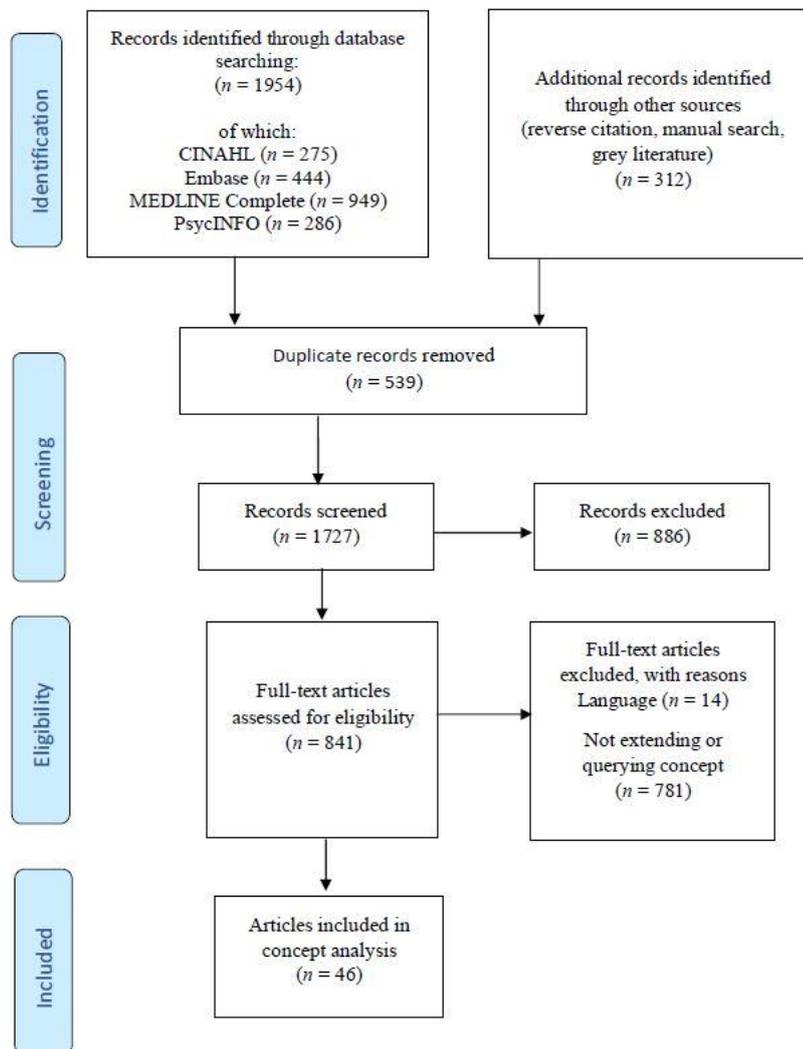
- uses the term “second victim” or related linguistic variations (eg secondary victim, second victimhood, second victimness, secondary victimisation), **and**
- relates to any healthcare worker experiencing distress after a PSI or near miss occurring in a healthcare workplace, **and**
- includes a novel or expanded definition, description, application, refinement of, or query about the concept “second victim” within healthcare, or discusses the concept of “second victim”, its definition, coverage, or the appropriateness of the term.

Figure 3 sets out the process of the updated literature search and record selection.

The identified literature is included in Table 4 in chronological order, to illustrate the development of the “second victim” concept, its coverage, and the views offered about its clarity and appropriateness. The 46 included records either refine, extend, or question use of the concept. Nineteen of the records comment on its appropriateness, and 11 of the 19 constitute a selection from one body of correspondence between patients’ relatives, clinicians, risk managers, and researchers, sparked by an explicit call to abandon the term “second victim” (Clarkson et al., 2019). Nine of the selected responses to Clarkson present arguments in favour of the second victim term, with one against. All 11 of these short records offer a different point about the term. The responses to Clarkson that were not included (n = 7) make very similar points, in agreement with Clarkson, about the term not being appropriate or helpful for healthcare professionals.

Figure 3

Flow chart of literature search and selection process



Note. Adapted from: Moher et al. (2009). Preferred reporting items for systematic reviews and meta-analyses

Table 4*Characteristics of the included records, in chronological order*

Authors	Year	Country	Article type	Healthcare profession / Sample	Contribution [SV = second victim]
Wu	2000	USA	Editorial	Focus on physicians. Brief mention of pharmacists, nurses, and other members of the healthcare team	Original SV description. Focus on serious medical error. Patient is the first victim. Idea of SV being wounded by their mistake and the fallout and needing but lacking emotional support. Raises issues of error disclosure
Denham	2007	USA	Interview	7 national patient safety and quality experts / leaders	Introduced the five rights of caregivers involved in unintentional patient harm: TRUST (Treatment that is just, Respect, Understanding and compassion, Supportive Care, and Transparency and the opportunity to contribute to learning). Extends coverage to caregivers and staff. Introduces concept of psychological harm caused to SV
Scott et al.	2009	USA	Qualitative study	10 physicians 11 registered nurses 10 other health professionals	Includes a “consensus definition” of SV, covering all healthcare providers and extending beyond medical error to all unanticipated patient injury. Victimised is explained to mean traumatised
Scott et al.	2010	USA	Survey	898 healthcare workers: nurses, physicians, medical students, allied health professionals	Quantifies frequency and nature of the SV experience and desired characteristics of institutional support. Clarifies the term healthcare provider to include support personnel, students, and volunteers

Table 4 (continued)

Characteristics of the included records, in chronological order

Authors	Year	Country	Article type	Healthcare profession / Sample	Contribution [SV = second victim]
US National Quality Forum (NQF)	2010	USA	Safe Practices for Better Healthcare, Safe Practice Guideline 8: Care of the caregiver	Caregivers	Definition of caregivers extended to include administrators. Defines involvement in an adverse event as either direct or indirect. Adds near miss. Adds that harm to SV may be experienced immediately or later
Wachter	2011	USA	Interview with Prof. Wu	Healthcare workers	Idea of two possible sources of trauma for the SV: self-criticism (internal) and organisational blame (external). Potential organisational victimisation
Clancy	2012	USA	Commentary	N/A	Introduces concept of “SV syndrome”
Dekker	2013	USA	Book: Second Victims	Various professions, including healthcare	Describes lived experience of SVs, responses to their errors, relationship to patient safety. Concludes that alternative labels do not work as well as SV
Davidson et al.	2015	USA	Scenario-based case studies of blame in healthcare workplaces	3 case studies: 2 nurses, 1 physician	Concludes that distinctions between moral distress, blame-related distress, and SV syndrome are unclear
Harrison et al.	2015	UK and USA	Cross-country survey	120 physicians 145 nurses	UK and US nurses reported stronger negative feelings after an error than physicians. Notes there is no agreement about the construct of SV on which to base construct validity

Table 4 (continued)*Characteristics of the included records, in chronological order*

Authors	Year	Country	Article type	Healthcare profession / Sample	Contribution [SV = second victim]
Krzan et al.	2015	USA	Surveys pre and post SV support programme implementation	121 pharmacy dept staff	Suggests broader antecedents for becoming an SV: experience of multiple physical trauma cases with negative outcomes; being assigned to care for a violent patient or family; or after caring for a patient who was a victim of abuse
Lewis et al.	2015	USA	Cross-sectional survey	218 registered nurses (RN)	Being involved in a preventable adverse event may lead to RN burnout if there is no colleague support. Conceptualisation of SV is said to be vague, hampering study of the effectiveness of SV interventions
NHS England	2015a	UK	Medical Patient Safety Expert Group, Meeting notes	N/A	Reports the UK charity Action Against Medical Accidents (AVMA) had fully considered the SV term but found it unacceptable
Pratt & Jachna	2015	USA	Personal experience of being an SV / Literature review	Focus on anaesthetists	Caregiver recovery time after adverse events varies from weeks to indefinitely. Notes no specific clinical criteria for SV; broad array of clinical presentations for this syndrome
Pellino & Pellino	2015	Italy	Literature review	Focus on surgery	SV concept is linked to defensive medicine and clinical judicial syndrome, which may be consequences of PSI involvement
Quillivan et al.	2016	USA	Cross-sectional survey	178 nurses	Patient safety culture is a possible antecedent to becoming an SV. Supportive patient safety cultures may reduce SV-related psychological trauma

Table 4 (continued)

Characteristics of the included records, in chronological order

Authors	Year	Country	Article type	Healthcare profession / Sample	Contribution [SV = second victim]
Burlison et al.	2017	USA	Survey	983 hospital staff including nurses, physicians, pharmacists, and medical technicians	Development and validation of a tool to measure SV effects and the quality of support resources: The second victim experience and support tool (SVEST), based on the definition by Scott et al. (2009). Acknowledges that SV experience now goes beyond medical errors to include any unanticipated adverse patient event
Delacroix	2017	USA	Qualitative study of medical errors	10 nurse practitioners	Nurse practitioners who make mistakes experience SV phenomena. SV term is appropriate
Edrees, Morlock & Wu	2017	USA	Qualitative study Interviews	43 patient safety representatives in acute care hospitals	Argues for a broad definition of SV to include those who support SVs. Organisations should re-evaluate the support currently provided by external Employee Assistance Programmes, and consider additional peer support mechanisms
Brunelli et al.	2018	Argentina	Cross-cultural adaptation and psychometric evaluation of the SVEST	452 nurses	Validation of the Second Victim Experience and Support Tool (SVEST) in Argentina. Notes ambiguity in the operative definition of SV
NHS England	2018	UK	Report: Towards Commissioning for Workplace Compassion Support Guide	All NHS staff	Errors in health and care also take a toll on health and care staff. Notes the term SV is sometimes used to describe the impact on the workforce of patient harm. Cites the Point of Care Foundation publication Behind Closed Doors: staff need practical and emotional support, and staff experience should be given equal priority to patient experience at all levels of the healthcare system

Table 4 (continued)

Characteristics of the included records, in chronological order

Authors	Year	Country	Article type	Healthcare profession / Sample	Contribution [SV = second victim]
Robertson & Long	2018	USA	Review of the effects of unintentional medical error	Healthcare professionals	Difficult to establish a definition for the SV concept because healthcare providers may have different responses
Tumelty	2018	Ireland	Qualitative study	6 medical training body representatives; 12 barristers	SV is a contested term. Impact on doctors not disputed. Uncomfortable connotations. Potentially insensitive to patients who have experienced harm
Vinson & Randel	2018	USA	Commentary on peer support for SVs	Healthcare professionals: focus on anaesthetists	Controversy about SV term: potentially de-emphasising the pain and experience of the patient and family
Chen et al.	2019	China	Psychometric validation of the C-SVEST	1442 nurses	Translation and validation of the Chinese version of the Second Victim Experience and Support Tool (SVEST)
Hartley et al.	2019	Canada	Theoretical review of the influences on OR clinicians' experiences when patients die	Operating room (OR) clinicians	Clinicians' moral and emotional experiences in OR care are shaped by biomedical and social discourses. Second victimisation and vicarious traumatisation have overlapping components
Vanhaecht et al.	2019	Netherlands	Cross-sectional survey	1619 doctors 2750 nurses with experience of a PSI	Uses term "second victimness", creating the idea of a quality. Recognises criticism of the SV term but "no other available"

Table 4 (continued)

Characteristics of the included records, in chronological order

Authors	Year	Country	Article type	Healthcare profession / Sample	Contribution [SV = second victim]
Clarkson et al.	2019	USA	Letter about SV term	Healthcare professionals	Call to “Abandon the term SV” as inappropriate. “By referring to themselves as victims, healthcare professionals and institutions subtly promote the belief that patient harm is random, caused by bad luck, and simply not preventable. This mindset is incompatible with the safety of patients and the accountability that patients and families expect from healthcare providers.”
Brailion	2019	France	Response to Clarkson letter (disagrees)	Healthcare professionals	SV term is appropriate. Referring to SVs as “collateral damage” equates to “pouring water on the drowning”
Gómez-Durán et al.	2019	Spain	Response to Clarkson letter (disagrees)	Healthcare professionals	SV term validates the damage that physicians have suffered in harming a patient. Neglecting SVs will not help harmed patients or improve patient safety
Kavanagh	2019	USA	Response to Clarkson letter (agrees)	Healthcare professionals	SV term is inappropriate. Healthcare professionals should not have a term that furthers the mental distress of the true victims of medical errors (patients)
Lawton et al.	2019	UK	Response to Clarkson letter (disagrees)	Doctors	SV term is provocative and may seem abhorrent to patients or families, but the consequences for professionals justify the term victim until better terminology is agreed
McDonald	2019	UK	Response to Clarkson letter (disagrees)	Colorectal surgeons	The SV term is useful and should still stand. Patients are the first and most important victims of medical errors, but doctors have killed themselves over these incidents
Nicholl	2019	UK	Response to Clarkson letter (disagrees)	Doctors	Victim is a fitting term. Refers to a doctor who was fined, imprisoned, lost her career, vilified and racially abused in the media: “that sounds like a victim”

Table 4 (continued)

Characteristics of the included records, in chronological order

Authors	Year	Country	Article type	Healthcare profession / Sample	Contribution [SV = second victim]
Petersen	2019	Denmark	Response to Clarkson letter (disagrees)	Health professionals	SV term is appropriate for unfortunate frontline workers involved in incidents
Strader	2019	USA	Response to Clarkson letter (disagrees)	Physicians or staff	SV term is appropriate. Physicians or staff are victims and need a label
Vetruigno et al.	2019	Italy	Response to Clarkson letter (disagrees)	Physicians	SV term is appropriate and does not equate to avoiding accountability. Latin origin of victim means “beaten” or “defeated”. Patients are not the only victims. Physicians experience failure and share the anguish of the patient
Wojcieszak	2019	USA	Response to Clarkson letter (disagrees)	Clinicians	SV term is embraced by clinicians. Doctors and nurses sometimes fare worse than patients when things go wrong
Kim et al.	2020	Korea	Psychometric properties of Korean SVEST (K-SVEST)	305 nurses	Second Victim Experience and Support Tool (SVEST) study, translation and validation of Korean version
Mira et al.	2020	Spain	Survey: the acute stress of the healthcare workforce during the COVID-19 pandemic	685 primary care and hospital healthcare professionals	Explicitly extends the SV concept to refer to any healthcare or support professional involved in the care of COVID-19 patients, who presents acute stress responses caused by the combination of social alarm, overwhelmed services, scarcity of resources, and poor patient outcomes

Table 4 (continued)*Characteristics of the included records, in chronological order*

Authors	Year	Country	Article type	Healthcare profession / Sample	Contribution [SV = second victim]
Mok et al.	2020	Singapore	Experience of SVs in Singapore, and quality of support resources	1163 nurses	SVEST study of nurses in Singapore. Younger and less experienced nurses more likely to be SV
Pyo et al.	2020	Korea	Survey of physicians' difficulties due to PSI	895 physicians	Adds post-traumatic embitterment disorder (PTED) as a consequence of SV experience
Stovall et al.	2020	USA	Critical review: moral injury in nurses after a PSI	Nurses	“Moral injury better describes the SV phenomenon” in nurses because it “removes the idea of victimisation”
Wu et al.	2020	USA	Review of SV term	Healthcare professionals	Acknowledges concerns that use of the SV term may connote passivity, stigmatise involved clinicians, or cause offence. Locally acceptable labels may be appropriate. Term needs to be memorable, connote urgency, be attractive to healthcare professionals
Ajoudani et al.	2021	Iran	Persian translation and psychometric evaluation of the SVEST	298 nurses	Second Victim Experience and Support Tool (SVEST) study, translation and validation of Persian version in Iran

Table 4 (continued)

Characteristics of the included records, in chronological order

Authors	Year	Country	Article type	Healthcare profession / Sample	Contribution [SV = second victim]
Leaune et al.	2021	France	Prevalence of exposure to patient suicide, the emotional, traumatic, and professional impacts, and perceived support	235 psychiatry trainees	Links the SV concept to professionals who are exposed to patient suicide or severe suicide attempts

3.7 Concept Analysis

All of the included records use the “second victim” concept in ways that convey workers in healthcare settings experiencing emotional or psychological distress after a PSI. This is the single consistent attribute, loosely captured by the word “victim”. Many of the records argue that this distress should give rise to emotional and psychological support, and as such the concept is intended to be supportive of affected staff. Beyond the experience of distress, additional attributes may be present, and these can differ from person to person.

3.7.1 The concept’s defining attributes

Based on a critical evaluation of the uses of the concept in the literature, the defining attribute of becoming a second victim is:

1. Emotional and/or psychological distress experienced by a healthcare worker following direct or indirect involvement in a PSI, including a near miss

Other features may be present, but these are experienced as a combination of potential effects that can be unique to the individual. They may include:

2. Possible physical, cognitive, and/or mental health symptoms, including suicidality
3. The possibility of a negative interpretation of one’s role in the event and/or a feeling of being wholly or partly responsible
4. Possible professional anxiety about competence, impact on reputation, or being blamed
5. Possible impact on subsequent work performance and patient safety
6. Possible impact on career intentions or decisions, or on personal life

3.7.2 Exemplar cases

Exemplar cases are used to illustrate the concept (a model case), a concept that shares some of the same features (a borderline case), and a contrary case that does not share the concept’s characteristics (Walker & Avant, 2011). The cases can be fictitious, but the exemplars used in this analysis have been taken from research studies that depict

real-life healthcare situations, capturing and illuminating the concepts the studies have investigated, to depict a “second victim” case and differences from other concepts. The overlapping nature of several concepts, and the implications of these overlaps, is explored below in section 3.8.2.

3.7.2.1 Model case

The model case depicts a “second victim” experience, and is taken from the exploration by Davidson and colleagues (2015) of work-related blame (see Table 4), that incorporates a second victim case experience:

A new nurse experiences her first patient with a cardiac arrest. She is the nurse administering medication during the resuscitation event. The patient expires. She is called into the supervisor’s office the next day and told that she administered an undiluted vasopressor (which should have been admixed into a piggyback solution and administered slowly on a pump) and that this was the likely cause of the patient’s death. She cannot live with the fact that she could have killed another human. She goes into the medication room and self-administers a lethal injection of a toxic substance. (p. 544)

This case exemplifies the principal attribute of a “second victim”, namely emotional and psychological distress following direct involvement in a PSI. It also incorporates several of the other possible attributes, including the nurse’s negative interpretation of her role in the event and a feeling of being responsible, and impact on her personal life because she chooses to die by suicide. This case depicts a “second victim”, using the concept as a descriptive label for an individual.

3.7.2.2 Borderline case

According to Walker and Avant (2011), a borderline case has some but not all of the concept’s defining characteristics. Borderline cases may share some antecedents and consequences with the concept (see section 3.7.3), but have other features, uses, or contexts. There are several concepts that share some of the “second victim” concept’s characteristics, and they are sometimes used interchangeably. This potential for conceptual overlap, problematic when considering the validity of the construct, is explored further in the discussion (section 3.8) below. The concept that has been selected to serve as a borderline case for this analysis is vicarious traumatization (VT),

explored in Chapter 1. The case has been taken from Wies and Coy (2013) who explored VT among sexual assault nurse examiners. They describe the experience of Christina:

She says that she almost always has trouble sleeping, regularly feels discouraged about the future, and lives in a constant state of anxiety because she expects bad things to happen. Despite all of this, she plans to continue her work with the hospital, performing her regular duties as a Registered Nurse as well as performing sexual assault forensic exams. (p. 23)

This case shares some of the characteristics of the “second victim” concept. A healthcare worker experiences distress and mental health impacts as a direct result of her work. However, the patients have had traumatic experiences prior to their healthcare intervention, rather than during their treatment. The healthcare professional with VT has not experienced the traumatic event first hand, but nonetheless can experience trauma effects as a result of working with the victims of such events and being aware of their emotional distress or physical injuries. VT describes an experience and impact, rather than serving as a label for the individual who has been affected.

3.7.2.3 Contrary case

A contrary case offers an account that does not depict the concept’s attributes, although it may occur in the same setting. The exemplar, taken from French et al. (2022), depicts a healthcare professional’s experience of moral distress, describing feelings of betrayal by hospital leaders during the COVID-19 pandemic, without the occurrence of a PSI:

They weren’t visible at all. They were in a building and locks were put on the buildings, which . . . what kind of message does that send out to the staff? You know, as a nurse the whole job is being by the patient bedside and we never saw them. And so I was really, really angry. Participant 5. (p. 518)

This case illustrates the negative feelings and sense of injustice experienced by a nurse towards senior managers because of a healthcare workplace situation, but without reference to any actual or potential impact on a patient.

3.7.3 Antecedents and consequences

The antecedents of potentially becoming a “second victim” include being a healthcare worker and being involved in a PSI that causes harm to a patient or a near miss incident. However, not all healthcare professionals who experience a PSI will automatically become a “second victim” or perceive themselves to be such. The PSI may be combined with additional antecedents, or intensifying factors, including a sense of personal connection with or similarity to the patient (Scott et al., 2009), or an unsupportive work environment (Quillivan et al., 2016) with unsympathetic or critical colleagues (Wu, 2000; Wu et al., 2020). Legal proceedings being threatened or initiated against the involved clinician following patient harm have been identified as a possible cause of “second victim” experience, or as a factor in making its impact more severe. This experience, termed clinical judicial syndrome, has been explicitly linked to “second victim” responses (Arimany-Manso et al., 2018; Pellino et al., 2021; Vargas-Blasco et al., 2020). The contribution made by incident investigations to the impact on involved staff also remains unclear, although the impact of investigation processes has been described (Maben et al., 2021; Wachter, 2011; Wu et al., 2020). The precise role of these processes in compounding negative staff outcomes is not fully explained or understood, and all of these antecedents may occur without giving rise to “second victim” impacts.

The consequences of a perceived “second victim” experience are almost all negative and can include a combination of emotional, cognitive, psychosomatic, and physical effects (Busch et al., 2020b; Scott et al., 2009; Vanhaecht et al., 2019), including distress; intrusive thoughts; anxiety; sleep disturbance; memory impairment; feelings of responsibility, guilt and regret; inability to concentrate; taking sick leave, wanting to change role within the organisation, or to leave one’s profession altogether; making changes to one’s clinical practice such as decisions that are more defensive (Pellino & Pellino, 2015; Pellino et al., 2021); further patient safety risks from impaired functioning; suicidal thoughts or decisions. The precise combination and degree of feelings and impacts can be unique to the individual. Consequences for the organisation may include the cost of the healthcare worker’s absence or departure; recruiting temporary or permanent replacements; retraining; and impact on staff morale (Moran et al., 2020; Zhang et al., 2019).

Table 5 sets out the negative psychological and psychosomatic consequences of being a “second victim”, adapted from a systematic review and meta-analysis by Busch et al. (2020b), who reported on 18 studies covering 11,649 healthcare providers (across all healthcare professions) involved in a PSI. Busch and colleagues reported these impacts as symptoms, in descending order of prevalence.

Table 5

Psychological and psychosomatic symptoms of being a second victim

Symptom	Prevalence
Troubling memories	81%
Anxiety/concern	76%
Anger toward oneself	75%
Regret/remorse	72%
Distress	70%
Fear of future errors	56%
Embarrassment	52%
Guilt	51%
Frustration	49%
Anger	44%
Fear	43%
Feelings of inadequacy	42%
Reduced job satisfaction	41%
Concern regarding colleagues' reactions	39%
Symptoms of depression	36%
Fears of repercussions/official consequences	36%
Sleeping difficulties	35%
Anger toward others	33%
Loss of confidence	27%
Concern regarding patients' reactions	8%
Self-doubts	6%

Some commentators have identified potential positive consequences after involvement in a medical error or other PSI, such as personal growth and development (Plews-Ogan et al., 2013; Plews-Ogan et al., 2016; Scott et al., 2009). Positive outcomes after traumatic experiences, referred to by Scott and colleagues (2009) as the potential for thriving, are by no means experienced by all. They seem to rely on having the opportunity to speak about the situation, and to receive appropriate social support (Tedeschi & Calhoun, 2004).

3.7.4 Measurement of the concept

Walker and Avant (2011) require the inclusion of any tools, termed “empirical referents” that have been developed to identify and measure the defining attributes of

the concept, to show that it exists. For the “second victim” concept, a specific measurement tool has been developed: the Second Victim Experience and Support Tool, or SVEST (Burlison et al., 2017). The SVEST was initially completed by 303 healthcare personnel involved in direct patient care, who described their own “second victim” symptoms and the quality and desirability of support resources. The tool was developed to assist healthcare organisations evaluate the “second victim” experiences of their staff, the quality of any existing support resources, and the types of support that their staff would prefer. This tool has been translated and validated for use in Argentina (Brunelli et al., 2018), China (Chen et al., 2019), Korea (Kim et al., 2020), and Iran (Ajoudani et al., 2021). It has also been used in a second victim study of nurses in Singapore (Mok et al., 2020). Since the search was undertaken for this concept analysis, the SVEST has also been translated and validated in Denmark (Knudsen et al., 2021), Italy (Pieretti et al., 2021; Scarpis et al., 2021), and Germany (Strametz et al., 2021).

Notwithstanding its widespread use, there are limitations to this tool, because its original sample comprised predominantly nurses (44%), which may not reflect the experiences of other professional groups, and its creation presupposed a discrete “second victim” construct. The basis of this construct uses the definition derived by Scott et al. (2009); this is potentially problematic if the elements of the underlying definition are not precise, raising questions about construct clarity and validity, explored below.

3.8 Discussion

This discussion will focus on four areas: the evolution in the definition of the “second victim” concept; its boundaries and overlap with other concepts; its validity as a construct; and the controversy that has arisen about its use.

3.8.1 Definition of “second victim”

The “second victim” concept has evolved over time in many respects, affecting what it describes, with respect to the scenarios and individuals it covers. It started out describing a distressed healthcare professional (principally doctors) following direct involvement in making a medical error (Wu, 2000), and has subsequently developed into a descriptor for experiences and impacts with a wide range of causes, encompassing impacts on additional staff groups, and individually varying consequences.

A widely accepted and often cited definition of “second victim” was arrived at by a research group and reported in Scott et al. (2009) as a consensus definition:

Second victims are healthcare providers who are involved in an unanticipated adverse patient event, in a medical error and/or a patient related injury and become victimized in the sense that the provider is traumatized by the event. Frequently, these individuals feel personally responsible for the patient outcome. Many feel as though they have failed the patient, second guessing their clinical skills and knowledge base. (p. 326)

The definition, intended to update and clarify the meaning of “second victim”, was presented without an underpinning published evaluation of its elements, and yet it is this definition that has formed the basis of large amounts of further research. This definition was superseded in December 2022 as this thesis was being finalised:

Based on expert consensus, a second victim was defined as: Any health care worker, directly or indirectly involved in an unanticipated adverse patient event, unintentional healthcare error, or patient injury and who becomes victimized in the sense that they are also negatively impacted. (Vanhaecht et al., 2022, p.1)

Retaining the “second victim” concept, this revision was based on a literature review conducted by a small group of European researchers with one US contributor. The intention was to address criticism that the previous definition had been created in the US. However, it does not necessarily reflect understandings elsewhere in the world. The latest version has removed the notion of being traumatised, replacing it with “negatively impacted”, thus lowering the threshold for impact and extending the effects beyond emotional and psychological. It broadens the coverage to encompass any healthcare worker directly or indirectly involved, including non-clinical staff, making explicit earlier interpretations (NQF, 2010). The updated definition confirms that healthcare errors are unintentional rather than just unanticipated, and there is now no mention of involved staff feeling responsible or doubting their skills, although this is known to be a possible consequence. This definition of “second victim” essentially describes any negative impact, without the need for distress, to any healthcare worker as a result of anything unexpected happening to a patient. As such it is extremely general, retains the problematic idea of “victim”, and increases the potential for overlap with other concepts.

Both definitions raise questions because they include and explicitly redefine terms such as “victimized” that were never part of the original concept: being victimised has different connotations to being a victim. Wu’s original description was of a professional suffering distress following an error of their making, and lacking emotional support or understanding (Wu, 2000). It did not speak of victimisation by other parties. The appropriateness of the word “victim” is not addressed in either definition, and both versions fail to explain the use of the phrase “unanticipated patient event”, which is potentially extremely wide-ranging and vague. Some healthcare professionals are deeply distressed by patient deaths that are not necessarily unanticipated, and could also refer to themselves as a “second victim” of this experience (Edrees et al., 2016).

The genesis of the impacts described using the “second victim” term now includes multiple possibilities, ranging from direct involvement in a medical error that may have caused patient harm or a near miss (NQF, 2010; Quillivan et al., 2016), to witnessing a PSI caused by a colleague, or caring for violent patients where nothing goes wrong in the treatment or care (Krzan et al., 2015). A recent extension encompasses the emotional and psychological effects on healthcare professionals after patients have attempted suicide or succeeded in taking their life (Leaune et al., 2021), without any suggestion of error on the professional’s part. Distress in these various situations may arise from the experience of the PSI itself, from self-blame, or from organisational handling of the incident (Davidson et al., 2015) and the experience of investigations or legal processes (Arimany-Manso et al., 2018; Pellino & Pellino, 2015). Other potential causal factors in becoming a “second victim” have been suggested; these include a sense of conflict or tension with one’s professional mandate (Dekker, 2013), which suggests an experience of moral injury, or the effects of not being supported by one’s colleagues or organisation (including Baas et al., 2018; Pettker, 2017; Robertson & Long, 2018; Vanhaecht et al., 2019). However, the potentially influential factors that have been identified amount to associations with being a “second victim”, and the extent of their influence on the occurrence of a “second victim” experience has not been established.

The types of workers potentially affected have extended considerably over time, starting with healthcare professionals directly responsible for clinical care, focusing chiefly on doctors (Wu, 2000), and now covering any staff who provide patient services,

including administrative staff, support workers, students, and volunteers (National Quality Forum, 2010; Scott et al., 2010).

The types and degree of impacts experienced can vary from person to person, and encompass a wide range of possible emotional, psychological, cognitive, and physical effects, reported by Busch and colleagues (2020b). Pratt & Jachna (2015) reported a broad range of clinical presentations for “second victims”, with a wide range in recovery time for those affected, from weeks to never. The term “second victim syndrome” was coined without delimiting a specific set of clinical or other criteria (Clancy, 2012; Jain et al., 2021), because of the wide range of individual experiences and responses.

The principal hallmarks of the concept are thus its wide range of possible causes and coverage, and the individuality of responses and impacts. The breadth of conceptualisation, extended in the most recent definition, creates the potential for blurred boundaries and overlap with other concepts.

3.8.2 Overlap with other concepts

The “second victim” concept is problematic because it has the potential to overlap with the concepts of vicarious traumatisation or VT (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995), secondary traumatic stress or STS (Bride et al., 2004; Figley, 1995; Joinson, 1992; von Rueden et al., 2010), and moral injury or distress (Jameton, 1984; 2013; 2017; Leggett et al., 2013; Oliver, 2018; Wilkinson, 1989), as explored in Chapter 1. This raises the question of whether the concept clearly contributes anything that other related concepts do not, or whether the overlaps result in unhelpful ambiguity and confusion.

VT can be employed for professionals outside the healthcare field (Levin & Greisberg, 2003; Peled-Avram, 2017), but apart from that distinction, the “second victim” and VT concepts are now used in ways that overlap (Shorey & Wong, 2021). The boundaries of the original VT conceptualisation of a professional bearing witness to episodes of prior harm experienced by patients have become blurred, with the word “vicarious” now being used to suggest indirect or no-fault involvement in PSI, even if the healthcare worker was present when the harm was caused.

STS has also moved away from its original conceptualisation, namely behaviours and emotions resulting from helping other traumatised individuals. There is potential for confusion surrounding use of the word “trauma” in STS, and whether it means physical injury sustained prior to care (Von Rueden et al., 2010), harm caused by staff during treatment, or psychological effects on the patient or the professional. These various connotations also complicate understanding of cause and consequence.

STS has recently been described as a potential antecedent to becoming a “second victim” after a contemporaneous involvement in a maternity PSI (Krupe et al, 2021): “Although adverse outcomes and medical mistakes primarily affect patients and relatives, healthcare professionals also feel upset and experience secondary traumatic stress in the aftermath of an adverse event. These individuals are sometimes referred to as ‘second victims’” (Schrøder, Jørgensen et al., 2016, p. 735). The confusion and crossover in the interpretation and usage of the two concepts is evident, including to interview participants: “It’s hard to tease out that second victim versus secondary trauma, because a lot of times I make myself into a victim, whether I actually committed the error or not” (Krupe et al., 2021, p. 4). Here, “victim” appears to be used as a synonym for a physician feeling misplaced guilt. However, this is not an explicit element, and the conceptual boundaries and distinctions between STS and “second victim” are not clarified. Furthermore, in a study interviewing patient safety representatives about support for “second victims” (Edrees et al., 2017), participants argued that support could also be needed for patient safety professionals who support “second victims” and have to deal with their colleagues’ distress. If taken on board, this would extend the overlap of the “second victim” concept explicitly with that of STS.

A third concept that has recently become conflated with “second victim” is moral distress (Jameton, 2013; 2017) or moral injury (Shay, 2012). The overlap occurs with respect to the emotional and psychological impact on the affected staff, originally focused on nurses or, in the case of moral injury, military veterans. In recent usage, the “second victim” term has been used in connection with healthcare staff experiencing acute stress responses caused by overwhelmed services and a shortage of resources during the COVID-19 pandemic, with consequent moral injury (Mira et al. 2020). Stovall et al. (2020) have gone further, explicitly equating the two concepts, in spite of the fact that antecedents of the two concepts differ. This proposed equivalence was not clarified, but the authors argued that “moral injury better describes what historically has

been called the nurse second victim phenomenon” because “this language avoids victimizing those involved” (p. 320). This usage appears to object to the idea of staff being victims, but also removes any element of responsibility for patient harm on the part of a healthcare professional.

3.8.3 Queries about construct validity

These conceptual overlaps, the lack of a precise definition for the “second victim” concept, and the broad array of possible experiences and impacts it describes, together complicate the foundation on which research studies, including those measuring the phenomenon, are based. While the concept appears mature, because it has been in existence for over 20 years and there is a recently updated definition (Vanhaecht et al., 2022), there is inconsistency or lack of clarity between the definition and its utilisation in research, and it cannot thus be considered “as mature as first thought” when assessed against the quality principles of Morse and colleagues (1996, p. 256).

Several of the included records in this analysis refer to and query this lack of specificity (Davidson et al., 2015; Harrison et al., 2015; Lewis et al., 2015; Pratt & Jachna, 2015). In their study of emotion and coping among UK and US healthcare professionals after making a medical error, Harrison and colleagues (2015) observed that there was no “agreement regarding the dimensions of the construct of ‘second victim’ to establish construct validity” (p. 33). While the work of Burlison et al. (2017) later aimed to address this by devising a tool to measure “second victim” experiences, authors who subsequently adapted this tool cross-culturally nonetheless noted that different researchers included different elements when evaluating the prevalence of “second victim” impacts, meaning that “there seems to be ambiguity in its operative definition” (Brunelli et al., 2018). Aspects of the concept may resonate with affected individuals who consider that it captures their challenging emotional experiences after involvement in a PSI. However, its lack of consistency and capacity for clear distinction from other concepts makes it difficult to be certain about what the concept actually describes, apart from the negative impacts on healthcare staff following various types of negative experiences involving patients.

3.8.4 Controversy about “victim”

In addition to uncertainty about what the concept covers in terms of healthcare scenarios, apart from a negative impact on staff when something has gone wrong for a patient, its use has been further undermined by the controversy that has recently developed about the terminology. This specifically relates to the word “victim” as applied to healthcare professionals, which has not been questioned in the definitions by Scott et al. (2009) or Vanhaecht et al. (2022).

The “second victim” concept was devised with the intention of drawing attention to the possible emotional and psychological impact of being involved in a medical error for those healthcare professionals negatively affected, in order to elicit sympathy and emotional support (Gómez-Durán et al., 2019), particularly from their own colleagues (Wu, 2000). However, negative views expressed by patient representatives bereaved as a result of medical error (Clarkson et al., 2019), specifically about the inclusion of the word “victim” to describe healthcare staff who have caused harm to patients, have served to call the concept into question on the grounds of inappropriateness and insensitivity. The records included in this analysis illustrate this controversy and the divergent views held, expressed in an exchange of letters sparked by the explicit call from Clarkson and colleagues (2019) to “abandon the term second victim” (p. 1). The debate was not about the lack of clarity inherent in the concept, but about its capacity to cause offence and deflect from responsibility and accountability for patient safety.

Opponents of the term have declared their perspective as representatives of individuals who have been seriously or fatally harmed by a PSI that involved a mistake: “We know who the actual victims of medical errors are because we arranged their funerals and buried them” (Clarkson et al., 2019, p.1). They consider victims to be the people injured, who had no agency or power in the incident. Use of the term “victim” to describe the staff who made the error is perceived as a way of letting those individuals and their organisations off the hook, rather than focusing on accountability at an individual and organisational level: “By referring to themselves as victims, healthcare professionals and institutions subtly promote the belief that patient harm is random, caused by bad luck, and simply not preventable” (Clarkson et al., p.1). Use of the word “victim” for any staff involved in a medical mistake is thus roundly and angrily rejected by these opponents, on the grounds that it is incompatible with patient safety, since a

victim in an event does not bear responsibility for its occurrence, and the staff involved in medical errors are, albeit unintentionally, agents of harm. Medical professionals take the Hippocratic oath, which is a promise to do no harm. Causing harm may involve physical injury to patients, but it could also be interpreted as causing distress to bereaved relatives. The “second victim” term is thus perceived to undermine the status of those harmed, “deemphasizing the pain and experience of the patient and family” (Vinson & Randel, 2018, p.283). Kavanagh (2019) also argued in support of Clarkson and colleagues that it is the responsibility of the medical profession not to use a term “which in any way furthers the mental distress of the true victims of medical errors” (p. 1).

Other arguments against use of the term, expressed after Clarkson’s robust intervention, include that using it to label affected staff could stigmatise them (Wu et al, 2020). Moreover, knowing that the term has become unacceptable to some stakeholders could create negative consequences for professionals if it delayed or stopped the introduction of staff support, or dissuaded staff from seeking the support they might need: “Where a healthcare professional is uncomfortable using such a term or being labelled a victim, they may be unlikely to seek help for the symptoms that they are experiencing” (Tumelty, 2018, p.1). Growing discomfort with the term’s connotations and sensitivity to patients and families suggest that the term no longer achieves what it set out to: “Terms that were once useful can outlive their usefulness” (Wu et al., 2020, p. 2). Without entering this exchange of views, the UK body Action Against Medical Accidents (AVMA), which positions itself as a charity for patient safety and justice, is reported in a meeting note of the NHS England Medical Patient Safety Expert Group (NHS, 2015a) to have fully considered the “second victim” term, but to find it unacceptable. No record of this debate has been found on the AVMA website, but these views may have influenced some UK healthcare bodies not to make use of this term.

The principal argument advanced in favour of continued use of the term, as evidenced in the responses of those who disagreed with Clarkson et al., is that it captures the severity of the distressing impact on staff, caused either by experience of the incident itself, or by subsequent treatment by colleagues or outside actors. The word “victim” as applied to healthcare staff after involvement in a PSI is still considered apt by some commentators, including relatives of patients who were harmed or killed, because of the personal and professional impact: “Clinicians quit or retire early, experience family

problems, and even die by suicide because they are not given proper emotional support after the event” (Wojcieszak, 2019, p. 1). The “second victim” term is considered effective because it can raise awareness of the needs of affected professionals, and is “dramatic enough to seize the attention of health care workers, managers, and policy makers about the extent and importance of the problem” (Wu et al., 2020, p.6). Staff are also considered by some to be the genuine “victims” of a chain of failures, rather than bearing sole responsibility as individuals: “Most adverse events can be traced back to systemic, strategic, or organisational faults” (Petersen, 2019, p. 1). Healthcare professionals can also be “victimised” by being required to behave unethically by risk managers or other colleagues after PSI, including in their communications with patients (Wojcieszak, 2019). Others argue that healthcare professionals who are attacked in the media after incidents are also accurately termed “victims” (Nicholl, 2019).

Growing recognition that the term is “provocative” (Lawton et al., 2019) and may offend patients or families has nonetheless not led to the identification of a suitable replacement that can adequately convey the potential severity of the emotional and psychological impact on staff (Busch et al., 2020b; Vanhaecht et al., 2019; Wu et al., 2020). The term “collateral damage” has been rejected as being too “sanitized” (Dekker, 2013). Other possible terms, framed in a more precise and less emotive way, may not give the same prominence to the issue, lacking “the gravitas required to affect change” (Vinson and Randel, 2018, p. 383).

[3.8.5 Studies not using the “second victim” term](#)

There have been some important studies since the “second victim” term was coined that clearly address the same issue of the professional and personal impact on healthcare professionals following involvement in PSI, but which do not use the term (Harrison et al., 2014). The decision to use different descriptors and avoid the use of the term “second victim”, apart from citing Wu’s original article, is noteworthy, since an earlier review of medical errors and coping by the same lead author expressly used the term “secondary victims” (Sirriyeh et al., 2010). This suggests that there may have been a developing sensitivity about the terminology, as well as a growing discomfort with a perceived lack of construct validity (Harrison, Lawton et al., 2015).

Other studies about healthcare workers’ distress after PSI that do not employ or cite the “second victim” term at all include the review by Sheen and colleagues (2014) of the

impact of indirect trauma exposure on midwives, and the study by Slade et al. (2020) of work-related PTSD symptoms in obstetricians and gynaecologists. It is not clear if these researchers considered the “second victim” term irrelevant to their work, inappropriate, or insufficiently precise. However, some recent UK studies have elected to use the “second victim” term to describe psychologically traumatic effects on healthcare professionals post PSI (McLaren et al, 2021; Serou, Husband et al., 2021), without questioning its relevance or ambit.

The arguments made for and against the term are summarised in Table 6.

Table 6

Arguments presented for and against the “second victim” term

Arguments in favour of the term	Arguments against the term
1. Provides a sense of gravity	1. Insensitive to and upsets harmed patients and their families
2. Draws attention to the issue	2. Passive term that may stigmatise professionals
3. Reflects the serious negative outcomes experienced by professionals, including lack of organisational support	3. Discomfort with the label may put professionals off seeking help
4. Errors derive from system faults	4. Out of date and no longer useful
5. Investigation processes can be like inquisitions	5. Absolves or deflects from responsibility and accountability
6. Elicits sympathy	6. Imprecise construct for research use
7. Other terms are too sanitised	
8. Does not absolve responsibility	

Arguments against the term are fewer in number, but the impact on patients and their families, coupled with the risk of healthcare staff being dissuaded from seeking support, carry substantial emotional and practical weight.

[3.9 Chapter summary](#)

This chapter has reviewed the concept of the “second victim” in healthcare, which has been in use for over 20 years, more noticeably in the US than the UK. The concept has evolved beyond the original primary focus on doctors, and now encompasses all healthcare staff who might become involved in, or be indirectly negatively affected by a PSI, including allied health professionals, healthcare support staff, students, and volunteers. Many researchers and commentators agree that the term accurately describes the seriousness of the emotional impact on some healthcare professionals

involved in PSI, including near miss incidents, although the most recent definition removes reference to a traumatic or emotional impact. In terms of the quality criteria considered, the concept has been operationalised, and is applicable to incidents in healthcare. However, the precision of the concept is questionable and what it describes is unclear. In spite of the concept having a recently updated published definition, this contravenes the quality criterion of clear differentiation from other concepts; it is used in ways that can overlap with the concepts of secondary traumatic stress, vicarious traumatisation, and moral distress, particularly with respect to the consequences for staff, which has created some confusion. This has called into question its validity as a measurable construct for research purposes, although a survey tool has been developed and used to measure “second victim” prevalence and outcomes for staff in several countries. To clarify the concept and make it distinct, it would need to revert to being used to describe the impact on staff of making an unintended and preventable medical error or causing a near miss.

Latterly, the use of the word “victim” within the concept has also become controversial with patients’ families and other patient representatives, polarising arguments in an adversarial way about whether patients and relatives merit the term “victim” whereas affected staff do not. Even if the ambit of the concept were tightened, this controversy could make distressed healthcare staff uncomfortable with seeking support to manage their feelings and continue working safely, if support were badged under a “second victim” heading. It could also detract from empathetic and supportive organisational responses towards distressed healthcare staff involved in PSI, which the term was originally intended to foster, and which could underpin efforts to maintain and improve patient safety.

The “second victim” term has offered an eye-catching way to focus attention on the experience and needs of staff negatively affected by their involvement in a PSI. The term may remain relevant and useful for policy development in this field, or for explaining the background to business cases for staff support, because of its place in this research field over the last 20 years. However, given the effects of the controversy, and the fact that NHS policy (NHS England, 2018) appears to be moving towards giving equal priority to the experiences of patients and staff, the ideas of first and second victims no longer reflect the state of the science. As part of establishing whether continued use of the “second victim” term would serve a useful purpose in the UK

healthcare policy arena, the views of UK healthcare policymakers and managers would need to be sought on the relevance and appropriateness of the “second victim” term. This work has not yet been carried out.

For the rest of this thesis, research that includes the “second victim” concept will be explored alongside work that is based on other terminology but describes the same phenomenon. This includes programmes that have been introduced to support negatively affected staff, some of which choose to use the “second victim” term, and some that do not. Views about the term will form part of the planned study to interview UK healthcare policymakers and managers on the subject of support for healthcare staff negatively impacted by their involvement in a PSI.

CHAPTER 4: LITERATURE REVIEW OF ORGANISATIONAL SUPPORT PROGRAMMES FOR HEALTHCARE STAFF AFTER EXPERIENCE OF PATIENT SAFETY INCIDENTS, AND THE POLICIES THAT INFORM THOSE PROGRAMMES

4.1 Introduction to the chapter

Support for healthcare professionals following their involvement in patient safety incidents (PSI) that is provided by the organisation where they work varies in availability, type, and in its use of policy frameworks or guidelines to inform the support offered. The aim of this review is to identify organisational programmes described in healthcare literature, that offer structured emotional and psychological staff support within the organisation, and to determine whether those existing support schemes are explicitly underpinned by policies, guidelines, or other stated rationales. An integrative review methodology (Whittemore & Knafl, 2005) was selected to guide this analysis and facilitate the inclusion of relevant studies using a variety of approaches: qualitative, quantitative, mixed methods, or with purely descriptive data, including from grey literature.

In this chapter, possible types of emotional or psychological support for healthcare professionals involved in PSI will be considered, and the rationale for exploring structured organisational support schemes will be set out. Each of the support programmes identified in the literature will subsequently be scrutinised to establish if a specific policy basis for the programme's introduction and development has been explicitly acknowledged, and whether any policies or guidelines referred to are expressly for the healthcare sector or more widely applicable. Investigating this use of policies or guidelines is intended to establish whether they make general calls or recommendations for support, or set specific requirements for healthcare organisations to engage in the provision of emotional or psychological support for the staff negatively affected by such events.

4.2 Support interventions

Calls to support healthcare professionals emotionally or psychologically following their involvement in PSI have been made by many commentators for over twenty years, before Professor Albert Wu first issued his plea in 2000 (see Christensen et al., 1992), and afterwards. See for example, De Biennassis et al. (2021); Coughlan et al. (2017);

Downey et al. (2021); Abd Elwahab and Doherty (2014); Federico and Conway (2011); Kable and Spigelman (2018); Kershaw (2007); Koyle et al. (2021); McCready and Russell (2009); Ozeke et al. (2019); Schröder, Lamont et al. (2019); Scott et al. (2009); Takahashi et al. (2011). There have been some interventions to respond to these calls, with support taking a variety of possible forms. These include publicly accessible informational websites that acknowledge the impact and signpost other sources of support; access to short-term counselling outside the organisation via Employee Assistance Programmes or professional bodies; access to emotional support and mental health first aid within the organisation from trained peers; access to emotional and psychological support within the organisation from mental health professionals. There may be many informal, practical initiatives underway within healthcare organisations or individual clinical departments that have not been publicised, meaning that any exploration of interventions will be limited to what has been reported and thus may not represent the complete array of support available. There is also limited available evidence evaluating intervention efficacy and effectiveness for the staff affected.

Staff support interventions specific to PSI were originally initiated in the US, many by clinicians, based on their own experiences or awareness of the emotional and psychological impact on colleagues. Interventions have in some cases been born out of or linked to other organisational aims, such as increased staff professionalism (Shapiro et al., 2014), or fostering transparency after medical errors (Pinto et al., 2012; Wu et al., 2013). Some support schemes have been devised for all healthcare staff in the institution (Scott et al., 2010; Trent et al., 2016; Van Pelt et al., 2008; Waterman et al., 2007), whereas others have been targeted for access by certain professional groups only (El Hechi et al., 2019; Hu et al., 2012; Krzan et al., 2015; Roesler et al., 2009; Vinson & Mitchell, 2014). Offers of support from some professional bodies are similarly limited to the profession concerned who have a paid membership of that body.

Relying on clinician-devised or led initiatives has the potential for support programmes to be created or implemented in ways which reflect the reality of incidents and impacts, but which may appeal to or meet the needs of only one specific professional group, potentially excluding or being inappropriate for other staff. They may also seek to support clinical colleagues in a way that could create a conflict of interest with investigation or other disciplinary processes where these are necessary. Without clear training, there may also be insufficient awareness of ethical issues and professional

boundaries, such as explicit limitations to confidentiality where harm to others has occurred or been disclosed.

Many of the support programmes that have been developed within organisations involve peer support from volunteer colleagues, which aims to keep costs down and responds to identified staff preferences for empathy and understanding being demonstrated by colleagues (Conway et al., 2010; Rinaldi et al., 2016; Scott et al., 2010; Shapiro & Galowitz, 2016). Organisation-wide take up of a general offer of support provided by paid specialist professionals would have considerable financial and other resource implications, given that the prevalence of healthcare staff being negatively affected by involvement in a PSI has ranged from ten per cent (Lander et al., 2006) to 82 per cent (O’Beirne et al., 2012). However, the reach and effectiveness of ad hoc or informal schemes is not known, and may not provide the route to staff recovery and safe professional functioning that organisations require to ensure patient safety.

[4.3 Rationale for investigating support programmes for healthcare staff after PSI](#)

It is now widely accepted that healthcare staff can experience severe, and in some cases very harmful reactions to being involved in a PSI. There have been over 50 literature reviews identified to date that investigate various aspects of the “second victim” phenomenon. The majority of these highlight the impact on healthcare professionals of being involved in a PSI, including Buhlmann et al. (2021); Herring (2020); Lewis et al. (2013); McDaniel and Morris (2020); Robertson and Long (2018), and some reviews explore individuals’ coping strategies (Busch et al., 2020a; Chan et al., 2018; Serou et al., 2017; Srinivasa et al., 2019). Given that the potentially negative impact on healthcare staff of involvement in PSI is well documented with qualitative or quantitative evidence in over 200 studies identified thus far, it is important to clarify whether the longstanding and widespread calls for staff to be cared for emotionally and psychologically at these challenging times are bearing fruit with respect to offering staff clear pathways to the support they need.

Support does not appear to be a uniform feature of healthcare organisations’ provision for their workers, and the lack of support for staff following PSI is mentioned in many recent studies and articles (including Biggs et al., 2020; Liukka et al., 2020; Malik et al., 2021; Serou, Husband et al., 2021; Tebala, 2020; Turner et al., 2020; Vanhaecht et al., 2019; Zarabian et al., 2020; Zhang et al., 2019). This suggests that calls for

emotional and psychological support have still in many quarters gone unanswered, and many healthcare staff have to manage without, negatively influencing their ability to cope and their return to professional functioning after traumatic workplace events (Shorey & Wong, 2021).

Even where support for healthcare professionals after involvement in PSI is accessible, it can be unstructured, without any implementation of consistent guidelines (Reiser Crelier et al., 2020). This lack of a structured approach, suggesting ad hoc, informal, or otherwise inconsistent support following PSI, increases the risk that support provided to negatively affected health professionals will be insufficient for their recovery. The rationale for focusing on structured support that is provided in healthcare workplaces stems from the need for transparency about who is affected after a PSI and to what degree. In-house support interventions create visibility of the impacts, as well as normalising access to support and recovery where they are arranged or promoted by the organisation; most importantly, they also enable an objective assessment of whether individual staff members are fit to continue working safely with patients, which self-referral to external sources of support, or reliance on family, friends, or not seeking any support all fail to achieve.

Four recent reviews have investigated staff support after PSI. A literature review carried out by Stone (2020b) provided an overview of second victim support in the US from eleven studies. However, not all of the included records described the implementation or evaluation of a specific support programme. Wade et al. (2020) carried out a scoping study to characterise the range of interventions used to support “second victims” of any health profession working in acute care settings. Using some studies and other literature such as brochures, they identified 22 programmes in Canada, Spain, and the US, providing peer support or staff education, but not necessarily including emotional or psychological support. Werthman et al. (2021) undertook an integrative review of the “second victim” phenomenon and support offered to nurses only, identifying six studies. Arguing that easy access to psychological support after PSI was crucial, Busch et al. (2021) undertook a systematic review of support resources available in healthcare organisations for providers impacted by a PSI. They included 16 studies, describing 10 “second victim” programmes and two other support resources: a toolkit for developing a support programme, and a website and online training course. They considered the conceptual basis of the resources they identified, focusing on elements of Safety I

(ensuring that as few things as possible go wrong in healthcare) and Safety II (ensuring that as many things as possible go right), identified by Hollnagel et al. (2015).

Having considered the reviews of the literature undertaken to date, there remains a need to understand how to make appropriate emotional and psychological support for healthcare staff after PSI available in an effective way. Evidence shows that there is some support, but it is not required of organisations, nor widespread. Educating staff about the impact of involvement in PSI may be a useful starting point, but it does not amount to the provision of support. To achieve consistency and widespread accessibility of support, especially within large healthcare organisations, which in some countries will be public bodies, necessitates resources. As a former UK government policymaker, I understand that to justify the use or extension of limited budgets and resources, there needs to be an official rationale, a business case, a policy decision, or a statutory requirement, and an eye to stakeholder and wider public opinion. One way to ensure provision is thus to have an overarching policy expectation and requirement or guidelines for organisations. Chapter 2 identified national and international policy documents calling for healthcare staff support after PSI, but it is not clear whether these have flowed through to support programmes for staff. Instituting and adhering to a specific policy standard or set of guidelines would provide a transparent means of establishing organisational commitment to action and resource allocation; it would clarify that support would be to restore psychological wellbeing and safety, rather than about “supporting” staff to learn from errors or improve their clinical practice; it would enable individuals to access the support they needed and, if necessary, to hold their organisations to account in the provision of such support.

Not having a policy or prescribed standard does not necessarily mean that there will be no support: organisations may have myriad supportive initiatives that are underway in various pockets of their operational areas, some initiated by local staff, some as pilots or trials. However, where resources are needed to enable the introduction of new schemes and programmes across organisations, or to bring about the expansion of existing interventions to create uniform availability for all staff, agreement at a high level in the organisation’s management structures is required. Where programmes are initiated without resource allocation, they inevitably rely on volunteers, goodwill, and the motivation of individual personnel to go above and beyond their usual duties. This may jeopardise either the start, or the continuation and sustainability of schemes. It may

also result in ad hoc support being offered in small corners of an organisation which is not accessible to all staff in need. This led to a focus on investigating support interventions in organisations where emotional and psychological support to staff after PSI is accessible in a known and structured way within the institution, and an exploration of whether the interventions included all staff or certain groups only. Given that the word “policy” in healthcare refers normally to an accepted treatment process, it was not possible to search effectively for the policy bases of the identified schemes using this term without ambiguity. For this reason, an analysis of the support programmes to establish any acknowledged policy basis was undertaken after the records were identified, meaning that not all included records would detail a basis in policy or other guidelines.

4.3.1 Definition of organisational support after PSI

Organisational support was defined as psychological or emotional support after a PSI, provided and accessible when needed in a structured process within the organisation.

4.4 Literature review

Whittemore and Knafl’s revised framework for integrative reviews was chosen because it offers a comprehensive methodology and provides for the inclusion of both quantitative and qualitative research data, from peer reviewed journals and other relevant sources, including grey literature (Whittemore & Knafl, 2005). The aim was to ensure that relevant studies of support programmes for healthcare staff after involvement in a PSI were not excluded by virtue of the study design, nor by profession type. The review approach was inductive in its aim to draw conclusions from the identified records, and not hypothesise about what would be found. Whittemore and Knafl consider that integrative reviews can “present the state of the science, contribute to theory development, and have direct applicability to practice and policy” (p. 546), which captures the objectives of this review. Table 7 summarises the stages of this review process.

Table 7

Stages of Whittemore and Knafl (2005) framework for integrative reviews

Review stages	
1.	Problem identification
2.	Literature search
3.	Data evaluation
4.	Data analysis
5.	Presentation

4.4.1 Problem identification and review question

Whittemore and Knafl set out the first stage of an integrative review as the identification of the problem and establishing the review’s purpose. For this review, the objective was to identify the structured programmes organisations have developed offering emotional or psychological support for healthcare staff who have been involved in a PSI, as described in healthcare research and grey literature. The review question was: What structured programmes have organisations developed to provide emotional or psychological support within the organisation for healthcare staff who have been involved in a PSI, and what does the support include?

4.4.2 Search

The second stage of the review process is to conduct a search of relevant literature. In consultation with a subject specialist librarian, a systematic search of the literature was first conducted in March 2020. It was evident that some of the authors of this literature do not use the “second victim” term, and so I elected to widen the search for records describing staff support in these situations, to encompass schemes that used either that term or other descriptors. The databases selected for this search were CINAHL, MEDLINE Complete, and PsycINFO, without date restriction, to capture journals specialising in healthcare practice and management, and articles about the emotional or psychological impact on healthcare staff of PSI. The sequence and combination of the database search lines and terms used is set out in Table 8; this shows how the search terms were designed to capture all possible records referring to support programmes or schemes for healthcare staff who had experienced distress after involvement in a PSI, whether the programmes used the term “second victim” or not, encompassing all study designs, and any branch of the health professions.

The total number of records retrieved was 4209. In May 2021, the search was updated using the same terms, and the total number of records rose to 4591. Alerts for this search were reviewed until December 2022. A manual search of the websites of healthcare ministries, patient safety authorities, and healthcare standards bodies in Australia, Canada, and the US was additionally undertaken in July 2022, to capture relevant grey literature not already identified relating to staff support interventions in those countries following PSI. The grey literature search was limited to three countries because of the potential scope of work and limited resources available; an additional 16 records were identified.

Table 8

Literature review search terms by line

Search terms by line	Search mode 'Find all my search terms'
S1	MH/MA "Physicians"
S2	MH/MA "Nurses"
S3	MH/MA "Health Personnel"
S4	MH/MA "Surgeons"
S5	AB "second victim*" OR clinician* OR nurse* OR doctor* OR "health* professional*" OR "health* personnel" OR obstetric* OR midwives OR physician*
S6	TI "second victim*" OR clinician* OR nurse* OR doctor* OR "health* professional*" OR "health* personnel" OR obstetric* OR midwives OR physician*
S7	S1 OR S2 OR S3 OR S4 OR S5 OR S6
S8	MH "Medical Errors" [see note below]
S9	AB "medical error*" OR "patient safety incident*" OR "adverse event*" OR "adverse medical"
S10	TI "medical error*" OR "patient safety incident*" OR "adverse event*" OR "adverse medical"
S11	S8 OR S9 OR S10
S12	MH/MA "Guilt"
S13	MH/MA "Shame"
S14	AB distress OR guilt OR shame OR traumat* OR coping OR support
S15	TI distress OR guilt OR shame OR traumat* OR coping OR support
S16	S12 OR S13 OR S14 OR S15
S17	S7 AND S11 AND S16

Note for search line S8

Equivalent Medical Subject Headings (MeSH)

- S8 CINAHL: MH "Health Care Errors"
S8 MEDLINE Complete: MH "Medical errors"
S8 PsycINFO: MA "Patient Safety"

4.4.3 Inclusion criteria and records selected

Stage three of the review process comprises selection of relevant records, and the criteria used for inclusion and exclusion.

Inclusion criteria:

- Description of structured programme available to some or all healthcare staff, offering support following PSI (harm to patient or near miss to patient), provided currently within their organisation, **and**
- Includes description or evaluation of the type of support offered or the mechanism for activating support, **and**
- Different studies of the same support programme (extensions, changes, refinements, updates)
- Published in English, French, or Spanish
- Published in a peer-reviewed journal or other healthcare literature
- No date restriction

Exclusion criteria:

- Published in languages other than English, French, or Spanish
- Support offered by professional bodies or insurers to their members, or by other groups outside the healthcare organisation
- Toolkits (methodologies) for introducing support programmes, unless they also describe a specific programme
- Websites offering education or signposting to other resources
- Purely educational and training programmes or curricula, without direct staff support
- Schemes proposed or under development
- Self-administered support (“self-care”)

Theoretical toolkits, educational curricula, and websites were excluded because they do not offer evidence that emotional or psychological support was provided or received in practice by affected staff in any given scheme. Support schemes run purely outside the organisation, such as by most Employee Assistance Programmes (EAPs) or by

professional and insurance bodies, were excluded because they normally only offer short-term, time-limited counselling including for personal problems, rather than being targeted at the specific needs of healthcare professionals after PSI such as trauma-focused provision (Klatt et al., 2021); they may include barriers to referral such as management agreement or discretion, or may require self-referral; EAPs do not include support from organisational colleagues, which is highly valued by healthcare professionals (Edrees & Wu, 2017; Vanhaecht et al., 2021). Stigma among staff in accessing EAP services has been identified, in part because of delays in response, waiting lists, and perceived lack of clinical expertise in externally provided services (Edrees et al., 2017). Moreover, EAP services cannot assess whether a healthcare worker is safe to continue in work, nor offer any advice or recommendations to the organisation because of confidentiality rules.

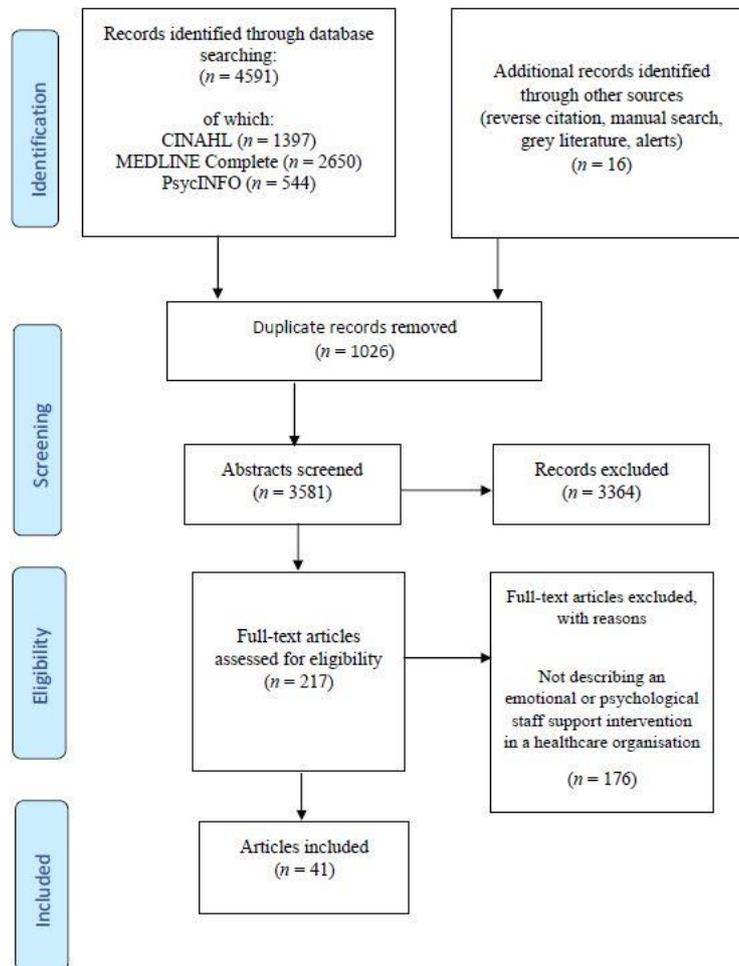
This stage of the review also encompasses an evaluation of the quality of records. Since there are relatively few published descriptions of organisational support schemes for healthcare staff following PSI, records were not excluded based on an assessment of methodological design, completeness, or rigour. For this review, records were included based on their informational value (Kirkevold, 1997), in describing structured programmes that have been developed by healthcare organisations to support their staff emotionally or psychologically after PSI. The quality of the included records is explored in section 4.5.2.

The records were managed in Endnote, and once duplicates had been removed, all abstracts were reviewed to establish their potential relevance. Records not pertaining to emotional or psychological support provided to healthcare staff after PSI were removed. Where the abstract did not offer sufficient information to be clear about the content, the full text was reviewed. 217 records were found to address healthcare staff support and were reviewed in full. Applying the inclusion and exclusion criteria resulted in a final total of 41 records.

Figure 4 sets out the process of record inclusion, exclusion, and final selection.

Figure 4

Flow chart of literature search and selection process



Note. Adapted from: Moher et al. (2009). Preferred reporting items for systematic reviews and meta-analyses

4.5 Results

4.5.1 Characteristics of included records

The data analysis stage of this integrative review process involves investigating the selected records to establish and compare features of the identified support programmes. Details of the 41 selected records, reporting on a total of 35 support programmes for healthcare staff after PSI, published from 2003 to 2022, are summarised in Table 9. The studies described programmes located in Australia (n = 3),

Canada (n = 6), France (n = 1), Israel (n = 1), Spain (n = 2), and the US (n = 22), with records included alphabetically by first author. One record described and compared six different programmes in the US State of Maryland (Edrees et al., 2017). The study designs were quantitative (n = 8); qualitative (n = 2); mixed methods (n = 18); and purely descriptive (n = 13). Populations reported included all healthcare providers (n = 14); physicians (n = 5); clinicians (n = 2); intensive care specialists (n = 2); mental health professionals (n = 2); nurses (n = 2); pharmacists (n = 1); surgeons (n = 1); anaesthetic professionals (n = 2); ambulance staff (n = 1); paediatric professionals (n = 2); operating room staff (n = 1); patient safety representatives (n = 1); residency programme directors (n = 1). Three records did not report either a specific population or sample.

Records describing the same scheme are identified within Table 9 by colour-coding, and all the programmes reported in multiple studies were located in the US: the RISE programme (shaded orange) was the subject of five separate studies (Connors et al., 2020; Dukhanin et al., 2018; Edrees et al., 2016 and 2017; Moran et al., 2020). The YouMatter programme (shaded lilac) was reported in three records (Krzan et al., 2015; Merandi et al. 2017 and 2018). The Brigham and Women's Hospital Peer Support programme (shaded green) was also described in three studies (Hu et al., 2012; Shapiro & Galowitz, 2016; Van Pelt et al., 2008). The Care for the Caregiver programme (shaded yellow) was the subject of two records (Morales & Brown, 2019; 2021). The forYOU programme was reported in two studies (Hirschinger et al., 2015; Scott et al., 2010), shaded blue, as was the HELP programme (Finney, Jacob et al., 2021; Finney, Czinski et al., 2021), shaded pink.

The forYOU three-tiered support model (comprising local emotional support, the intervention of trained peer supporters, and referral to further professional support), devised by Scott and colleagues (2010), was the acknowledged basis for nine other schemes. This is illustrated in Figure 5 below. Twenty-five programmes of the 35 involved peer supporters in various capacities.

[4.5.2 Study quality](#)

Records were included because they reported on programmes healthcare organisations have developed to support their staff emotionally or psychologically after PSI, and provided information about the nature of the support offered (Kirkevold, 1997), rather than based on their study quality, which was variable. Thirteen records offered purely

descriptive information without data collection; of these, three did not report a population sample. Where samples were reported, they ranged widely from 2 (case scenarios) to 3171 (surveyed physicians). Some programmes reported support for specific departments or groups of staff only, whereas others targeted support to all affected staff. Evaluative data were included in some of the records, particularly where the programme had been in place for several years and subsequent studies were undertaken to review the development of the programme and evaluate its operation. Available evaluative data are included in Table 9 to illustrate where the evidence extended beyond description.

Table 9*Summary of the included records*

First author Year	Country	Design Method/s	Setting	Population Sample	Evaluative data	Study aim	Programme name	Support elements
Bueno-Dominguez 2016	Spain	Descriptive	El Grup Sagessa (Health and social care group)	Not reported	Report of learning from experience about the support elements that are important to assist recovery: empathy, listening, timely intervention	To describe the USVIC, its composition and functions	USVIC: Unidad de Soporte a las Segundas Víctimas del Incidente Crítico (Support unit for second victims of critical incidents)	The support unit is a rapid response team comprised of a doctor/bioethicist, a psychologist, two nurses, and a lawyer. It provides legal guidance as needed, and emotional/psychological support to second victims, Support can be activated by self-referral, colleagues, or management.
Canadian Patient Safety Institute 2019	Canada	Descriptive	Alberta Health Services	Alberta Health Services employees No sample reported	Not reported	To describe the programme aims and features	Peer Trauma Response Team Program	The programme provides support for the group or individual after a critical incident or other traumatic workplace causing physical or mental stress. It aims to reduce the impact of the incident and accelerate recovery, educating about prevention of critical incident stress, recognising signs and symptoms, and ways to access to further support

Table 9 (Continued)

First author Year	Country	Design Method/s	Setting	Population Sample	Evaluative data	Study aim	Programme name	Support elements
Canadian Patient Safety Institute 2019	Canada	Descriptive	British Columbia Emergency Health Services	British Columbia Emergency Health Services employees No sample reported	Frequency of programme activation (on average four times per day)	To describe the peer support programme basis and aims	Critical Incident Stress Program	The Critical Incident Stress peer support programme covers all 4000 employees across the province. Peer support is the central pillar of a five-pillar approach that includes Readiness, Resilience, Response, Recovery, Re-entry on a Research/Standards base. The aim is to reduce, stigma, listen, and link affected staff to early and appropriate psychological intervention
Canadian Patient Safety Institute 2019	Canada	Descriptive	Chatham Kent Health Alliance	Not reported	Not reported	To describe the peer support programme	Peer Support Group	Aim is to provide a psychologically safe workplace by means of individual or group crisis intervention using CISM. The programme, situated within occupational health, can be triggered by the affected individual, a concerned co-worker or by leadership. Peer supporters are trained volunteers

Table 9 (Continued)

First author Year	Country	Design Method/s	Setting	Population Sample	Evaluative data	Study aim	Programme name	Support elements
Canadian Patient Safety Institute 2019	Canada	Descriptive	Health Canada system	Nurses working in First Nations communities across Canada No sample reported	Not reported	To describe the programme goal and features	Occupational & Critical Incident Stress Management	The goal of the programme is to safeguard nurses' wellbeing after a critical incident, to help them maintain/return to health, offering ideas for coping, to prevent/ reduce occupational stress injuries, promote nurses' resilience, accelerate normal recovery, and minimise absenteeism.
Canadian Patient Safety Institute 2019	Canada	Descriptive	Michael Garron Hospital Toronto	All hospital staff No sample reported	Not reported	To describe the aim and features of the peer support programme	Second Victim Peer Support	24-hour care to help all healthcare team members (clinical and non-clinical) and volunteers, directly involved in or witnessing an incident, or anyone who experiences a long period of high-stress or repeated exposure to emotional trauma at work. Aim is to help affected staff understand they are experiencing a normal reaction to a distressing event and to help them quickly return to work

Table 9 (Continued)

First author Year	Country	Design Method/s	Setting	Population Sample	Evaluative data	Study aim	Programme name	Support elements
Canadian Patient Safety Institute 2019	Canada	Descriptive	Sickkids Hospital Toronto	Hospital staff No sample reported	Reports number of active peers on the team	To describe the programme aims and features	Sickkids Toronto Peer Support and Trauma Response Program	The programme aim is to improve the psychological health and safety of staff. It acknowledges that compassion fatigue, burnout, second victim distress, and traumatic stress are common issues that affect healthcare professionals. The programme offers hospital-wide one-to-one confidential peer support and CISM following distressing and traumatic work events, to promote prevention, staff resilience and effective coping strategies. Peers are a mixture of clinical and non-clinical staff

Table 9 (Continued)

First author Year	Country	Design Method/s	Setting	Population Sample	Evaluative data	Study aim	Programme name	Support elements
Cobos-Vargas 2022	Spain	Descriptive Quantitative analysis of serious adverse events reports	Clínico San Cecilio University Hospital Granada	All healthcare workers involved in a serious adverse event where the support programme was activated	Number of adverse events reported and triggering the PSAE; number of healthcare professionals involved; number of healthcare workers showing second victim symptoms; number of healthcare workers accessing first, second, and third tier support, by profession. Interview data about healthcare workers' experiences of the support	To share two years' experience of a second victim support intervention integrated into a serious adverse events management programme	Procedure for Serious Adverse Events (PSAE)	Based on the Scott model, support includes three tiers: one-to-one emotional and psychological first aid; peer support; and referral if needed to external support services. The main difference with respect to the Scott model is that all professionals involved in a serious adverse event are proactively identified and automatically receive support from trained peers, regardless of whether or not they have received first-level support. This aims to remove stigma

Table 9 (Continued)

First author Year	Country	Design Method/s	Setting	Population Sample	Evaluative data	Study aim	Programme name	Support elements
Connors 2020	US	Evaluation of awareness and utilisation of the RISE programme	Johns Hopkins Hospital Baltimore	Nurses No sample reported	Data about programme awareness and usage; perceptions of programme benefits; measures of resilience, job satisfaction, and burnout, and among RISE users / non-users	To evaluate levels of awareness, use, and benefits of the programme	Resilience in Stressful Events (RISE)	Timely peer support (confidential Psychological First Aid and emotional support) to staff who encounter stressful patient-related events
Devencenzi 2006	US	Descriptive	Kaiser Permanente Healthcare Organization	Patient care providers No sample reported	Evaluation of the intervention is sought from the recipient. Survey process underway (not reported) to evaluate the interventions and outcomes	To describe the rationale for, development, and process of the support programme for patient care providers after a mistake or near miss	Employee and Physician Assistance Program	Support for patient care providers. Programme offers CISM psychological support: crisis management group briefing 24-48 hours post event; defusing for individuals or small groups, up to 12 hours post event; individual emotional support at any time post event. Aim to lessen the impact, restore individual functioning, provide a supportive forum for staff to discuss the event

Table 9 (Continued)

First author Year	Country	Design Method/s	Setting	Population Sample	Evaluative data	Study aim	Programme name	Support elements
Dukhanin 2018	US	Mixed methods 1) Quantitative Pre-and post-implementation surveys 2) Content analysis of open-ended comments about support experience and feedback	Johns Hopkins Hospital Paediatric Dept Baltimore	202 healthcare workers. Initial survey: no composition reported. Follow up survey: 49% nurses, 20% physicians, 10% managers, 21% others	Quantitative analysis: awareness of the availability of support; likelihood of accessing the programme. Content analysis identified barriers to scheme use	To report on the RISE programme as a case study, to evaluate effectiveness, and identify barriers to addressing the needs of second victims, four years after implementation	Resilience in Stressful Events (RISE)	Confidential Psychological First Aid and emotional support provided 24/7 by trained peers to staff who have had stressful patient-related events, one-to-one or in groups (as requested)
Edrees 2016	US	Mixed-methods Description of scheme development Survey evaluating feasibility and subsequent implementation	Johns Hopkins Hospital Baltimore	144 paediatric department staff (clinical and non-clinical) 50 peer responders	Evaluation by frequency counts of encounters; staff surveys; evaluations by peer responders	To describe the development of RISE, evaluate its initial feasibility and subsequent implementation	Resilience in Stressful Events (RISE)	Support for paediatric healthcare workers (hospital-wide) Peer support (confidential psychological first aid and emotional support by trained colleagues) for workers after stressful patient-related adverse events, medical errors, deaths. 24/7 one-to-one or group support offered (as requested)

Table 9 (Continued)

First author Year	Country	Design Method/s	Setting	Population Sample	Evaluative data	Study aim	Programme name	Support elements
Edrees 2017	US	Qualitative Semi-structured interviews	6 schemes in 7 hospitals Maryland	43 Patient Safety represent- atives from 38 acute care hospitals in one US State	Not reported	To describe the support elements and programme activation processes in the 6 identified support programmes	1. Immediate Debriefing Team 2. Critical Incident Stress Support 3. Critical Incident Stress Management 4. COPE (Compassion Outreach Peer Encourage- ment) 5. RISE (Resilience In Stressful Events) 6. Outpatient Psychiatry Support Team	Support for staff experiencing emotional distress after patient- related events. All 6 programmes are activated if requested by the affected individual. All offer group and individual support. 5 out of 6 can be activated by department leader, unit manager, or risk manager referral. 2 programmes offer support when the healthcare worker is a defendant in a lawsuit

Table 9 (Continued)

First author Year	Country	Design Method/s	Setting	Population Sample	Evaluative data	Study aim	Programme name	Support elements
El Hechi 2019	US	Mixed methods Description Quantitative and qualitative survey data	Massachusetts General Hospital Dept of Surgery Boston	Survey: 30 surgeons and surgical trainees, including: affected peers evaluating peer supporters; peer supporters evaluating programme; all participants evaluating programme	Evaluation of frequency of interventions; feedback received from programme recipients and peer supporters, including level of reported participant satisfaction	To describe and evaluate a second victim peer support programme for surgeons and surgical trainees	Second Victim Peer Support Program	Email sent to all surgeons and surgical trainees involved in identified adverse events, offering peer support and resources. Recipients can opt out. Nominated and trained peer supporters follow a specified “dos and don’ts” strategy, offer empathic listening and co-create a coping strategies plan
Finney 2021	US	Mixed methods Description of programme and Quantitative Statistical; data	Mayo Clinic Rochester	Anaesthesia professionals	Statistical data tracking programme activations; supported staff completed an evaluation of support received; peer supporters evaluated their interventions	To describe the implementation of a second victim peer support programme for paediatric healthcare professionals	Healing Emotional Lives of Peers (HELP) program	Three-tiered model of support: Tier 1 psychological first aid by colleagues at the local level; Tier 2 assistance by trained peer supporters; Tier 3 use of institutional resources beyond peer support

Table 9 (Continued)

First author Year	Country	Design Method/s	Setting	Population Sample	Evaluative data	Study aim	Programme name	Support elements
Finney 2021	US	Quantitative Surveys pre- and post programme implement- ation	Mayo Clinic Rochester	194 (pre) and 177 (post) paediatric healthcare professionals	Statistical data using the Second Victim Experience and Support Tool to assess awareness of the support programme; barriers to and perceptions of support available for staff distress after incidents	To evaluate a second victim peer support programme for paediatric healthcare professionals	Healing Emotional Lives of Peers (HELP) program	Paediatric healthcare professionals can self- refer or anonymously refer an affected colleague to the peer support programme to initiate a supportive outreach intervention from a trained peer supporter
Graham 2019	US	Quantitative Surveys at baseline and after 3 months	University of California San Diego Health San Diego	75 staff and physicians responded to the surveys	Frequency of interventions; feedback and satisfaction with the support; number of suicides prevented	To test the feasibility of providing a Caregiver Support Team to provide emotional first aid in the workplace	Caregiver Support Team	Caregiver Support Team (trained peer supporters) proactively provide emotional first aid to healthcare clinicians affected by stressful work-related events, and triage those who would benefit from further care or psychological support

Table 9 (Continued)

First author Year	Country	Design Method/s	Setting	Population Sample	Evaluative data	Study aim	Programme name	Support elements
Hirschinger 2015	US	Quantitative Statistical analysis	University of Missouri Health Care System Columbia (6 hospitals)	1075 clinicians	Quantitative data about programme use, reasons for and frequency of one-to-one and group interventions; numbers of peer supporters trained; percentage of interventions delivered in each Tier	To evaluate the programme over first 5 years	forYOU	Provision of real-time monitoring to identify affected staff after distressing work events. Immediate on-demand emotional support via a rapid response service for to help affected staff return to pre-event performance. Three-tiered model: 1) immediate, proactive local emotional first aid, 2) peer support, 3) fast-track referral to professional counselling. Group debriefing and mentoring also provided where needed
Hu 2012	US	Quantitative Survey	Brigham and Women's Hospital Boston	108 physicians	Not reported	To expand a support programme to meet the needs of physicians	Peer Support Team	Support for physicians. Existing group support programme following adverse medical events was underused by physicians. Barriers to accessing support: stigma attending a group or external mental health services. Implementation of one-to-one support from trained physician peers

Table 9 (Continued)

First author Year	Country	Design Method/s	Setting	Population Sample	Evaluative data	Study aim	Programme name	Support elements
Klatt 2021	US	Description of programme development Quantitative 2 surveys (3 and 9 months post-programme introduction)	Froedtert and MCW healthcare system Wauwatosa	1786 health-care team members (first survey) 1188 health-care team members (second survey)	Data reporting number of trained supporters, number of support interventions, evaluation of and changes to supporter training	To report the implementation of a peer support programme for an entire healthcare system	Supporting Our Staff (SOS) Peer Support Program	Support for the entire healthcare team (inpatient and outpatient settings). Programme follows the Scott three-tiered SV support model, activated by self- or peer-referral. Tier 1: Local unit/department emotional support, one-to-one reassurance, signposting to peer support programme if needed Tier 2: Trained peer supporters Tier 3: Expedited referral to professional support, including Mental and Behavioural Health services, Employee Assistance Programs (EAPs), and Spiritual Services

Table 9 (Continued)

First author Year	Country	Design Method/s	Setting	Population Sample	Evaluative data	Study aim	Programme name	Support elements
Krzan 2015	US	Quantitative 2 surveys (pre- and post- programme introduction)	Nationwide Children's Hospital Columbus	Both surveys: 121 Pharmacists	Second survey 5 months after programme launch Intention to continue to collect data to evaluate benefits (not reported)	To develop, pilot test, and replicate a support programme	YOUMatter	Support for: Pharmacy staff, then expanded to peri- operative teams, emergency department, and intensive care units. Based on the Scott Three-Tiered Model of Rapid response, support delivered by trained peer supporters
Lane 2018	US	Descriptive and Quantitative Statistical analysis of programme referrals	2 hospitals in an academic medical centre: 1 adult (Barnes- Jewish Hospital), 1 paediatric (St Louis Children's) St Louis	36 clinicians as peer supporters	Count of referrals to the programme by profession over 34 months; number of interactions per person referred; number of referrals to further support. Report of changes made to overcome barriers to scheme access	To describe the development of a clinician peer support programme, the process used to select and train supporters providers, referral routes, and barriers to programme development	Washington University School of Medicine Clinician Peer Support Program (PSP)	Trained peers provide support to clinicians (physicians, residents, fellows, physician assistants, nurse practitioners, certified registered nurse anaesthetists) after medical errors and adverse events. Clinicians can self-refer, or be referred by a peer supporter, or by safety/ risk management staff. All clinicians involved in a serious medical error or adverse event are contacted proactively

Table 9 (Continued)

First author Year	Country	Design Method/s	Setting	Population Sample	Evaluative data	Study aim	Programme name	Support elements
Leaune 2020	France	Mixed methods collaborative and participatory action research, using pre- and post-measures of participants, ethnographic observation, and semi-structured interviews	Centre for Suicide Prevention care unit Lyon	Mental health and social work staff No sample reported	Quantitative evaluation includes pre- and post-measures of the emotional, traumatic, and professional impacts, and perceived social support	To evaluate the effectiveness of the programme to buffer the impacts on staff; to improve social support for professionals exposed to patient suicide	SUPPORT	6-week programme based on Scott model, to buffer the emotional, traumatic, and professional impacts of patient suicide in 4 stages: 3 mandatory stages are (a) basic emotional first aid at the local level; (b) team-based brief supportive intervention in the institution (1 to 2 hours); and (c) follow-up. Fourth optional stage offers long-term support and training or workshops on suicide prevention
Merandi 2017	US	Descriptive Quantitative Usage statistics	Nationwide Children's Hospital Columbus	All healthcare providers accessing the programme	Reports number of individual and group support encounters, by profession and reason; number of peer supporters trained, by profession	To describe replication of the Scott support model in this institution; document events to track programme impact; and identify further support needs	YOUMatter	The programme follows the Scott three-tiered SV support model, activated by self- or peer-referral. Tier 1: Local unit/ department one-to-one emotional support Tier 2: Trained peer supporters, patient safety team/ risk management activation if needed Tier 3: Expedited referral to professional support/ guidance as needed

Table 9 (Continued)

First author Year	Country	Design Method/s	Setting	Population Sample	Evaluative data	Study aim	Programme name	Support elements
Merandi 2018	US	Mixed methods Survey with 2 open-ended questions	Nationwide Children's Hospital Columbus	250 neonatal intensive care staff from 7 units in one hospital	Report of scheme usage statistics Some qualitative comments described barriers to access and feedback	To assess healthcare provider satisfaction with the hospital staff support programme	YOUMatter	The programme follows the Scott three-tiered SV support model, activated by self- or peer-referral. Tier 1: Local unit/ department one-to-one emotional support Tier 2: Trained peer supporters, the patient safety team/ risk management activation if needed Tier 3: Expedited referral to professional support/ guidance as needed
Morales 2019	US	Descriptive 2 case scenarios	MedStar Health system (10 hospitals) Maryland and Columbia	2 case scenarios reported	Report of reflection on lessons learned, including introduction of tracking data for support encounters and usage by profession (no detail) Feedback from support recipients in 2 case scenarios	To describe staff support programme	Care for the Caregiver within the GO Team	Amalgamates the National Transportation Safety Board Go Team, and components of the Scott three-tiered model support. Peers trained in Communication and Optimal Resolution (CANDOR) offer confidential emotional first aid support for any staff involved in a serious unanticipated event and identify long-term needs and additional resources, if needed

Table 9 (Continued)

First author Year	Country	Design Method/s	Setting	Population Sample	Evaluative data	Study aim	Programme name	Support elements
Morales 2021	US	Descriptive	MedStar Health system (10 hospitals) Maryland and Columbia	Caregivers No sample reported	Not reported	To describe evolution of the staff support programme	Care for the Caregiver Go Team	Evolution of the peer support programme in response to the COVID-19 pandemic, including 24/7 support, seeking out staff proactively, provision of wellness spaces for talks with peer supporters. Care for the Caregiver resources now consolidated on an internal webpage
Moran 2020	US	Cost-benefit analysis of RISE support programme for nursing staff using a Markov model	Johns Hopkins Hospital Baltimore	80 nursing staff who used the RISE programme between 2015 and 2016	The model and budget impact analysis reported the net monetary benefit savings per nurse who initiated a RISE call, and potential annual savings per hospital	To carry out a cost-benefit analysis of the RISE support programme	Resilience in Stressful Events (RISE)	The programme aims to provide timely multi-disciplinary, peer-to-peer support in a non-judgmental environment, to help healthcare providers adopt healthy coping strategies, and to promote overall well-being

Table 9 (Continued)

First author Year	Country	Design Method/s	Setting	Population Sample	Evaluative data	Study aim	Programme name	Support elements
Nadel 2020	US	Description of programme development Quantitative Statistical data about number of interventions Participant feedback examples	Cohen Children's Medical Center New York City	Paediatric haematology/oncology staff	Reports number of interventions conducted. Reports testimonials and feedback about scheme interventions	To share experience of building, training, and piloting a peer support team based on CISM	HOPES Helping Our Peers Endure Stress	Trained peer supporters cover all haematology/oncology workspaces and shifts, providing CISM interventions within fixed timeframes after any traumatic work event: voluntary group defusing and debriefing, where participants can receive emotional support. One-to-one support and referrals to additional support can also be provided
Queensland Government 2018	Australia	Mixed methods Quantitative Telephone survey Support usage statistics Qualitative 5 focus groups	Queensland Ambulance Service	Survey: 1042 staff members Focus groups: Total of 40 participants (between 5 and 11 peer group, various roles)	Focus group themes and feedback were fed into survey construction. Survey data (descriptive statistics). Usage statistics for peer support and counsellors, by staff role and location	To report a multi-method evaluation and examination of QAS Staff Support Services	Priority One	Support provided by Peer Support officers, and counsellors, supervisors and managers, recognising the impact of work-related events including tragic and severe human trauma and suffering; and the injury, illness and deaths of children. Affected staff can choose the way they prefer to be helped

Table 9 (Continued)

First author Year	Country	Design Method/s	Setting	Population Sample	Evaluative data	Study aim	Programme name	Support elements
Roesler 2009	US	Descriptive	Neonatal Intensive Care Unit, Methodist Hospital of Indianapolis	6 nurses and 1 pharmacy technician involved in the critical incident	No data reported	To report a fatal critical incident and describe the support for and recovery of the involved nursing staff	Critical Incident Rapid Response Team (CIRRT) / Healing Beyond Today	Emotional impact on staff Introduction of a mandatory CISD debriefing programme for staff after incidents. Ongoing individual counselling support Support for other unit staff
Scott 2010	US	Quantitative Survey Description of programme implementation	University of Missouri Health Care System Columbia (6 hospitals)	898 Healthcare providers (184 physicians, 65 medical students, 362 nurses, 287 allied health professionals)	Tier 1 interactions with untrained peers not quantified. All Tier 2 and Tier 3 support encounters (with staff role) recorded in first 10 months, to evaluate programme effectiveness. Number and length of interactions; referrals to Tier 3	To quantify the frequency and nature of the second victim experience and explore desired characteristics of effective institutional support	forYOU	Identification of desired support elements including a break from duties and 24/7 access to support. Implementation of an on-demand emotional support rapid response service, in a three-tiered model: 1) immediate, proactive local emotional first aid, 2) peer support, 3) fast-track referral to professional counselling

Table 9 (Continued)

First author Year	Country	Design Method/s	Setting	Population Sample	Evaluative data	Study aim	Programme name	Support elements
Shapiro 2016	US	Description of programme origin and evolution Quantitative Frequency counts of support provided	Brigham and Women's Hospital Boston	Physicians No sample reported	Records of outreach calls made over four years. Counts of physicians supported in multi-disciplinary group peer support sessions. Limitations of programme reach explored	To describe the benefits of a peer support programme for physicians, and the elements of support	Center for Professionalism and Peer Support	Support for physicians One-to-one support from trained clinician peers, who proactively contact staff involved in adverse or emotionally stressful events, to offer a supportive conversation (empathic listening) and information about resources
Slykerman 2019	Australia	Description of programme origin and implementation	Royal Brisbane and Women's Hospital Brisbane	Anaesthetic staff	Changes reported since the start of the programme to increase effectiveness and feasibility of contacting affected staff	To describe hospital staff peer support programme	RBWH Department of Anaesthesia and Peri-operative Medicine Peer Support Programme	Consultant anaesthetist peers trained in Psychological First Aid offer confidential support, resources and referral to on-site psychologist as required. Support is intended as a psychological safety net for all anaesthetic staff. All support is provided on-site. Modes of contacting staff extended

Table 9 (Continued)

First author Year	Country	Design Method/s	Setting	Population Sample	Evaluative data	Study aim	Programme name	Support elements
Trent 2016	US	Qualitative study design, 6 focus group interviews	Scott & White Healthcare (SWH) Central Texas and 5 surrounding regions	20 Faculty and medical residents	The focus group data evaluates the programme over 12 years of operation. Identifies a need for specific support where providers face board complaints	To describe requirements for the adequate delivery of health care adversity support and necessary programme improvements	SWADDLE	Immediate one-to-one peer support after an unanticipated outcome; training for high-risk areas in Psychological First Aid. A licensed behavioural health clinician assesses psychological crises and fast-tracks referrals for psychiatric care
Turner 2021	Australia	Description of Framework introduction, Quantitative Statistical data about suicide prevention	Gold Coast Mental Health and Specialist Services Queensland	Mental health staff	Data reporting suicide prevention framework, and perceived benefits of the staff support programme, including more staff feeling emotionally supported after incidents	To describe the implementation of a Zero Suicide Framework for patients, some of the outcomes to date, and learnings from this process, including introducing staff support	Always There	The staff support programme, based on the Scott model, provides a confidential, rapid response to staff involved in any critical incident, and all staff who may be experiencing cumulative and vicarious stress reactions. The responder team includes trained volunteer peer supporters who provide emotional and practical support using the principles of psychological first aid.

Table 9 (Continued)

First author Year	Country	Design Method/s	Setting	Population Sample	Evaluative data	Study aim	Programme name	Support elements
Van Pelt 2008	US	Quantitative survey Descriptive	Brigham and Women's Hospital Boston	78 Operating room staff	Types of emotional support available and used by staff before the programme. Number of one-to-one peer support interventions and group sessions reported, and how confidentiality was maintained	To investigate the availability of emotional support following adverse medical events before the programme. To describe the origin and implementation of a peer support programme for care providers after adverse events	The Peer Support Service	Support for: care providers Lack of structured emotional support services for care providers after adverse events led to developing a structured peer support service. The programme offers a safe environment to share the emotional impact of adverse events, and fosters open communication and workplace compassion
Vinson 2014	US	Quantitative 2 Surveys	Beth Israel Deaconess Medical Center Boston	64 Resident Programme Directors 168 Residents	Survey includes data from respondents evaluating support resources and their effectiveness	To determine the prevalence, efficacy and utilisation of support for residents after adverse events. To develop a best-practice support model	Anesthesia Resident Wellness Committee	Support for Anaesthesia Residents.. Structured peer support offered by peers to residents experiencing distress related to adverse clinical outcomes, or other distressing events. Aim to prevent escalation into dysfunction. Referral to additional services where necessary

Table 9 (Continued)

First author Year	Country	Design Method/s	Setting	Population Sample	Evaluative data	Study aim	Programme name	Support elements
Waterman 2007	US and Canada	Quantitative Survey and Descriptive	BJC Healthcare: 13 hospitals Missouri and Illinois	1767 US Physicians 1404 Canadian Physicians	The data reports how physicians are affected by errors, preferred support, and barriers to support. No evaluation of the support programme reported	To investigate the impact of errors on physicians	Save Our Staff (SOS) (US programme)	Negative emotional impact on physicians of errors and near misses Lack of emotional support and barriers to access. Support programme (in a US healthcare group) offers group debriefing for health professionals after a medical error, and individual counselling as needed
Wilf-Miron 2003	Israel	Descriptive Quantitative Statistical data (not about support)	Maccabi Healthcare Services Tel-Aviv	Caregivers (medical staff) No sample reported	Statistical data about programme outputs (numbers of adverse events reported). No data about the support aspects	To describe the development of a medical risk management programme, including support for staff	Telephone Hotline	The telephone hotline is for medical staff to report errors and adverse events, and to receive emotional support alongside medical guidance. The support element is designed as an incentive to report errors more readily, to improve patient care

Table 9 (Continued)

First author Year	Country	Design Method/s	Setting	Population Sample	Evaluative data	Study aim	Programme name	Support elements
Wuthnow 2016	US	Description of the Critical Incident Stress Management (CISM) process	Nemours A.I. duPont Hospital for Children Wilmington	Hospital staff	Programme in early stages of implementation	To describe the rationale and process for activating CISM group and one to one support after critical incidents	CISM Support Team, and Hospital Peer Support Group	The trained CISM team conduct structured small group discussions (defusing) of 30 minutes, within 12 hours of a critical incident (any stressor event that has the potential to lead to a crisis response). They offer information about critical incident stress and resources, and identify at-risk individuals. Peer supporters contact staff within 24 hours by email to offer a one-to-one conversation. Group Critical Incident Stress Debriefing can be provided to staff involved

4.5.3 The programmes' policy and other bases

Having identified the reported support programmes for healthcare staff after PSI as the review's primary focus, the review investigated as a secondary and subsidiary element which, if any policies or guidelines the included records referred to as having informed the development of each programme, and whether these policies were specific to healthcare. There are limitations to this analysis, because records may not have reported all the elements that led to the development of a given programme.

Thirty-seven of the records each referred to between one and six policies, guidelines, or other principles underpinning the support programme. One of these programmes was based on aviation safety concepts without a specific reference, including the provision of support to staff involved in incidents on the assumption that staff were more likely to disclose errors and learn from them if they were supported (Wilf-Miron et al., 2003). Six of the records (two reported by the Canadian Patient Safety Institute, 2019; Devencenzi et al., 2006; Nadel et al., 2020; Roesler et al., 2009; Wuthnow et al., 2016) cited Critical Incident Stress Management (CISM) principles as a basis for the support provided. Seven of the studies (two reported by the Canadian Patient Safety Institute, 2019; Devencenzi & O'Keefe, 2006; Merandi et al., 2017; Merandi et al., 2018; Roesler et al., 2009; Shapiro & Galowitz, 2016) mentioned local healthcare organisation or in-house hospital policies. Four of the records (Hu et al., 2012; Moran et al., 2020; Vinson & Mitchell, 2014; Waterman et al., 2007) did not reference any basis in policy or guidelines for their inception.

Four theoretical, rather than policy, bases were cited as foundations to the development of the programmes: the wounded healer (Conti-O'Hare, 2002) was cited by Connors et al. (2020) in a recent description of the RISE programme at Johns Hopkins Hospital in Baltimore. Post-traumatic growth theory was also cited by Connors et al. (2020) as Palmer et al. (2010). However, when investigated further, the theory elaborated by Palmer and colleagues is the separate theory of self-transcendence, which describes how nurses can experience increased self-awareness and inner strength, and thereby make sense of challenging patient-care experiences. A theory of quality caring in nursing and health systems (Duffy, 2013) was cited by Graham et al. (2019), although it is about how nurses should be caring towards patients. The G.R.A.C.E. model

(Halifax, 2014), cited by Turner et al. (2021), refers to nurses Gathering attention, Recalling intent, Attuning to self, Considering, and Engaging; it describes a process for nurses to be attentive to their patients’ experience with empathy and compassion. None of these cited theories addresses supporting healthcare professionals emotionally or psychologically, including after PSI.

The policies and frameworks mentioned in the records that do not refer to the need for, or provision of emotional or psychological support following involvement in PSI (n = 15) are set out in Table 10. Eleven of these 15 are specific to healthcare.

Table 10

Cited policies that do not mention emotional or psychological support

Policy / report / framework	Originated by / Date	Focus	Cited by
Aviation Safety principles	Not stated	Aviation: Three safety principles: (1) errors inevitably occur and usually derive from faulty system design, not negligence; (2) accident prevention should be an ongoing process based on open and full reporting; (3) major accidents are the “tip of the iceberg” indicating possibilities for organisational learning	Wilf-Miron et al. (2003)
G.R.A.C.E. for nurses: Cultivating compassion in nurse / patient interactions	Halifax (2014)	Healthcare: A deficit of compassion might be relevant to the nursing experience, affecting nurse wellbeing, patient and family satisfaction, frequency of nursing errors, and the retention of nurses	Turner et al. (2021)
Health Insurance Portability and Accountability Act	US Department of Health and Human Services (1996)	Healthcare: Federal law requiring the creation of national standards to protect sensitive patient health information from being disclosed without the patient’s knowledge or consent	Morales & Brown (2019)

Table 10 (continued)

Policy / report / framework	Originated by / Date	Focus	Cited by
Healthy Work Environment Standards	The American Association of Critical Care Nurses (2016)	Healthcare: Six standards: Skilled communication; True collaboration; Effective decision making; Appropriate staffing; Meaningful recognition; Authentic leadership	Morales & Brown (2019)
Investigation Process (for all civil aviation accidents in the United States and major accidents in the other modes of transportation)	The National Transportation Safety Board: Go Team [since 1990s]	Transport: Deployment of specialist on-call investigation teams following major transport accidents	Morales & Brown (2019)
Local hospital's Just Culture initiative	Not stated	Healthcare: Just cultures in healthcare focus on not blaming healthcare personnel for unintended harm	Shapiro & Galowitz (2016)
Looking at Sentinel Events along the Continuum of Patient Safety	The Joint Commission (2010)	Healthcare: Managing serious patient safety events to protect the patient, improve systems, and prevent further patient harm	Dukhanin et al. (2018) Edrees et al. (2016) Edrees et al. (2017)
Post-traumatic Growth Theory	a) Tedeschi & Calhoun (2004)	Trauma psychology: Potential positive changes that may arise for individuals after a traumatic experience, but post-traumatic growth is not universal or inevitable	Connors et al. (2020)
Quality Caring in Nursing and Health Systems	Duffy (2013)	Healthcare: Reaffirming nursing as relationship-centred work where patients feel cared for, leading to positive outcomes for patients, families, providers, and healthcare systems	Graham et al. (2019)
Social Resilience Framework	Paton and Johnston (2001)	Disasters: Considers the vulnerability, resilience and preparedness of communities with respect to natural disasters	Turner et al. (2021)

Table 10 (continued)

Policy / report / framework	Originated by / Date	Focus	Cited by
Theory of the nurse as wounded healer	Conti-O'Hare (2002)	Healthcare: Wounded healers are care providers who use and transcend their own personal experience of trauma to support patients to recover	Connors et al. (2020)
To Err is Human: Building a Safer Health System	Institute of Medicine report (Kohn et al., 2000)	Healthcare: Promoting a culture of safety to improve the reliability of care for patients and reduce medical error	Devencenzi & O'Keefe (2006) Lane et al. (2018) Merandi et al. (2017)
Treat Me With Respect: Hospital strategic quality initiative	Brilli et al. (2014)	Healthcare: One pillar of a hospital's five-domain strategic plan to promote quality and safety, organised entirely from the point of view of the patient and family	Merandi et al. (2017)
Unsafe Acts Algorithm [for managing a critical incident] part of a local hospital Just Culture policy	Roesler et al. (2009) Adapted from Reason (1997)	Healthcare: The algorithm is a flowchart to identify if unsafe acts were intentional or accidental, and the individual or system factors involved	Roesler et al. (2009)
Wellbeing Playbook: A Guide for Hospital and Health System Leaders	AHA (American Hospital Association) Physician Alliance (2019)	Healthcare: Addressing clinician burnout and cultivating a culture of joy and wellbeing, so clinicians can best care for their patients	Connors et al. (2020)

Twelve policy frameworks, models, or toolkits cited in the records referred to the need for, or provision of emotional or psychological support for healthcare staff involved in traumatic events at work. Of these, three described Critical Incident Stress Management/Debriefing, or Psychological First Aid approaches (Everly et al., 2006; Everly & Mitchell, 2000; Mitchell, 1983; Mitchell & Everly, 1997; 2000; Rubin, 1990) that are used within healthcare, but originated outside the healthcare field in the realm of disaster response. The remaining nine policy frameworks cited were specific to healthcare. The 12 policies and frameworks are set out in Table 11.

As illustrated in Figure 5, 13 records describing nine support programmes (Cobos-Vargas et al., 2022; Finney, Czinski et al., 2021; Finney, Jacob et al., 2021; Graham et

al., 2019; Klatt et al., 2021; Krzan et al., 2015; Leaune et al., 2020; Merandi et al., 2017 and 2018; Morales & Brown, 2019 and 2021; Trent et al., 2016; Turner et al., 2021) explicitly acknowledged the forYOU staff support model (Scott et al., 2010) as having been drawn upon in their own programme’s development. Of these nine programmes, six are based in the US, one in Australia, one in France, and one in Spain.

Figure 5

Support programmes based on the three-tier model by Scott et al. (2010)

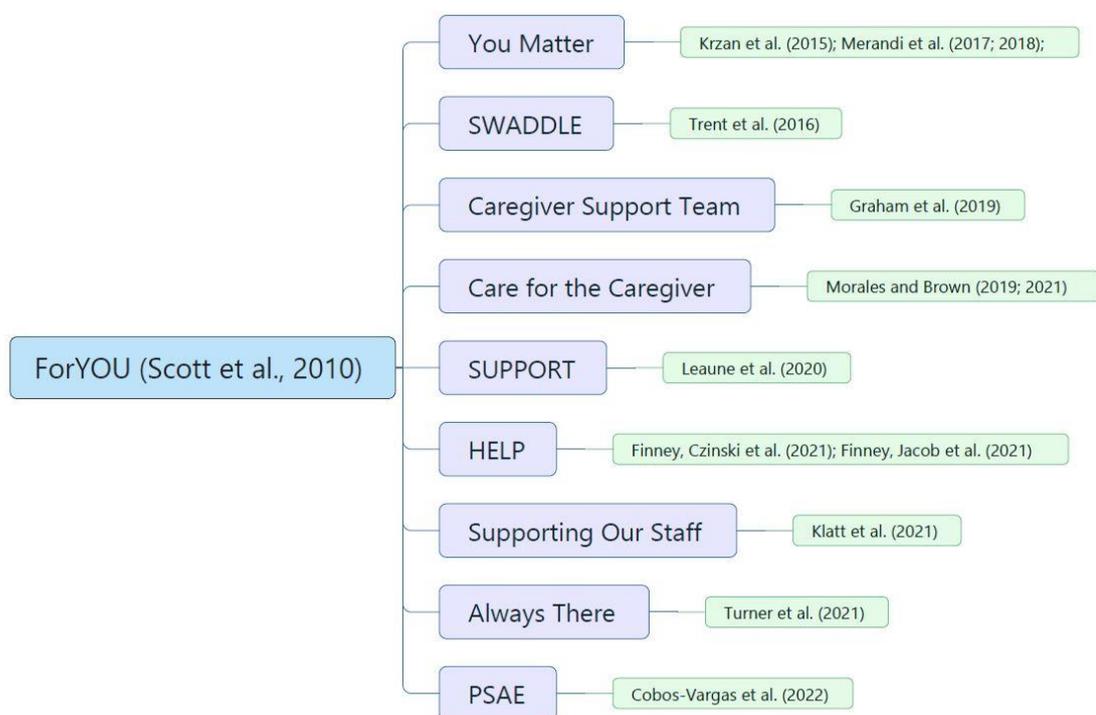


Table 11*Cited policies that mention emotional or psychological support*

Policy / report / framework	Originated by / Date	Focus	Cited by
Communication and Optimal Resolution (CANDOR) toolkit. Module 6: Care for the caregiver	Agency for Healthcare Research and Quality (AHRQ) (2016)	Care for the Caregiver programme implementation guide	Morales & Brown (2019)
Critical Incident Stress Debriefing	Rubin (1990)	Helping helpers after critical and emergency incidents, based on Mitchell (1983)	Roesler et al. (2009)
Critical Incident Stress Management	Everly & Mitchell (2000) Mitchell (1983) Mitchell & Everly (1997; 2000)	Helping rescue workers who become psychological casualties from witnessing suffering, to cope and minimise long-term effects	Canadian Patient Safety Institute (2019) Devencenzi & O’Keefe (2006) Nadel et al. (2020) Roesler et al. (2009) Wuthnow et al. (2016)
forYOU programme model (Missouri Healthcare)	Scott et al. (2010)	Deployment of a system-wide second victim rapid response team: the Scott Three-Tiered Integrated Model of interventional support (emotional first aid; peer support; professional counselling)	Cobos-Vargas et al. (2022) Finney et al. (2021) Graham et al. (2019) Klatt et al. (2021) Krzan et al. (2015) Leaune et al. (2020) Merandi et al. (2017) Merandi et al. (2018) Morales & Brown (2019; 2021) Trent et al. (2016) Turner et al. (2021)
MITSS program development toolkit	Medically Induced Trauma Support Services (Pratt et al., 2012))	Supports, educates, trains, and offers help to victims of medically induced trauma, including patients, their families, and healthcare providers	Trent et al. (2016) Van Pelt et al. (2008)
Psychological First Aid	Everly et al. (2006)	Crisis intervention after critical incidents such as trauma and mass disaster	Turner et al. (2021) Van Pelt et al. (2008)

Table 11 (continued)

Policy / report / framework	Originated by / Date	Focus	Cited by
Quick Safety Issue 39: Supporting Second Victims	The Joint Commission (2018)	Guidance on supporting second victims (the traumatised healthcare worker) as soon as possible after an adverse event	Connors et al. (2020) Edrees et al. (2017) El Hechi et al. (2019)
Respectful Management of Serious Clinical Adverse Events	Conway et al. / US Institute for Healthcare Improvement (2010)	Managing serious clinical adverse events with respect, empathy, and support, balancing the needs of the patient, family, staff, and organisation	Lane et al. (2018)
Responsible Reporting and Accountability Policy	Kaiser Permanente (2003)	Step 6 of the policy: Support the patient care team, with psychological and emotional support for individual staff and groups	Devencenzi & O’Keefe (2006)
Restorative Just Culture	Weitekamp (1999) Zehr (2002) Barton (2003) Turner et al. (2020)	Restorative just culture focuses on the needs and obligations of all affected by an adverse event. It places obligations and accountability on healthcare organisations and leaders to provide support for all those in need, and to provide clinicians with an adequate response to their distress	Turner et al. (2021)
Safe Practices for Better Healthcare—2010 Update: A consensus report	National Quality Forum (2010)	After serious unintentional patient harm, all caregivers including administrative staff should receive timely and systematic care that is just, with respect, and compassion	Dukhanin et al. (2018) Edrees et al. (2016) El Hechi et al. (2019)
TRUST: The 5 rights of the second victim	Denham (2007)	Five human rights of caregivers that are an integral part of a just culture when patients are harmed during care. TRUST: Treatment that is just; Respect; Understanding and compassion; Supportive care; Transparency and the opportunity to contribute to learning	Turner et al. (2021)

4.6 Discussion

4.6.1 Identified programmes and their contexts

This review has identified that only a small number of structured support programmes for healthcare staff following their involvement in PSI have been reported, and the majority of known programmes (28 out of the 35 identified) are located in the US or Canada. Only 14 out of 35 schemes are reported to cover all staff within the organisation, with many offering support to one specific department or one professional group only. No structured support programmes were found currently operating in the UK. The level of detail included in the studies was variable, and very few contained evaluative data: for example, there was one cost-benefit analysis of one scheme, and no other data about programme costs and training or other budgets. Much of the available evaluative data reported frequency counts of interventions and number of staff trained, rather than detailed evaluations of the programme's effectiveness. One structured programme, operating in Australia for staff in the Queensland Ambulance Service, was the subject of a detailed multi-method evaluation and examination, including scheme usage data, but no published assessment of cost-benefit.

The healthcare systems in the North American locations where the majority of identified programmes operate are predominantly funded by insurance contributions, which is a very different basis to that of public healthcare in the UK which is funded by general taxation and provided free at the point of delivery for citizens. From the available evidence, it is not possible to be certain if the support programmes that exist, most of which rely in part on clinical staff serving as peer supporters offering emotional first aid and signposting colleagues to further resources, could be replicated successfully within health systems elsewhere, including the UK, where resources are constrained and staffing levels stretched.

4.6.2 Policy and other programme bases

There are numerous potential policy bases and other frameworks or guidelines that have been cited as underpinning the provision of support to healthcare staff after PSI, and it is clear there is no lack of reference material on which to base and implement a scheme to provide support to healthcare staff in the challenging circumstances of a PSI, should a healthcare organisation wish to do so. The policies and frameworks referenced have evolved from those drawing attention to the unintended nature of medical errors (Kohn

et al., 2000) and the need to stop blaming individual clinicians without referring to the need for staff support, to focused guidelines, strongly recommending that healthcare organisations provide support for staff involved in PSI (including Agency for Healthcare Research and Quality, 2016; Conway et al., 2010; National Quality Forum, 2010; The Joint Commission, 2018). All these frameworks and recommendations have originated in the US. There are no known internationally binding requirements that support be made available to the healthcare staff involved in PSI, although there are calls and recommendations by international and multi-lateral organisations for support to be made available, in many cases linked to promoting quality and safety in healthcare, as explored in Chapter 2.

In the US and Canada, there are examples of programme methodologies and approaches that are acknowledged to have been used as frameworks to inform the development of several other support programmes, particularly Scott and colleagues' (2010) three-tier forYOU programme model at University of Missouri Health Care, and Critical Incident Stress Management guidelines. Both of these support types make use of staff as volunteer supporters to their peers. This has resource implications for the volunteers' own clinical duties, and the time and funding needed to train them to assist their colleagues. Given the lack of available cost data, it is not possible to establish whether this methodology would be applicable or feasible in all organisations and all healthcare systems.

There may well be structured support schemes in existence that have not been described in healthcare literature. However, the many and recent studies describing healthcare professionals' ongoing experience of inadequate or unreliable support after PSI suggest either that schemes may not be based on known policies or good practice guidelines, or that there are very many healthcare staff who have no ready and consistent access to appropriate, structured organisational support provided by their workplace.

[4.6.3 Strengths and limitations](#)

Strengths of this review include an extensive and comprehensive search strategy, aiming to capture as many relevant records as possible, including from academic databases and grey literature, and reported in three languages. Support programmes pertaining to all healthcare professions were included.

Limitations include the fact that in spite of conducting a thorough search strategy, examples of current support programmes may nonetheless have been missed. Excluding schemes under development may have omitted programmes that are now operational, and programmes that were included may have changed their focus or strategy, or no longer be running. The included records were heterogenous with respect to their design, population, and sample (some very small and from one department or professional group only), limiting the potential for comparison and synthesis of findings. The data extraction was conducted by one researcher because of the requirements of a PhD study, with the risk of subjectivity in the selection and summarising of key findings. The quality of the records was variable, and detail was very limited for some. No overall analysis of the programmes' effectiveness was feasible because of limited evaluative data, which in some cases was from self-report surveys, and the very nature of confidentiality requirements for peer support and potential litigation concerns with respect to PSI makes the collection of data for evaluation problematic.

[4.7 Chapter summary](#)

This chapter has explored the available literature about structured emotional and psychological support programmes provided by organisations to help healthcare staff recover if they are negatively affected following their involvement in PSI. It has also sought to identify any policies, guidelines, and other frameworks that have been used as part of these programmes' underpinning foundations. The majority of the small number of known programmes are located in North America; the underpinning frameworks, guidelines, and models of support have originated in the US, and offer rationales for providing support, or methodologies to adopt that correspond to the features of their healthcare contexts.

There is plenty of information about how organisations could offer support for their staff following PSI, with various models, toolkits, and approaches to follow, but there is no reference in the identified programmes to a mandatory policy or specific requirement, and evaluative data for most of the programmes is very limited. Some programmes that are described were based on established policy guidelines; some arose following a specific patient safety incident, or as part of incentivising staff to disclose medical errors, and others make no reference to their origins or policy basis, suggesting that whether and how programmes are devised is primarily a local and ad hoc decision.

While some support programmes for healthcare staff following PSI may exist that have not been described in a published study or report, the findings of this review, identifying just 35 programmes in six countries, highlight that structured support programmes are by no means uniformly available to all healthcare staff in all organisations. Several of the programmes that are described are intended for specific professional groups only, and there is no evidence about programmes currently operating in the UK. As a result, however severe the distress and negative impact upon healthcare professionals after involvement in a PSI, there is no certainty that individual staff members will have access to or receive the psychological or emotional support they may need.

CHAPTER 5: METHODOLOGY

5.1 [Introduction to the chapter](#)

This chapter sets out the approach taken in designing the research study, selecting a qualitative, inductive methodology using semi-structured interviews, recruiting participants, and conducting, transcribing, and analysing the ensuing interviews. It explores the ontological and epistemological perspectives that shaped my decisions, and my positionality within the research, as part of reflexively and transparently considering the context for this work and the influence of my background and professional values on the choices made. I explain why thematic analysis (Braun & Clarke, 2006; Braun & Clarke, 2019; Braun & Clarke, 2021; Braun et al., 2019; Terry et al., 2017) was selected as the approach to analysing the interview data.

This chapter sets out ethical considerations in the conduct of the research and how they were addressed, including the approach to informed consent, confidentiality, and data protection, ensuring the anonymity of participants, and issues of power and status in this research, specifically in the context of the UK healthcare profession.

5.2 [Ontology and epistemology](#)

In accordance with the Consolidated criteria for reporting qualitative research - COREQ (Tong et al., 2007), I set out here the methodological and theoretical orientation underpinning the study. My perspective on the nature of reality (ontology) and understanding of the nature of knowledge (epistemology) are of key importance to my role as researcher, because what I consider to be real, and my beliefs about how we know what we know (Crotty, 1998) have informed all the subsequent decisions about my approach to the research project and what has been prioritised in the process.

I consider that reality is a result of our constructions and interpretations of what we perceive and experience, and that these constructions and interpretations, which may vary from person to person, are valid. I agree that social reality is “multiple, processual, and constructed” (Charmaz, 2014, p. 13), which necessitates acceptance of research as a co-constructed endeavour between the researcher and participants, with acknowledgement of the concomitant influences that have shaped all those involved. Carter and Little (2007) argue that it is impossible to create knowledge “without at least

tacit assumptions about what knowledge is and how it is constructed” (p. 1319), which inevitably influences the relationship between researcher and participant, and whether participants are viewed as subjects to be studied or active contributors. I view participants as active contributors, but I recognise that my choices, and the constraints the participants and I face, affect the nature of that contribution. All these factors require consideration of my position, privilege, and perspectives in the endeavour, and an awareness that researchers are not neutral observers.

My view of the nature of knowledge and its construction finds constructivist theory to make the most sense. It emphasises the importance of the role played by others in the construction of knowledge by individuals (Vygotsky, 1978), and describes how individuals bring with them implicit theories and perspectives derived from their environment and cultural influences, but also employ their own cognitive processes. Lincoln and Guba (2016) highlight the importance of considering social contexts and interaction, as well as acknowledging that our understandings rest upon individual interpretations. Developing theories of learning, Vygotsky (1962) considered that forming interpretations, and the consequent construction of knowledge by learners, was the product of social interaction and socially developed understanding. For me this interaction of social influences and individual cognitive processes forms the essence of constructivism, which informs my own approach to teaching, to psychotherapy, and to research. Charmaz argues that knowing is “embedded in social life” (Charmaz, 2014, p. 14) and I share this view, recognising that the individual also has agency and autonomy in this process. Young and Collin (2004) describe how individuals engage in the construction of knowledge and make meaning (constructivism) and they distinguish this from social constructionism, whereby knowledge and meaning are historically and culturally constructed through social processes and action, without emphasising the part played by the individual. They also note the “considerable ambiguity” (p. 378) in the ways the two terms constructivism and constructionism have been used, and that some (Burr, 2003; Gergen, 1999) have used them interchangeably, which causes confusion.

I do not espouse a social constructionist perspective, where this term is employed in a way that minimises or erases the individual and the subjective, and sees perspectives existing entirely as a consequence of socio-cultural influences and pressures that create realities (Berger & Luckmann, 1967). While I consider it is very important to acknowledge the role of socially constructed systems and pressures on individuals, this

approach can risk placing insufficient emphasis on individual agency, and the interplay between people and their environment. In research this could lead to a lack of focus on the researcher's or participants' unavoidable subjectivity, namely what is real and relevant to each involved party, and yet may not be shared by all, even those in the same social environments. For the researcher, transparency about perspectives, prior knowledge, and any assumptions is what matters, and this is illuminated by a reflexive approach to analysing and interpreting data (Braun & Clarke, 2019).

I consider that there is no possibility of being a passive, neutral observer of a single, objective external reality that can be captured and rendered reliably as a fixed or indisputable entity, and that this is consequently not the aim of qualitative research. For me it is essential "to acknowledge subjectivity and the researcher's involvement in the construction and interpretation of data" (Charmaz, 2014, p. 14), rather than claiming to discover new knowledge in an objective or unbiased way.

For me, acknowledging subjectivity, being transparent and engaging in reflexivity about it, so that the internal worlds of researcher and participants are brought together with what is perceived to be in their experience of external reality, is a necessary balance to attempt to strike if we are to make sense of the world in a way that is useful. It is about considering themes as "actively crafted by the researcher, reflecting their interpretative choices, instead of pre-existing the analysis" (Braun & Clarke, 2016, p.740). Themes are presented as an evidenced interpretation of the data, which means approaching the data inductively, clarifying with participants what they mean, without imposing assumptions, and not assigning codes or any fixed analytical framework in advance that would constrain the data analysis. The approach taken to analyse the data is discussed further in section 5.4. My intention is to draw meaning from the interviewees' individual perceptions, interpretations, and expressions of their world, the knowledge they have gleaned, and what they consider matters, in a way that is useful and relevant for informing ideas about policy and practice in the healthcare sphere, and thus potentially benefiting groups as well as individuals within that sphere.

5.3 [Positionality](#)

I consider it impossible to approach research without preconceptions, or to claim that this has been achieved. I am sure that the research process will have been shaped from the outset by my personal and professional experiences (explored further in section

5.3.1), including influencing the selection of research questions; the focus on National Health Service (NHS) organisations for participant recruitment; choosing to use interviews to gain detailed individual perspectives on the topic; the development of the interview topic guide (Appendix B); the conduct of the interviews, and the choice of follow-up questions; the interpretation of the contributions; the identification of initial codes and development of themes; and the selection of a small number of quotations from each of the transcripts to illuminate these (Berger, 2015). I consider that understanding the positioning and social location of the researcher in relation to the research project and to the participants is an essential part of understanding the context of the study (Finlay, 2002; Morse, 2015). This supports the reader to make decisions about the potential relevance of the information to other contexts, and it can shed light on the worldview of the researcher, and the lenses through which the phenomenon of interest has been studied.

The idea of a researcher being a blank slate is, for me, both unrealistic and undesirable (Crotty, 1998). The assumptions we hold as individuals from our background, experiences, beliefs, values, and cultural influences all contribute to how we perceive and respond to the same events or information, in highly individual ways. What matters is to be as aware as possible, open to new awareness developing, and transparent about the lens through which we view the research topic, and about the perspectives we adopt on participants' different ways of responding.

Maykut & Morehouse (1994) describe the qualitative researcher's perspective as one that requires tuning in to the experiences and meaning systems of others, while recognising how one's own biases and preconceptions may be influencing the subject being explored. Etherington (2004) draws attention to the need for researchers to find ways of working that fit with who they are, reflecting their values, philosophies, and beliefs about reality and how knowledge is created. Moreover, if the beliefs and assumptions of the researcher will influence how she collects and analyses the data, it is important to be as clear as possible about what these beliefs and assumptions are, and to disclose one's perspective (Elliott et al. 1999; Etherington, 2007). I recognise the potential for bias in the interpretation of the findings, or in my underlying assumptions that the meanings and understandings I have drawn from the data were shared with or intended by the interviewees (Etherington, 2004; 2007), although whenever I was unsure, I clarified this explicitly with the participant. It has been argued that "The

reflexive work of the researcher is also a crucial part of any genuine scientific study” (Parker, 2004, p. 99), contributing to the trustworthiness of research. I agree that reflexivity, which is a practice that is considered fundamental to the ethics of my psychotherapy profession, is also an imperative in research: considering the impact of the researcher on the research process (Spencer et al. 2003; Yardley, 2000) and, I would add, the shaping of the researcher by engaging in this process.

5.3.1 Critical insights into my positionality

Crotty argues that the conception of a research study grows from “a real-life issue that needs to be addressed, a problem that needs to be resolved, a question that needs to be answered” (Crotty, 1998, p. 13), and the researcher will inevitably approach the work according to her own priorities. My own background brings together elements that have influenced my beliefs about the value of research, of individual accounts, the importance of making support available to people in distress, and the way that practice is informed and made possible by policy. I began my professional life as a UK government policymaker in the area of international trade; later I trained as a teacher, and still work in that profession. I am also a qualified psychotherapist, in practice currently with private clients, and clients referred by two Employee Assistance Programmes (EAPs). I have previously worked in a specialised NHS outpatient service. I am aware that my various professional perspectives combine in a way that have influenced my approach to this research, and it was important for me to consider and interrogate my location within this work, the impact my experiences may have had on my choices and priorities for this research (Mason, 2002), and how to address this reflexively.

I focused initially on identifying potentially relevant policy about emotional and psychological support for healthcare staff who have experienced distress and difficulty following involvement in patient safety incidents (PSI), disseminated by national and international organisations (see Chapter 2), whether such policy constitutes a recommendation or a requirement, and what the existence of policy may mean for practice. Considering policy as a potential foundation to the development of practice stems from my past work as a government policymaker, albeit in a completely different field. This experience has provided me with an understanding of the processes involved in formulating and consulting on government and regulatory policy, and an awareness

that issuing general policy statements may not lead to change being implemented in practice. I thus bring to this research project the knowledge that how policies are framed, and the motivations behind this framing, can result in differing outcomes with respect to change taking place (Hill & Hupe, 2002). Moreover, making policy proposals that seek to persuade organisations to amend or add to their practice can have resource implications that influence, delay, or prevent practical implementation (Nolte, 2018). This experience has led me to the view that if a policy outcome matters, it may need to offer clear incentives or be made a requirement. This perspective means that my interest lay principally in research participants' individual knowledge and lived experience of policy and related practice about support for staff after PSI, rather than making any theoretical assumption about the value of policy on paper, or presenting participants with information about the policies I had identified.

My experience as a psychotherapist has also developed my knowledge about how some organisations offer time-limited psychological therapy support to their employees, provided outside their organisation, as a way of resolving emotional issues and facilitating the employee's return to work. I have worked with some healthcare professionals in this capacity, but never about the impact of PSI. Exploring in this research project whether policies are known about by healthcare professionals, and whether support is in fact wanted by or available for affected professionals, in their experience and from their viewpoint (not mine), has been my aim. My work as an Allied Health Professional, including previously in an NHS specialised outpatient service, does not mean that I locate myself as an insider in this research (Bonner & Tolhurst, 2002), because I have not worked in or experienced any of the participants' settings or roles, and I have not experienced a PSI. Working in psychological healthcare means, however, that I have professional experience of distress arising in workplaces, and of support to address such responses. As such, I consider myself to be positioned along the continuum between insider and outsider (Breen, 2007; Dwyer & Buckle, 2009), and have maintained reflexive consideration of how my professional experience, ethics, and opinions, which others may not share, have informed or influenced my perspective.

To engage in this type of psychological work also involves having a professional view that there is value in offering emotional and psychological support to individuals in distress, if they decide that they want such support. To offer empathy and non-judgemental understanding, emphasising the autonomy of each individual, are central

aspects of my profession's explicit ethical code (BACP, 2018), and of the professional values I have developed. I also consider that empathy in research can help build trust in what Watts (2008) refers to as the shared space between researcher and participant. As such, the knowledge and direct experience of some aspects of this research topic have inspired interest and motivation to engage in this work. They have also affected my responses to existing literature in the field, and to the information and views offered by the study participants. I am aware that my choice of codes and the themes I have developed will have been impacted by my experience and values, but I have also striven not to exclude any voices that did not accord with my professional approach. An important aspect of my training and professional code of practice requires focusing on and prioritising the reality and autonomy of patients and clients, and being reflexively aware of (and stepping aside from) any inclination to overlay this with my values or perspectives. This means that for this thesis, I sought to learn what participants knew and considered important, not to impose a view or make assumptions about others' priorities, preferences, and perspectives, nor shape them to reflect my own values.

I feel comfortable acknowledging the researcher's agency in data construction and interpretation (Bryant & Charmaz, 2007), rather than seeking to deny or neutralise this influence. To work with an awareness of my background and prior experiences, I selected a methodology that makes reflexivity a central facet of the data analysis. I maintained a close reflexive perspective on all my decisions, which is an aspect of my professional training that I found very helpful, both during project development, the interviews, and the interpretation and analysis of the data. I wrote reflexive memos (see Appendix C for examples) to elucidate my thoughts, feelings, and interpretations of the data, and to make this explicit and transparent, including to myself.

[5.4 Rationale for data collection and analysis methodology](#)

An important consideration in selecting the methodology for data collection and analysis was to ensure that the approach could support my views about the importance of reflecting individual realities within social systems (Robins & Kashima, 2008), and approach the data inductively. I did not wish to predetermine a framework which might preclude, constrain, or ignore certain contributions (Thomas, 2006). Although I had become familiar with the considerable amount of existing literature in the field, and with the concept of the "second victim" (Wu, 2000) that has been incorporated into

much of the research (see Chapter 3), it was essential for me to be able to approach the data with an open mind, and to explore the participants' own knowledge and views, without presenting them with any hypothesis. It is my view that extant concepts can inform the data collection, without being used as a way of producing fixed, automatic codes for data analysis at the outset; but nor need they be ignored, hidden, or otherwise sidestepped, provided their potential relevance and value are considered in the light of participants' contributions and perspectives. Bowen (2006) notes that research often begins with existing concepts, whether researchers state this or not. What is important is to acknowledge whether and why extant ideas have been explored and included, and to analyse their contribution.

I also recognised that in a research area that already had a very substantial number of studies, it would not make sense to avoid being aware of what had been undertaken, and to identify a new research focus for this PhD project necessitated an exploration of the existing work in the field. I wanted to remain aware of the potential to stray into the realms of moulding the data to accord with an existing way of seeing the world, or with prior beliefs (mine or others') about what occurs, or what matters, in certain settings, and to avoid this possibility.

5.4.1 Use of semi-structured interviews

I attach great significance and value to individual accounts that reveal individuals' knowledge and experience of the world, and the rich qualitative data that these accounts offer (Sutton & Austin, 2015). My aim was to explore what the participants knew, believed, and considered important about policies and practices to support healthcare professionals negatively affected after PSI. This led me to seek a method of data collection and analysis that would accommodate contributions from participants based in different healthcare workplace settings, that would value inductive data, and focus on what the data revealed, not test out any preconceived hypothesis. The qualitative approach, using one-to-one interviews, was selected with the aim of describing the reality of the participants' understanding of current policy and actual practice with regard to staff support following PSI, rather than hypothesising about or predicting responses.

I selected one-to-one, semi-structured interviews, using an interview schedule (Appendix B) to guide the discussion, and make it possible to compare responses and

develop themes, particularly bearing in mind the broad coverage of possible interview participants in terms of work setting, role, or seniority, while also allowing for flexibility and individuality in the responses given. The interviews explored the participants' individual knowledge of any relevant policies and protocols that underpinned how they had dealt with or would deal with the emotional, psychological, and practical consequences for their colleagues, or possibly for themselves, of involvement in a PSI. My aim was to glean the individual meanings the participants attributed to their understanding and to any relevant experiences they or their colleagues had had. I aimed to avoid making fixed prior assumptions about participants' experiences, perspectives, or what would be salient to them in their specific context.

I chose one-to-one interviews because they provide the opportunity for participants to respond authentically from their own experience, and to share their knowledge and views freely and fully, including where the topic might evoke distress (Dempsey et al., 2016; Draucker et al., 2009). I considered that a focus group might inhibit participants from openly sharing relevant knowledge, given the potential for sensitive material to be explored (Dickson-Swift et al., 2007), and because of potential reticence if more senior staff were present (Morrow et al., 2016; Worrall & Cooper, 2004). Semi-structured, one-to-one interviews also permit flexibility in follow up and further exploration beyond the initial open-ended questions, to reflect the interviewees' priorities and the avenues they wish to pursue. Section 5.7 below explores further the ethical considerations, including potential distress and power dynamics.

[5.4.2 Use of thematic analysis](#)

Thematic analysis (TA) with a focus on reflexivity was selected to analyse the data (Braun & Clarke, 2006; 2019) because of its clarity with regard to steps to follow, its flexibility to be used with different theoretical underpinnings, and its capacity to give voice to participants' perspectives and priorities in an inductive methodology. "Inductive analysis means that the patterns, themes, and categories of analysis come from the data; they emerge out of the data rather than being imposed on them prior to data collection and analysis" (Patton, 1990, p. 306). TA is a method for identifying patterns within a dataset, while at the same time acknowledging and valuing the researcher's interpretation of what has been shared (Braun & Clarke, 2021; Braun & Clarke, 2019). It can be employed to reflect participants' individual realities, and "to

unpick or unravel the surface of ‘reality’” (Braun & Clarke, 2006, p. 9). I sought an approach that acknowledged the role of the researcher’s interpretations of the participants’ perspectives and comments in shaping the data analysis process, as components of the data were identified as being particularly salient or as potential indicators of the codes and themes that were developed. TA’s expressly reflexive approach (Braun & Clarke, 2021) accorded with the importance I attach to being transparent about my perspective and positionality, and the choices I made in interpreting the data.

My intention was to explore participants’ knowledge and to illuminate the nature of their workplace reality, as they described it, incorporating contributions that could reflect areas of conflict and contradiction, rather than trying to play down or dispense with views that lay beyond those of the majority in order to focus only on commonly held or stated views (Saldaña, 2016). Observing any variations in the data as part of the analysis formed part of identifying what actually happens in the participants’ workplaces, and what they considered salient. Braun & Clarke (2006) argue that “more instances do not necessarily mean the theme itself is more crucial” (p. 10). The objective was to allow the data to speak for themselves and to reflect the voices I heard in the themes developed, while transparently acknowledging that data analysis involves selecting, editing, and deploying data in ways decided by the researcher.

Braun and Clarke (2006) argue that researchers should clearly state how they conducted their analysis, which seeks to explore a dataset, in this case 27 one-to-one interviews, “to find repeated patterns of meaning” (p.15). In TA, the analysis involves “a constant moving back and forward between the entire dataset, the coded extracts of data that you are analysing, and the analysis of the data that you are producing” (Braun & Clarke, 2006, p. 15), rather than being “a linear process where you simply move from one phase to the next” (p. 16). The analysis thus occurs concurrently with data collection (DiCicco-Bloom & Crabtree, 2006), so that the researcher can reflect on and write about ideas, codes, and themes throughout the process.

Critics of TA have argued that it is too flexible, and that it can be too descriptive or lack nuance, subtlety, or interpretative depth (Braun & Clarke, 2014). However, I consider this not a failing of the method per se, but of the way it may at times have been used. The flexibility of TA means it can be used to analyse datasets of varying size, and

which have either homogenous and heterogeneous samples (Clarke & Braun, 2017), which accords with the heterogeneity of my sample in terms of work roles and settings. Although it can be employed in a deductive analysis using a predetermined coding framework, TA can also be used inductively, as in this research, allowing the data and the researcher's interpretation to offer the codes and themes. The key is to be transparent and explicit about the intention (Holloway & Todres, 2003; Kiger & Varpio, 2020), and to align the data analysis with the stated approach (O'Reilly & Kiyimba, 2015; Morse & Field, 1995), which in this thesis is exploratory and interpretive. The aim is to develop explanations of the researched phenomena, and to avoid imposing a priori expectations (Lincoln & Guba, 1985).

Braun & Clarke (2013) do not use coding frames, which are intended to facilitate the generation of measures like interrater reliability, because they consider this concept "problematic in relation to qualitative research" (Braun & Clarke, 2014, p. 1). I agree with this analysis, because a fixed coding frame has the potential to constrain the elements of the data which can be included. Themes in TA can be a mix of "semantic" (explicit) or "latent" (interpretative). "With a semantic approach, the themes are identified within the explicit or surface meanings of the data and the analyst is not looking for anything beyond what a participant has said" (Braun & Clarke, 2006, p. 13). Latent themes are developed from identifying the ideas, assumptions, and conceptualisations underlying the semantic level (p. 13). This capacity to combine descriptive information that the participants considered relevant and important with interpretation about the data that extended beyond their descriptions and views was an aspect I valued.

5.5 Research aims and proposal

The focus of this research, as set out in the research proposal and applications for ethical approval, was on the views or experiences of UK healthcare professionals about the support available for healthcare staff distressed or otherwise negatively affected by being involved in a PSI, including near miss events. The aim was to interview healthcare professionals with policy, management, or supervisory responsibility to find out what policies or protocols were in place, according to their knowledge and experience, for supporting staff involved in PSI, to prevent them from being negatively affected by their experience, or to help them recover. The aim included investigating

whether any support processes were formally structured or informal, and if any identified policies matched or differed from support in practice.

The second research objective was to investigate the views of the same healthcare staff about the term “second victim”, and its appropriateness or otherwise in supporting the recovery and professional progression of healthcare staff following involvement in PSI. Given that the “second victim” term had recently become controversial (as described in Chapter 3; see Clarkson et al., 2019), the aim was to explore whether the participants had heard of the term and deemed it acceptable to refer to professionals involved in and negatively affected by PSI, or if different terminology was used or would be preferred by interviewees in place of the “second victim” descriptor.

The project aimed to identify healthcare policymakers', managers', and supervisors' usual or preferred ways of supporting their staff after involvement in PSI, and to explore whether support for healthcare staff was considered effective in minimising negative consequences by those who offered or received it, or if different support would be preferable. The research investigated whether these healthcare personnel considered there to be any link between providing support for staff wellbeing after PSI and patient wellbeing, because healthcare professionals who have been negatively affected by their involvement in a PSI are known to fear making subsequent clinical errors (McLennan et al., 2015). It has also been argued that unsupported healthcare professionals who are in poor mental health may go on to make medical errors (Melnik et al., 2018; 2021).

Before undertaking this research, it was not known whether there were specific policies, protocols, or practices in place to prevent negative consequences to NHS healthcare staff involved in treatment errors, near miss events, or actual patient harm, or if there were national or local arrangements for staff support. There has been a lot of research and commentary on the topic of “second victims”, but policies, protocols, and practices to support healthcare professionals affected by PSI experiences in formal UK healthcare settings had not previously been identified, and interviews had not been undertaken with healthcare policymakers, managers, or supervisors, whose views on the “second victim” terminology were also unknown.

The interview data collection took place in healthcare settings in England. The rationale for focusing on England was because in the UK the NHS is governed by different organisations that are based in each of the nations. This means that policies and

processes are disseminated by NHS England to Trusts¹² within that country, whereas Trusts elsewhere in the UK have different oversight bodies issuing guidance or policy. Narrowing the scope to NHS England was intended to create a degree of uniformity in the overarching requirements that each Trust would be adhering to in terms of policies related to staff, and to counterbalance the breadth of potential participants in terms of heterogeneous professional roles and levels of seniority.

5.6 Method

The method is reported in accordance with the elements included in the COREQ checklist (Tong et al., 2007).

5.6.1 Study design

The study design was individual semi-structured interviews of approximately 60 minutes, conducted with healthcare policymakers, managers, and supervisors based in healthcare settings in England, to address the research questions.

5.6.2 Data collection setting

The interviews took place at the participants' workplaces (healthcare settings in England), initially in the northwest where the researcher is based, and subsequently in other regions of England, either in person, or by telephone or video, according to the participants' preferences and COVID-19 restrictions.

5.6.3 Inclusion and exclusion criteria

Inclusion criteria for the qualitative interviews were that the participants were employed or had been employed in the last five years as UK based healthcare staff with policy, management, or supervisory responsibility, (termed “healthcare policymaker, manager, or supervisor”), at any level of the management structure; they could be or could have been clinicians, but this was not a requirement. Employing the descriptor “with policy, management, or supervisory responsibility” was advised by the Advancing Quality Alliance (Aqua) - an NHS health and care quality improvement organisation whose member organisations include NHS Trusts and their staff, and by a patient representative who commented on the draft ethical approval documents. This was in case potential participants ruled themselves out because they did not have the term

¹² An NHS Trust is an organisational unit within the UK National Health Service, generally serving either a geographical area or a specialised function. A Trust may run several hospitals.

“manager” or “supervisor” in their job title. The rationale for these inclusion criteria was that personnel with management responsibility (and this could be for other staff or a clinical department) were more likely to have had to manage PSI and their follow up, and so would potentially be aware of any policies and practices that applied to supporting staff in these situations. Seeking participants who had been in their role within the last five years was intended to include staff who had recent experience or knowledge of any such policies and practices.

Inclusion criteria for the interview study participants were:

- 1) Identified as a current or recent (within the last five years) healthcare policymaker, manager, or supervisor
- 2) Over 18 years
- 3) Able and willing to give informed consent at the time of the interview

Exclusion criteria for the interview study participants were:

- 1) Not a healthcare policymaker, manager, or supervisor currently or within the last five years
- 2) Under 18 years
- 3) Unable or unwilling to give informed consent at the time of the interview

[5.6.4 Participant recruitment](#)

The interview participants were recruited via the lead NHS research site: the Research and Innovation Department of an NHS Foundation Trust (not identified here to protect participant anonymity), and by the Advancing Quality Alliance (Aqua). Recruiting via these organisations was intended to avoid the possibility of any undue influence in recruitment that could arise by the researcher approaching potential participants direct. Further recruitment took place when Covid-19 restrictions eased (see section 5.6.6) via one other NHS Foundation Trust Research and Innovation department. Snowball recruitment also took place throughout, originated voluntarily by the participants. Recruitment continued until sufficient participants had contributed data to elaborate the codes and themes as they were identified, within the practical and time constraints of a three-year PhD project.

The methods of approach used by the Research and Innovation Departments and Aqua were via email, their workplace intranet and member networks, or face to face. Potential participants then emailed the researcher to express their interest in participation, and the study information pack (Participant Information Sheet, Annex E, and Consent Form, Annex F) was sent by email.

Interview participants were asked to initial each section of the consent form to show their agreement. The researcher and the participant both signed and dated the consent form, either in person or electronically where interviews were conducted remotely. Participants were given or emailed a copy of the completed consent form to retain, unless they declined. The ethical issue of informed consent is explored in section 5.7.4 below. Twenty-seven participants meeting the inclusion criteria took part in the study. Their demographic data is included in Chapter 6 (Findings). No participants who expressed an interest refused to participate, and none dropped out of the study.

5.6.5 Data collection

The interview guide (Appendix B) was used in each interview to provide an initial structure and allow for comparability between respondents. The guide was drafted to elicit participants' knowledge and views, without leading questions or offering hypotheses, and it was discussed with stakeholder (including patient) representatives via Aqua, in advance of the ethical approval application and the interviews, to maximise relevance and appropriateness.

No non-participants were present at the interview besides the participant and researcher (Tong et al., 2007). Audio recording was used, with each participant's agreement, to collect the data. The ethical considerations in recording and storing the data are set out in section 5.7.5. The interviews were recorded on a portable digital voice recorder, transferred electronically to my secure University network drive, and the recordings were then erased on the portable device. I transcribed the interviews shortly after they occurred, verbatim and noting emphases and emotions, to immerse myself in the contributions, acquire an unfolding sense of the data, and identify any areas where I considered more data could be useful. Page numbers were added to enable referencing for the analysis. Participants' names and any allusions to identifying information were removed in the transcripts, and each was described with P plus the interview number, in sequence (for example, P1). The files were password protected.

Field notes were not taken during the interviews and no repeat interviews were carried out. All participants were offered the opportunity to receive and check or correct their interview transcript, but all declined.

Data saturation was discussed in the research team, to explore if further data was needed to pursue avenues raised by participants or to elaborate the identified themes. This included participants whose roles included supporting staff psychologically, including after PSI, who were recruited via the third approved Trust. Twenty-seven interviews were conducted. The duration ranged from 22 to 94 minutes. The average interview length was 48 minutes.

5.6.6 The COVID-19 pandemic

Ethical approvals for the project were granted in October and November 2019. (See section 5.7 and Table 12.) The approved lead site issued formal Confirmation of Capacity and Capability, and the University Sponsor granted Green Light approval, allowing the project to begin. Recruitment commenced and the first interview took place on 3 January 2020. Part way through data collection, on 11 March 2020, the COVID-19 pandemic was declared by the World Health Organization. On 20 March, after seven interviews had been conducted, the lead site stated that they could no longer be actively involved in research apart from COVID-19 studies, and their part in recruitment was immediately suspended. Two other NHS Foundation Trusts in northwest England, who had agreed to be additional sites for the research (not identified to protect participant anonymity), and for which ethical approval processes at Lancaster University and the HRA were underway, also put non-COVID-19 research on hold. All NHS administrative and project support activity with this study was thus curtailed; new Trusts were no longer able to devote any time or resources to the HRA documentation needed to approve the study in their locations, and nor could approved or new sites plan to disseminate the study to potential participants. This had a serious impact on the routes for recruitment, and the timeframe for ethical approval also became uncertain and lengthier in the University and the HRA, as organisations were affected by staff shortages.

Two further Trust Research and Innovation Departments were approached informally to establish if they might agree in principle to be a site for the project, on the basis that research had previously been carried out in their locations relating to the impact on staff

of adverse events, or to staff support schemes. However, the capacity of Trusts to consider becoming involved with non-COVID-19 research was reduced or removed entirely, because of their changed institutional priorities during the pandemic, and they declined.

The COVID-19 pandemic resulted in an increased reliance on snowball recruitment, and on dissemination via Aqua, which for several months became in practice the only routes by which study recruitment was achieved. The pandemic restrictions impacted interview mode, resulting in three face to face interviews. The remaining 24 were conducted remotely (19 by telephone; five via online video meeting), in accordance with the prevailing pandemic rules and participants' individual preferences. The 27 interviews were conducted over an eleven-month period, between January and November 2020.

5.6.7 Conducting the data analysis

After transcription of each interview, the data were coded and analysed in Word, following the six steps of thematic analysis (Braun & Clarke, 2006). Coding software packages NVivo and Atlas.ti were initially explored as a way of helping to organise the data, but I concluded that I would be more likely to retain the nuances of codes and gain a deeper understanding by coding the data and organising the analysis without the use of software.

Phase one of the analysis was familiarisation with and immersion in the transcribed data, "taking notes or marking ideas for coding that you will then go back to in subsequent phases" (Braun & Clarke, 2006, p. 17). I listened three times to each recording, to ensure that the transcription was faithful, to be clear about participants' emphases, and to be aware of any emotion in their voices. I read and re-read each transcript several times, and if I was not sure of participants' comments or meaning, or my transcription accuracy, I listened to the recording again.

Phase two involved the generation of initial codes, which "identify a feature of the data (semantic or latent) that appears interesting to the analyst" (Braun & Clarke, 2006, p. 18). I carried this phase out by copying the transcript into the central section of a three-column template. I added reflexive comments and notes in the right-hand column about my initial reactions and where I considered the data were interesting or particularly salient. Codes were added in the left-hand section, including in vivo codes that used the

participant's words, and codes using my own summary wording. Where a reflexive note was lengthy or required deeper explication, I wrote separate memos (examples at Appendix C), referencing the interview and date of analysis when they had arisen. I amended or added to the codes and to my reflexive comments as ideas arose, according to my reactions and impressions in the moment (Saldaña, 2016). I completed the initial analysis of each transcript before moving on to analyse the next interview transcript, with the aim of keeping the interviews and each participant's priorities clear in my mind. (Exemplars of coded transcripts, redacted to preserve anonymity, are included in Appendix L.) After separately completing the coding for each interview, I then turned to considering the data as a whole. I reviewed the initial codes and considered where there were patterns, similarities with, or differences from other participants' views and experiences. I noted these ideas, included references to other interviews that came to mind, on the coded transcripts.

I conducted phase three of the analysis once all the data had been initially coded, sorting and combining the different codes into categories, and grouping the categories into potential overarching themes, removing duplications, and collating all the relevant coded data extracts within those identified themes. No themes were discarded at this stage. Phase four involved reviewing the themes for "internal homogeneity and external heterogeneity" (Patton, 1990), so that the data within each theme formed a coherent pattern, and there were clear and identifiable distinctions between the themes (Braun & Clarke, 2006, p. 19). Where a piece of each collated extract of data did not seem to fit, or had been included in more than one collated set, I reviewed and amended the analysis to make the groupings more internally coherent, and to clarify the distinctions between them, moving or removing coded extracts as needed to achieve this. I then reviewed the entire dataset and the themes, to consider if the themes fitted together, and whether they adequately captured the data as a whole, and in sufficient depth.

Phase five involved defining and refining the themes, to determine what aspect of the data each theme captured. This was carried out by organising the collated data extracts for each theme "into a coherent and internally consistent account, with accompanying narrative" (Braun & Clarke, 2006, p. 22), identifying what I perceived to be of interest and important for each theme and why. At this point the themes were given working titles, and a quotation that seemed aptly to capture the essence of each theme was identified.

The final sixth phase comprised writing up the data analysis to tell the story of the data, within and across the themes, using quotations from the participants' contributions to evidence the themes, each identified by participant number, and linking the themes back to the research questions. The analysis considered the meaning of each theme, any assumptions and conditions underpinning them, implications arising from the themes, and the overall story that the themes together revealed about the topic (p. 24).

Participants were sent a summary of the findings and were offered the opportunity to provide feedback (Tong et al., 2007), but none chose to do so beyond general comments about finding the summary interesting and useful.

5.7 Ethical considerations

For this research study carried out within the NHS with healthcare staff participants, ethical approval was required not only from the University, but also from the Health Research Authority (HRA). The approval processes are set out in detail below and the full timeline is set out in Table 12. The approval letters received are at Appendix D.

Undertaking more interviews, or re-interviewing participants, was potentially problematic in a PhD study, since ethical approval processes required that a proposed sample size was indicated in the research proposal and related documents, and the known constraints of time meant that to be realistic there needed to be a sample ceiling. The ethical approval documents set the parameters for recruiting a minimum of twenty participants and a maximum of thirty. These parameters were selected as a means of ensuring that the project would be achievable in the total time available for the PhD, and to allow for some flexibility in seeking additional data, as needed, to respond to emerging codes and themes as the analysis progressed.

The ethical requirements for approval of this project taking place in the NHS were multi-layered. They involved the University Research Ethics Committee, the University then separately agreeing to act as Sponsor for the research, and detailed documentation required by the HRA and the NHS Trusts who agreed to be involved. These documents included a form elaborating a full set of project plans, an Organisation Information Document that was agreed with each Trust involved and then served as a contract between the Sponsor and that NHS site, a Schedule of Events spreadsheet, and proof of the Sponsor's insurance. Ethical approval for the study was sought from Lancaster University, and subsequently from the HRA via the Integrated Research Application

System (IRAS)¹³ process. HRA approval was necessary because the data collection would take place in the NHS, even though no patients were involved.

I aimed to adhere throughout to ethical principles of research in the development and conduct of this project (British Psychological Society, 2021), including minimising the risk of physical and psychological harm or distress to participants and the researcher; ensuring that participation was voluntary, and avoiding any coercive or deceptive practices in recruitment, by being transparent about my identity and that of my University; providing the right to withdraw; including all material information in the recruitment literature and a detailed Participant Information Sheet (Appendix E), to obtain fully informed consent; protecting anonymity and confidentiality. All ethical issues are considered in turn below.

¹³ IRAS is an online system for applying for the permissions and approvals required for health, social and community care research in the UK.

Table 12*Timeline of ethical application processes and approvals*

Date	Organisation	Decision
27.06.19	Advancing Quality Alliance (Aqua)	Agreed to be involved in study dissemination to members. Draft IRAS application document approved
28.06.19	Aqua Lived Experience Panel member (patient representative)	Comments provided on the proposed research design and ideas, including terminology
10.07.19	NHS Foundation Trust 1	Agreed to be lead NHS site for the study
15.10.19	Lancaster University Faculty of Health and medicine Research Ethics Committee	Approval of ethical application (FHMREC19002)
01.11.19	Lancaster University Sponsorship	Lancaster University agreed to undertake the role of research sponsor
01.11.19	Health Research Authority	Application for ethical approval submitted
11.11.19	Health Research Authority	Ethical approval granted
25.11.19	NHS Foundation Trust 1	Confirmation of Capacity and Capability received
27.11.19	Lancaster University Sponsorship	Issued Green Light approval for study to commence at lead site. Recruitment started
23.01.20	NHS Foundation Trust 2	Agreed in principle to be second NHS recruitment site
28.01.20	Health Research Authority	Submission of non-substantial Amendment 1 to add the second NHS research site
07.02.20	NHS Foundation Trust 3	Agreed in principle to be third NHS site
11.02.20	Health Research Authority	Approval of amendment adding second NHS research site
17.02.20	Health Research Authority	Submission of non-substantial Amendment 2 to add the third NHS research site
12.03.20	Health Research Authority	Approval of amendment adding third NHS research site
20.03.20	NHS Foundation Trust 1	All involvement in non-COVID-19 research paused following WHO pandemic declaration
01.06.20	Health Research Authority	Submission of non-substantial Amendments 3, 4 and 5 changing dates and local collaborator details for NHS Foundation Trust 3
10.06.20	Health Research Authority	Approval of Amendments 3, 4, and 5
29.06.20	NHS Foundation Trust 3	Confirmation of Capacity and Capability received
30.06.20	Lancaster University Sponsorship	Sponsor issued Green Light approval for study to be conducted at NHS Foundation Trust 3
01.07.20	NHS Foundation Trust 3	Recruitment commenced

[5.7.1 Payments and incentives to participants](#)

No payments were made to volunteers, nor any other incentives offered to participants in this research. This raised the question of valuing the contribution and time of

participants and making this value clear. On balance, I decided that not recompensing participants for their time, and not inducing participation by offering incentives, was the preferred option, so that participants would self-select as being interested in the topic. I did not approach potential participants directly in advance of an expression of interest in the research, to avoid the possibility of participants feeling obliged into participation in the study.

5.7.2 Interview location and researcher safety

It was decided for safety reasons to conduct any in-person interviews in the participants' workplaces when others were in the building, as far as this was practicable, to avoid potential risks for the researcher from conducting interviews as a lone worker, outside of the participants' working environment or after working hours. Lancaster University's Guidance for Lone Working (2016), the University's Division of Health Research Lone Researcher Policy (2019), and Student Safety Handbook (2011) were adhered to. Access to a University safety checker system (SkyGuard) was arranged; it provided an electronic device to connect to a monitoring service, to alert named individuals or send medical or police assistance if the safe completion of an interview in a lone-working situation was not signalled. In practice, none of the in-person interviews were conducted out of hours or outside participants' workplaces.

5.7.3 Power

In this research process I considered any potential power imbalance between myself as the researcher and the interview participants. This perspective informed the approach of not contacting possible interviewees directly, to avoid any perceived or actual coercion. It also gave rise to reflection about my role in this collaborative production of knowledge, since I made key decisions about which points to follow up with participants, and how far to extend the discussion, because of their available time. I was aware of making decisions about what was most relevant, in my estimation, for further exploration at the time of data collection, or inclusion in the subsequent analysis. While the participants could have their own agenda in the research situation (Karnieli-Miller et al., 2009), it was nonetheless important to acknowledge that as the researcher I retained considerable power in the relationship and control in the process. It became evident that some participants wanted to share views and experiences that went beyond the scope of the project, such as episodes of workplace bullying unrelated to PSI, and

it became a careful balancing act in each interview to allow participants to share their experiences and make their contributions with autonomy, while keeping the discussion focused on exploring the topic of support for healthcare personnel following adverse or near miss events. In practice I chose at times not to follow the participant's avenue of interest, if this meant moving completely outside the topic under investigation. When participants and their data led the research into unanticipated areas, I made decisions in the moment about the extent to which I should aim to follow their leads or funnel the discussion back to fit with the stated research objectives, and I explained this to the interviewee.

The unique contribution of the researcher and participants to a project makes both inseparable parts of the final creation (Karnieli-Miller et al., 2009). As a foundation to the research, I considered it important to establish a climate of trust with participants, in which the process was clear, considerate, and non-threatening. This formed part of valuing and respecting participants, and aimed to facilitate their capacity to offer full and frank accounts of their personal experiences and knowledge. As a practising psychotherapist, I understand that the creation and maintenance of empathy and rapport form the bedrock of enabling people to be open in describing what they have experienced, and to share their genuine views. For me this aspect is also needed in the research relationship (Taylor & Bogdan, 1998), and represented a way of balancing power between researcher and participant. When participants feel able to be authentic, this can foster a willingness to move away from the scripted messages of institutions (Cheney, 2009), to reveal what actually happens in practice, and what they consider important.

I was aware of the potential effects of hierarchies within organisations (Morrow et al., 2016; Worrall & Cooper, 2004), and this seemed particularly relevant for a study where participants could potentially have relatively junior supervisory positions within the NHS, or very senior management responsibilities. I aimed to have a mixture of levels of seniority, to explore whether there was a difference between the views of more frontline staff compared to more senior managerial participants. I also reflected on whether I would, for example, potentially be drawn in to deferring more to, or letting the interview be steered by, senior staff, and how I could find ways of avoiding such eventualities (Guillemin & Heggen, 2009). This required close reflexive attention at each stage of the process, to ensure I was not allowing certain participants to have a

greater control of the interview because of their status, or conversely privileging more junior participants' comments or observations to increase their voice, if either approach diverted from the research aims.

A separate consideration was my position along the continuum between insider and outsider, not being a colleague working in an NHS hospital environment or a healthcare professional body. I wondered whether this would have an impact on participants' willingness to contribute, or their beliefs in my capacity to understand their work situations and experiences. I was also aware that my professional background as a psychotherapist facilitated engaging in empathic listening to accounts of adverse experiences, and while I was not intending to offer a therapeutic effect, I knew that being closely attentive to narratives, for example of negative experiences following involvement in a PSI which some participants recounted, could be construed as encouragement to share more detail of personal impacts that might extend beyond the aims of the interview. Equally, cutting participants off in their accounts in order to guide them to my own research agenda could harm the trust I wished to develop, which was important for gleaning authentic data that offered depth and insight. As a psychotherapist, conducting interviews and eliciting information involves a familiar set of skills, but I carefully reflected on the differences between a therapeutic encounter and a research interview (Jootun et al., 2009), to help me avoid being drawn into areas beyond the scope of the study.

All these power-related considerations about the recruitment, the data collection and the analysis stayed with me as the project developed, and I tried to address my own concerns about potential power imbalances principally by remaining as aware as possible of the issues and choices as they arose, being transparent with participants, and by reviewing decisions in memos as I subsequently transcribed and analysed the interview data.

[5.7.4 Informed consent](#)

All participants taking part in the interviews had to be able and willing to give informed consent, based on the Participant Information Sheet (Appendix E) and any questions they posed. Consent was taken at the start of in-person interviews, or by email if the interview was scheduled to be remote, so that the participants could sign and return their interview consent form in advance. In the form (Appendix F), it was made explicit

that participation in the interviews was voluntary, and that the participant was free to withdraw from the process both during the interview and until a specified date (two weeks following the interview) without giving any reason. This was to enable participants to reconsider their willingness to participate once they had contributed. Participants were informed that if they contacted the researcher within this timeframe, their anonymised data could be withdrawn on request. It was explained that after this time it might no longer be possible to extract individual anonymised data from the collated dataset. I also asked each participant explicitly at the end of the interview if they were still content for me to use their anonymised data. None of the participants availed themselves of the option to withdraw or remove their data.

5.7.5 Confidentiality and anonymity

A key consideration in preparing and carrying out this project was to ensure that data were handled and stored in a way that would maintain their confidentiality, at the same time prioritising the anonymity of participants. This was to protect the information gathered from disclosure to anyone outside the research team (student and supervisors), recognising that individual participants might only be willing to contribute on the understanding that what they divulged would simply be used for the stated research purpose, and would not be made available in a way that could be attributable to them. Taking careful steps to maintain confidentiality and protect anonymity, and being explicit about this in dialogue with potential and actual participants, was an important element of fostering trust in the research relationship, to facilitate a willingness on the part of participants to share their perspectives and experiences openly and fully, particularly where their contribution could be considered critical of their organisation.

It was made clear in advance that if as part of an interview a whistle-blowing incident arose and a risk of harm to the participant or another person was revealed, the participant would be informed that confidentiality might need to be broken in line with safeguarding policies and procedures. In any such situations, it was planned that supervision advice would be sought, or if the incident involved immediate risk, relevant authorities would be informed immediately. A protocol for breaking confidentiality was developed as part of the ethical approval processes, for use as necessary (Appendix G). In practice I did not need to make use of this protocol.

5.7.5.1 Confidentiality of data

To ensure the confidentiality of data, the requirements of the General Data Protection Regulation (GDPR) were complied with (Data Protection Act, 2018), and this was explained to participants. The arrangements for data storage aimed to protect the data from any unauthorised access. In line with the ethical approval documents, audio recordings of the interviews were made once the participant had consented for this to occur, and all audio recording equipment was stored securely in a locked cabinet when not in use. No video recordings of interviews were made. Digital audio recordings of the interviews with participants were made on an encrypted recorder and transferred as soon as possible to my secure University network drive. The transcription and analysis were conducted via the University's virtual private network (VPN) so that all files remained on the University network and were accessible only by the researcher and research supervisors, via password protection; they were not stored on a personal computer. The primary supervisor acted as the Data Custodian, and the participant information sheet stated that only the research team would have access to the anonymised transcripts, via password protection, and the data would not be made accessible to other researchers. Upon transcription in anonymised form, with individual numerical codes, the audio recordings were destroyed. Participants were made aware that copies of the consent forms and the anonymised transcripts would be scanned and stored on my secure University drive, and transferred to the Data Custodian. As agreed with the HRA, the scanned consent forms would be stored for a maximum of three months after the end of the project, and the anonymised interview transcripts would be stored securely for ten years at the University. Hard copies of the consent forms were destroyed via the University's confidential waste service after they had been scanned.

5.7.5.2 Anonymity

It was explained that participation in the research would remain confidential unless participants chose to reveal this themselves, and in-person interviews were arranged as far as possible to ensure that participants were not identifiable as such by their colleagues. I confirmed that the data would be anonymised so that all personal identifying information was removed in the transcripts, and no-one reading the research could establish the identity of any participant.

It was recognised that there might be concern on the part of participants that, if their responses included criticism of their workplace, colleagues, or management, this could affect their professional situation or relationships. I explained to participants that direct quotations would only be selected for use if anonymity could be ensured, and they could not be attributed to an individual. Three participants were particularly concerned that they should not be identifiable by their organisation on the basis of a quotation from their interview. I confirmed to all participants that if there was any possibility of identifying the originator of a quotation, I would not use that data; if I was unsure, I undertook to contact the interviewee concerned to seek express advance permission to make use of that data segment. I offered all participants the opportunity to receive a copy of their transcript on request. None of the participants asked to receive their transcript.

It was explained that use of the electronic lone-working safety checker system (SkyGuard) would include details of the time and place of interviews, but without revealing the identities of interviewees. This was to avoid compromising participant anonymity, while protecting the safety of the researcher when lone working. In practice, the safety checker system was not required.

5.7.6 Interviewee or researcher distress

It was recognised that participants might experience distress while being interviewed on the topic of PSI and negative impacts on involved healthcare staff, possibly arising from recollecting their own or colleagues' experiences as healthcare professionals when distressing patient safety events had occurred. It was important to ensure that procedures were in place to respond to participants in the event of any undue emotional stress caused during the interview (British Psychological Society, 2021; Richards & Schwartz, 2002). I developed a distress protocol (Appendix H) for use in the event of participant (or researcher) distress, and it was included in the applications for ethical approval.

Some participants found the interview process did bring up recollections of difficult experiences, and one participant (a nurse) explained that she had been diagnosed with PTSD several years previously, following a PSI. She anticipated finding the interview difficult. Another participant (a psychiatrist) mentioned that he believed he had experienced a PTSD response after a PSI, although he had not been formally diagnosed.

These contributors had chosen to participate via video, which enabled me to see their expressions and gauge their feelings, and ensure they were explicitly made aware that they could choose how much or how little to impart, or to stop at any time. It was important that I paid very close attention and responded to any emotional cues from interviewees, including those who had chosen to participate by telephone, to ensure that they felt emotionally able to continue. This is a familiar process in my psychotherapy work, which I also carry out online and by telephone, and was achieved by checking regularly with each participant as the interview progressed, and at the end. All participants were reassured at the start of the interviews that they could pause the interview, or stop and withdraw, at any moment, but all participants continued, and the distress protocol was not needed. A debrief sheet (Appendix I), also included as part of the ethical approval applications, was provided at the end of each interview, which included signposting to resources in the event of a participant experiencing distress at a later point.

The second part of the distress protocol was designed for use in the event of distress being experienced by me, so that appropriate support and advice could be sought, with the research supervisors in the first instance. This outcome was known to be unlikely, given my professional background, training, and familiarity with hearing others' distressing accounts; in practice, this part of the distress protocol was not required.

The decision to undertake all transcription of the interview data myself was made to maintain data confidentiality, but also to avoid the possibility of distress to other transcribers when listening to potentially distressing material about the experience of PSI.

[5.8 Chapter summary](#)

This chapter has set out how this research project was designed, explained the decisions that were taken and intentions behind them, and outlined the University and HRA ethical approval requirements and process timeline. The ethical considerations arising in the conduct of this research have been addressed. The reasons for selecting thematic analysis with a reflexive focus as the method for analysing the qualitative interview data have been explored, elaborating how this methodology aligns with my beliefs about knowledge construction and the nature of reality, and the inductive approach I wished to follow. I have outlined the approach taken to recruit participants, and to

collect and analyse the data within the constraints of a time-limited PhD research project undertaken in the NHS, and have described the impacts on the recruitment process and interview modes used of the COVID-19 pandemic. I have explained my positionality, my professional influences, and my intention to be transparent about the choices made. I have emphasised the priority I place on investigating participants' individual perspectives, knowledge, and lived experience, within an awareness of the social constraints and expectations put in place by the institutions and organisations to which those individuals belong.

CHAPTER 6: FINDINGS

6.1 [Introduction to the chapter](#)

This chapter reports the findings of the project, and the contributions the interview participants made in relation to the research questions posed:

- 1) What policies, protocols, and practices are healthcare policymakers, managers, or supervisors aware of that aim to support healthcare personnel in their organisation who have experienced unanticipated adverse medical events or near misses in UK healthcare settings?
- 2) What are the views of healthcare policymakers, managers, or supervisors about the term “second victim”?

This chapter sets out the views of participants, conveyed during semi-structured individual interviews, about supporting healthcare professionals after experience of patient safety incidents (PSI). It reports participants’ experience, perceptions, and knowledge of the impact of PSI on staff, of any relevant policies to address this, and whether support practices were formalised in such policies, achieved in practice without policies, or not achieved. The chapter also explores participants’ views about the “second victim” term, and whether the affected staff, or the support offered to them, should be identified with this or other specific terminology.

The clear communication of research findings, which is my aim, is emphasised by Williams and Morrow (2009) as one of the key criteria of qualitative research trustworthiness (Elliott et al., 1999), alongside using reflexivity to remain aware of researcher subjectivity and influence, and maintaining the integrity of the data. My overriding objective was to convey as much as possible of the participants’ individual voices and priorities in this analysis.

6.2 [Participant information](#)

The demographics of the interviewees who volunteered (n = 27) and salient information including participant number, roles, interview duration and mode (Tong et al., 2007) are presented in Table 13. All participants identified as healthcare professionals with policy, management, or supervisory responsibility (for staff, a service, or a professional group), located in England, in a total of ten NHS Trusts, covering 14 sites. Twenty

participants were in clinical roles (some with additional non-clinical responsibilities), and seven non-clinical. Participants identified their own gender (22 female and 5 male). Interview length ranged from 22 to 94 minutes (average 48 minutes). Geographical location is not included to avoid possible identification of individuals.

Table 13*Participant demographic and interview information*

Participant number	Gender (self-identified)	Role (self-described)	Interview month/year	Interview duration (minutes)	Interview mode
P1	Female	Senior Midwife (non-clinical)	01/20	94	In person
P2	Female	Senior Critical Care Nurse	01/20	49	Telephone
P3	Female	Senior Cardiac Nurse	01/20	29	Telephone
P4	Female	Senior Heart Failure Nurse	01/20	51	Telephone
P5	Male	Consultant Haematologist	02/20	77	In person
P6	Female	Specialist Paramedic Team Lead	02/20	32	Telephone
P7	Female	Associate Director of Governance	03/20	31	In person
P8	Female	Assistant Director of Nursing	03/20	53	Telephone
P9	Female	Regional Director, professional body	03/20	44	Telephone
P10	Male	Doctor, Emergency Medicine	03/20	40	Telephone
P11	Female	Profession Lead, professional body	04/20	64	Video
P12	Female	Profession Lead, professional body / Senior Nurse	04/20	53	Telephone
P13	Female	Consultant Endocrinologist	06/20	79	Video
P14	Male	Paramedic Service Manager	06/20	41	Telephone
P15	Female	Consultant / Director of Quality Improvement	06/20	41	Telephone
P16	Female	Clinical Psychologist / former Patient Safety Lead	07/20	48	Telephone
P17	Female	Senior Paediatric Critical Care Nurse	07/20	36	Telephone
P18	Male	Consultant Occupational Health Physician	07/20	36	Telephone

Table 13 (continued)*Participant demographic and interview information*

Participant number	Gender (self-identified)	Role (self-described)	Interview month/year	Interview duration (minutes)	Interview mode
P19	Female	Paediatric Research Nurse Co-ordinator	07/20	45	Telephone
P20	Female	Intensive Care Matron	07/20	22	Telephone
P21	Female	Head of Community Nursing Services	07/20	55	Video
P22	Female	Deputy Director, Organisational Development	07/20	45	Telephone
P23	Female	Clinical Psychologist, Critical Care	07/20	28	Telephone
P24	Female	Clinical Psychologist, Critical Care	08/20	54	Telephone
P25	Female	Community Nursing Team Lead	08/20	43	Video
P26	Female	Patient Safety Lead	09/20	59	Telephone
P27	Male	Consultant Psychiatrist	11/20	56	Video

6.3 Development of themes

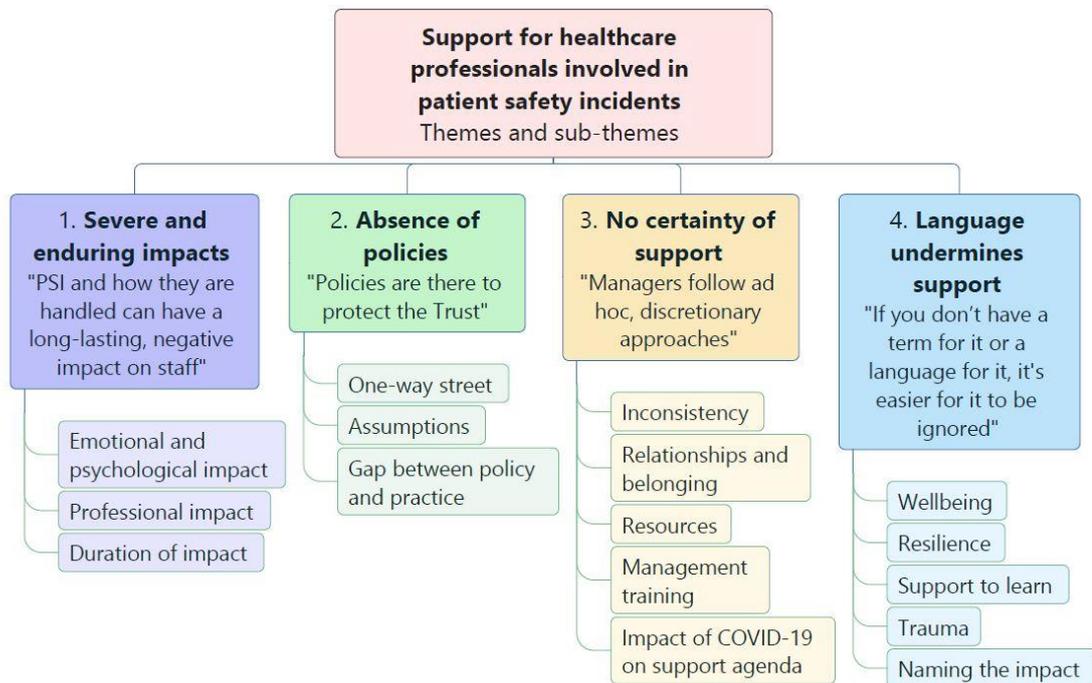
The method followed for conducting the data analysis, generating initial codes inductively, developing these into categories and eventually into overarching themes is reported in Chapter 5, section 5.6.7. The 27 interview transcripts were reviewed individually at first, and the total number of initial codes derived inductively from the data was 875, once duplications had been removed. The initial codes varied from single words (for example “anxiety”) to short phrases (for example “harm to career”), each capturing an idea conveyed by the participant. The codes were sorted into categories (for example “professional impact”), with relevant data extracts collated for each category. Overlaps were removed; some categories were moved or merged, and they were eventually arranged into four major themes.

6.4 Summary of findings

The four overarching themes drawn together from the participants’ contributions are set out in this chapter. Evidenced by quotations and key words used by the interviewees, they comprise: 1) Severe and enduring impacts; 2) Absence of policies; 3) No certainty of support; 4) Language undermines support. Figure 6 depicts the four themes and 16 sub-themes that were developed from the data, and they are presented with examples of the initial codes at Appendix J.

Figure 6

Themes and sub-themes



Participants described the potentially severe and enduring impact of PSI on the staff involved (theme 1), in terms of negative emotional, psychological, and professional effects. Fear of or actual damage to careers was a repeated topic, together with experiences of being blamed, and of isolation from colleagues if they were under investigation or suspended. The duration of the negative impact arising from the incident and also from the organisational handling was potentially long-term, staying with some individuals for many years.

The experience of policies (theme 2) was focused on human resources policies that placed requirements on staff, such as sickness absence limits and disciplinary rules. Many participants assumed that policies setting out support would exist, but were unable to pinpoint any specific documents, in spite of their managerial and supervisory roles. One participant knew of an NHS England patient safety policy that included mention of the need to support staff after incidents. Several participants were aware of general statements made by their organisations about the importance of staff looking after their own physical and mental health and wellbeing.

Participants described the elements of support that were lacking but necessary to create effective support after PSI (theme 3). The experience of support after PSI was described for most staff as uncertain, ad hoc, or entirely absent, and support received did not depend on or necessarily relate to the impact experienced by the individual. It depended instead on having good existing relationships with team colleagues, including being perceived to fit in or be deserving of support, or on individual leaders' varying approaches and choices. Resources were allocated to differing extents, ranging from access to individual psychological support, to no support at all. Time, professional mentoring or supervision, and funding were all reported to be scarce. Where resources were made available, these were for different types of provision, and often applied only to certain restricted groups of staff within an organisation. The data were collected at the start of the COVID-19 pandemic, and participants described more generally supportive attitudes towards staff because of the impact of the pandemic. Some hoped that more support would persist, and others considered this a short-term response which would not last.

It became apparent that accepted usage of language in healthcare gave particular meanings to the words "wellbeing", "resilience", "support", and "trauma" (theme 4), which did not place priority on addressing emotional impacts or supporting staff, and spoke more to what is required of, rather than provided to staff. Participants considered it more appropriate to describe the support offered after PSI, rather than label the staff involved, while acknowledging the impact. The term "second victim", found to be an accurate descriptor of the potentially traumatic experience of being involved in a PSI, nonetheless caused discomfort, because of sensitivity to other stakeholders' responses and potential objections. Participants could not identify a preferred, alternative term.

6.5 Theme 1: Severe and enduring impacts

All participants spoke of the distressing impact on staff of being involved in or witnessing a PSI, and how severe the effects could be. Three sub-themes depict the participants' contributions about different facets of the negative impact experienced, and its potential duration.

6.5.1 Sub-theme: Emotional and psychological impact

Participants described the range and severity of negative emotions that were experienced by staff following involvement in a PSI where harm was caused, including profound shock, anxiety, hypervigilance, distress, horror, guilt, self-directed anger, and self-doubt about their clinical competence. Staff involved were described as “absolutely mortified and devastated” (P21, Head of Community Nursing). There was a broad range of incidents that could cause a high level of distress and emotional trauma. This included near miss incidents without any adverse impact on the patient, apparently minor incidents, and patient deaths even if nothing had gone wrong in the care provided. The suicide of a patient or a colleague, violence to staff from patients or their families, and incident investigations or disciplinary processes following PSI also gave rise to traumatic responses. Many managers were said not to understand that no-harm or low-level incidents could have a negative effect on staff, but there would be “some people involved in quite a minor incident that could be enough to break them, and they could still be completely devastated by a near miss” (P15, Consultant).

Where they had not been addressed with appropriate support, the psychological impacts did not dissipate, but tended to accumulate, combining to trigger a trauma response that could appear out of proportion to an individual event, and creating psychological risk for the individual’s emotional health and functioning over the longer term, including an increased risk of suicide. This was described as “that box with the lid on, that sits at the back of your head”, arising from “years and years of attending quite nasty, serious incidents that one day becomes unbearable, possibly triggered by a minor incident” (P14, Paramedic Service Manager). Each PSI experienced put “another drip in the bucket, and it’s important to understand the impact of trauma lying dormant, sometimes for years” (P11, Trade Union Professional Lead).

In spite of the potential seriousness of impacts, they frequently went without management acknowledgement, which was considered inappropriate: “HR, team leaders, and managers need to understand the physical, psychological, and social wellbeing impacts of adverse events on individuals and on teams” (P9, Regional Director of a Professional Body). Understanding was said to be particularly lacking where staff were under investigation, and it was “easier to acknowledge negative effects where there was no question of staff fault” (P21, Head of Community Nursing), but it

was recognised that all staff could be impacted after PSI: “Incidents cause a lot of emotional trauma ... including those accused of poor practice or under investigation” (P26, Patient Safety Manager), and that ignoring this could lead to differential and unfair treatment of certain staff.

Being investigated after a PSI, and restrictions placed on the staff involved led to specific negative psychological impacts, including fear, vulnerability, desperation, and a sense of isolation from colleagues, with potentially extreme consequences. Suspension from duty, and being required to cease contact with colleagues, was also known to be a key factor in negative outcomes: “Isolation from colleagues leads to escalating mental health issues and emotional toil for suspended staff, who have a lot to shoulder alone, waiting for the axe to fall” (P9, Professional Body Regional Director). It was widely considered that the impacts on patients and on the organisation were perceived by managers to be of prime importance, whereas the risks to affected staff were often disregarded by managers and organisations: “Staff experiencing disciplinary and clinical investigations after incidents are more likely to suffer from mental health problems, and then be at risk of suicide” (P14), and it took staff self-harm to draw this risk to wider attention: “A very extreme event, such as a staff suicide, seems to be needed for healthcare managers to understand the emotional impact on staff of adverse events” (P9). This was also reported to be the case for organisations engaged in psychological healthcare: “Although mental health Trusts should have a greater awareness of the need for psychological support after adverse experiences, it nonetheless takes a crisis event before staff support is made available in practice” (P12, Professional Body Lead and Nurse).

[6.5.2 Sub-theme: Professional impact](#)

The impact of negative professional consequences after involvement in a PSI was a common topic, with staff fearing repercussions for their reputation or career, or the loss of their job altogether. This created further adverse emotional and psychological effects. Anxiety about how a PSI would be handled by management and professional repercussions added to the emotional and psychological impact, and could engender as much negative impact as the incident itself, or sometimes more.

Key among these fears were the experience and impact of a blame culture in healthcare, and while there was now said to be an explicit focus on the importance of learning from

incidents, there seemed to be a reluctance to give up blaming individual staff when patient care went wrong, as an established and familiar way for organisations to behave: “Some organisations have progressed beyond the old NHS blame culture, but others retain pockets of it” (P8, Assistant Director of Nursing). Scapegoating persisted as a commonplace strategy after PSI: “The organisational dynamic of it was: they’ve done wrong; get rid of them, which was a complete denial of [the organisation’s] responsibilities, and an attempt to deflect blame onto staff” (P27, Psychiatrist). The targeting of individuals was a recognised norm in some organisations:

I’ve worked for employers where, you know, if something went wrong, they would be the first to try and — well, I suppose use you as a scapegoat, would try and kind of pinpoint the blame on one individual as such, rather than looking at the bigger picture. (P14, Paramedic Service Manager)

Trusts were understood to be motivated to avoid negative financial and reputational impact on the organisation from being corporately accountable for outcomes:

If they can find somebody to make responsible, why should they take responsibility? Responsibility is either assigned to the Trust, or to the single individual. Now it's much easier to say it's a single individual, because if it's me, then it's my insurance which will compensate this family. (P5, Consultant)

Blame after PSI came not just from higher management, but from colleagues trying to protect themselves, their profession, or their own teams. There was a sense of wanting to find someone in another staff group to be held accountable, rather than acknowledging that errors and incidents were often the end point of a chain of actions: “Senior Consultants lined up to blame a nurse for administering a wrongly prescribed dose of morphine, instead of addressing the prescribing error with the originating doctor” (P15, Consultant). This approach served to target nurses in particular after PSI:

The blame is always apportioned to the end point user. So it's always the nurse who's administered the drug who's at fault. Even if you go further back and find that the medical staff wrote the prescription incorrectly, the nurse is always held to account. (P11, Trade Union Professional Lead)

Fear of blame responses and related professional impacts could develop after a PSI, and could in turn lead to specific mental health difficulties among involved staff, particularly where the impact was not acknowledged or addressed:

It starts with fear of management first when a near miss happens or something actually happens, and then slowly, if nothing is done to resolve the incident quickly, then it can become pathologised. So people can actually develop depression, have severe anxiety, panic attacks. (P18, Occupational Health Physician)

Feeling traumatised, anxious, guilty, or distressed about a PSI added to the professional impact, by undermining or impairing the ability of involved staff to function competently. This risked subsequent patients receiving suboptimal or unsafe clinical care, because of staff being distracted and unable to focus calmly or accurately on tasks and procedures. Either the incident itself or the handling by colleagues was known to have “significant repercussions for how individual staff could continue to work safely” (P1, Midwife).

6.5.3 Sub-theme: Duration of impact

The negative impact on staff of being involved in a PSI could continue for a long time, with the distressing experience staying in their memory and causing repercussions emotionally or professionally many years later, according to several participants. This extended period was characterised for some by anxious waiting, worrying, guilt, rumination, and replaying the incident over and over: “Staff live with that for the rest of their lives” (P21, Head of Community Nursing). The effects of how PSI were handled by organisations, including incident investigations, could also last for years, with those involved unable to move on from the experience: “They can have a long-lasting, negative impact on staff” (P8, Assistant Director of Nursing). Not finding a way to resolve and come to terms with being involved in a PSI risked causing psychological harm to staff after any subsequent incidents, because of the cumulative effect and the possibility of being reminded of earlier traumatic experiences: “Unless staff are supported, the impact of a PSI will remain, and future incidents will have a more severe effect” (P19, Nurse). Delayed support could also compound the negative impact: “It took years for me to process the severity of several horrendous incidents” (P27,

Psychiatrist). This participant was offered counselling four years later, but “the psychological damage had been done by the time support was offered”.

6.5.4 Theme 1 summary

Participants described staff feeling distressed and vulnerable after involvement in PSI, with the potential for serious emotional, psychological, and professional impacts and repercussions that could remain with staff for many years. The serious nature and effects of these impacts on the involved individuals were clearly recognised, and the impacts had the potential to ripple out to colleagues and subsequent patients. Staff experienced or feared being blamed after incidents, by their organisation or by colleagues, and described the experience of negative professional consequences including lengthy investigations and possible suspension from duties, which in turn impacted their emotional wellbeing. Participants described healthcare organisations recently making more mention of moving away from a blame culture and towards a learning culture, but reported that this was often theoretical.

6.6 Theme 2: Absence of policies

No policies were identified by participants that required emotional and psychological support for staff after involvement in a PSI or specified how to provide this. One national policy, identified by only one interviewee, made a general mention of the need to support staff, in the context of improving patient safety. Organisational policies that participants were familiar with related to the requirements on staff to fulfil their duties, such as human resources disciplinary rules, sickness absence limits, and clinical standard operating procedures (SOPs). The idea of a policy had specific connotations relating to patient care and agreed processes for staff to follow, rather than setting out what should or might be provided to assist staff negatively affected by their experience of an incident. A policy that could be used to provide legal support to staff in court after a serious PSI, by the Trust taking on vicarious liability, could be withdrawn by senior management. Three sub-themes explicate this theme.

6.6.1 Sub-theme: One-way street

Participants stated that they were aware of policies relating to human resources (HR) policies about equality and diversity, sickness absence rules, discipline processes, reporting incidents, risk management, being open and honest when things went wrong

(Duty of Candour), apologising to patients, whistleblowing (Freedom to Speak Up), or about the conduct and mechanics of investigations. Participants generally conveyed the idea of a policy amounting to a requirement, duty, or pressure placed onto staff, rather than an organisational statement of intent, such as to provide staff support after a PSI. They conveyed a sense of an imbalance, whereby heavy expectations on staff to follow processes to ensure patient care and adhere to professional duties were not reciprocated with supportive provision or care for staff after involvement in PSI: “There are unspoken psychological contracts in healthcare that are, in reality, one-sided... there’s no policy requiring support, and in practice it’s not the case” (P12, Professional Body Lead). Professionals exercised a duty of care to their patients, but did not receive the same care from their organisations: “Trusts believe they have a duty of care to patients, but not to staff” (P1, Midwife), and this could include withdrawing legal support for staff, at the discretion of the organisation: “Although I loyally supported the Trust over years of service and followed all their policies, the senior executives have not supported me in return” (P5, Consultant).

Policies required managers “to reassess staff competence” after incidents (P20, Matron), with the emphasis on staff learning from their identified shortcomings. Known policies also required staff to write a post-incident reflection as part of investigation processes, “to show the individual something about their own practice that needs to change” (P20). This requirement was intended to highlight deficiencies, and not as a way of supporting the staff involved: “Reflections are not a supportive thing, no, definitely not” (P7, Assistant Director of Governance). Connotations of the word “support” as used in healthcare are explored further in section 6.8.3.

Participants in different Trusts had no knowledge of any policies developed within their organisation that included references to supporting staff involved in a PSI: “In my Trust there’s no policy in place about staff support after an adverse event, and no existing formal support process or specified support roles, including within the RCA [root cause analysis] investigation policy” (P25, Nursing Team Lead). “Any mention of staff in an RCA refers to staff learning from the event... There is nothing in there that will support the clinician” (P20). A Consultant in a third Trust observed: “Policies are instructions for processes, but they don’t cover how managers should look after their team when an adverse event happens” (P15). The absence of a policy about staff support was observed even in organisations where some structured support was provided: “We have tried to

ensure what we are offering is good practice and best practice, but in terms of actually falling within a specific policy in the hospital, no, there isn't one" (P24, Psychologist).

Only one interviewee identified any policies that had, in part, informed her Trust's development of support for staff following PSI: "It is also part of the national patient safety policy, the new policy that's come out, there's general guidelines to say that organisations should be supporting staff more" (P26, Patient Safety Manager). She nonetheless noted that these policies were primarily about organisational imperatives, including the safe care of patients and promoting improved staff attendance at work, and less about meeting staff needs.

Policies were also potential causes of distress and negative impacts, where they were unclear: "There are so many different hospitals, with so many different systems for dealing with incidents" (P17, Nurse). The application of policies was often focused on investigating, disciplining, and in some cases wrongly accusing staff. A participant who was eventually cleared of any wrongdoing after a four-year investigation process, explained:

My experience of policies has given me a lot of anxiety around practising, not my capability or my skills, but around the processes and policies in the systems that I've been through, meaning that I couldn't cope with another adverse event.
(P1, Midwife)

Policies were also known to be applied in a discretionary way, to favour the organisation. This included vicarious liability policies to offer legal support to staff at Coroner's Court after serious incidents, which could be withdrawn at the Trust's discretion, for example if the member of staff did not accept responsibility for the patient outcome. This meant that the staff involved then had to assume individual legal liability for the PSI. This policy was used as a lever to persuade certain staff to admit to being at fault in negative patient outcomes, whether they were responsible or not, in order to protect the reputation of the organisation. Having vicarious liability withdrawn by the Trust was described by two participants, who were both subsequently exonerated from all accusations made against them by their organisations. The experience of having a potentially supportive policy removed gave rise to negative feelings of being cast out: "I felt like the black sheep" (P5, Consultant, whose organisation withdrew vicarious liability when he refused to say he was responsible for a patient death).

Another participant described feelings of abandonment and isolation: “I had to fend for myself as a lone individual without Trust support” (P1, Midwife). She considered that the policy which was ostensibly available to defend staff was in fact there for the benefit of the organisation: “I think the policies, it's felt, are there to protect the Trust, so that they can withdraw the vicarious liability”.

6.6.2 Sub-theme: Assumptions

Several participants assumed there must be a policy in their organisation about supporting staff after involvement in PSI, but they did not have any specific knowledge of the title or content of such documents, in spite of their long experience and management responsibility for staff: “I do get a sense there is a policy [about staff support] out there. I think I just don't know much about it if I'm honest” (P27, Psychiatrist). Most of the participants who were providing staff support in practice assumed that relevant policy frameworks existed somewhere, but that they did not need to know about them, as if policy and practice were two entirely unconnected elements: “I can't remember what the various things are. But we have a suite of kind of HR policies where they make reference to the different things that are available” (P21, Head of Community Nursing).

The lack of specific policies and processes to follow in providing staff support after PSI gave rise to potentially incorrect assumptions about who might need such support. This could lead to missing staff who were negatively affected after involvement in an incident, or pinpointing colleagues who were not negatively impacted: “Without an accepted policy or protocol, it's possible to end up checking on staff who are not struggling emotionally, making assumptions based on the seriousness of the event, and not identifying the right people in need of support” (P15, Consultant).

6.6.3 Sub-theme: Gap between policy and practice

Many participants were aware of an increasing number of general policy statements being made by healthcare organisations about the importance of staff wellbeing and the need to support staff, without clarifying what was meant by support, nor stipulating the processes that the organisation would follow to make staff support available and accessible: “There are now official references to offering more robust support to staff. However, none of these policies are specific. They don't actually say: you need to do this, this, and this, step by step” (P26, Patient Safety Manager).

General policy statements were understood to be a way of organisations giving an impression of genuine concern for their staff, but were not considered to be something staff could depend upon, because they were vague and often at odds with the reality of staff experience. Referring to organisational “mission statements” in healthcare about looking after their staff, P9 (Professional Body Regional Director) noted that the NHS People Plan stated an intention “to make the NHS the best place to work, but if that were true, the staff survey wouldn’t read like it does”:

What’s said and what’s practised isn’t always the same. So you’ve got rhetoric and then you’ve got reality, and the members that we come across don’t always experience that; you know, what’s written or what’s articulated, they don’t actually — it’s not part of their lived experience. (P9)

It was recognised that the impact of incidents on staff wellbeing would not be addressed by statements alone: “Staff need supportive action, not words” (P11, Professional Body Lead). Supportive interventions made available in practice were considered essential: “There’s a gap between policy and practice, and policies are only as good as the way in which they’re implemented” (P11). However, top management statements did not reflect an understanding of staff experience, and were dismissed as rhetoric: “General high-level statements and communication from senior executives just makes you realise that the people who run the show, how disconnected they are from the reality of the situation” (P2, Nurse).

6.6.4 Theme 2 summary

The second theme describes experience of organisational staff policies identified by participants, principally about HR matters, clinical patient care processes, reporting and investigating incidents, and other rules relating to what was required of staff. The experience of policies was mainly a one-way street of staff duties, without a corresponding duty of care shown to staff. Some policies to provide support to staff in legal situations could be withdrawn at the organisation’s discretion, to leverage outcomes supportive of the Trust. There was an assumption by some that staff support policies would exist, but without any specific knowledge. Participants also perceived a gap between high-level policy or mission statements with respect to supporting staff wellbeing, and a lack of identifiable approaches to providing organisational support

interventions in practice. It was widely perceived that, in policy and practice, staff were accorded a lower priority than patients or the organisation's reputation.

6.7 Theme 3: No certainty of support

This theme comprises five sub-themes. It addresses participants' comments about the inconsistency in experiencing emotional or psychological support after PSI, the fact that receiving support was often dependent on colleagues' inclinations and the quality of workplace relationships, and views about resource provision for staff support. It also includes contributions about how the COVID-19 pandemic was perceived to be influencing the staff support agenda within organisations.

6.7.1 Sub-theme: Inconsistency

Emotional or psychological support after involvement in PSI was considered necessary and beneficial: "Offering support to staff is part of being a psychologically informed NHS Trust" (P16, former Patient Safety Lead). It was, however, not available to some staff at all, available only to the staff in certain departments of some hospitals, or was provided informally within teams where colleagues were empathetic or motivated to be supportive. Provision was thus at best ad hoc and variable: "Support approaches within the same organisation are not joined up or consistent, and tend to be local to departments" (P16). In some organisations support was non-existent for many staff, because not all managers made it a priority: "As a manager, I know staff are not always supported after adverse events" (P20, Matron), and attitudes and approaches varied: "Even within one hospital, staff support is dealt with differently by different Consultants, different Ward Managers, different team leaders" (P19, Nurse).

Participants observed that while the need to offer support to staff after PSI was now discussed and beginning to be recognised within some organisations, this was a relatively new idea: "Organisations are only just starting to think about the staff involved in incidents" (P7, Associate Director of Governance), because "Nobody's ever really thought this is required" (P25, Nursing Team Lead). Within some Trusts there was still no talk at all of staff support after PSI, and no known avenues for staff to access support, even after very serious incidents: "I have no experience of any discussion about staff receiving support after care has gone wrong, including patient deaths" (P10, Doctor).

Where support was provided, it might not be accessed by staff who needed it, either because of lack of transparency about the processes, or insufficient availability: “At the moment, [staff have] got no guidance about how or where to seek support, and there’s also a waiting list, because there’s not enough Counsellors” (P7). The criteria for accessing support, where these existed, also differed by the type of incident and degree of patient harm, rather than with reference to the severity of impact on the staff member: “There’s no formal support for staff involved in near misses, although they can still have a traumatic impact” (P12, Professional Body Lead).

There seemed to be more recognition of the need for emotional and psychological support for the staff in certain healthcare specialisms, and this resulted in some departments giving their staff access to support, with others having no provision: “Different departments within a Trust have their own approaches to support, and some appear to be more aware of the psychological impact of events on staff than others” (P7). Emergency, Maternity, and Critical Care were reported to have a greater focus on staff wellbeing after PSI: “Senior managers in some departments, including Emergency, are very proactive in looking out for the emotional welfare of their staff, but others aren’t” (P18, Occupational Health Consultant). P26 (Patient Safety Manager in another Trust) described “pockets of peer supporters in the Maternity and Emergency Departments that originated in ad hoc and informal ways to meet the needs of these particular staff”. In one Trust, the staff who worked in Critical Care, including “nurses, doctors, allied health professionals, the admin team and the domestics” (P23, Psychologist) had access to psychological support, whereas staff from other departments in the same hospital or wider Trust did not.

The individual qualities, inclinations, and priorities of managers influenced whether or not support was offered: “It comes down to the micro system culture of a department and team, and the way that your peers there work and support each other” (P15, Consultant). Staff in supervisory positions were known to exercise individual discretion about being supportive: “Not all managers prioritise staff support after incidents” (P8 (Assistant Director of Nursing)). It appeared to be accepted that this resulted in inconsistent availability: “Staff support after adverse events is ad hoc, at the discretion of managers” (P21, Head of Community Nursing). There was no mention of attempts to make managers operate in a consistent way.

There was also a high degree of variability between organisations in the types of support offered, on what basis, and how and by whom it could be accessed. There was a sense of randomness about the availability of staff support for certain professions or geographically: “Psychological support has never been appropriately rolled out for nurses generally across the board, and there’s a postcode lottery” (P12).

There was also an evident inconsistency and confusion about what constituted support. Some organisations used trauma assessments of staff such as TRiM¹⁴ immediately after incidents in place of emotional or psychological support, either because managers were ill-informed about what this amounted to, or to obviate the need to make support provision:

There is very little support amongst their managers, and they’re just sent to me for a TRiM assessment, and I have to constantly explain to them: I’m not really there to provide support; my job is, as a TRiM Assessor to say: yes, this person’s at risk of PTSD; let’s refer them for some specialist input; or no they’re not. And if they don’t hit the threshold, which they very rarely do, there’s no further support from TRiM. But the managers seem to see it as: right, ticked box, sent them to TRiM, that’s my job done, and it’s not overly helpful. (P6, Paramedic Team Lead)

Staff who met the threshold would be referred to Occupational Health, but P6 explained: “I’ve never had anybody who’s met the criteria”.

Post-incident debriefing was offered in some organisations to certain groups of staff, but it could encompass different interventions and was carried out in different ways. Clinical or “hot” debriefs (about the medical facts of an incident) were run if individual Consultants chose to hold them, and were not about emotional or psychological support: “Hot debriefs are ad hoc, not usual, and not required, and not about seeing what support is needed by the staff” (P19, Nurse). Debriefs specifically to address the feelings of staff affected by involvement in a PSI were held within some departments of some organisations, “enabling the staff team to come together and reflect on an incident as a group, share feelings, and explore ways of coping” (P23, Psychologist). Accessibility

¹⁴ TRiM is a trauma-focused peer support system, designed to help people who have experienced a traumatic, or potentially traumatic, event at work.

even within one department was inconsistent, however, since not all affected staff would be able to attend because of their shift patterns, or not being allowed to take time away from their duties.

There were inconsistencies about whether support could be offered to staff involved in incident investigations, with different organisations interpreting legal requirements differently and taking varying approaches, which in some cases meant that staff received no support. In two organisations staff involved in investigations could access in-house counselling support (P18 and P26). However, in two other organisations there was “no access to formal support during investigations or disciplinary processes” (P13, Consultant), and elsewhere “Staff who are suspended can’t receive any support from organisational colleagues” (P21, Head of Community Nursing).

It was recognised that individuals might require support in different circumstances or provided in different ways, which was presented as an argument in favour of differential treatment: “Support should be tailored to the staff member. We have to be very much guided by the individual circumstances, because what fits one person from an anxiety and distress level may not suit somebody else” (P8, Assistant Director of Nursing). However, it was also recognised that flexibility in processes could result in staff not being offered any support; to receive support also meant being perceived by colleagues to need or deserve it, which could be shaped by perceptions of competence or fitting in, addressed in the next sub-theme.

6.7.2 Sub-theme: Relationships, belonging, and empathy

Staff support after PSI was described as predominantly informal, and contingent upon the quality of existing relationships with colleagues, on managers’ skills and priorities, and on their inclinations towards and treatment of individuals or groups. This made access to support variable and, for some, precarious or unlikely. A Doctor observed that “Clinical line managers are a possible source of informal support, depending on the relationship” (P10). There was a risk that staff who did not have established working relationships, because they were agency or Bank¹⁵ staff, “can be left completely unsupported” (P4, Nurse).

¹⁵ A staff bank is an entity managed by an NHS Trust or through a third-party organisation who contract healthcare professionals to take on temporary shifts at hospitals.

Some managers were known not to be supportive to certain staff, and yet this usually went unchallenged, meaning that “The culture of managing incidents can create a second layer of trauma” (P8, Assistant Director of Nursing). Where relationships were unsupportive, several participants had experienced harsh treatment by senior colleagues after PSI when they were more junior, including being frightened as a deliberately punitive management strategy to ensure they did not repeat their mistake, made to feel professionally inadequate, or placed under duress to continue working and simply ignore the emotional and psychological impact: “Colleagues frightened me with the possible legal implications, and made me feel weak and not up to the job. There was pressure to knuckle down, carry on, and get on with it” (P25, Nursing Team Lead). This type of experience had influenced some staff to support their own teams after PSI: “Experiencing an incident that left a secondary impact shaped my supportive management approach towards staff after incidents” (P25).

It was recognised that some senior staff would not appreciate how PSI could affect staff nor feel empathy: “Staff support depends on the willingness of individuals in management roles to instigate it, and managers need to understand the emotional impact of events on staff, but not all do” (P2, Nurse). Empathising with staff involved in a PSI, either based on individual experience, character, or having good relationships within the team, was considered an important aspect underpinning informal support among colleagues. However, it was not formally part of a manager’s role or training, and experiencing empathy after incidents was considered a question of good fortune and individual kindness, rather than an expected norm: “I feel particularly lucky to be in a tight-knit team and a supportive environment” (P17, Nurse). However, even where colleagues were empathetic, shift patterns meant that “There are very few opportunities for staff to come together naturally, to offload after a difficult day or check in with each other” (P24, Psychologist), limiting opportunities for informal support.

The level of support from colleagues after PSI could differ according to judgements made about individuals or groups, relating to their perceived skills and abilities: “Staff are treated in a more positive way after errors if they’ve previously been considered competent” (P2, Nurse). The fact that support was mostly provided informally by colleagues meant that these judgements strongly influenced decisions about being supportive, and some participants justified showing empathy to certain staff only. P9 (Professional Body Regional Director) sympathised more “with staff who own up and

show remorse and feel mortified after an incident, rather than individuals who drive a coach and horses through treatment protocols and can't be bothered".

Cultural differences were also recognised to be a source of differential and discriminatory treatment, meaning that some staff would not receive support: "Excuses are sometimes made for not supporting certain colleagues, and this can potentially relate to race, or not being perceived by colleagues to fit in with the organisational culture" (P12, Professional Body Lead). This was confirmed by a participant from a different Trust, who was strongly of the view that his unsupportive treatment by managers after a PSI related to his ethnicity, and to "not being perceived to belong" (P5, Consultant). He described feeling unsafe and afraid of future negative consequences, based on his identity:

I'm just a very tiny element in the organisation. Now if I was John Smith or if I was Antony whatever, probably my element would be slightly bigger. Now this is just my — I sometimes start to feel desperate: why this, is it because —, why? I don't know, but obviously I don't feel protected. I feel vulnerable, extremely vulnerable. (P5)

6.7.3 Sub-theme: Resources

A low level of resource allocation to staff emotional and psychological health was perceived to be the norm in most organisations, which had a negative impact on the availability of staff support after PSI. Several participants commented that psychological, emotional, and mental health support for staff was inadequately prioritised, and "urgently needs an injection of resources" (P18, Occupational Health Consultant). It was widely recognised that "The leadership layer is crucial in establishing the right kind of supportive culture" (P27, Psychiatrist), and that securing resources meant having "somebody at Executive level who's known to lead for the organisation on wellbeing" (P20, Matron). Structured interventions could not be established without funding, and provision depended on recognition of the need by senior managers, underpinned by specific budget allocation. This necessitated Board level "buy in" (P26, Patient Safety Manager) before support resources would be made available.

The need for a business case to secure ongoing financing for support provision either in-house or externally was emphasised by several participants: “Business cases are essential in the modern NHS to show that staff support is worthwhile and to build in capacity” (P16, former Patient Safety Lead). Short-termism in funding and a focus on time-limited projects constituted a barrier to ensuring that support interventions could continue: “Projects tend to fizzle out without continued staffing or funding for resources, training, and to roll schemes out Trust-wide” (P26, Patient Safety Manager). High-profile incidents were known to attract resource allocation, but not for the long term: “Significant incidents that impact on the organisation tend to bring in short-term resources that then go” (P15, Consultant).

Arguments were presented by some participants for resourcing structured support provision in-house, on the basis that healthcare work was particularly challenging, and had “more potential for traumatic experiences than most professions” (P13, Consultant). Support offered in-house was intended to facilitate a prompt intervention and recovery from the impact of the PSI, signposting staff externally only “if they need longer-term psychotherapeutic support” (P24, Psychologist). Prompt support was considered particularly important for new or inexperienced staff: “It’s necessary to get in really early, especially when it’s Junior Doctors and people at the start of their careers that are scared and think it can be career damaging” (P15, Consultant). In-house resources were thought to benefit the wider team, because staffing levels could be maintained, and “Accessing support externally can sometimes slow people’s return to work” (P18).

Resources for external counselling were only available to some staff in some organisations, where there was provision via an Employee Assistance Programme (EAP) for a fixed number of counselling sessions per year, or if they belonged to a trade union offering counselling support appointments. This type of counselling support was, however, intended for general wellbeing rather than to manage traumatic incidents, and it was not possible to provide longer or specialist support through these avenues for staff who were more negatively affected by PSI. Healthcare professionals could choose to pursue “the same access to counselling or psychological support as members of the public, via their GP, when something terrible has happened at work” (P10, Doctor). However, it was recognised that waiting lists and limited community resources could

mean staff being left without support for weeks or months, or not receiving the appropriate, trauma-focused treatment needed.

There was an evident tension between participants' preference to offer support proactively and automatically to all negatively affected staff involved in a PSI, and their awareness as managers and supervisors that this could be unworkable in practice because of stretched resources. The high number of incidents, "happening far more than most lay people would think it does" (P10), was recognised as an important barrier to offering support to all who were impacted in the way that participants believed staff needed, namely "immediately, and later after the initial shock phase" (P16), because this could result in very large numbers of staff seeking to access emotional and psychological support.

Resources were not seen as purely financial; time was an important factor, but often in short supply. Organisational rhetoric about supporting staff with their mental health was again perceived to be at odds with the reality staff experienced: "All the talk about support for staff mental health hasn't been given a corresponding allocation of resources or time" (P3, Nurse). This included lack of time to assimilate and recover from PSI and associated emotions: "After an incident, staff need time to pause, reflect, and process the experience and the feelings" (P25, Nursing Team Lead). Heavily loaded work schedules meant that there was no slack in the system, and most teams did not have spare staff to cover others having time off, or time to devote to a supportive conversation with a colleague: "There's no time to heed or manage the feelings of distressed colleagues, because it would take too much time in the clinical day" (P13, Consultant). Even in departments where access to psychological support was available, there were challenges in getting staff released from their duties to have time to attend appointments, and line managers were left with unenviable choices between staffing their wards or deciding "whether to allocate scarce time resources to being supportive" (P2, Nurse). This meant that managers' responses would depend on their individual inclinations and on relationships:

It's a case of trying to manage with inadequate financial resources, less than is needed. We don't have the money to look after the patients, let alone time to look after the nurses. So you rely on a hell of a lot of goodwill. (P2)

The increasing constraints on time and staff resources had led to supervisors, including those with psychological training, being unlikely to identify or support distressed colleagues:

A very astute ward manager or a team lead would be able to say: I'm worried about you. But in the last few years, with the resources being so slim, people are tending to not really have the time to provide that level of psychological support. (P12, Professional Body Lead)

Most healthcare environments did not have the private space available within which to support negatively affected staff after PSI. There was one exception to this, in a specialist service that was acknowledged to have “the rarity and good fortune” (P17, Nurse) of having more resources:

We're quite lucky here in that we've got separate rooms, so we can take people to one side. Generally, we've got time and space to speak to people, and we've got the opportunity that if they feel that they can't carry on with their shift, that we can send them home, and that somebody will cover the rest of their shift. (P17)

Professional clinical supervision was reported to be a valuable supportive resource for staff to discuss the impact of challenging experiences, but it was rarely available: “There's a professional lottery about receiving clinical supervision. Almost every other discipline has sessions; nurses don't” (P12). Professional supervision, for those who could access it, provided a way of reducing the risk of harm coming to staff who were “dealing informally with colleagues' serious mental health issues, and could get out of their depth” (P6, Ambulance Team Lead). It was also considered an investment that would “help staff stay psychologically healthy and prevent long periods of staff sick leave” (P6) and thus bring long-term benefits to the organisation, but was not routinely provided.

Providing peer to peer support, which was in the process of being rolled out in one Trust and used in many US healthcare support programmes (see Chapter 4), was seen by participants speaking from their managerial perspective as a useful resource that minimised costs, because it was undertaken by volunteers. However, as practising clinicians, they recognised that there were risks inherent in using a volunteer system,

because staff still needed time to carry out these duties, and there was a recognised “danger of inappropriately loading too much responsibility onto individuals who were not mental health professionals, unless they were resourced with clinical supervision and in-house counselling, because of the stressful emotional toll of the work” (P26). Peer support was thus not regarded as a panacea, and was viewed as “one intervention of multiple interventions needed to support staff” (P16).

6.7.4 Sub-theme: Management training

There was a perceived gap in management training, considered necessary to ensure understanding of when and how to support colleagues appropriately and effectively after PSI. This lack of training was identified by many of the participants as indicative of the low priority organisations accorded to staff wellbeing, and one reason why there was a lack of emotional and psychological staff support in practice after PSI. Psychology professionals’ focus in most Trusts was said to be purely on patients, and they were “rarely involved these days in staff support provision” (P12, Professional Body Lead). As a result, “challenging experiences are often not acknowledged or followed up, because no properly trained colleagues are available to offer emotional support” (P13, Consultant).

Managers in clinical roles were “rarely trained other than for their specialism” (P2, Nurse) and “Many have no managerial experience when they’re appointed” (P1, Midwife). Risk management training about incidents was “all about the mechanics, not about the emotional impacts or psychological responses” (P7, Associate Director of Governance). Consultant Doctors received “clinical and leadership training, but this never included being trained to consider or offer psychological support” (P13); training was “all about the patient and their treatment, because hospitals pride themselves on being safe for patients, not for staff” (P13). There was no knowledge of training for clinical staff “in how to talk to someone about an error” (P15, Consultant). This meant that informal support was often left to clinicians who had limited experience of people management when appointed to a supervisory role, no knowledge of support methods or best practice, and in some cases no inclination to take on this aspect of teamwork: “Managers often don’t know how to engage with or support their staff” (P27, Psychiatrist), and Trusts provided “no training for managers or supervisors to pre-empt

staff suffering negative consequences after involvement in a PSI”. (P25, Nursing Team Lead).

Lack of training about the impact of PSI or appropriate responses to affected staff could lead to situations where additional harm was caused during incident debriefs, because those in charge had not received training about the potential psychological impact: “Clinical debriefs take place soon after catastrophic incidents, but they’re not about offering emotional support. Staff can therefore be traumatised by an incident despite attending the debrief” (P7). Where staff were distressed in a debrief, their responses “wouldn’t necessarily be followed up, because there’s no-one in the room with psychological training to pick up on who might be affected negatively” (P7).

6.7.5 Sub-theme: Impact of COVID-19 on support agenda

No interview questions were asked about the pandemic unless this was raised by the interviewees themselves, but the pandemic had given rise to additional resources in some Trusts, and several participants referred to COVID-19 helpfully shaping awareness of the need for staff emotional and psychological support, although this was not specifically about PSI. It had also drawn attention to the need for psychology professionals to be involved, rather than expecting team colleagues to shoulder this work on top of their clinical duties. The first participant to mention that the pandemic had brought about an increased focus on the emotional wellbeing needs of staff observed: “We’d been pushing against a closed door, and now with COVID-19, it’s suddenly on top of everybody’s agenda, at last” (P11, Professional Body Lead). As a result of the pandemic, the impact of distressing events was better understood, and the need for organisations to acknowledge and respond to, rather than ignore or dismiss staff distress was increasingly accepted:

Increased staff support was already going to happen before COVID came about, but it's really heightened the need for staff to be able to unburden themselves emotionally after challenging experiences, with somebody that actually understands how they're feeling at that particular time. (P26, Patient Safety Manager)

Before the pandemic, staff in many Trusts had been expected to wait for their manager to notice if they needed emotional support, and to decide if it was warranted, and

referrals “would have been only if they were visibly very distressed” (P20, Matron), but now managers had become more proactive in referring staff to wellbeing services, if they were available:

I think it's accelerated things. I think people were aware that they needed to become more supportive, and that people did need more support, but COVID really sort of amplified that. And because it was so widespread and affected everybody, I think that was a good thing, because it made more people see the need for it. (P20)

COVID-19 had also changed perceptions of what support was needed after distressing patient incidents and outcomes, and the ways in which it could be delivered. This had led to the introduction in some Trusts of new methods of offering support to staff who were negatively impacted, including Critical Incident Stress management (CISM) and defusing, which had been initiated in one Trust specifically in response to the pandemic, to “provide a supportive process for staff to process the traumatic experiences and to help stabilise a member of staff who felt anxious, overwhelmed, or traumatised” (P22, Deputy Director of Organisational Development). In some organisations, support had also been introduced in practical ways, such as wellbeing rooms and areas to relax and regain composure after distressing experiences, which aimed to support staff psychologically in a way that had not previously been seen as necessary or important. Previously staff areas had been “stripped away to make way for patient beds”, and the pandemic had “increased awareness of the need for a safe space in which staff could look after their mental health or have a cry” (P21, Head of Community Nursing).

COVID-19 was understood and accepted as a source of staff distress and vulnerability that managers needed to address with empathy, but participants interpreted this new way of approaching the impact of negative workplace incidents as a consequence of staff not having any responsibility for the pandemic or the harm it caused. In Occupational Health departments, the pandemic was perceived as an external crisis, and considered “an understandable reason to support staff with their psychological health” (P18, Occupational Health Consultant). This was recognised to be different to an event such as an error for which staff could be considered individually accountable, and which could “require disciplinary intervention and ensuring that staff learned and improved” (P21).

It was also recognised that there would be longer term and potentially delayed negative impacts for staff from their experiences, including traumatic patient deaths, and an ongoing need for emotional and psychological support for those affected: “As a team we’re going to have longer term, potentially, issues around PTSD, that won’t emerge initially” (P22). Being able to access psychological support after the pandemic had ended was recognised as potentially more important than during it, and that individual needs would differ: “People don’t necessarily have the emotional capacity to access highfalutin psychological support in the middle of crises, so it’s important to recognise and provide what’s needed at different times” (P24, Psychologist).

There was, however, a noticeable hesitation to assume that the support introduced for staff during the pandemic would continue as a way of providing support after PSI, and there was concern that the pandemic would be seen as a big event requiring short-term initiatives that would be scaled back once COVID-19 receded: “I hope the new focus on supporting staff will remain, but I suspect it might get lost again for a little while” (P20, Matron). The possibility of emotional support being reduced or removed, in spite of the challenging and distressing events staff faced with on a daily basis, was considered unacceptable, and made the support that had been offered appear tokenistic:

Now that everything’s stepping down from the COVID, possibly the comfy sofas and the incense have gone, and there are still people dealing with bad stuff every day. It feels like we just pulled something out of the box, and it looks really ugly. (P15, Consultant)

[6.7.6 Theme 3 summary](#)

The third theme comprises interviewees’ comments about the experience of staff support after PSI, and its inconsistent, ad hoc, or discretionary nature. Some structured support avenues were available in-house within some organisations, some for certain staff only, and for some staff there was no emotional or psychological support provided. Participants described how most support after PSI, if available, was offered informally by close colleagues, with dependence on good working relationships, empathetic managers, and being perceived to belong and fit in with colleagues. The lack of training for managers about the need to be supportive after PSI, or how to go about this, contributed to the uncertainty of receiving support. This theme also addresses how securing financial and time resources for organisational staff support required a

business case to be made and accepted, and how resources could be insufficient, short-term, or lacking entirely. Interviewees described ongoing high expectations of staff, while support when things went wrong often remained rare.

The COVID-19 pandemic was reported to have favourably influenced the staff support agenda and provision within organisations, although participants were not clear that these resources would continue. PSI were perceived in a less supportive way than events arising from the pandemic, because PSI could involve holding staff to account with a disciplinary, rather than supportive, response.

6.8 Theme 4: Language undermines support

This theme draws together five sub-themes about the language used in healthcare that shapes understanding of staff support, including whether emotional or psychological support is deemed necessary. The participants' contributions demonstrated that certain words relevant to this topic were interpreted in specific ways as part of the norms of healthcare vocabulary, contributing to an expectation of staff coping with challenging incidents, with an emphasis on learning, improving skills, and carrying on. These influential words included the accepted connotations in healthcare of "wellbeing", "resilience", "support", and "trauma".

This theme also includes participants' comments about not currently having widely accepted ways of referring to UK healthcare staff affected by involvement in PSI. It addresses whether contributors considered it would be useful to have one descriptive label or term, including views about "second victim".

6.8.1 Sub-theme: Wellbeing

Most participants appeared to struggle to identify types of support available for staff within their organisations. Several eventually mentioned a focus on improving staff wellbeing; however, this was largely arranged as a self-directed activity, with the aim of individuals engaging in self-care to manage their own wellbeing. It was not an acknowledgement of the impact of involvement in PSI or the provision of emotional and psychological support at times of need. Optional activities for staff to foster their own wellbeing in their own time, such as relaxation, yoga, or meditation, were understood to have the aim of benefiting the organisation by promoting better health and work attendance. It was noted that most staff, who had long and demanding shifts,

did not have the time to attend them. An NHS Commissioning for Quality and Innovation (CQUIN) goal for staff wellbeing, with a financial incentive for organisations to achieve the aim, was said to be “more about encouraging healthy lifestyles to reduce staff absence than to be supportive” (P15, Consultant).

Staff wellbeing was reported to be gaining a higher profile within healthcare organisations, but it was not yet considered an issue of central importance. It was seen as an “add-on” in official Care Quality Commission (CQC)¹⁶ reports, “rather than as an integral part of or a significant thread running through” (P12, Professional Body Lead). Organisational statements about staff wellbeing were plentiful, but not perceived to be grounded in an intention to act: “There’s currently a lot of talk about staff wellbeing, but I don’t think it’s taken as seriously as it should” (P6, Paramedic Team Lead). The statements were thought to amount to hollow gestures:

Management tend to pay lip service to the connection between patient care and staff wellbeing. I suspect if you were to speak to managers, they would probably say: oh yes, yes, yes ... but I’m not aware from a policy point of view that that’s actively monitored, and that data are actually gathered to demonstrate that. (P18, Occupational Health Consultant)

There was an evident disparity between what staff were expected to cope with in their work, and the lack of care shown by the organisation after PSI: “Staff are encouraged by managers to look after their own wellbeing, although they have to manage horrific life and death events. Bearing a relentless emotional load, staff just have a cry in the toilets and a cup of tea” (P6).

All participants considered that good staff wellbeing would correspond to better patient care, and poor staff wellbeing was likely to have the reverse effect, negatively impacting on patients: “If you do emotional mapping of patients on a journey and you match it to the emotional mapping of the staff, you know they’re pretty damn close” (P15, Consultant). However, this did not mean that organisations acted to foster staff wellbeing by acknowledging the impact of PSI on staff mental health, or supporting them after incidents. The view of many participants was that organisations chose to see patient experience and staff wellbeing as separate, and accorded a lower priority to staff

¹⁶ The Care Quality Commission is the independent regulator of health and social care in England.

emotional welfare and care: “The Trust show very little consideration for the staff, and everything’s about the patient” (P2, Nurse). Management priorities were focused on protecting the patient, and disregarded staff needs: “The balance of power and esteem has been tilted too far towards patient experience, forgetting that staff are equally vulnerable” (P12). This imbalance extended to addressing the need for support after challenging events: “There’s a set policy and pathway for patients to be vulnerable and receive psychological support for their wellbeing, but there’s absolutely nothing for staff” (P13, Consultant).

6.8.2 Sub-theme: Resilience

There was a clear expectation on staff to be strong, resilient, and withstand negative work experiences including PSI, rather than need or seek support. Finding ways of achieving and maintaining resilience was a responsibility placed on staff themselves: “Staff are expected to engage in self-care activities to achieve greater resilience” (P12, Professional Body Lead). The expectation of resilience included the norm of staff carrying on with their shift immediately after distressing experiences: “Traumatic incidents are not unusual, and staff are just expected to absorb the trauma, carry on, and process it outside work time” (P13, Consultant). Challenging events were normalised with unsympathetic language: Staff were often told to “get a grip” (P3, Nurse), and that “these things happen” (P25, Nursing Team Lead). Organisations expected staff to “man up” (P19, Nurse). Moreover, expressions of vulnerability or distress were frowned upon, or regarded as evidence of not being up to the job, with emotional staff after a PSI called “overreactive” (P4, Nurse), and vulnerability “perceived by some colleagues to amount to weakness” (P13).

The identified norm of resilience was coupled with a lack of empathy or compassion for staff involved in and negatively affected by PSI: “There’s a real lack of ability to be compassionate to staff who are involved in incidents, or to realise the harm [to the staff] that’s done there” (P15, Consultant). Clinical Supervisors were said to “explicitly minimise and normalise the traumatic impact of events for medical trainees” (P13), in spite of the latter’s inexperience and the psychological risk this could create. Checking whether colleagues felt safe to continue working or needed support was not part of the accepted culture, and senior doctors “feel annoyed if colleagues crumble, because there’s no time or spare capacity to offer support” (P13).

Staff also tended to place the organisational expectation of strength and resilience onto themselves, believing they should not feel or show distress, and should be seen to be able to cope: “There’s a culture amongst healthcare staff of wishing to be perceived as being able to handle the work” (P6, Paramedic Team Lead). There was a recognised stigma around help-seeking, and many staff hesitated to signal that they needed emotional or psychological support, for fear of looking inadequate or weak to their managers, peers, or patients. This desire to appear strong could be misinterpreted as coping: “Clinicians, especially senior doctors, often feel it’s their job to bear the brunt for their patients: ‘I’m a clinician; I should be able to weather the storm’” (P22, Deputy Director of Organisational Development).

6.8.3 Sub-theme: Support to learn

The concept of support was identified by participants to have specific connotations in healthcare organisations that did not convey any sense of offering emotional or psychological support for staff. Being supportive to more junior colleagues was not about understanding or addressing distress after negative workplace incidents, but involved ensuring adherence to processes: “Immediate support after an incident means ensuring that the member of staff follows procedures and reports the event correctly” (P20, Matron). This use of the word “support” confirmed participants’ impressions of an organisational focus on the patient and a lack of focus on the welfare of staff. Clinical roles included checking on and filling any gaps in staff knowledge, adding to their skillset or correcting deficiencies, so that their patient care and safety would improve: “Band 7 job descriptions for nurses often mention providing support to staff, but this does not refer to emotional support or reassurance” (P19, Nurse). Senior staff understood support to mean guiding and advising juniors on correct patient care: “I’m expected to be supportive to Junior Doctors in a clinical skills sense, but not emotionally” (P13, Consultant). Where emotional support was offered, this was designed less to assist staff, and more to encourage them to fulfil organisational objectives, such as being more open about mistakes and identifying better clinical approaches: “If staff are provided with emotional support through their organisation, they take ownership of learning and improvements and become advocates of change” (P26, Patient Safety Manager).

6.8.4 Sub-theme: Trauma

The word “trauma” was initially understood by participants, apart from psychology professionals, to have predominantly physical rather than psychological connotations in healthcare, usually meaning physical injury sustained by patients. This understanding underpinned the focus on patient harm, and deflected from the idea of considering the psychological harm to staff incurred during their work. As a consequence, emotional impacts on staff received less attention, concern, or intervention: “In medicine, more priority is given to physical experiences than to psychological or emotional experiences” (P11, Professional Body Lead). The need for a safe environment required approaches that included acknowledging and addressing traumatic impacts on staff: “Recognising the impact of [psychological] trauma on individuals is part of ensuring staff psychological safety” (P11), but there was no evidence that this was a widespread priority.

6.8.5 Sub-theme: Naming the impact

Most participants were not aware of any set phrase or term used in their organisation to describe staff involved in, or negatively affected by the experience of PSI. Several interviewees saw benefits in having a recognised term to draw attention to the issue: “If you don’t have a term for it or a language for it, it’s easier for it to be ignored. Having a name for it gives it a presence almost, and a realism” (P6, Paramedic Team Lead). It was recognised that healthcare staff were familiar with framing problems clearly, using specific terminology: “Medical professionals use many terms in their day-to-day work, and giving a name to something does help people accept what’s going on a bit easier, like having a diagnosis...provided it accurately captures the message” (P18, Occupational Health Consultant). A known descriptor could be supportive in itself, fostering acknowledgement by colleagues of the potential for serious effects, and legitimising help-seeking: “A term acknowledging distress would remove the opportunity for managers to dismiss the traumatised reactions of staff” (P1, Midwife). A self-explanatory descriptor was also considered necessary in order to create awareness of the issue, bring clarity, and serve as a way of promoting and publicising support: “You need a header, and it’s just how you do that without creating so much complexity and distress” (P15, Consultant). One suggested approach was to name the support provision, rather than affected individuals. A pilot staff support scheme had

selected the name “Emotional Resilience Unit, to focus on assets” rather than negative effects, and “deliberately to name the provision, and not the person accessing the support” (P16, former Patient Safety Lead).

Having a known term was also considered helpful for staff to recognise the emotional and psychological impact they had experienced following involvement in a PSI: “If you have a label, you can go and do a bit of research to explain and understand the feelings and impact” (P25, Nursing Team Lead). Introducing a term was one way of changing the norm of staff ignoring negative effects on themselves:

It’s important to use a term to help combat the healthcare culture of the brave face; staff have to open up and accept that they’re vulnerable, and they’re a human being, and that everybody needs support, and we’re not just robots. (P22, Deputy Director of Organisational Development)

A distinction was drawn between recognising and naming the impact, which could be helpful, and describing the affected staff, which could have its own negative consequences. Labelling individuals was considered potentially problematic for professional reputations, and for negative feelings a label might engender in staff about their own competence, compounding the impact from the incident itself. Staff could fear being labelled to mean they were considered as “not cut out to be doctor, or ending up with negative elements in your portfolio” (P13, Consultant). There was concern that terminology should not undermine the ability of staff to feel they could continue doing their job, and that any descriptor needed to convey the idea that those affected could work through that trauma, and find a way to manage and overcome it:

One term may not fit everybody, because language underpins identity; individuals might feel that a certain term puts them in a weaker, kind of more powerless position, and therefore make it harder to step back in to looking after their next patient. (P23, Psychologist)

Choosing to label the experience of other staff without their agreement was also considered inappropriate, because language could be interpreted in different ways, rather than encompassing shared perceptions: “It would be incredibly supportive to have the distress and impact acknowledged, but if others describe staff as ‘traumatised’, then immediately you’ve put them into some sort of pigeon-hole and you’re already

making assumptions about their ability” (P12, Professional Body Lead). Having a term imposed on staff by management might not reflect the full range of experience or responses, or make sense to affected individuals, and this was considered potentially disrespectful:

I don't think we should ever use a phrase, or a word as such that describes that staff member who's involved in adverse incidents. Any one of us could be involved in an adverse incident, and I think that staff members deserve, you know, the privacy, the respect, and the dignity when being dealt with after those incidents. (P14, Paramedic Service Manager)

There was a specific concern about appearing to diagnose individuals with a perceived long-term impairment, which could have its own negative effects: “If we weren't careful, and we used more diagnostic labels, or maybe perhaps more psychiatric language, that could quite easily make people anxious that there was something wrong with them” (P24, Psychologist). Using the language of psychiatric diagnosis was considered appropriate “only as a fallback, because it could lead to stigma” (P27, Psychiatrist).

6.8.5.1 Second victim

One possible term, mentioned by some participants was “second victim”. It was used in one organisation (P20, Matron) as part of a training programme for newly qualified staff on the topic of medical errors and responses. It was also known to be used in the police service to describe psychologically impacted personnel (P14). Views articulated about the “second victim” term described a tension between its useful ability to acknowledge the negative experience of staff involved in PSI, giving clear expression to the feelings that arose and highlighting the need for support, alongside sensitivity about how staff, or patients and their families could feel about the term.

All participants who spoke in detail of having personally experienced a PSI with serious negative consequences recognised themselves in the term. It was considered “apt, because the second victim thing is just happening all the time in healthcare” (P13), and “a 100% true and accurate description of staff distress and trauma. Staff are the real victims of incidents, because of storing so much distress and trauma in their head, and trying to hold themselves together when things go wrong” (P3, Nurse). It was

considered useful as a way of “helping staff realise and understand that they too have been impacted and affected by events, and not just the patients or families” (P19, Nurse). It was also thought appropriate “because it contains a flavour of survivor guilt”, and reflected the suffering of staff after PSI which was “akin to a bereavement, a loss” (P4, Nurse).

The term was also seen to depict accurately how the handling of a PSI by the organisation could negatively affect staff: “The way in which staff are treated when mistakes happen can lead them to become a ‘second victim’” (P20). Negative feelings were not caused solely by involvement in the incident: “It was the combination of the event and the poor handling that resulted in my post-traumatic response, rather than just experiencing the event itself” (P25, Nursing Team Lead). Use of the “second victim” term could serve to encourage managers to be more empathetic to affected staff, and “to change less supportive mindsets about how staff are managed” (P8, Assistant Director of Nursing).

The fact that the “second victim” term was already in existence to describe the impact of PSI on staff was advanced as a good reason for its application, because it was “embedded in the research literature, and served as a reference point” (P16). The lack of a known replacement term which could command attention and create awareness of the issue was presented as an argument for its retention: “No-one has come up with a better phrase than second victim, and there’s a strong argument in support of the term because it’s well established” (P15).

Negative impressions of the “second victim” term nonetheless created concern and outweighed its perceived usefulness. The doubts expressed were chiefly with negative connotations of the word “victim”. With respect to staff, it was recognised that some would object to being considered a victim, even if the term was deemed accurate: “Staff *are* victims in a way, because sometimes they’re made to be scapegoats, but ‘victim’ is not the right word” (P4, Nurse). There was a gap between how others might interpret the impact staff had suffered, and how those staff wished to be seen: “Some staff are quite adamant that they’re not victims, and yet, from an outside perspective, they are at times the victims of situations and events; some have had their lives destroyed” (P26, Patient Safety Manager). Staff who had experienced severe psychological reactions to PSI did not find the term appealing: “I wouldn’t relish being thought of as a victim,

even though I was a victim of an event and equally a victim of what happened afterwards” (P25).

There was a further duality observed in the word “victim” because it had the potential to be derogatory when used to describe the staff involved, or to dismiss as invalid and inappropriate their emotional responses, but could be caring when describing patients: “Unsupportive managers tend to see the patient as the victim and are more likely to refer to the staff involved as ‘the person who could have killed the patient’” (P8). Some participants had had direct experience of the word victim being used to belittle their reaction to a PSI: “Victim is a loaded word. My manager told me that the patient is the victim, and to ‘stop playing the victim’” (P1, Midwife):

I feel like a victim because, as an individual, I’ve put myself in that position expecting to be protected and supported by an employer and by the NHS, and I wasn’t. I don’t feel like a victim from the adverse event; I feel like a victim of the NHS, and the structure and the policies and the politics. (P1)

The term evoked some unwelcome impressions of weakness, passivity, helplessness, and powerlessness, undermining expectations of healthcare staff as competent and strong. It was noted that it was difficult to get healthcare professionals “to admit to perceived weaknesses, such as being emotionally affected by events” (P13) There was a perceived risk of staff feeling diminished by the term: “Clinicians want to feel like the strong one in the patient care relationship, and ‘victim’ has connotations of weakness and stigma” (P22). Objections included that “‘second victim’ sounds downtrodden” (P2, Nurse), and that it contained “connotations of incapacity, incompetence, or inability to control one’s emotions and manage events” (P14, Paramedic Service Manager).

Potentially negative reactions from other stakeholders to the “second victim” term were anticipated by some participants, making it unpalatable. These included patients and their families, who could resent professionals who had been involved in patient harm being regarded with any sympathy or understanding. Considering where a description such as “second victim” could be used required careful thought, because of the potential to cause offence. It was acknowledged that employing it in documents “in the public domain, such as serious incident reports or other official records, might upset or offend families” (P15). There was particular sensitivity towards families who had been

bereaved, or patients who had experienced serious harm: “Grieving families might not want to hear that the staff were also considered to be a victim” (P14). Some considered that referring to staff as victims did not align with pinpointing blame and achieving redress for patient harm: “Society expects punishment; the public might not like the term ‘victim’, and would find it difficult if perpetrators were being supported” (P9, Professional Body Regional Director).

There was a further concern for managers that the word “victim” was incompatible with the idea of staff having accountability within the organisation after incidents, and its use raised questions: “It conveys innocence and no direct involvement, and I wonder if a staff member who’s caused harm, even unintentionally, can be a victim?” (P21, Head of Community Nursing). Employing the term “second victim” in a supportive way was considered by some to deflect from the identification of wrongdoing, and undermine the need to correct staff behaviour that led to PSI or to discipline individuals: “It might place too much emphasis on support, and not on addressing performance issues” (P8). There was a further perceived risk that “Staff who are labelled as victims could start behaving like victims” (P9).

Use of the word “second” or “secondary” was also considered problematic for the opposite reason: that it inappropriately attached less importance to the staff member’s experience than to the patient’s: “I wonder if ‘second’ implies that staff trauma is less than patient trauma?” (P27, Psychiatrist), and P8 was aware that the staff member “might be the primary victim, experiencing far more harm than the patient, who may not have been harmed at all”.

The need to identify any term such as “second victim” was itself considered evidence of the principal problem, namely the lack of organisational provision of emotional and psychological support for staff after PSI: “Staff wouldn’t be helpless victims if they had their own and organisational resources to draw on” (P16). Others considered that staff would not mind the term used “provided support was offered and it made a difference” (P26). Having a term to describe the negative experience of involvement in a PSI was considered by some to be pointless if it did not lead to the availability of support for staff in practice: “Terms are irrelevant because no attention is paid to nurses” (P2, Nurse). A Nurse in another Trust (P4), perceived danger in identifying a term that would

raise false hopes of support: “There’s no point having a rhetoric of concern if nothing will be done,”.

6.8.5.2 Other terms

Identifying a preferred term to “second victim” was perceived by all participants to be difficult, because of connotations and interpretations that could be inaccurate, misleading, or unhelpful, or because ideas might not adequately capture all relevant staff experiences in an acceptable way to those affected. Various existing concepts were mentioned by participants, but found not to convey the necessary elements, or to have evidence bases that offered different meanings to popular understandings, which could create ambiguity or confusion.

Some interviewees offered ideas in an exploratory way. These included “secondary survivors”, with one participant noting that “A survivor movement exists for patients, but not for staff who have experienced adverse events” (P12, Professional Body Lead). Terms that might appeal or be familiar to staff were understood to reflect a range of different experiences and impacts to those reflected in the “second victim” concept. P24 (Psychologist) noted that staff “seem comfortable talking about the idea of burnout”, but she did not consider that this idea could capture a PSI scenario involving a clinical error. Moral distress or injury were considered to be “separate concepts that don’t equate to distress after involvement in adverse events” (P15). The term “emotional labour” was offered as a potentially useful way to convey the idea of staff expending effort to deal with challenging feelings (P11, Professional Body Lead). However, it was recognised that this term described “different ideas to the experience of involvement in PSI” and that, if terms were used in a different way to theorists’ intentions (discussed in Chapter 7), this could lead to potential ambiguity or confusion. “Vicarious trauma” was proposed as a possible term, “because it describes the impact, rather than the person, and includes the idea of trauma which would resonate with healthcare personnel” (P11). However, this participant was aware of the potential for misunderstanding about the physical or emotional meanings of the word “trauma”, and the fact that “vicarious” suggested an indirect effect resulting from another person’s traumatic experience, which was not necessarily the case. Preferring the term “‘traumatised’, ‘having a trauma response’, or ‘PTSD’ to victim”, P27 (Psychiatrist)

considered it essential to validate the feelings of fear staff experienced. He nonetheless recognised that these words did not fully capture the experiences of all affected staff.

6.8.6 Theme 4 summary

The fourth theme draws together the participants' comments about ways language is used in healthcare that has embedded culturally specific meanings for the words "wellbeing", "resilience", "support", and "trauma", potentially affecting perceptions of the appropriateness of offering or receiving emotional support after involvement in a PSI, or causing confusion and misunderstanding. Some participants considered that having a term to capture and acknowledge staff experiences and negative impacts after PSI would be beneficial or essential, but others thought that the need for a term was itself evidence of the lack of appropriate support. There was notable concern that staff should not have labels imposed on them by others. Although the established term "second victim" was considered an accurate description of staff emotional experiences, it caused discomfort, with perceived connotations of weakness or passivity, and concern that patients and families would find it unacceptable. There was no consensus about a preferred term, although there was some support for the inclusion of words that clearly conveyed the emotional and psychological impact, and some participants considered it more constructive to name the support provision than the negatively affected staff.

6.9 Chapter summary

This chapter presents the findings of an interview study with 27 participants in healthcare roles with policy, management, or supervisory responsibility, across ten NHS Trusts in England. It identifies four themes from the data, containing a total of 16 sub-themes that are summarised in Figure 6. The evidence shows that access to emotional and psychological support after PSI is unreliable, and is undermined by traditional responses of blaming staff or expecting resilience, and by the norms of language use. The needs of many negatively impacted staff are not being met.

The data highlight that potentially serious and long-lasting emotional, psychological, and professional impacts on staff occur from experiencing PSI and from the ways in which organisations handle incidents. This was recognised by all participants. No national, international, or organisational policies requiring and specifying emotional or psychological support for staff after PSI were identified by those contributing, although

it was assumed by some that policies would exist. Two NHS documents were identified that made general reference to providing support for staff.

Offering support to staff after PSI was not the norm in most organisations. Some structured support approaches were in place, covering some staff in some departments, in an inconsistent way. Informal support from colleagues could occur where existing work relationships were good and the staff member was perceived to fit in, or where managers had personal experience of PSI and empathised with their staff. In-house peer support for healthcare professionals after PSI was being introduced on a self-referral basis in one Trust, but had not yet come on stream, and was not currently available in the other organisations described. Supporting staff after involvement in PSI was considered to have benefits for staff and their organisations; blaming staff for incidents was known to occur in organisations, and was considered detrimental to wellbeing and incompatible with being supportive.

Language usage in healthcare had not contributed to normalising emotional and psychological support for staff. Employing a recognisable term to acknowledge impacts and promote the idea of supporting staff after involvement in a PSI was considered useful. “Second victim” was considered by most participants to be an apt description of staff experience and distress, and to have a recognised basis in research literature, but it also caused discomfort with the potential to sound passive or weak, or to upset patients and their families. No replacement term was clearly identified, but describing the support provided was considered more appropriate than labelling or diagnosing affected staff.

These data are discussed in Chapter 7 in the context of the wider literature and the other findings derived from the elements of this thesis.

CHAPTER 7: DISCUSSION

7.1 Introduction to the chapter

This chapter presents a synthesis of the overall evidence from this research project, including the study findings set out in Chapter 6, and the four overarching themes identified from the data collection: 1) Severe and enduring impacts; 2) Absence of policies; 3) No certainty of support; 4) Language undermines support. It will explore the meaning of this evidence as it applies to the provision of emotional and psychological support for healthcare professionals involved in patient safety incidents (PSI). The chapter will set out what has been learned in relation to the thesis questions posed, and the discussion will situate the findings within the context of existing literature and knowledge.

The chapter will draw out the implications of the findings, presenting insights into how the evidence generated from this project could inform effective solutions for the provision of emotional and psychological support for healthcare staff following involvement in PSI, by identifying the components considered necessary as part of support. It will also acknowledge the limitations of the research.

7.2 Research questions

The principal research question was:

What policies, protocols, and practices are healthcare policymakers, managers, or supervisors aware of that aim to support healthcare personnel in their organisation who have experienced unanticipated adverse medical events or near misses in UK healthcare settings?

The subsidiary question was:

What are the views of healthcare policymakers, managers, or supervisors about the term “second victim”?

The findings of the project in respect of these questions are explored below, with evidence gleaned from the investigations and reviews reported in the preceding chapters, including the evidence provided by study participants during the qualitative data collection.

7.3 Summary of research findings

This section sets out what has been learned from the elements of the research project.

The investigation in Chapter 2 identified many policy statements and recommendations from national and international organisations, in some cases strongly advocating that emotional and psychological support for staff after PSI should be instituted. However, the few policies that did set an expectation or requirement for such support did not specify how this should be achieved. The context for the policy statements was the aim of promoting improvements in patient safety and quality of healthcare, and creating transparency about disclosure of PSI. Most of the study participants involved in the present project, all of whom were in management, supervisory, or policy roles, were not aware of any policies or protocols directed at supporting staff after PSI, although several assumed there must be such a policy. Their experience of policies within healthcare organisations was that they were targeted towards requirements for staff to adhere to in the delivery of patient care, or stipulated limits on staff entitlements such as sick leave, rather than being about supporting staff. Known policies were considered to be chiefly a means of prioritising and protecting the needs or reputation of the organisation and holding staff to account, rather than as foundation for providing support to negatively affected staff.

This research project has found that healthcare professionals still experience negative emotional and psychological consequences from being involved in PSI, confirmed by the study participants who described their own and others' negative lived experiences. It is these potentially harmful mental health effects that underpin the need for affected staff to be able to access emotional and psychological support after involvement in a PSI. Chapter 3 explored the concept of the "second victim", widely used in the literature to describe affected staff, and found that it was still considered to reflect their experience and to convey the potential gravity of the effects, but that it was recognised to be no longer acceptable to all stakeholders. Many of the study participants had not heard of the term, and those who had felt varying degrees of discomfort with its connotations and use. As such its use requires review and caution, particularly in connection with staff support resources and labelling either those affected or the support provided.

In Chapter 4, programmes providing emotional and psychological support to healthcare staff after PSI were investigated. Forty-one programmes were identified, the majority of which were located in the United States, and many of which followed a three-tier model, originating in the US, of departmental support, peer support, and referral to external resources for more severe needs. No programmes were reported in the UK.

Study participants from the interview study reported in Chapter 6 mentioned some support resources, but none were specific to the effects of involvement in PSI, and some were only available to certain staff. The experience of support was principally one of uncertainty, inconsistency and unreliability, or complete lack: one organisation had an in-house counselling service to support staff mental health with respect to personal or work concerns; only some staff in one department within one organisation had access to structured in-house psychological support, not limited to PSI. Most support, if available at all, was informal, ad hoc, and discretionary, and depended on colleagues' or managers' skills and inclinations and on being perceived to fit in; otherwise, there was an expectation of resilience and coping, and no provision of support. The interview participants identified necessary and preferred support elements within a structured and transparent process available to all affected staff. These elements are set out in section 7.5.5. Barriers to accessing support included lack of resources, perceived stigma among healthcare professionals around help-seeking, lack of time to attend support during working hours, and a lack of management training about how to recognise potential impacts and respond appropriately to affected staff.

Chapter 6 also reported that the typical use of language in UK healthcare employed specific connotations for the ideas of “wellbeing”, “trauma”, and “support” that prioritised physical injury over psychological harm, and conceptualised wellbeing and resilience as something individuals should foster for themselves. These connotations combined to deflect from or undermine awareness within healthcare organisations of the need for emotional and psychological support for staff, and resulted in the minimising or invisibility of emotional and psychological impacts on staff, or in professionals being expected to be resilient and not need support. Study participants were unable to offer a way of referring to staff negatively affected by PSI which could adequately capture their concerns.

7.4 What the findings mean for healthcare staff support after PSI

Drawing on the evidence from the investigations that make up this thesis, and the themes derived from the interview study, leads to an understanding of the components needed when providing emotional and psychological support to healthcare professionals after involvement in a PSI.

To achieve reliable and consistent access to support would suggest the need for an acknowledgement from healthcare organisations of the potentially serious impact of PSI on staff, as the basis for offering structured emotional and psychological support. The support components would thus be underpinned by an organisational recognition of the need to resource and proactively offer timely support on the basis of need, and individual choice whether and when to receive support. This would align with the requirements of the NHS Patient Safety Incident Response Framework (NHS England 2020). The support, directed to address negative feelings, restore confidence and a safe return to duties (The Joint Commission, 2012), would need to flow from a transparent and publicised protocol, methodology, or pathway, establishing what structured support would include; how it could be accessed, and by whom; transparency around the emotional and psychological support provided for staff involved in incident investigations; and training for managers and supervisors about acknowledging impacts, the processes relating to support, and their role and duties in signposting, or facilitating staff access and attendance.

The necessary elements of the support needed, based on evidence from this research project and the wider literature, are explored in section 7.5.5.

7.5 Discussion

This discussion will explore the findings of this research project including the necessary elements of support depicted in Figure 7 below, and will situate them within the wider literature. It will address the themes emerging from the data collection and situate them in turn within the context of existing research, to illuminate the severe and enduring impacts for staff after PSI; the absence of specific policies to underpin and achieve support provision; the uncertainty of receiving support in practice; how language can undermine support and the sensitivities about naming support, and why this matters in transforming policy into practice.

7.5.1 Severe and enduring impact

The findings of this research project confirmed, with respect to healthcare professionals in England, existing research about the potentially serious and long-lasting impact of PSI on staff emotionally and psychologically. The emotional impact of medical errors was described by Christensen et al. (1992); Hilfiker, (1984); Newman, (1991), and Wu (2000), and over two decades later Busch et al. (2020b) identified a similar range of responses to those of this study's participants. Many prior studies have found that being involved in a PSI, which may include a near miss incident, can produce in healthcare professionals a wide range of negative emotional and psychological responses, including anxiety and distress, feelings of guilt, an inability to concentrate or focus, intrusive thoughts, and sleep disturbances (McCarthy et al., 2021; Scott et al., 2009; Stone, 2020a; Wahlberg et al., 2019). Although much of the pertinent research has been carried out in the US, Harrison, Lawton et al. (2015) identified a stronger reported impact among UK professionals than their US counterparts. Much of the UK research has investigated responses to PSI among surgeons (Biggs et al., 2020; Mallon et al., 2018; Pinto et al., 2013 and 2014), physicians (Firth-Cozens, 1987; McLaren et al., 2021; Parnis et al., 2018), or in the field of obstetrics and gynaecology (Cauldwell et al., 2015; Coldridge & Davies, 2017; Kershaw, 2007; Sheen et al., 2016; Slade et al., 2020), and the present study adds to the evidence in the UK that nurses may be seriously affected after PSI.

In the present study, the participants described the experience of severe negative emotional or professional consequences even where the incident had been a near miss and caused no patient harm, or where participants had not been present at the incident, but had treated the patient earlier in the process of their care. This aligns with the conclusions of Waterman et al. (2007) and Serou, Slight et al. (2021), who found that near miss incidents could cause distress in physicians and operating room staff respectively. Harrison, Lawton et al. (2015) also found no difference in the emotional response of nurses or physicians as a function of the degree of patient harm. This is different to the findings of Van Gerven, Bruyneel et al. (2016), and Vanhaecht et al. (2019) that the severity of incident is linked to the severity of the impact on the involved professional. Being suspended as part of an investigation without any direct involvement in an incident, was also reported in the present study to engender severe impacts, particularly where there was either no organisational support, or support was

only offered years after the event. This also accords with the findings of Waterman et al. (2007) and Scott et al. (2010), that negative effects were exacerbated by perceptions of a lack of emotional or psychological support within the organisation to mitigate them or shorten their duration, and with Quillivan et al. (2016) who found that it was less the severity of the PSI that caused distress and other negative reactions in providers (in that study nurses), and more the perceived lack of organisational acknowledgement of the impacts or support to address them.

Professional impacts described by the study participants included not feeling able to function at the optimum level to continue working confidently or safely with patients, findings also reported by Pinto et al. (2013) and Biggs et al. (2020) with regard to UK surgeons. Professional behaviour changes reported in the present project, such as altering practice and becoming risk averse or defensive, taking sick leave, or changing role or career, were found by Buhlmann et al. (2022); Edrees et al. (2017); Kable and Spigelman (2018); and Mok et al., 2020. Many of the present study's contributors described their own or other healthcare professionals' need to take sick leave or their consideration of leaving the professions entirely, with negative professional consequences not only for the individual, but also for the organisation. These impacts were also reported by Slade et al. (2020) in a study of work-related PTSD experienced by UK obstetrics and gynaecology professionals. In the present study, these professional impacts were reported across a range of healthcare professions and specialisms.

Negative professional impacts were also described in the interview data as a further cause of distress or other negative emotional and psychological responses for individuals. In particular, being blamed by colleagues or the organisation gave rise to many descriptions of anxiety, as participants perceived a threat to their career or livelihood. This arose in some cases as a result of incident investigation processes, particularly if professionals perceived their organisation not to be supporting them, or actively seeking to blame them. Blame after PSI has been found in the literature to increase the negative psychological impact on the involved healthcare professionals (Berman et al., 2021; Biggs et al., 2020; Christoffersen et al., 2020; Van Gerven, Bruyneel et al., 2016). A norm of blame and organisational defensiveness has previously been described after medical errors and other patient harm (Berman et al., 2021; Davidson et al., 2015; Hunter et al., 2017; Luk et al., 2021), including in

Morbidity and Mortality conferences (Pinto et al., 2013), and Serou, Slight et al. (2021) have reported the negative impact on operating theatre staff of investigation processes. Being suspended and removed from their working environment caused additional distress as reported by participants in this study, because of isolation from colleagues, lack of information, and uncertainty about professional outcomes, sometimes lasting years. This accords with the findings of a study by Verhoef et al. (2015) in the Netherlands.

In the present study the psychological impact reported was less about malpractice litigation engaged in by patients or families, which has become a recognised cause of stress and distress in healthcare professionals, known as clinical judicial syndrome (Arimany-Manso et al., 2018), nor about the impact of fitness to practise investigations (Maben et al., 2021). Some participants shared a perception that their own organisations were adversarial towards them, or abandoned them legally by withdrawing or threatening to withdraw vicarious liability, in order to ensure that the individual professionals took the blame following an incident and deflected a perception of fault away from the organisation. The particular effects of UK healthcare professionals experiencing the threat or actual removal of vicarious liability, being legally cut adrift by their organisations, and the ensuing negative impact on their emotional and psychological wellbeing of being required to fend for themselves, is an important new finding, highlighting an intersection between specific organisational behaviours and negative emotional or psychological impact.

The duration of the negative emotional impacts either of being involved in a PSI, including a near miss, or from being poorly treated by colleagues or management having been a witness to an incident rather than present and directly involved, was described by the participants in this UK study to be potentially long lasting, and for some to be permanent. This aligns with other UK findings (Serou, Slight et al., 2021, with respect to operating room staff), and with studies from other countries by Kable and Spigelman, (2018); Rinaldi et al. (2016); Rodriguez and Scott (2018); Scott et al. (2009); Strametz et al. (2021); Vanhaecht et al. (2019).

7.5.2 Absence of policies

The evidence from this research is that while the organisation and practice of healthcare is characterised by numerous policies, UK healthcare professionals with management,

supervisory, or policy responsibility were not aware of policies that underpinned or stipulated emotional and psychological support for healthcare staff involved in PSI. As set out in Chapter 2, national and international policy statements about the need to support staff after PSI, and calls for such support, are plentiful. In the UK, seventeen public reports or guidelines, dating back to 2004, acknowledge the potential for PSI to cause serious psychological and emotional impacts on staff, including PTSD, and call for or recommend the provision of immediate and tailored emotional or psychological support either to healthcare staff in general, or to specific professional groups. Relevant extracts from these reports, including several from the UK Royal Colleges representing sectors of healthcare professionals, are included at Appendix K. However, consideration and formulation of specific policies that would require such support for staff has only recently begun in the UK (NHS England and NHS Improvement, 2020) and, at the time of data collection, calls for support had not filtered down into the experience of structured support after PSI for all but two of the participants in this project. Even in those cases, the support was not specifically a response to the impact of PSI, nor to national policy, and within one large Trust it was only available to staff in one hospital department.

There is guidance to all UK employers from the National Institute of Health and Care Excellence (NICE) in NICE Guideline NG13, covering how to improve the health and wellbeing of employees, with a specific focus on organisational culture and the role of line managers (NICE, 2015). There is also recent guidance specific to high-risk occupations, including healthcare, on mental wellbeing at work (NICE Guideline NG212), which recommends that “Risks to the mental health of staff are identified and managed, for example having an effective procedure in place to support staff following a traumatic incident” (NICE 2022, p. 47). While serving as benchmarks for good practice, NICE guidelines are not legally binding on organisations.

UK law does, however, enshrine a duty of care on all employers to protect the health, safety and welfare of their employees and any other people who might be affected by their work activities (Health & Safety Executive, 1999), and employers must do whatever is reasonably practicable to achieve this. The legal duty is applicable whether work is the cause of a health issue, including psychological, or aggravating it. With respect to healthcare, this duty does not, however, appear to be applied to managing and addressing the work-related stress faced by staff, including the experience of PSI.

This legal duty of care was not part of the experience of the present study's participants, most of whom experienced policies as a way for institutions to leverage appropriate action from staff, or to hold them to account following incidents, rather than to show concern for distressed staff or provide them with emotional or psychological support. These healthcare professionals were aware of policies to follow for every clinical eventuality (as found by Scott et al., 2009), apart from how to access emotional and psychological support for themselves. From the perspective of these participants, the policies that did exist, such as those originating in HR, or standard operating procedures stipulating patient care processes, were about staff duties and obligations, and not about organisational duty to staff.

In research studies about negatively affected healthcare staff after their involvement in PSI, there is very little discussion about policy. In spite of the impacts on staff that have been widely documented, there seems to be a gap between the acknowledgement of need, and the availability of specific organisational policies, protocols, or guidance to underpin responses, including support for healthcare professionals (Buhlmann et al., 2022; Christoffersen et al., 2020; Ferrús et al., 2021; Greenwood, 2006; HSIB, 2021b; Malik et al., 2021). Within the wider literature, there are many protocols, models and frameworks that could be used as the basis for developing support interventions (Agency for Healthcare Research and Quality, 2016; Denham, 2007; HSE Ireland National Quality Improvement Team, 2021; Joint Commission, 2018), including in the UK (Health and Safety Executive, 2020; HSIB, 2021b; NHS England and NHS Improvement, 2020). However, evidence shows that calls for support have not yet been translated into schemes that are accessible to staff in most organisations. It is clear from this research that where relevant policies or policy statements are not backed up by requirements for action or implementation in practice, they are of themselves insufficient as a basis for support.

Not having a policy within an organisation that explicitly outlines a support process, and instead using ad hoc, unofficial, or discretionary approaches can lead to assumptions about who might be affected after a PSI, as reported by the present study participants. It is known that trauma responses can be unrelated to the severity of an event (including patient outcome or harm, as reported by this study's participants), which means that emotional and psychological support protocols need to be based on the staff member's needs, rather than on the severity of any incident. This aligns with

the theory of nurses' psychological trauma developed by Foli (2021). Focusing on the seriousness of the event may result in checking up on staff who in fact remained unaffected, and missing the staff who were actually impacted, perhaps by a lesser incident such as a near miss or a lower level of patient harm, as confirmed by study participants in this research. This accords with the findings of Reiser Crelier et al. (2020) about the largely unofficial and unstructured nature of support in Swiss hospitals after PSI. The authors concluded that not having a policy or a transparent methodology to stipulate consistent support processes available to all staff would be likely to negatively affect the quantity and quality of support provided to health professionals after incidents. The need for formally structured support underpinned by a published protocol is thus necessary (Van Gerven et al., 2014) for staff to be able to cope with the impact of a PSI.

7.5.3 No certainty of support

The need for and benefits of support to mitigate the impacts of PSI on staff have been identified in many studies, across many countries. Providing emotional and psychological support has been found to reduce distressing impacts (Mohamadi-Bolbanad et al., 2019), and to assist and improve coping (Kaldjian, 2021). This accords with the Conservation of Resources theory (Hobfoll, 2012; Hobfoll et al., 2018), developed to inform understanding of how individuals cope with major stress or trauma, and how resourcing supportive interventions can provide individuals with opportunities to recover from stressful circumstances (Hobfoll, 1988; Hobfoll and Freedy, 1990); Hobfoll et al., 1990).

The lack of structured emotional and psychological support after involvement in a PSI was described by most of the participants in the present research. Research studies have also frequently reported a need for, but ongoing lack of available emotional or psychological support resources after PSI. See, for example, Cabilan and Kynoch (2017); Denham (2007); Hood and Copeland (2021); Koehn et al. (2016); Malik et al. (2021); Mokhtari et al. (2018); Monteverde and Schiess (2018); Sirriyeh et al. (2010); Ullström et al. (2014); Wu et al. (2013). The lack of support may worsen the impact on staff (Stukalin et al., 2019), and their sense of isolation (Stone, 2020a). Research undertaken in the UK has also reported a lack of available emotional and psychological support for healthcare professionals, and has presented arguments that organisations

should provide more for their staff. There is no evidence from the present study, however, nor other UK research (Harrison et al., 2014; Serou, Husband et al., 2021; Sheen et al., 2016; Slade et al., 2020) that such support has become the norm in UK healthcare organisations.

The lack of support provision crosses professional boundaries in UK healthcare, as confirmed by participants in the present study. Investigating doctors' experiences of adverse events in secondary care, and the ensuing professional and personal impact, Harrison et al. (2014) found that "Adverse safety events affect physicians, but few formal sources of support are available" (p. 585). The authors observed that two-thirds of participants "did not think that healthcare organisations adequately supported doctors in dealing with the stress associated with an adverse event" (p. 587). Other healthcare professionals are reported to have fared no better. In a recent UK study of work-related post-traumatic stress symptoms in obstetricians and gynaecologists, Slade and colleagues (2020) described the prevalence of traumatic events and serious psychological responses: "Two-thirds reported exposure to traumatic work-related events. Of these, 18% of both consultants and trainees reported clinically significant PTSD symptoms" (p. 600). They identified "having lower levels of perceived support in the workplace" as a risk factor for PTSD (p. 603), and observed that the culture in obstetrics and gynaecology presented a barrier to trauma support. Sheen et al. (2016), in a study of UK midwives' experience of traumatic perinatal events and their impact, described how after such an event, staff "perceived support from senior colleagues and supervisors to be either absent or inappropriate" (p. 61).

[7.5.4 Language undermines support](#)

An important thread running through the findings of this research was that language within healthcare environments was used in specific ways that could undermine attitudes towards the need for or provision of emotional and psychological support after PSI. This is a new finding, and included specific connotations of "wellbeing" as the responsibility of individual staff to develop and sustain their own resilience, "trauma" understood to mean patients' physical injuries rather than negative psychological impacts on staff, and "support" used in the sense of ensuring staff made efforts to improve their skills. There was no known phrase to describe the impact on staff of involvement in a PSI, which interview participants considered had contributed to not

acknowledging the harmful impacts experienced. They were nonetheless cautious about labelling affected staff in any way that could either convey weakness or offend patients and families.

There is a considerable body of literature relevant to the relationship between staff and patient wellbeing, presenting arguments that it is in the interests of healthcare organisations and their patients for leadership to support the wellbeing of staff, including after PSI, and not to expect this to be based on resilience or self-care (Paine & Prochnow, 2022). Use of language and the linguistic and sociocultural context of terms can have considerable influence on understanding and attitudes (Yardley et al., 2006), and an organisational norm or expectation of strength or resilience in individuals can result in a reluctance for those needing support to seek it. It is also inappropriate to expect healthcare staff to develop individual resilience to protect the organisation, in place of addressing the demands and causes of distress they may face as part of their work (Card, 2018). Resilience should be fostered through supportive interventions: “Whilst proactively developing individual level psychological resilience is important, so too is addressing the organizational and system factors that affect staff resilience which are outside individual staff control” (Janes et al., 2021, p. 2).

Studies have shown that poor staff wellbeing negatively impacts patient care, good staff wellbeing leads to better care, and it has been argued that staff welfare should therefore be included as an important element of patient safety culture (Dukhanin et al., 2018; Pratt et al., 2012; Vanhaecht et al., 2021; Waring, 2005). This connection has been established in several studies. Employee wellbeing was found to be “an antecedent rather than a consequence of patient care performance. That is, if staff wellbeing at work is good, it is likely that staff will perform better in their jobs, rather than the other way around” (Maben, 2013, p. 17). Moreover, of seven key variables associated with good wellbeing, one was perceived organisational and supervisor support, and nurses who perceived greater support for wellbeing at their worksite had better physical and mental health outcomes (Melnyk et al., 2018).

The negative implications of poor staff wellbeing for patient outcomes have also been investigated. In a systematic review of healthcare staff wellbeing, burnout, and patient safety, Hall et al. (2016) confirmed that 16 of 27 studies found a significant correlation between poor staff wellbeing and worse patient safety. UK doctors have perceived links

between their stress and “lowered clinical care” (Firth-Cozens & Greenhalgh, 1997, p. 1017), and trainee physician distress following PSI “appears to negatively affect patient care” (West et al., 2006, p. 1075). A recent study found that Critical Care nurses (CCNs) in poor physical and mental health reported significantly more medical errors than CCNs in better health, and that the mental health of these nurses was “adversely affected by their work with critically ill patients, which includes frequent exposure to traumatic events” (Melnyk et al., 2021, p. 177). This supports the analysis by West and colleagues (2006) suggesting the existence of “a vicious cycle whereby medical errors may lead to personal distress, which then contributes to further deficits in patient care” (p. 1075).

Within healthcare reports found in the grey literature, there is also widespread linkage between good levels of wellbeing for healthcare staff and their capacity to provide good and safe care for their patients (WHO, 2020a). This connection underpins arguments in favour of establishing synergies between health worker safety and patient safety policies, and for supporting staff emotionally and psychologically after PSI. In the UK, healthcare regulatory bodies have also explicitly argued for recognition of this connection: “The wellbeing of doctors is vital, because there is abundant evidence that workplace stress in healthcare organisations affects quality of care for patients as well as doctors’ own health” (West & Coia, 2019, p. 12). This GMC report elaborated that data from the NHS (England) Staff Survey have consistently shown “Better staff wellbeing is linked to positive patient outcomes within NHS organisations” (p. 28). This connection between staff wellbeing and patient outcomes, and the need to support professionals’ emotional and psychological health was restated by the NHS Staff and Learners’ Mental Wellbeing Commission report (Health Education England, 2019a).

It is evident, however, that while there are increasing references to the connection between healthcare staff wellbeing and patient wellbeing and safety, there seems to be a disconnect in following through in practice to UK healthcare organisations undertaking to support the emotional and psychological wellbeing of their staff specifically after involvement in PSI. As long as maintaining or restoring wellbeing continues to be considered a matter of staff self-care, to be achieved without structured organisational help, work-related impacts on staff will continue to risk consequent negative repercussions for their patients.

7.5.4.1 Naming support

The findings of this project also highlighted the importance of careful consideration of the language used to describe and promote support provision for staff after PSI, to be mindful of potential stigma around support-seeking among healthcare staff, and staff or stakeholder sensitivity to the implications of certain labels. It is acknowledged in the wider literature that language has an important role to play when naming service providers or users, particularly where stakeholder groups have different and influential perspectives and sensitivities. Terminology can enable clarity about how stakeholders see themselves and other parties, and yet the choice of terminology to describe stakeholders “can be controversial, even among the group concerned” (Wallcraft et al., 2011, p. 230). Participants in the present interview study expressed discomfort with the “second victim” term to describe negatively affected staff, and considered it could undermine them by implying weakness or passivity, or that it could offend patients and their families. This accords with the literature, which has recently begun to highlight the controversial nature of the “second victim” term in its capacity to inspire protest and objections among some patient representatives (Clarkson et al., 2019; Tumelty, 2018; Wu et al., 2020).

The evidence from this project and existing research literature was that the “second victim” term still appeared to resonate with the experience of healthcare professionals involved in a PSI, and to convey the potential severity of the impacts. It has been argued that the risk of healthcare workers being victims “should be addressed in the support of our current healthcare workforce” (Heinz and Kim, 2021, p. 97). Sensitivity about the term’s potential either to diminish healthcare professionals, or to cause offence to others impacted by patient harm was, however, noted by the present study’s contributors, and has been increasing within the wider literature. The “second victim” term, although still often employed with caveats in research studies, has recently fallen out of favour as a preferred way of describing negatively affected staff in official reports. The influential guidelines from US health standards organisations that referred to support for healthcare staff following involvement in PSI chose originally to follow Wu (2000) and use the term “second victim” (Agency for Healthcare Research and Quality, 2016; Conway et al., 2010). However, recent patient safety reports originating in the US have opted to avoid the “second victim” term altogether and, while continuing to advocate for staff emotional and psychological support after PSI, the authors have selected

different language such as “the wellbeing and physical and psychological safety of the workforce” (Institute for Healthcare Improvement, 2020, p. 22). As multilateral organisations have drafted and consulted on reports among international partners, they have also recently amended their chosen language, calling for healthcare organisations to ensure psychological support for staff after involvement in incidents, but removing references in early drafts to “second victims” (WHO, 2020b) from the final agreed iteration (WHO, 2021). This suggests that WHO member nations did not collectively support use of the “second victim” term to refer to healthcare staff involved in PSI.

Negative feeling about using the word “victim” to describe staff has been expressed increasingly overtly, with arguments presented that being labelled a victim after a traumatic experience is not supportive to any of those involved, nor conducive to recovery, because it does not foster a sense of agency and can lead to the labelled individuals feeling disempowered: “‘Victim’ labels rarely promote healing; on the contrary, they tend to increase feelings of shame and helplessness” (Gorlin et al., 2021, p. 7). This accords with concerns expressed by participants in this research and in the literature about the “second victim” term having unwelcome connotations of passivity (Wu et al., 2020). However, Gorlin and colleagues’ analysis is based on the experiences of military veterans, and their conceptualisation of healthcare workers as “frontline warriors” (p. 13) seems equally problematic. This commentary also argued that healthcare workers involved in adverse events should “take ownership of errors”, and support should focus on “moral repair rather than moral reassurance” (p. 9). Such a narrative would suggest that healthcare staff were trying to deny their responsibilities, which is an unhelpful and inappropriate basis for offering psychological support. The wider literature about the negative impacts experienced by victims of challenging events has provided evidence that victims may find themselves unfairly blamed by others “in emotionally laden situations” (Alves and Correia, 2013, p. 1), and be on the receiving end of “unsupportive reactions” (p. 2), thus minimising or denying the impacts. This research may explain why distressed healthcare staff are at times treated harshly by colleagues or managers after involvement in PSI.

It follows that although the “second victim” term may usefully be employed in business cases and other ways of arguing for organisational support resources, as acknowledged by the participants in this research because of its known basis in the research literature, the forceful objections that have been made and connotations of weakness could

dissuade staff from seeking or accepting support associated with this term, because of their own discomfort with the terminology. The evidence from this study and the wider literature suggests that making use of the word “victim” as a label for affected professionals is no longer appropriate or welcome. The choice of identifying other language to describe healthcare staff negatively affected by a PSI is nonetheless fraught with the potential for misunderstanding or ambiguity, because of the connotations in healthcare of certain words or ideas, or using concepts in a different way to their original definitions within theory.

Many participants in this project preferred use of the words “trauma response” or “traumatised” to describe the potential responses of staff, but they recognised that this idea might be ambiguous given the usual physical connotation of trauma in healthcare. Other concepts participants suggested, including “vicarious trauma” or “emotional labour” have different connotations within the research literature that could cause confusion. “Vicarious trauma”, as originally defined by Pearlman and Saakvitne (1995), does not suggest any direct involvement in a PSI, and refers to healthcare staff being traumatised by hearing of or bearing witness to patients’ own prior traumatic experiences. “Emotional labour” was mentioned by a participant as a way of conveying the strenuous efforts made by healthcare professionals to carry out their role, or the suffering experienced when care went wrong. However, as defined in theory and used in research (Brotheridge & Lee, 2003), this term refers to employees regulating their emotional display and holding themselves in check, in an attempt to meet organisationally based expectations specific to their roles. This idea is in opposition to the intended focus of emotional and psychological support, which would involve affected staff being able to express their emotions openly after PSI, in accordance with the theory of psychological safety (Edmonson & Lei, 2014). To use terms in ways that do not accord with their conceptualisation and intended usage could cause misunderstanding among those providing or wishing to receive support.

Some of the study participants considered it would be more appropriate and would avoid controversy to name the support provision rather than label affected professionals. Labelling either the support provision, or the staff accessing it, would thus need to be supportive of staff in its tone and connotations, evaluating and being and mindful of wider sensitivities, while not undermining staff, their responses, or their belief about having competence and capacity to do their job.

7.5.5 Necessary elements of emotional and psychological support

The findings of this research project including the evidence provided by the study participants have led to the identification of the elements of emotional and psychological support that could be incorporated into the provision of effective support interventions for negatively affected staff after their involvement in PSI. The preferred components derived from this research project are as follows: that support should be structured within a known and transparent process, rather than relying on informal and ad hoc contacts. It would be proactive and timely, meaning offered promptly after involvement in an incident, and empathetic, with the impact on staff acknowledged by clinical managers and supervisors who had received training in how to manage involved and affected staff. Being permitted to have time away from duties to process events and feelings, if needed by the individual, was considered important, as was being able to access support in a convenient location. The evidence also suggested that individuals should be allowed to make choices about whether and when to access support, in line with their needs, rather than having a process imposed or assumptions made. These elements, confirmed by existing research, are depicted in Figure 7, and elaborated below with the evidence for their inclusion, contextualised within the literature.

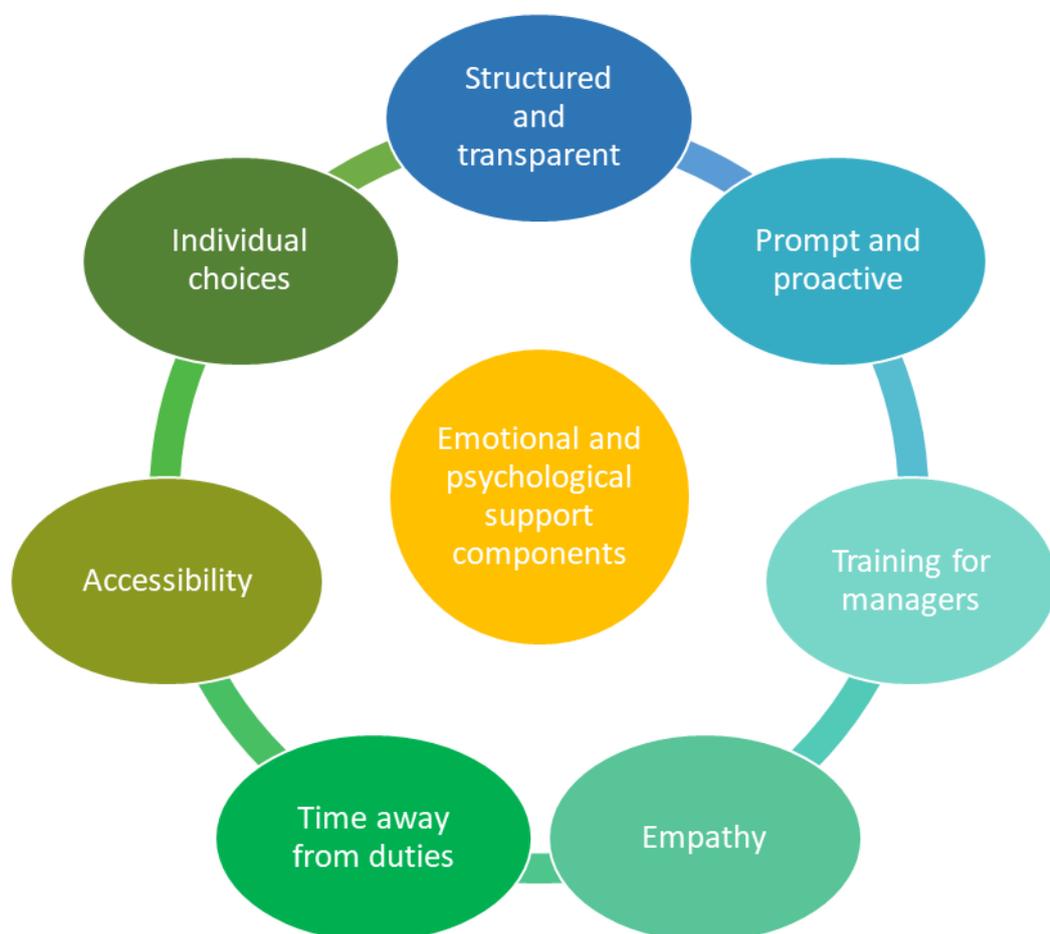
Structured and transparent

A known, formalised support structure would ensure that staff were aware that they could access emotional and psychological support after PSI if needed, within a fair and consistent system across the organisation, according to their needs, rather than depending upon the quality of existing workplace relationships, preconceptions and assumptions, or any inclinations to blame individuals for incidents. A system of support with equality of access would also remove the risk of individual staff being excluded from support because of not being perceived to fit in or be deserving, because of their work relationships, or their individual characteristics such as race, which was the experience of some of the participants in this research. The lack of support experienced by many professionals after PSI indicates that informal processes are inconsistent and inadequate (Biggs et al., 2020; Cabilan & Kynoch, 2017; Hood & Copeland, 2021; Liukka et al., 2020; Mokhtari et al., 2018; Ullström et al., 2014). The need for a structured and transparent support process, with underpinning infrastructure to ensure access, has been identified in a number of studies and reports (Berman et al., 2021; Health Education England, 2019a; NHS England and NHS Improvement, 2020; Reiser

Crelier et al., 2020; Scott et al., 2009; Serou, Husband et al., 2021; Van Gerven et al., 2014). Support provided externally through Employee Assistance Programmes (EAPs) may be inadequate (Klatt et al., 2021) because it is time-limited, does not involve the support of known colleagues, and providers may not have the requisite training in appropriate, trauma-focused interventions.

Figure 7

Components of support for healthcare staff after involvement in a PSI



Prompt and proactive

Offering support promptly and proactively to involved staff after an incident would create the opportunity for affected staff to address their feelings quickly, and reduce any potential impact on subsequent patient safety of professionals being distressed or

distracted by the event. It is recognised that for staff who experience the emotional or psychological impact of a PSI, organisations should ensure access to “timely” support (Health Education England, 2019a, p. 83). Studies have also identified a staff need and preference for prompt access to emotional and psychological support in the immediate aftermath of a PSI to aid their recovery (Edrees et al., 2017; Koyle et al., 2021; Scott et al., 2009; Strametz et al., 2021; Vizcaíno-Rakosnik et al., 2022).

It is already recognised that all affected staff should be proactively identified by their healthcare organisations and be given “access to the support they need” (NHS England & NHS Improvement, 2020, p. 37), rather than expecting staff to step forward to signal their need. This would avoid the need for staff to speak up for themselves to ask for emotional or psychological support, which they may not do because of perceived stigma, feelings of guilt at letting colleagues down, or not wanting to admit to the negative impact or to not being able to cope. Healthcare professionals may be loath to step forward to seek support because help-seeking is not the norm or is frowned upon. This is recognised in the literature about psychological safety, whereby workers in psychologically unsafe environments may not feel able to speak up about emotionally challenging impacts or their need for support (Edmonson & Lei, 2014), which is particularly observed in the healthcare professions (Health Education England, 2019b; NHS England & NHS Improvement, 2019) and hospital environments (Freedy & Hobfoll, 1994).

The research evidence shows that without support being proactively offered, healthcare professionals may feel they should manage emotional or psychological impacts without showing vulnerability or seeking assistance, potentially putting subsequent patient safety in jeopardy. Either the psychological impact of involvement in a PSI or the stigma attached to needing support can remove the ability to request help (Berman et al., 2021; Kaur et al., 2019; Serou, Husband et al., 2021). Professionals may hesitate to seek support because of what it may suggest about them and their ability to cope in the face of adversity, and within the norms of some professions including surgery, it has been found that stoicism is valued over vulnerability (Scott et al., 2021), such that waiting for healthcare professionals to step forward to seek assistance is unrealistic and ineffective.

The negative organisational responses to PSI that some staff have experienced or come to expect, including criticism or blame, also deter staff from help seeking. In a study of Dutch nurses' and doctors' preferred type of support after involvement in a PSI, Vanhaecht et al. (2021) found that the fear of blame or feelings of guilt and shame could create "a taboo on reaching out for support" (p. 5). Where there is a perception that the organisation prioritises its own interests above those of clinicians after a PSI, fear may arise of being made "a scapegoat" (Berman et al., 2021, p. 836), reducing the likelihood that professionals would single themselves out by highlighting their need for emotional or psychological support.

Training for managers

In addition to training staff to be aware of the potential impacts on themselves of a PSI experience, which may be beneficial (Cauldwell et al., 2015; Pinto et al., 2014; Venus et al., 2012; Vinson et al., 2016), training for clinical managers and supervisors and patient safety or risk managers is essential to achieve a consistent understanding of how to be emotionally or psychologically supportive to involved staff, and not just to individuals they like or respect. Individual managers without such training may not understand the relevance or importance of being supportive, or may exercise discretion to the detriment of some staff. Others may not have the requisite skills, or may consider they have no time to engage in supportive action (Edrees, Brock et al., 2016). Many of the staff support programmes described in the literature involve trained peer supporters, but it is managers and supervisors who have the authority to encourage and allow support for their staff, and management approaches can increase or limit the harm experienced by affected staff (Christoffersen et al., 2020). Many clinicians in the NHS have management responsibility for colleagues, and yet have not received professional training in people management, including responding appropriately when things go wrong:

It is interesting that only three per cent of those who work in the NHS are officially classed as managers or senior managers. In fact, if a manager is simply someone who has responsibility for managing people, more than 30 per cent of hospital staff are "managers". These include team leaders, supervisors, and consultants. People who combine managerial responsibilities with other clinical duties outnumber "pure" managers four to one. Many of these may not see

themselves as managers and may not have had much training in managing people. (Point of Care Foundation, 2014, p.15)

One aspect of emotional and psychological support is about impacted staff having the opportunity to re-establish a sense of belonging within their organisation by means of trusting professional relationships (Scott et al., 2009; Wahlberg et al., 2019), and a staff preference has been shown for receiving support from managers and supervisors (Klatt et al., 2021). However, some studies have found that healthcare professionals did not trust their managers to support them after PSI (Ajri-Khameslou et al., 2017; Berman et al., 2021), which means that training to disseminate consistently appropriate manager and supervisor responses is needed. Training for managers and supervisors within the post incident support process has been included as an element of the recently trialled Patient Safety Incident Response Framework in the UK (NHS England & NHS Improvement, 2020), although how this would be achieved is not yet known.

Empathy

Showing empathy to staff affected by PSI is about acknowledgement by colleagues, especially managers and supervisors, of the impact of incidents, rather than dismissing or ignoring staff reactions or emotions. Emotional support is grounded in empathic understanding, and this is not a characteristic of all individuals or working relationships, which connects this element of support to the need for management training. The preference for empathetic responses after PSI identified in many studies appears to underpin the preponderance of programmes based on peer support, as explored in Chapter 4. However, this type of scheme may not work as well in all organisations or healthcare systems, where clinical staff do not have time available to undertake on-call support during shifts, and other ways of offering empathy as part of support interventions may be equally effective.

Participants in the present study, particularly those who had previously been treated negatively by managers after their own experience of PSI, described their approach of being empathic as an important part of support for their staff after PSI. Research evidence has indicated that empathy and understanding helped reduce fear and other negative emotions, such as a sense of isolation and insecurity after PSI (Health Service Executive National Quality Improvement Team, 2021; Wahlberg et al., 2020). Several studies have found that staff wanted the opportunity to receive empathy and reassurance

from local leadership and senior colleagues as part of experiencing a supportive response from the organisation, and not just from peers (Jones et al., 2019; Rivera-Chiauzzi, Smith et al., 2022; Scott et al., 2009; Serou, Husband et al., 2021; Stone, 2020a; Vanhaecht et al., 2019), and that this enhanced interpersonal trust between staff and their immediate managers (Christoffersen et al., 2020).

Time away from duties

Having time away from duties after involvement in a PSI is an element of support intended to give professionals the chance to regroup, process emotions, and ensure that they are fit and safe to be caring for patients. If staff have experienced severe emotional responses to an incident, it forms part of the duty of care to patients to ensure that they are in an appropriate emotional and psychological state to continue or resume their duties. However, the evidence from this research project was that time after PSI was not given, and most participants in the present study reported being obliged to continue without any break until the end of their shift. After this, the only option available to them was to continue working while unfit, or to take sick leave. Moreover, in the NHS there are limits to the number of sick leave days staff can take before it becomes an HR or disciplinary issue. Within the literature, Vanhaecht et al. (2019) identified the need for a “time-out period” away from duties (p. 4) for staff involved in a PSI. Scott et al. (2010) also found that an officially sanctioned break from duties immediately after a PSI, to give affected staff the opportunity to compose themselves before resuming patient care, was the most desired characteristic of an effective support programme.

Accessibility

The opportunity to access emotional and psychological support was mentioned by the study participants in this research project with respect both to being given time, which connects with the idea of being permitted to take time away from duties during working hours, and to a convenient location; the latter was particularly relevant for staff in large healthcare organisations. There was concern that having to rely on referrals from a manager could also be a barrier to accessing support in practice where managers and supervisors had discretion to refer or not, and made judgements about individual need. Difficulties with access to support have been reported in the research literature, including having time to access support (Edrees & Wu, 2017; Johnson et al., 2019), which was one of the top two barriers to receiving support (Edrees et al., 2017). The

need for “readily accessible” staff support after PSI was identified by Scott et al. (2010, p. 235), and yet many research participants in recent studies did not know how or where to access support (Stone, 2020a). It was particularly problematic for staff to access support if arranged in an off-site location (Edrees et al., 2017). The literature also identified that it would be important for those providing support to have access to support themselves, through clinical supervision, mentoring, or counselling, since supporters could also experience psychological distress (Edrees et al., 2017; Hobfoll & London, 1986).

Individual choices

The importance of staff having choice in whether and how to access support was identified by research participants, in contrast to having an imposed process or a requirement to receive support in a specific way or at a specific time. Choice was recognised to be important within a known support structure, so that there would be certainty of the option to access support if desired. This was mentioned with respect to the timing of support, and being able to access it either immediately or later. Within the research literature, having different levels of support has been a preferred way of structuring support, to meet different needs (Scott et al., 2009; 2010), and reviews have identified a need to offer support to involved staff immediately and in the medium and longer term (Seys et al., 2013). Offering support to staff in ways that met their needs was highlighted as an ethical issue (Monteverde & Schiess, 2017), and some staff who did not consider they could trust their organisation did not want to be made to access support (Van Gerven, Deweer et al., 2016).

7.6 Answering the research questions

The research questions for this project (reiterated in section 7.2) explored what policies, protocols, and practices participants were aware of with respect to emotional and psychological support for staff involved in PSI, and any views they held about use of the term “second victim” to describe staff negatively impacted after involvement in an incident.

Twenty-six out of 27 participants did not know of any relevant policies related to staff support after PSI, including near miss events, from national or international sources, or from within their organisations. This came as a considerable surprise, given the number of official reports and policy recommendations for support that were found to exist. Just

one participant mentioned a national NHS Patient Safety Strategy document (NHS England & NHS Improvement, 2019) that recommended support for staff, and the NHS People Plan 2020/21 (NHS, 2020) that included a general call for staff support. Neither of these documents stipulated what support should include, nor made it a requirement. Participants were all aware of specific policies relating to what was required of them by their organisations with respect to standard operating protocols for patient care, reporting adverse events, Duty of Candour disclosures, and other HR rules and requirements.

In terms of practice, access to emotional and psychological support after involvement in a PSI was considered necessary by study participants and within the wider research literature to meet the needs of staff who experienced distress, but this was not reported to be available on a widespread, consistent or reliable basis. Known support practices after such events were described as chiefly informal, coming from close colleagues if relationships were good, but ad hoc, and often unavailable for staff involved in incident investigations, who could be told not to contact colleagues at all. Only three participants in this research project described structured support after PSI: one scheme had ceased to operate after a pilot period; one was still in the process of being introduced; and one was current but open only to staff in one clinical department of one hospital within a large NHS Trust. Another participant described the ad hoc use of defusing, recently introduced for staff overwhelmed by work with COVID-19 patients, and the use of Critical Incident Stress Management, if requested by staff, to support staff affected by a traumatic incident. It was observed that clinical debriefing, while welcomed by some professionals, did not constitute a form of emotional or psychological support, and that some staff could be traumatised by attending debriefs.

The term “second victim” was found by study participants to capture accurately the experience of being involved in a PSI and the associated negative feelings, but was considered to have unwelcome connotations of passivity, weakness, or to be unacceptable to other stakeholders such as patients or their families. No single term was identified or suggested that could be used in its place, although participants were mainly in favour of identifying a way of acknowledging the psychological and emotional impact on staff of such events, and considered the words “traumatised” or “trauma response” to be apt descriptors. There was hesitation from many participants about labelling staff in a way that could be detrimental to the organisation’s view of them, or

to their future career progression. Participants nonetheless acknowledged that the “second victim” term was recognised in the research literature, and could be used as part of the background to attempts to explain the need for and secure organisational resources for support.

7.7 Limitations of the research

This research has some limitations, including the known time constraints within a PhD project, which restricts the number of interviews that can be undertaken. As explored in Chapter 5, ethical approval processes required the inclusion of a proposed sample size in the research proposal and documentation, and to be realistic there needed to be a sample ceiling.

The time available for healthcare professionals to participate may have constrained their contributions. I endeavoured to convey as many of the points raised by participants as possible within these constraints, recognising that in making these decisions my subjective choices may not have been the same as another researcher engaged in this field; for example, the interest in language use that I brought to this project targeted part of my analysis to the relevance of connotations, whereas another researcher might have not considered this to be of such importance, and could have identified a completely different set of thematic categories.

A further potential limitation was created by the fact that in this doctoral project only one researcher could carry out the coding, rather than several collaborators working on, sharing, and reviewing the identification of codes and themes. Quality criteria in qualitative research highlight the benefit of coding being corroborated by several researchers, to demonstrate inter-rater reliability (Armstrong et al., 1997; Mays & Pope, 1995; Spencer et al., 2003). I do not consider that inter-rater reliability, which is not in any event possible by the nature of PhD research undertaken by one student, is an essential aspect of research quality, provided that subjective choices in the process are acknowledged. I nonetheless recognise that this could mean that another researcher would have identified or prioritised different codes. The aim of the analysis was to achieve a careful and transparent balancing act between consideration of the data, placing priority on the study participants’ views and experience, awareness of the research questions, and my subjective inclinations and interests. I was open to the possibility (that did not in fact arise) that some or all participants would subvert or

contradict the existing research evidence, and state that support for staff after PSI was plentiful, or that it was not needed, wanted, or relevant.

This project expressly envisaged a wide potential range of participants in the project approvals, and it could be argued that a narrower focus on one profession or one Trust would have been preferable, as a way of facilitating depth rather than breadth. However, in this qualitative research, generalisability or representativeness was not the aim. While knowing I would be limited by the practical constraints, it was nonetheless important for me to endeavour to glean the knowledge and views of a broad spread of healthcare staff, in different roles and locations, in as much detail and depth as possible. I was concerned about investigating the experience of staff from one Trust alone, or within one profession, which could have been very specific and unlike the approach found in other parts of the country, or unlike the experience of other professional groups. Directing the recruitment to England, which is one regulatory area within the NHS, was a way to maintain consistency in policy and oversight terms, although this naturally removed potential contributions from healthcare professionals in other parts of the UK. Ensuring the common thread of participants all having management, supervisory, or policy responsibility was of prime importance for this study, to capture the views of those with lived experience of responsibility for other staff or a service, and that criterion was maintained as the participants volunteered.

The COVID-19 pandemic gave rise to an important limitation, because NHS Research and Innovation departments were suddenly unable to be involved in disseminating the research to their staff from March 2020 onwards; new sites could not commit to being involved, and only one of the three approved sites subsequently resumed recruitment. This resulted in a potentially smaller reach. While allowing for snowball sampling seems to have been a beneficial strategy to counteract this, resulting in 27 in-depth interviews, it may have diminished the heterogeneity of the sample, as some participants may have knowingly or inadvertently passed the study information to like-minded individuals with similar views about staff support needs. The approved dissemination of the study information by a national health and care quality improvement organisation helped prevent this, by extending the reach to potential participants in a variety of NHS Trusts who did not know any other interviewees.

Qualitative research methods are known to produce large amounts of data, and this was the case in this research. Working with a large volume of data from detailed interviews can be difficult for a single researcher to manage, and not having previous experience of this quantity of interview data could be considered a limitation as I developed ways of handling, analysing, and interpreting the lengthy contributions. Endeavouring to maximise rigour and trustworthiness in the analysis while allowing for authenticity and relevance, I used the topic guide as an overarching frame to guide all the interviews, asking all the questions of all participants. I then approached each transcript as a separate entity to analyse, aiming to reflect what was of priority and prime importance to each interviewee as they contributed views about the research questions. I was careful not to shortcut the process by identifying themes before I started, or at any point before all transcripts had been coded, so that the views I had encountered while exploring the literature did not overshadow the voices of the participants. To respect and convey the essence of these voices was my overriding objective in completing this work.

7.8 Quality criteria

With the aim of ensuring the quality of this work, I focused on the four guiding principles for qualitative research outlined by Spencer et al. (2003). These are that research should advance wider knowledge and understanding; employ a research strategy that can address the questions posed; be rigorous, systematic, and transparent in its conduct, including the collection, analysis, and interpretation of the data; be credible in claim by presenting plausible arguments about the value of the data generated. These are the criteria that have informed this project from the outset.

I believe that this research advances wider knowledge and understanding by investigating the views of study participants about any policies, protocols, and practices of which they were aware about emotional and psychological support for healthcare staff after PSI. The qualitative research design provided the opportunity for volunteer interviewees, from a population not previously studied, to convey their own knowledge and experience in detailed, original contributions.

The data were collected after rigorous explorations of existing academic and grey research literature on this topic. The conduct of each element was thorough and painstaking, to provide a comprehensive foundation to the research study. The process of data collection and analysis have been described clearly and transparently, and

relevant aspects of my own background have been disclosed as part of ensuring researcher authenticity and openness.

To achieve credibility in this research I endeavoured to become closely familiar with the research topic and to understand the settings in which participants worked, within the umbrella of NHS England. I studied in detail the prior research about support for healthcare staff after involvement in PSI, and paid very close attention to the views and insights of my participants, located in ten Trusts and 14 workplace sites. I believe that within the constraints of a PhD project, the research data are sufficient to merit an assertion that accessible emotional and psychological support for healthcare staff negatively affected by PSI, including near miss incidents, is needed and yet frequently lacking, and that there are clear links that the reader can perceive between the data gathered and my argument and analysis.

The contributions of this research, including new insights and knowledge, are addressed in Chapter 8.

[7.9 Chapter summary](#)

This research provides evidence that emotional and psychological support for healthcare staff after involvement in PSI is not currently the norm in healthcare organisations in England, although there is a perceived need for such support. This evidence confirms prior research that not supporting negatively affected healthcare staff via a known, structured pathway after involvement in PSI can add to distress, can lead to the risk of staff being unable to function at their optimum level, and potentially gives rise to distrust within the organisation where staff may not feel able to continue safely in their patient care role, or their career.

National and international healthcare organisations have called for staff support after PSI for over 20 years, but proposed ways of structuring support have mostly been based on research and practice within the US healthcare system, and tend to focus on peer support models, which may not work as well in the UK system. Healthcare policy in the UK has begun to acknowledge the need for staff emotional and psychological support after PSI, and NHS England has recently stated that organisations should support their staff in these circumstances. However, there is no specific model that organisations are required to replicate, and the Trusts where research participants

worked did not have clear support pathways that were accessible to all their staff. Many had no known support process at all.

This research has identified the elements that healthcare staff would value as part of a support programme, including formal acknowledgement by the organisation of the potential emotional and psychological impacts from PSI involvement leading to structured support; proactively offered emotional and psychological support, provided in an accessible way within the organisation for all affected staff, including those subject to investigations; permission to have time away from duties after a PSI if needed for recovery and to restore safe functioning; training for managers and supervisors about the impacts, how staff can access the support pathway, and the importance of showing empathy. These elements would shift expectations and responsibility away from individual self-care and towards a direct role for organisations and trained managers in supporting staff and helping them to cope and recover. These elements, if incorporated into new or updated policy and practice regarding emotional and psychological support for healthcare staff after PSI, could lead to reduced sickness absence and a greater retention of staff. They would represent the implementation in practice of the legal duty of care that all UK employers are required to show to their staff with respect to their mental as well as physical safety and wellbeing.

CHAPTER 8: CONCLUSION

8.1 Introduction to the chapter

This concluding chapter will summarise the research undertaken, showing what new knowledge and ideas this work has contributed, and making recommendations for future work in this field. Finally, it will offer a personal reflection on the research project and process.

8.2 Summary of the research project

This PhD project began in October 2018, with a general focus on investigating the topic of “second victims in healthcare”. It has evolved into a qualitative study, with Health Research Authority and Lancaster University ethical approvals granted to interview volunteer participants with any level of managerial, supervisory, or policymaking responsibility, from NHS healthcare Trusts within England. Recruitment planned through three approved NHS Trust Research and Innovation Departments, and underway in one, was stopped in March 2020 when the COVID-19 pandemic was declared; it only restarted in one Trust. However, the envisaged recruitment via an approved healthcare quality organisation continued, and snowball recruitment also took place. During in-depth one-to-one interviews, semi-structured by means of a topic guide, 27 participants gave their views on two research questions: 1) the policies, protocols, and practices they were aware of that aim to support healthcare personnel in their organisation who have experienced unanticipated adverse medical events or near misses; and 2) their views about the term “second victim”.

8.3 Contributions of this research

This project has encompassed several elements that each make a new contribution to knowledge.

8.3.1 Analysis of national and international policies about support for healthcare staff involved in patient safety incidents

An important element of this research was a comprehensive investigation into and analysis of existing national or international policies about the provision of emotional and psychological support for healthcare professionals after their involvement in patient safety incidents (PSI), to show whether and how the negative experiences of affected healthcare professionals were being addressed in relevant policy (Chapter 2). This

project is the first to investigate these policies. A documentary analysis explored the nature and status of the policies, and found that policies at the international level, and at the national level in a small number of countries, mostly called for or recommended, rather than required, access to psychological or emotional support for healthcare professionals involved in PSI. The very few identified policies that set an expectation or requirement of such support were unclear about how this would be achieved or ensured. The context for all but one of the policies was the overarching policy aim of fostering open disclosure of incidents and promoting improvements in care quality. In other words, emotional and psychological support for staff is an adjunct to different policy targets and priorities, principally intended to benefit patients and organisations, not the involved professionals.

[8.3.2 Learning from the experience of healthcare managers, supervisors, and policymakers](#)

The in-depth interview study that collected data for this project (Chapter 6) using thematic analysis methodology, reports for the first time the knowledge and lived experience of UK healthcare personnel in managerial, supervisory, or policymaking roles, across several professions and workplaces, on the topic of staff support following patient safety incidents (PSI). The views of healthcare staff in these roles have not previously been sought or gathered on this subject, and the perspectives of those in policy, management, or supervisory roles illuminated the topic in a way that extended beyond individuals' personal experience of distressing events, to encompass how such events and related staff support needs were managed in practice, and on what basis. The interviews addressed the two research questions, and the participants provided a wealth of evidence about the reality of staff emotional and psychological support needs after PSI, and the lack of any identifiable policy or widely accessible structured provision to meet these needs.

[8.3.3 Investigating staff support schemes and their policy bases](#)

A key contribution was investigating the policies that are reported to have influenced or informed existing structured emotional and psychological support provision for healthcare staff involved in PSI. No previous research has been identified that explores whether the studies describing such staff support schemes acknowledged a specific policy basis. The integrative literature review of support programmes in place for

healthcare staff involved in PSI (Chapter 4) is the first review setting out to identify the policies used to underpin the programmes reported in the research literature.

This review demonstrates that there are relatively few published studies describing specific support programmes: just 35 programmes in six countries, some of which are intended for particular professional groups only, and none of which are in the UK. This highlights that support programmes are by no means uniformly available to all healthcare staff in all organisations, and this means that however severe the negative psychological impact upon healthcare staff after involvement in a PSI, there is no certainty that affected staff will have access to the emotional and psychological support they may need. The review also shows that there is plenty of information within these studies and programmes about how organisations could structure an offer of support for their staff following PSI, with various approaches to consider. The evidence reveals that the existence of many guidelines and reports recommending staff support after PSI has not brought about the widespread introduction of support programmes in practice.

[8.3.4 The impact of near miss events can affect all healthcare professionals](#)

The potentially serious impact of PSI including near miss events, identified in previous studies with respect to UK doctors (Harrison et al., 2014), was confirmed by the participants in this research also to occur among other UK healthcare staff, including nurses and midwives. This is a new finding, because previous UK studies (Kaur et al., 2019; Serou, Slight et al., 2021; Sheen et al., 2016; Slade et al., 2020) have not reported on the negative impacts of near miss events.

[8.3.5 Rhetoric about staff wellbeing is not applied in practice to PSI](#)

This research draws together evidence about the connection made in many official healthcare reports between good staff wellbeing on the one hand and good patient care and wellbeing on the other. It shows that this link is understood and accepted in theory, and also made sense to the study participants. However, a further gap between policy and practice is identified by this research: the connection amounts to rhetoric, because it has not flowed through to organisations instituting structured emotional and psychological support for staff involved in PSI. Wellbeing appears to be something staff are meant to achieve and maintain themselves, for the benefit of their organisation, without reference to the traumatic experiences they may undergo while at work. The participants in this project have made clear that wellbeing is not something separate or

distinct that healthcare staff can simply achieve on their own by attending health-promoting activities in their spare time. The impact of traumatic and distressing work experiences requires formal acknowledgement and specific, targeted organisational responses and structures.

8.3.6 Rhetoric about not blaming staff is not the lived experience of healthcare staff

A gap was also identified between general recommendations to move away from blaming healthcare staff for unintended PSI, and the reality of staff experience. The evidence from this project reveals that the prevailing situation in participants' organisations still involves blame or fear of blame. This has previously been reported in relation to UK obstetricians and gynaecologists (Slade et al., 2020), and in one Trust (Kaur et al., 2019), but not across several Trusts and healthcare professions, as shown by the data from this interview study. Experiencing or fearing being blamed is incompatible with having a culture of care and support for staff. Moreover, it not only has the potential to inhibit the disclosure of PSI, but it can lead to anxiety and other responses that may reduce functioning and increase the risk of errors with subsequent patients.

8.3.7 Imbalance between duties or expectations placed on staff and the resources provided for staff

The data illuminate a perceived imbalance between the duties and requirements placed on healthcare staff, and what their organisations are required, or elect, to provide to them. This research shows that the threefold legal duty on UK employers to protect the health, safety, and welfare of their employees, to do whatever is reasonably practicable to achieve this, and to consult their employees in the process, has not resulted in overt acknowledgement of the need to protect the psychological health of staff involved in PSI, nor mechanisms to consult on or ensure this protection is achieved in practice.

The analysis presented by this study's participants of staff experience after involvement in PSI suggest that this duty of care can be more theoretical than practical, and in some cases essentially a tick-box exercise. This demonstrates that the specific psychological health and safety implications of being involved in PSI have not been transparently addressed, or specifically consulted upon in most healthcare organisations where traumatic events can and frequently do happen.

8.3.8 Routine language usage in healthcare negatively impacts emotional and psychological support provision

An important contribution of this research is to have clarified that the routinely accepted understanding and specific use in healthcare of the word “support” to mean assistance to learn and improve staff skills, as a way of benefiting the organisation and patients, appears to have negatively influenced assumptions about the need for provision of emotional and psychological support for staff, or about what such support might include. This usage has contributed to a focus on staff being resilient and carrying on meeting organisational needs for care quality improvement, rather than to consideration of the emotional and psychological needs of individuals distressed by workplace events, to maintain or restore their wellbeing. Routine use of the word “trauma” in healthcare to signal physical rather than emotional injury was also identified as a contributory factor in the lesser priority accorded to psychological health and wellbeing within the healthcare sector, in contrast to the general lay connotation of trauma as mental or emotional harm. In an environment that routinely places substantial psychological demands on its workers, it is important that healthcare organisations decide to support staff psychological and emotional wellbeing after PSI, by acknowledging the impact where this occurs, and offering structured support through which staff can re-establish their emotional and psychological equilibrium.

8.3.9 Identifying a lack of UK support provision

The integrative review (Chapter 4) found that of the 35 staff support schemes described in the 41 studies identified, none are currently located in the UK. This indicates either a low level of interest in investigating this topic, or a lack of emotional and psychological support provision in practice. This knowledge informed the planning of the qualitative study, and the framing of the participant criteria and the research questions, to establish whether staff support did exist in practice in England, but had not been reported in the literature. The study findings demonstrate that structured provision of emotional or psychological support for staff involved in PSI is neither widespread nor automatic in UK healthcare settings. It is notable that one participant knew of a pilot staff support scheme in one hospital department, that had now ended, and another referred to a plan to roll out a peer support programme in the same Trust. Only one current, formally structured support scheme was described, covering staff in one department only of one hospital in one Trust.

This finding reveals a central aspect of this project’s contribution, namely the stark gap between the many recommendations issued in national and international policy for healthcare staff to have emotional and psychological support after PSI, and the reality of healthcare staff experiencing limited or no support in practice. NHS policy has recently set a requirement for staff to have access to support after PSI, and yet the evidence does not demonstrate that staff have access to known pathways for support in practice. This gives rise to an additional contribution to knowledge in this field, namely that it is not a lack of healthcare policy recommendations that has led to a dearth of UK staff support schemes, but an apparent lack of will to date within healthcare organisations to make use of and implement such recommendations in practice, by devising programmes, training managers, and allocating resources.

8.3.10 The second victim concept is unclear and controversial

A further new contribution to knowledge is the findings from the concept analysis of the “second victim” in healthcare (Chapter 3). A concept analysis was necessary to clarify the coverage and use of the “second victim” idea and term, and this analysis demonstrates that “second victim” is used in different ways by different users, including researchers, creating the potential for confusion or misunderstanding. It shows how the coverage of the term has expanded, with the most recent uses including healthcare professionals who have been negatively affected by the experience of the suicide of their patients or service users, and those who have had negative and distressing work experiences during the COVID-19 pandemic. The “second victim” concept has also been conflated with other concepts, including vicarious traumatisation, secondary traumatic stress, and moral distress. The lack of clarity and precision in the concept’s usage undermines its validity as a construct, and means that it is an unstable foundation on which to compile research evidence about healthcare staff support.

The analysis also highlights the fact that the “second victim” term fell out of favour during the development of this project. The term’s growing unpopularity and the weight of the related controversy that emerged in 2019 provided a clear rationale for subsequently carrying out a literature review that aimed to locate and include studies about staff support schemes that did not use the “second victim” terminology, as well as those that did. It also informed the inclusion of a research question specifically seeking study participants’ views about the “second victim” term. Moreover,

undertaking the concept analysis informed my awareness that the term no longer reflected the state of the science, and that its continued use could serve to side-track or obscure arguments in favour of staff support after PSI, and to risk delaying implementation of support in practice.

8.3.11 The second victim term is no longer fit for purpose

The study expressly sought the views of participants about the term “second victim”. This has not previously been asked of healthcare staff in the UK, including those with managerial, supervisory, or policy responsibility. The only participant who described being in the process of rolling out a Trust-wide staff support scheme explained that staff had not been consulted on the “second victim” term as part of the scheme implementation, but that the (negative) views of patients and families had been heeded. The data from this study reveal that the “second victim” term is considered by participants in UK healthcare organisations to be an apt description of how staff can be affected, but that it also causes considerable discomfort because other stakeholders object to it, and because it can convey weakness or passivity. As such, the term represents an unhelpful distraction and is thus no longer appropriate for the purpose of underpinning or naming staff support, apart from as a possible reference point for business cases and resource bids.

8.3.12 Identification of preferred elements of support

The argument I advance in this thesis is that emotional and psychological support for healthcare staff involved in PSI should be made available in practice, in line with policy recommendations and stipulations. The necessary elements of this support to ensure its effectiveness were identified by study participants and are supported by existing research. They include support being structured and transparent, so that all staff would know how to access it and be able to do so; support would be offered proactively and promptly, enabling involved staff to determine if they were negatively affected, including by near miss or no harm incidents; there would be training for managers on appropriate and agreed approaches to supporting staff after PSI, including the need for understanding and empathy; affected staff would be allowed to take time away from their duties as needed to regain their composure and restore safe functioning; support structures would be made accessible by line managers giving staff the time to attend,

and by locating the support conveniently; staff would be able to choose whether to access support at all, immediately, or at a later date if this became necessary.

Implementing these support elements would serve to rebalance the unspoken and arguably one-sided psychological contracts between organisations and workers in healthcare, whereby staff exercise a duty of care to their patients, but do not feel that a corresponding duty of care is shown to them by their institution. These elements could redress this imbalance, focusing on organisational and management responsibility, rather than placing further demands onto the affected staff themselves.

8.4 Recommendations for future research

To understand more fully the implications of these results and take them forward, future studies could address several aspects, with suggestions outlined below.

8.4.1 Consulting healthcare staff

It would be useful to carry out a consultation of healthcare staff, including those with managerial and financial oversight, to explore views about the possible support elements, and to investigate how these elements could be brought together into a workable system. Professional healthcare bodies could be approached to consult their memberships. Partnering with a specific NHS Trust to research staff support preferences, and then develop and implement a support scheme would be a constructive way of taking the findings of this project forward, to achieve a real practical benefit.

8.4.2 Evaluations of current support and the impact of shift working

Future studies could also include evaluating the current and proposed structured staff support services mentioned by participants, investigating the views of staff in specific organisations about their experience of emotional and psychological support in practice. These studies could investigate how arrangements for staffing and shifts in the NHS impact existing support after a PSI, since the shift system was mentioned in this study as a specific and important barrier to offering and accessing support. Research could include how peer support works or is intended to work in practice within a shift system, for example in the Trust currently rolling out such a scheme, both for those offering support voluntarily, and the staff who receive it. It would also be useful to investigate how shift arrangements affect staff who need time away from their duties to recover emotionally after traumatic experiences.

[8.4.3 Investigating approaches to eliminating blame after PSI](#)

It would be valuable to investigate the extent to which the fear of being blamed after involvement in PSI affects the willingness of staff to seek emotional and psychological support, and to evaluate staff perceptions of new approaches aimed at creating a just culture in some healthcare organisations. This could take place where such approaches have been adopted, and where the stated focus of the organisational climate is on resolution and staff support after PSI, or in organisations where this is a new idea. Studies could also explore whether the recent willingness to introduce support for some healthcare staff during the COVID-19 pandemic is associated with the fact that staff cannot be blamed for the occurrence of the pandemic, in contrast to clinical errors, where public or organisational sympathy for the staff involved may be much reduced.

[8.4.4 Investigating staff support after PSI in other UK jurisdictions and in Ireland](#)

It would be informative to carry out research in the other UK jurisdictions of Scotland, Wales, and Northern Ireland, to establish whether there are differences in the approaches to staff support policies and practices in those countries by comparison with Trusts in NHS England, and whether their different oversight and regulatory frameworks have led to the provision of more effective emotional and psychological support in practice after PSI. Specific examples of support referred to in UK healthcare reports, including the peer support scheme in Scotland (West & Coia, 2019), could be a starting point for such an investigation. NHS organisations in Wales and Northern Ireland could be approached to investigate whether and how they provide staff support after PSI, and on what policy or other regulatory basis. It would also be useful to investigate whether healthcare organisations in Ireland have taken up the Irish Health Service Executive support model, and how they may have implemented it in practice for their staff involved in PSI.

[8.4.5 Investigating staff experience of emotional and psychological support in mental health Trusts](#)

Focusing future research on the availability of staff support specifically in NHS mental health Trusts would enable a deeper understanding of elements of the data from this project. Participants suggested such Trusts were not better at providing emotional and psychological support for their staff than Trusts engaged in physical care, although the psychological health expertise in mental health organisations might have suggested

otherwise, and Mersey Care Trust has publicly recognised the need to begin to change this (Whitehouse, 2018).

[8.4.6 Investigating the emotional and psychological impact of investigation processes and access to support](#)

It would be illuminating to explore further the impact of formal investigation processes on staff involved in PSI that have caused patient harm, to identify what emotional and psychological support is currently available to staff in practice in these circumstances, and on what basis. Given the evidence from the present study that such support may be lacking, inconsistent, or largely a tick-box exercise, it would be useful to explore how best to provide support in a fair and consistent way that is perceived to meet staff needs, and at the same time to be acceptable to the relevant authorities and legal entities overseeing such cases.

[8.4.7 Investigating the support received by healthcare staff of different ethnic origins](#)

Two participants spoke of race and ethnic origin potentially giving rise to a different level of support following PSI, based on not being considered to fit in with peers, or being perceived to be lower in a hierarchical sense and somehow less deserving of supportive responses. This is an important issue that could usefully be investigated in collaboration with professional bodies, to establish if their members have had similar experiences. It could also be a valuable aspect of future research that evaluates support schemes once they are in place, to gauge whether having a structured and automatic system of emotional and psychological support is an effective way to remove the current discretion of managers and colleagues to offer informal support based on their own inclinations and potentially biased assessments of who among their colleagues would need or deserve support.

[8.5 Personal reflection](#)

My professional experience across the areas of government policymaking, teaching, and psychotherapy has led me to the view that what matters for the lived experience of individuals is what professionals do to help in practice, when help is needed. For me, this is an ethical issue. For this project, it means organisations identifying how they can provide effective emotional and psychological support structures that are known and accessible to staff, resourcing them for the long term, and signposting and encouraging

their use. What matters is that action is not limited to making policy pronouncements and enunciating a rhetoric of concern, as one participant described it, if nothing is done.

The experience of undertaking this research has been a steep learning curve in the practical matters and processes of doctoral research, understanding the ethical requirements and procedures for undertaking research within the NHS, and developing the new skills necessary to carry this out and support my decision-making at each step. It has led me to reflect more deeply on my values and objectives, and to aim to reflect these carefully and as closely as possible in the methodology I selected, maintaining a practical focus, and with the aim of making an evidenced, pragmatic contribution.

The main discovery of this research project is that healthcare staff working in the NHS in England who become involved in patient safety incidents cannot currently rely upon having access to professional emotional and psychological support in all organisations or across all the professions. Existing support is piecemeal and ad hoc, and rests chiefly upon the informal goodwill of empathetic colleagues, placing yet more responsibility on staff to care for one another, as well as for their patients. Given the constraints of limited time and other resources in healthcare, and considerable work pressure, staff may be unable to offer this support in practice, or may not have the skills or inclinations to do so. Unsupported staff may be unable to work safely or effectively, and may be a risk to subsequent patients, end up seriously unwell, or leave their professions.

The argument I have advanced in this thesis is that structured emotional and psychological support should be provided by healthcare organisations for their staff after involvement in PSI. For such support to be effective, it must be transparent, accessible to all, offered promptly and proactively, and include training for managers on appropriate approaches and responses. My aim is to redress the current imbalance between the high expectations and requirements placed upon healthcare staff, and what their workplaces offer in return after involvement in unintended PSI, so that negatively affected staff experience the legal duty of care in an effective and empathetic way. This means organisations providing easy access to appropriate emotional and psychological resources after staff involvement in these distressing and traumatic events at work.

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Appendices

Appendix A: Reflective Journal Extracts

Entry Date	Journal Extract
18.01.20	I have started reflecting on the medical model and ideas about potentially pathologizing experiences into symptoms, which researchers and participants refer to. Should I be using this language? The interviews are only just underway, so I've decided I must pay close attention to the language used by future participants as the interviews progress – do they think of or describe their experiences in terms of symptoms? Is that normal for them? Is it ok to consider symptoms, provided someone else is not imposing the labels? Am I buying in to an inappropriate or simplistic way of seeing things? Or is this kind of language natural and what makes sense to participants? Am I entering their world (which would be a good thing?), rather than trying to impose something I might prefer? I use this language myself in my other professional worlds. I need to keep all this in mind going forward.
12.12.20	All the interviews have been completed now. All participants were comfortable with and freely used language referring to symptoms. It resonated with them and was not seen as a negative. What was seen as a negative was not doing anything to help people clearly displaying distress. The key thing was that staff needing support were not themselves labelled by others in a derogatory or belittling way, that could make organisations hesitate to offer support, or could impact their later careers by becoming a negative marker.

Appendix B: Semi-Structured Interview Topic Guide

Healthcare personnel as second victims of adverse medical events:

Interviews with healthcare policymakers, managers, and supervisors

Opening:

Welcome and introduction - Seek consent to continue and to audio-record the interview.

Re-cap of project and plan for interview

The interview will explore the policies and practices used to support healthcare personnel following adverse medical events and near misses. We are interested in your perceptions, on the basis of your knowledge and experience. If you do not feel you are able to comment on any area, please say so.

Do you have any questions before we start?

Questions:

1. Could you tell me about who you are: your role and responsibilities? What attracted you to your current post; what was your career path to this post?
2. Could you talk me through what staff might experience if they are involved in an adverse patient event and near miss? [This might include medical error, unintended injury, other unanticipated patient harm, critical incidents, or never events.] Have you had personal experience of such events?
3. Have you been responsible for staff who have been involved in this kind of situation? What's it like having to manage this?
4. What happens after staff have been directly or indirectly involved in experiencing adverse patient events?
5. What policies, practices or schemes are there within your organisation to identify and support staff in these circumstances? To which staff do they apply? [How do these link with NHS policies/guidelines/quality indicators eg CQUINs, or local requirements?]
6. What kind of support is a) offered or b) provided? Is it practical or emotional? Formal or informal? Who offers or provides the support? Are there specified support roles? Is support combined with or separate from any clinical or disciplinary investigation into the event?
7. What kind of policies, protocols or training aim to anticipate or pre-empt staff experiencing negative consequences following involvement in adverse patient events?
8. How do policy and practice in your organisation connect the health of patients (patient safety) to the health and well-being of healthcare personnel?
9. Is there a particular phrase or definition used in your organisation to describe staff in this kind of situation?
10. Are you familiar with the term 'second victim'? [Offer definition as needed.] Do any of the policies within your organisation use the term 'second victim'?

11. What are your impressions of the relevance and usefulness of this term? Do you have a preferred term?

Closing:

Is there anything that we haven't covered in the interview that you think we should know or think about?

Check that the participant is still happy for us to use all the information provided.

Thank the participant for their time and contribution.

Appendix C: Examples of Data Analysis Memos

Interview Memo Date	Memo
P1 05.01.20	<p>P1 is very upset and angry about her experiences, and particularly her treatment at the hands of her organisation. She mentioned that it felt beneficial to be able to talk about it and express herself to someone outside, who wasn't trying to defend the organisation. This has made me reflect on the potential for therapeutic benefit from a research interview. How does this differ from a therapy session? What are the similarities? Are there crossover points? It's important to me not to edge (or slip) into a therapeutic role, although I recall from past research how participants may find their interview emotionally helpful. I really want to keep an eye on acknowledging the feelings expressed, and allowing them, while at the same time avoiding being drawn into areas beyond the scope of the study. Why is that? Should I be 'following the data'? Does this mean it's ok to be drawn off topic? How does that fit with the ethical approvals and the stated research questions? I feel I must create some kind of connection between the participants, who are from so many professional and geographical areas, to support finding a thread. So I do think there has to be some structure that I adhere to. Also, I'm mindful that a substantial departure would mean seeking an HRA amendment. Would it make sense or be realistic to seek an amendment after every interview? No. As a therapy practitioner I should 'follow the feelings', and that may be the crossover point. Participants need to be heard, but here that has to be within the outer boundaries of the topic set out in the information sheet, and the framework of the topic guide. Otherwise there's a big risk of diluting the topic.</p>
P2 09.01.21	<p>There is something emerging here about the use of language influencing ideas about support, and its legitimacy. Support is being used by participants to refer to support to learn and improve, not emotional or psychological support. This seems to be an established connotation. What are the implications for providing support if the word is routinely taken to mean a staff member's individual skills improvement process? And the connotations of trauma could be relevant here too: if trauma is assumed to be a physical thing, then does this undermine presumptions (mine?) that emotionally or psychologically traumatic events will require support in an emotional sense? Is there a lack of concern for non-physical injury, or just a disregard for its occurrence? Must keep this in mind during future interviews.</p>
P5 21.02.20	<p>P5 is the most senior participant so far, a Consultant medic. I was conscious that I might end up deferring to his agenda because of his senior role and letting him steer the interview. Did I? I don't think so – he shared the view near the end that the lack of organisational support for him flowed from potentially racist attitudes among senior management. I had already heard another interview from a person of a completely different ethnic origin who had had a similar experience to his, but of course I couldn't mention that to him. I made the decision not to extend the interview (already well over an hour) to start exploring specific issues of race and racism. Should I have? I don't believe so. This could be a topic for future research, eg does the professional's racial origin impact the support given, or the perception of support?</p>

<p>P11 23.04.20</p>	<p>This interview has brought back the thoughts about how far off the topic I allow interviewees to stray. This participant wanted to share extensive views and information about past experiences of workplace bullying, unrelated to adverse or near miss events and going well beyond the scope of the project. I realised I needed to steer this participant back onto the research topic several times. It felt like a careful balancing act to allow P11 to share her contributions in an autonomous way, while keeping the discussion largely focused on the topic of support for healthcare staff after adverse or near miss events. So in practice I had to maintain boundaries to avoid moving substantially outside the topic under investigation. Bit of a tightrope to walk.</p>
<p>P12 25.04.20</p>	<p>This interviewee thought that excuses were sometimes made for not being supportive to certain colleagues, because of their race and their likelihood to socialise with colleagues and be part of peer/friendship groups eg going for a drink. They might not be perceived by colleagues to fit in with the organisational culture. She had not experienced this herself as a white female, but had witnessed it among colleagues and team members. This recalls P5's comments about treatment or support being different for colleagues of different ethnicities, although his point was less about not fitting in socially, and more about being regarded as lesser in hierarchy terms, and somehow being an easier target for blame as a result, when things went wrong. This is clearly an important suggestion that two participants have made independently. However, several white interviewees also described the same kind of unsupportive handling by organisations. So I've decided it's not appropriate to make this a new central factor for this project, although these views will need to be included in the findings, and this may be an area to suggest for future research: being perceived to fit in and belong (in terms of ethnicity, behaviours, social groups?) leading to better support? It supports the idea that a formal system triggering automatic offer of support is needed: giving less leeway for discretionary and potentially judgemental approaches by managers and colleagues.</p>

Appendix D: Letters of Ethical Approval

Please double-click on the PDF document icon below:



Appendix D Approvals.pdf

Appendix E: Participant Information Sheet



Participant Information Sheet

Title of Study:

Healthcare personnel as second victims of adverse medical events

For further information about how Lancaster University processes personal data for research purposes and your data rights please visit our webpage:
www.lancaster.ac.uk/research/data-protection

My name is Anna Godwin and I am conducting this research as a PhD student at Lancaster University, Lancaster, United Kingdom.

What is the study about?

The purpose of this study is to identify the policies, protocols and practices that are in place to support healthcare personnel who are involved in adverse patient events or near misses.

Why have I been approached?

You have been approached because the study seeks the views and experiences of healthcare staff who have policy, management or supervisory responsibility, and who may have knowledge of policies, protocols, practices or guidelines used to support healthcare professionals who experience adverse clinical events at work.

Do I have to take part?

No. It's completely up to you to decide whether or not you take part.

What will I be asked to do if I take part?

If you decide you would like to take part, you would be asked to participate in a one to one interview of about one hour, exploring your knowledge and experience in this area.

Will my data be identifiable?

The information you provide will not be identifiable to you. It will be recorded but the transcripts will be anonymised. The data collected for this study will be stored securely, and only the researcher conducting this study and the research supervisors will have access to this data:

- In accordance with safe working practices, a safety checker will be informed of the interview time and location but will not have any access to the interview data.
- Interview recordings will be destroyed and/or deleted once the data has been analysed.
- The files on the computer will be encrypted (that is no-one other than the research team will be able to access them) and the computer itself password protected. Anonymised transcripts of the interviews will be kept securely at the University for ten years. Only the research team will have access to these transcripts.
- Hard copies of consent forms will be kept in a locked cabinet.
- Hard copies of consent forms will be scanned and the hard copies destroyed via confidential waste. The electronic files will be saved on a password-protected University computer network for a maximum of three months beyond the end of the project. At the end of this period, they will be destroyed.
- The typed version of your interview will be made anonymous by removing any identifying information, including your name, and will then be available for the research supervisors to read. Anonymised direct quotations from your interview may be used in the reports or publications from the study, so your name will not be attached to them.
- All your personal data will be confidential and will be kept securely and separately from your interview responses.

There are some limits to confidentiality: if what is said in the interview makes me consider that you, or someone else, is at significant risk of harm, I may have to break confidentiality and will seek advice from the research team on possible courses of action. If possible, I will tell you if I need to do this.

Who is the data controller?

Lancaster University will be the data controller for any personal information collected as part of this study. Under the GDPR you have certain rights when personal data is collected about you. You have the right to access any personal data held about you, to object to the processing of your personal information, to rectify personal data if it is inaccurate, the right to have data about you erased and, depending on the circumstances, the right to data portability. Please be aware that many of these rights are not absolute and only apply in certain circumstances. If you would like to know more about your rights in relation to your personal data, please speak to the researcher on your particular study.

What will happen to the results?

The results will be summarised and reported in a PhD thesis, and will be submitted for publication in an academic or professional journal in the healthcare field.

Are there any risks?

There are no risks anticipated with participating in this study. However, if you experience any distress following participation you are encouraged to inform the researcher and contact the resources provided at the end of this sheet.

Are there any benefits to taking part?

Although you may find participating interesting, there are no direct benefits in taking part.

Who has reviewed the project?

This study has been reviewed and approved by the Faculty of Health and Medicine Research Ethics Committee at Lancaster University and the Health Research Authority.

Where can I obtain further information about the study if I need it?

If you have any questions about the study, please contact the main researcher: Anna Godwin (a.godwin@lancaster.ac.uk).

The research supervisors are: Dr Ian Fletcher (i.j.fletcher@lancaster.ac.uk); Dr Sabir Giga (s.giga@lancaster.ac.uk); Dr Liz Brewster (e.brewster@lancaster.ac.uk)

Complaints

If you wish to make a complaint or raise concerns about any aspect of this study and do not want to speak to the researcher, you can contact:

Professor Fiona Lobban
Research Director
Division of Health Research
Faculty of Health and Medicine
Furness College
Lancaster University
Lancaster
LA1 4YG

Tel: +44 (0)1524 593752
Email: f.lobban@lancaster.ac.uk

If you wish to speak to someone outside the Division of Health Research, you may also contact:

Professor Roger Pickup
Associate Dean for Research
Faculty of Health and Medicine
Division of Biomedical and Life Sciences
Lancaster University
Lancaster
LA1 4YG

Tel: +44 (0)1524 593746
Email: r.pickup@lancaster.ac.uk

Thank you for taking the time to read this information sheet. Please note the resources signposted below.

Resources in the event of distress

Should you feel distressed either as a result of taking part, or in the future, the following resources may be of assistance:

GP consultation; self-referral to a counselling service either via your GP or privately; contacting a crisis helpline such as Mind Infoline: 0300 123 3393

Appendix F: Consent Form



Consent Form

Study Title: Healthcare personnel as second victims of adverse medical events

We are asking if you would like to take part in a research project. This research aims to identify the policies, protocols and practices that are in place to support healthcare personnel who are involved in adverse patient events, which can include unanticipated medical error, injury or other unintended harm happening or nearly happening to their patients.

Before you consent to participating in the study, we ask that you read the participant information sheet and mark each box below with your initials if you agree. If you have any questions or queries before signing the consent form, please contact the principal researcher: Anna Godwin (a.godwin@lancaster.ac.uk).

Please initial each statement:

1. I confirm that I have read the Participant Information Sheet (Version No: 1.8 Date: 06/11/2019) and fully understand what is expected of me within this study.
2. I confirm that I have had the opportunity to ask any questions and to have them answered.
3. I understand that my interview will be audio recorded and then made into an anonymised written transcript.
4. I understand that audio recordings will be kept until the research project has been examined or published.
5. I understand that my participation is voluntary and that I am free to withdraw within two weeks of this interview, without giving any reason, and without my legal rights being affected in any way, and without my relationship with the organisation I am affiliated to being affected in any way.
6. I understand that once my data have been anonymised and incorporated into themes it might not be possible for it to be withdrawn, though every attempt will be made to extract my data, on request, up to the point of publication.
7. I understand that the information from my interview will be pooled with other participants' responses, anonymised, and may be published.

8. I consent to information and quotations from my interview being used in reports and conferences.
9. I understand that the researcher will discuss data with her supervisors as needed.
10. I understand that any information I give will remain strictly anonymous and non-identifiable, unless it is thought that there is a risk of harm to myself or others, in which case the principal investigator will need to share this information with her research supervisors.
11. I consent to Lancaster University keeping written transcriptions of the interview for 10 years after the study has finished.
12. I consent to take part in the above study.

Name of Participant _____ **Signature** _____
Date _____

Name of Researcher Anna Godwin **Signature** _____
Date _____

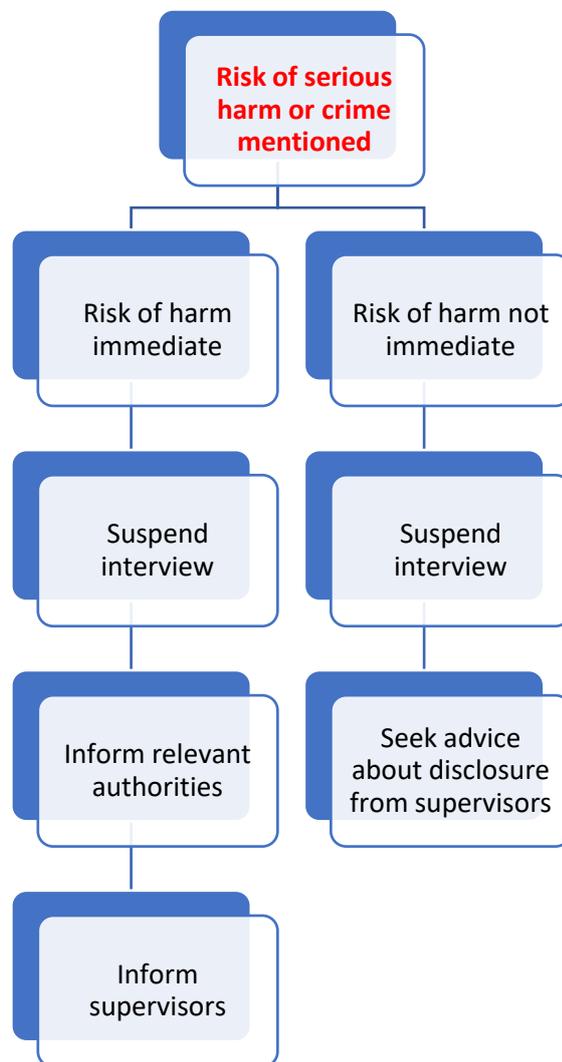
Version 1.8 06/11/2019 1 copy for participants, 1 copy for researchers

IRAS Project ID 265927

Appendix G: Breaking Confidentiality Protocol

Breaking Confidentiality Protocol

The information provided in the research interviews will remain strictly anonymous and non-identifiable, unless it is thought that there is a risk of serious harm to the participant or another person, and where disclosing the information may be necessary to prevent a serious crime or serious harm (including terrorist activity, money laundering, violence, physical harm, or serious mental distress). In this case, the following protocol will be employed:



Appendix H: Advisory Distress Protocol

Advisory Distress Protocol (Research Participants)

Protocol for managing participant distress in the context of a research interview



Advisory Distress Protocol (Researcher)

Protocol for managing researcher distress in the context of a research interview



Appendix I: Debrief Sheet



Debrief Sheet

Title of Study:

Healthcare personnel as second victims of adverse medical events

Thank you very much for taking part in my research. The data you have contributed will help me to complete my thesis, which aims to identify the policies and protocols that underpin support for healthcare personnel who are involved in adverse patient events (including unanticipated medical error, injury or other unintended harm happening or nearly happening to their patients), and explore ways of minimising the negative consequences to healthcare personnel.

What happens now?

A transcript of our interview will be typed up in the weeks following our meeting. In the two weeks following interview, you may still choose to withdraw from the study if you no longer wish your data to be used. If this is the case, please contact me via email (details below). After this two-week period, the transcript will be analysed and collated together with other interview transcripts, and I will be unable to extract and delete your individual data.

If you would like a lay summary of the results, I would be happy to send this to you upon completion of the study. Please let me know if you do require this summary so I can make a note and ensure that I send it to you.

What if I need to speak with someone following the interview?

I hope you found the interview to be a positive and interesting experience. If, however, the experience has brought up difficult feelings, or left you feeling distressed, I would encourage you to contact one of the services listed below:

Your GP; self-referral to a counselling service either via your GP or privately; a crisis helpline such as Mind Infoline: 0300 123 3393.

Finally, if you have any further questions, or would like an update on the research, please feel free to contact me using the details provided below:

Anna Godwin
Email: a.godwin@lancaster.ac.uk

Thank you again for taking part; your input was invaluable.

Appendix J: Development of themes

Examples of codes →	Sub-themes →	Themes
Dealing with horrific events Relentless emotional load Traumatic experiences Anxiety Frightened Guilt Distress Completely isolated Vulnerable Not feeling safe Organisation causing stress Staff suicides	1. Emotional and psychological impact	1. Severe and enduring impacts (Sub-themes 1-3)
Suspended Taken off duties Fear for reputation Harm to career Afraid of losing job Afraid of losing career Afraid to be off sick	2. Professional impact	
Stays with you for years Takes years to process the impact Never get over it	3. Duration of impact	

Appendix J (continued)

Examples of codes →	Sub-themes →	Themes
<p>Policies are there to protect the Trust No guidelines No policy Managers' ad hoc decisions No policy set in stone Grey areas Nobody answerable Hundreds of policies to remember for patients Searching for a policy Expired policies Triggering the sickness policy: risking the sack Withdrawing vicarious liability Feelings not articulated in policy One-sided psychological contracts</p>	<p>4. One-way street</p>	<p>2. Absence of policies (Sub-themes 4-6)</p>
<p>Looking for policies Sure there would be a policy Surprised there was no policy Assuming approaches are based on national guidelines No knowledge of specific policies for support Fatal and public incidents assumed to impact more Individual patient incidents assumed not to impact Near misses assumed not to impact No policy about near miss incidents</p>	<p>5. Assumptions</p>	
<p>Debriefs ad hoc High-level statements Lived experience mismatch Sounding supportive Not being supportive</p>	<p>6. Gap between policy and practice</p>	

Appendix J (continued)

Examples of codes →	Sub-themes →	Themes
Ad hoc processes Treating staff differently No support Support not laid out in policy Ad hoc approach to debriefs Managers' inclinations Support informal and unofficial No specified support contact Postcode lottery	7. Inconsistency	3. No certainty of support (Sub-themes 7-11)
Managers making assumptions about character Fitting in Deserving support Empathy discretionary Lack of sympathy No contact with support network Support from close colleagues Lack of trust in management Depends on manager's engagement Lack of understanding about cultural differences Ethnic minority staff cannot be themselves Distress shown in different ways Adhere to the culture of the environment, or get out Either on the inside or the outside Cliques More blame attached to certain staff	8. Relationships and belonging	

Appendix J (continued)

Examples of codes →	Sub-themes →	Themes
<p>No time to recover No time to access support Finishing the shift Carrying on No space for conversations No leeway Fixed term counselling Limited annual entitlement EAP counsellors lack expertise Assessments in place of support Struggling for resources Supervision is expensive Support is a good investment No time to offer psychological support Resources are slim Priorities</p>	<p>9. Resources</p>	
<p>No training No-one truly knew what they were doing Lip service to support Thrown into managerial roles No managerial experience or knowledge System lets managers down Managers do not understand function of TRiM Inappropriate signposting Managers ticking boxes</p>	<p>10. Management training</p>	

Appendix J (continued)

Examples of codes →	Sub-themes →	Themes
Mental health nurses redeployed to physical healthcare Not staff fault No blame Awareness of need Support staff to stay at work Not about PSI Comfy sofas and incense Short-term support Uncertainty about long-term	11. Impact of COVID-19 on support agenda	
Activities in own time Self-care Responsibility to foster own wellbeing Invest in yourself Healthy eating CQUIN Half-hearted and tokenistic efforts No-one checking wellbeing Not integral Staff wellbeing a low priority	12. Wellbeing	4. Language undermines support (Sub-themes 12-16)
Expected to cope Expected to be strong Vulnerability is a sign of weakness, a failing Overuse of term ‘resilience’ Resilience means able to put up with challenging situations Vulnerable staff are picked on Patients have more rights	13. Resilience	

Appendix J (continued)

Examples of codes →	Sub-themes →	Themes
Meaning of support Checking processes followed Retraining skills Clinical advice	14. Support to learn	
Mainly physical connotations Refers to patients Physical impacts prioritised over psychological No parity of esteem Stigma and low kudos in mental health work Undervaluing of mental health	15. Trauma	
Playing the victim A term validates what you are going through A term is helpful “Second victim” is appropriate Risk of pigeon-holing Making assumptions about ability “Second victim” is positive Reflects experiences and feelings Mixed views about the term Secondary survivors	16. Naming the impact	

Appendix K: UK Reports: Support for Healthcare Staff After Adverse Medical Events (chronological order)

Organisation, Document Title, Date	Report extracts about support for healthcare staff after adverse medical events
<p>Organisation: Confidential Enquiry into Maternal and Child Health (CEMACH)</p> <p>Title and Date: Why Mothers Die 2000–2002. The Sixth Report of the Confidential Enquiries into Maternal Deaths in the United Kingdom (2004)</p>	<p>An unexpected maternal death is devastating for the staff who cared for her. Some staff, doctors and midwives appeared to blame themselves inappropriately when a mother for whom they had been caring died. These staff appeared to have been left to shoulder the guilt they felt alone and were not offered counselling or support. A few left their profession as a result (p.23)</p> <p>Trusts must make provision for the prompt offer of support and/or counselling for all staff who have cared for a woman who has died, individually and as the whole team who cared for the mother (p.23)</p> <p>Supportive counselling of anaesthetic personnel involved in a maternal death is essential. It should be remembered that such an event represents a tragedy not only for the mother’s family but also for the anaesthetist involved who commonly assumes full responsibility for the death (p.54)</p> <p>It is very distressing for staff to have to watch a woman bleed to death while refusing effective treatment. Support must be promptly available for staff in these circumstances (p.95)</p> <p>The need for proper support for the anaesthetist(s) involved in a maternal death is vital although the best source of support will vary between individuals (p.126)</p> <p>Counselling or debriefing for midwives and other health professionals in these situations [where women patients commit suicide] should be available if required (p.256)</p>
<p>Organisation: Royal College of Nursing</p> <p>Title and Date: Counselling for staff in health service settings (2006)</p>	<p>The RCN has recognised the value of counselling in healthcare settings, providing a counselling service to RCN members for more than 20 years (p.3)</p> <p>Many staff wait too long before accessing help and the availability of immediate psychological support can reduce distress, helping the individual maintain their role at work (p.7)</p> <p>While only a small proportion of staff exposed to critical incidents develop PTSD, support following a traumatic incident at work should be available to all staff (p.10)</p>

Appendix K (continued)

Organisation, Document Title, Date	Report extracts about support for healthcare staff after adverse medical events
<p>Organisation: National Advisory Group on the Safety of Patients in England</p> <p>Title and Date: A Promise to Learn – A Commitment to Act. Improving the Safety of Patients in England (2013)</p>	<p>Because human error is normal and, by definition, is unintended, well-intentioned people who make errors or are involved in systems that have failed around them need to be supported, not punished (p.12) Leaders and managers should actively support staff by excellent human resource practices, promoting staff health and wellbeing, cultivating a positive organisational climate, involving staff in decision-making and innovation, providing staff with helpful feedback and recognising good performance, addressing systems problems, and making sure staff feel safe, supported, respected and valued at work (p.22)</p>
<p>Organisation: NHS England</p> <p>Title and Date: Serious Incident Framework: Supporting learning to prevent recurrence (2015)</p>	<p>It is important to recognise that serious incidents can have a significant impact on staff who were involved or who may have witnessed the incident. Staff involved in the investigation process should have the opportunity to access professional advice from their relevant professional body or union, staff counselling services and occupational health services. They should also be provided with information about the stages of the investigation and how they will be expected to contribute to the process (p.39) The final report should include a description of the support provided to staff following the incident (p.42)</p>
<p>Organisation: Royal College of Physicians</p> <p>Title and Date: Work and wellbeing in the NHS: Why staff health matters to patient care (2015)</p>	<p>Doctors can also experience psychological stress when their patients suffer adverse events, such as clinical mistakes that cause actual or potential harm... [It is] particularly important for employers to support healthcare professionals to manage the psychological and emotional impact of adverse clinical incidents, yet a significant majority of physicians (67%) report that healthcare organisations do not offer adequate support to deal with the stress associated with an adverse event. At least 24 doctors committed suicide while under fitness-to-practise investigations between 2005 and 2013 (p.5) While 92% of NHS Trusts in England offer staff some form of access to psychological therapies, only 57% have an organisational plan or policy to support the mental wellbeing of their staff (p.6) Tailored support must be available to help clinicians manage psychological stress following adverse clinical incidents and during fitness-to-practise investigations (p.10)</p>

Appendix K (continued)

Organisation, Document Title, Date	Report extracts about support for healthcare staff after adverse medical events
<p>Organisation: Care Quality Commission</p> <p>Title and Date: Briefing: Learning from serious incidents in NHS acute hospitals A review of the quality of investigation reports (2016)</p>	<p>When an incident has serious consequences for a patient and their family it can also have a profound effect on the staff involved and the teams in which they work. While it is clearly a priority to manage the immediate needs of the patient and their family, it is also important to support members of staff who may be affected by the incident (p.3)</p> <p>The majority of the investigation reports in our sample (58 reports) included a section which stated that staff had been supported after the serious incident was identified. However, in many cases Trusts used a standard phrase that was repeated in each report that we reviewed, irrespective of the impact on the individual member of staff involved (p.3)</p>
<p>Organisation: Royal College of Midwives</p> <p>Title and Date: Work, Health and Emotional Lives of Midwives in the United Kingdom: The UK WHELM Study (2017)</p>	<p>Midwives... may experience vicarious secondary trauma when caring for women who experience adverse situations such as pregnancy complications and loss of their baby (p.7)</p> <p>Fears about being sued or caught up in litigation cases were thought to be well founded, with midwives describing a failure of the system and their management to support them in adverse clinical situations (p.20)</p> <p><i>Participant quotation:</i> When something goes wrong, which inevitably will always happen, as sadly not every pregnancy ends well, however good the care, midwives are treated appallingly; it is shocking and devastating to observe good hard-working midwives torn apart by the absolutely disgusting way that incidents are dealt with... Trusts persecute individual midwives in order to cover their own back as far as litigation. There is never any support; it is a truly horrific witch-hunt (p.21)</p> <p><i>Participant quotation:</i> Constant fear of blame culture (p.24)</p> <p>Whatever was introduced to support their emotional wellbeing, there needed to be an assurance that they would be given protected time to attend (p.27)</p> <p><i>Participant quotation:</i> Isolation for those that make a mistake. Far too punitive (p.27)</p> <p>When participants described anxieties about possible litigation, they indicated that the managers often could not be relied on for support: They haven't got our backs (p.30)</p> <p>[Managers were perceived by midwives to be] over-focused on meeting organisational demands at the expense of ensuring the emotional wellbeing of the workforce (p.30)</p>

Appendix K (continued)

Organisation, Document Title, Date	Report extracts about support for healthcare staff after adverse medical events
<p>Organisation: NHS</p> <p>Title and Date: Workforce Health and Wellbeing Framework (2018)</p>	<p>Priority should be given to addressing any immediate risks to staff health and wellbeing (p.29) Risks to the mental health of staff are identified and managed, for example having an effective procedure in place to support staff following a traumatic incident (p.47) <i>A best practice example</i> (West Midlands Ambulance Trust): After a traumatic situation staff go through a Critical Incident Debrief. These are tailored to the needs of the individuals following an incident. They aim to address the trauma by defusing the situation, debriefing, and following up (p.48)</p>
<p>Organisation: NHS Health Education England</p> <p>Title and Date: NHS Staff and Learners' Mental Wellbeing Commission (2019)</p>	<p><i>A case study of Mersey Care NHS Foundation Trust:</i> Mersey Care recognises that in an untoward incident, caregivers can be victims too ... They have introduced support for staff in difficult circumstances, especially those involved in adverse incidents, to create a wrap-around of compassion and care. Mersey Care estimate a total saving of between £1 million and £2.5 million based on the combination of the reductions in absenteeism, staff turnover and legal and termination costs (p.59) <i>Report recommendations:</i> For staff that experience the emotional or psychological impact of a specific clinical incident, organisations should ensure access to debriefing and support in timely and confidential fashion (p.83) NHS service managers should develop incident protocols for when staff are placed in a situation that would disproportionately impact on their wellbeing (p.84)</p>
<p>Organisation: General Medical Council</p> <p>Title and Date: Caring for doctors Caring for patients (2019)</p>	<p><i>A case study from one NHS Trust of interventions to support staff mental health:</i> Development of the Critical Incident Stress Management service (CISM). This is a coordinated response to support staff following a distressing incident, offering debrief sessions to support staff with the after-effects, their stress reaction and levels of resilience (p.126) <i>A case study of a peer support programme for consultants and doctors:</i> Trained peer supporters offer support to colleagues who struggle from the emotional impact of an adverse event or a difficult professional or personal experience. Peer support is not therapy but offers temporary social support as empathic and non-judgemental listening from a colleague in a safe space (p.127)</p>

Appendix K (continued)

Organisation, Document Title, Date	Report extracts about support for healthcare staff after adverse medical events
<p>Organisation: Intensive Care Society The Faculty of Intensive Care Medicine</p> <p>Title and Date: Guidelines for the Provision of Intensive Care Services (2019)</p>	<p>Intensive care staff are particularly vulnerable to work-related stress (p.103) All staff members should have access to an independent, professional psychological support service, which provides counselling services (p.103)</p>
<p>Organisation: NHS England and NHS Improvement</p> <p>Title and Date: The NHS Patient Safety Strategy (2019)</p>	<p>Fear is too prevalent across NHS staff, particularly in relation to involvement in patient safety incidents (p.7) To work at our best, adapting as the environment requires, we need to feel supported within a compassionate and inclusive environment. Psychological safety operates at the level of the group not the individual, with each individual knowing they will be treated fairly and compassionately by the group if things go wrong (p.8) We must also recognise the importance of staff wellbeing for patient safety (p.12) The new Patient Safety Response Framework sets expectations for informing, involving and supporting patients, families, carers and staff affected by patient safety incidents (p.23) <i>Consultation comments:</i> Merely minimising the numbers of adverse events... can result in more second victims in the form of staff (Annex I, p.47) Some respondents felt the strategy... needed to consider the safety of staff rather than be limited to only the safety of patients. This was felt to actually support patient safety as well. This theme also linked to the need to support staff in the aftermath of incidents (p.50) Staff need to have their welfare put at the centre of what happens to them as much as patients and supporters do, especially after a serious adverse incident (p.50)</p>

Appendix K (continued)

Organisation, Document Title, Date	Report extracts about support for healthcare staff after adverse medical events
<p>Organisation: The National Workforce Skills Development Unit (commissioned by Health Education England)</p> <p>Title and Date: Workforce stress and the supportive organisation: The importance of staff wellbeing (2019)</p>	<p>It is important to acknowledge that the nature of the work done by any caring profession can be challenging to psychological wellbeing (p.4)</p> <p>The organisation has a substantial role to play in supporting the workforce to undertake what is an inherently psychologically demanding role (p.4)</p> <p>An organisation should maintain a culture and operate in such a way that the need for personal resilience is minimised (p.8)</p> <p>[Workplace mental health] interventions can be used at an individual staff level to address coping mechanisms. Many of these interventions sit within the psychological safety pillar, but the behaviours, attitudes and beliefs of an organisation are essential to ensure access and availability to these interventions (p.45)</p>
<p>Organisation: NHS Clinical Leaders Network</p> <p>Title and Date: Enhancing mental health resilience and anticipating treatment provision of mental health conditions for frontline healthcare workers involved in caring for patients during the COVID-19 Pandemic – A call for action (2020)</p>	<p>Research of effects on mental health from pandemics show that clinical staff, if not adequately supported, are at higher risk of experiencing moral injury and developing mental health conditions such as depression, anxiety and PTSD (p.2)</p> <p>Greater co-ordination is needed to identify mental health needs, wellbeing needs of healthcare staff, and the required help and support for this is urgently provided (p.2)</p> <p>Senior Trust board leadership and sponsorship to galvanise resources to support mental health and psychological wellbeing of healthcare staff (p.4)</p> <p>Develop an organisational strategy to deal with mental health and psychological consequences for staff affected by this pandemic now and for the later mental health consequences post pandemic (p.4)</p> <p>Support the forming of peer support structures like Huddles, Psychological First Aid, Mental Health First Aid, Trauma Risk Management, Employee Assistance Programmes and Schwartz Rounds (p.4)</p>

Appendix K (continued)

Organisation, Document Title, Date	Report extracts about support for healthcare staff after adverse medical events
<p>Organisation: Royal College of Psychiatrists</p> <p>Title and Date: “Going for Growth” An outline NHS staff recovery plan post-COVID-19 (2020)</p>	<p>There is good evidence from scientifically conducted reviews that the most predictive risk factors for the onset of post traumatic mental ill-health are those which operate after the traumatic incident is over. These main post-incident factors are: a) access to effective social support and b) the pressure that people experience as they try to recover (p.1)</p> <p>The unwritten psychological contract between NHS staff, their managers, and the public, has been that staff members will give their all to save lives, and in return the nation will give them the support and time they need to be able to recover (p.1)</p>
<p>Organisation: NHS England, NHS Improvement, Health Education England</p> <p>Title and Date: We are the NHS: People Plan for 2020/2021 - Action for us all (2020)</p>	<p>This plan focuses on looking after our people particularly the actions we must all take to keep our people safe, healthy, and well - both physically and psychologically (p.6)</p> <p>Changes that have emerged through the COVID-19 response so far: there has been a greater focus on the health and wellbeing of our colleagues, with support offered in teams and organisations. This includes psychological support, Schwartz Rounds, and workplace wobble rooms (p.9)</p> <p>Leaders, teams, and employers must keep offering people support to stay well at work, and keep offering it consistently, across teams, organisations, and sectors (p.14)</p> <p>The COVID-19 response by NHS England and NHS Improvement includes a dedicated health and care staff support service, including confidential support via phone and text messages (p.15)</p> <p>REACT mental health conversation training was also provided to enable managers to support staff through compassionate, caring conversations about mental health and emotional wellbeing (p.16)</p> <p>As a good employer, it is our moral imperative to make sure our people have the practical and emotional support they need to do their jobs. Each of us must build on the support given during the COVID-19 response and make sure it continues (p.17)</p> <p>NHS organisations should have a wellbeing guardian... to look at the organisation’s activities from a health and wellbeing perspective (p.17)</p> <p>Employers should make sure that staff have safe rest spaces to manage and process the physical and psychological demands of the work, on their own or with colleagues. Employers should ensure that all their people have access to psychological support (p.18)</p>

Appendix K (continued)

Organisation, Document Title, Date	Report extracts about support for healthcare staff after adverse medical events
<p>Organisation: NHS</p> <p>Title and Date: Patient Safety Incident Response Framework 2020: An introductory framework for implementation by nationally appointed early adopters (2020)</p>	<p>Staff should never be automatically suspended or their duties restricted or changed unless that is required to support their wellbeing, or to protect patients, irrespective of whether they have been involved in other patient safety incidents (p.19)</p> <p>Ensure staff are not unfairly exposed to punitive disciplinary action (p.22)</p> <p>Ensure recommendations made following analysis of patient safety incidents do not inappropriately focus on training and self-reflection for individuals (p.22)</p> <p>Those affected should be able to say: we were treated with respect; we were supported appropriately (p.34)</p> <p>Organisations must “never lose sight of the staff at the sharp end of the error” and plan accordingly (p.36)</p> <p>For staff to be appropriately supported, all organisations must have systems and structures that ensure managers and wider staff ... understand the potential impact of patient safety incidents on staff, can recognise and help to manage the signs and symptoms of stress (including those associated with post-traumatic stress disorder) in themselves and colleagues, and have access to support (pp.36-37)</p> <p>Organisations must establish procedures to identify all staff who may have been affected by a patient safety incident and to provide access to the support they need. In some cases, line managers and peers can provide enough support, but in complex cases (often where moderate or more severe harm has occurred) an appropriate named contact may need to be appointed (p.37)</p> <p>Staff should be supported throughout the PSII process because they too may have been traumatised by their involvement (p.65)</p> <p>While patients and families will always be the first priority following safety incidents, the wellbeing of staff involved is often overlooked but can leave staff lacking confidence, unable to perform their job, requiring time off or leaving their profession. There is existing evidence on the importance and effectiveness of support programmes for such staff and their potential to counter the negative impact outlined above to result in more positive impact for staff and patients alike (p.78)</p> <p>Managers and others can use the ASSIST ME model (produced by the Irish Health Service Executive) to guide appropriate conversations and to develop the necessary procedures to support staff following their involvement in patient safety incidents (p.79)</p>

Appendix L: Coded Transcript Extracts

Initial coding	Transcript Extract 1 (P1)	Initial reactions and comments
<p>Upset Anger Shocked Expecting support</p> <p>Brushed off by organisation Duty of care to staff</p> <p>No policy followed No guidance</p> <p>Fear culture</p> <p>Vicarious liability in theory</p> <p>Form of organisational support</p>	<p>P: I was upset; I was shocked. I felt very much: how dare you do this to us, when we are here for support. I then went to the managers myself and said to them: you cannot do this to us; you cannot treat us this way. You are saying we have a duty of care to patients. You have a duty of care to us, as your employees. It was brushed off. So when the RCA was started again and the interviews all commenced, the Unions by now were very heavily involved. But again, there was no policy followed; there was no guidance; nobody had ever been part of an actual face to face interview at the Trust, for an RCA. As I say they introduced a new system, which is a very good system, but they introduced it at a time they had already created a fear culture, and they would never get anywhere. By this point, I was really struggling mentally, really struggling.</p> <p>...</p> <p>P: Yeah, it's always happened that — so as a practitioner you have vicarious liability, which means when you are employed, that employer is saying they have gone through the interview process with you; they've seen your qualifications, and you are safe to practise under their insurance.</p>	<p>Mixture of emotions. No fear reported at this point, more anger.</p> <p>Objecting to treatment by managers. Referencing duty of care to patients and stating staff should receive the same: how would organisations say they enacted this duty? To keep staff physically safe? Is there any acceptance of a duty to care for psychological and emotional health?</p> <p>No system for investigations or support. Systems don't work if they are developed within a fear culture: need for trust between staff and organisation? How is this developed/ sustained? Emotional impacts from the patient outcome and from the handling and professional consequences.</p> <p>Vicarious liability sounds like a professional back up that staff would expect if things went wrong in care but there had been no intended harm.</p>

<p>Organisation decision not to support</p> <p>Theoretical support removed Withdrawing vicarious liability</p> <p>No formal communication No policy or process</p> <p>Discretionary decisions</p> <p>No contact from managers Months of silence Completely isolated</p> <p>No permitted access to colleagues</p> <p>Very isolated Lone individual Struggling with the incident</p>	<p>I: Yes.</p> <p>P: Okay, so because I was undergoing a Trust investigation, the Trust decided not to support me, and said: because we are investigating her practice, we are not going to represent her, because if we find anything wrong with this practice, we cannot defend her in a court of law. So they withdrew the vicarious liability. Again, no HR were involved. I received no formal letter. This was all done, all of this was done through telephone conversations, through Union representatives. There was no policy or process followed; the managers made a decision about what they were going to do, told me what they were going to do, and that was that. There were times where I didn't hear from a single manager. I was sat at home for four, five months, didn't hear from HR. I was completely isolated from the Trust, because once you are suspended, you cannot go on to Trust grounds; you cannot access your work email, and you cannot speak to your colleagues.</p> <p>I: Gosh, so it's very isolating then?</p> <p>P: Very isolated, very, very isolated. On my own. A lone individual. So I basically had gone through the loss of this lady that I was really struggling with — and this is other midwives, not just myself; the Trust had put</p>	<p>This decision to withdraw VL sounds defensive and a way of blaming the staff member?</p> <p>Ad hoc decision, ad hoc process: nothing for staff to challenge with or question. No framework to fall back on.</p> <p>Being left to fend for herself: sounds quite cruel. No empathy. She can't get in touch, so onus on managers to maintain contact? She is obeying their requirements. One-sided? Sounds neglectful, dismissive.</p> <p>I feel shocked by what she says and her distressed tone. This is four years on. Feelings still very strong.</p>
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<p>Putting staff through investigations Layers of processes</p> <p>No support</p> <p>Not allowed to contact colleagues</p> <p>Lost everything Mental breakdown</p> <p>Triggering the sickness policy</p> <p>Could be fired Policies used against staff No policy set in stone</p> <p>Doing whatever they wanted Policies expired Policies unclear Policies not robust Policies not black and white Policy grey areas Managers interpreted policies to suit A mess Careers ruined by managers Using policies against staff Policies not supportive of staff No policies to defend staff Shooting down staff use of policy</p>	<p>me through an investigation; they'd referred me for an investigation; the RCA investigation was ongoing; I had no support; they didn't refer me to Occupational Health; I had to self-refer for counselling, despite asking; they withdrew the vicarious liability and I could not contact anybody. So it was very isolating, and I literally lost everything; I had a mental breakdown. And the amount of sickness that I've had — that's the other side, because I've been off sick for so long, or so in periods, I've now triggered in the sickness policy, so that if I'm off sick again, I'm at a point I could be fired. So they have used the policies against us, the sickness policy; the fact that there's no policy that was set in stone for a process that you should follow, they've been able to do whatever they've wanted to us but now, how can I explain? It's hard to explain. Because the policies that were in place were either expired or not robust or not, they were not clear in black and white; there were too many grey areas in them that left them open for managers to interpret them as they wanted; it's made such a mess that the managers have been able to do whatever they want and ruin people's careers; but yet when you try to throw a policy back, it didn't work. So they were using the policies against us, but when we tried to use the policies to defend ourselves, it was just shot down.</p>	<p>Layers of processes to endure and yet no clarity about these processes, timeframes.</p> <p>Expectation of staff seeking support for themselves. But requests for support ignored: because of the investigation? Or for any specific reasons?</p> <p>Emotional consequences, personal family consequences, combined with professional consequences: Being off sick to cope and yet this brings its own negative consequences. Even now that the case against her has been dropped and no sanctions. This is still a risk to her career. Sounds adversarial: policies used against staff in a discretionary way with no comeback possible.</p> <p>No policies available for staff to use to 'fight' back. Power imbalance. No level playing field. One-way street. 'Shot down' sounds like warfare. Dismissed. Sense of unfairness, rejection.</p>
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<p>'Victim' word challenging</p> <p>No empathy Managers making it worse Stop playing the victim</p> <p>Victim of the Trust and managers</p> <p>Not a victim of the incident</p> <p>Victim of the NHS</p>	<p>...</p> <p>I: So it's not used. So is there a phrase that is used for staff in that situation?</p> <p>P: I think the word victim for me is very challenging, because throughout this investigation, when I was having a breakdown, and I sat, as a grown woman, I sat sobbing in my manager's office, saying: you're not understanding how this is affecting me; you are not understanding how what you are doing is making it worse. I was literally told to stop playing the victim.</p> <p>I: So it's in a way, a loaded term?</p> <p>P: Yeah, very much so.</p> <p>I: So is there something that you think would be preferable, that would still convey the suffering of staff or distress, but that wouldn't have perhaps those more challenging connotations?</p> <p>P: It's really hard, because in a way, I do individually feel like a victim of what the managers and the Trust have put me through. I don't feel like a victim because I was exposed to or experienced an adverse event. I feel like a victim of the NHS, and the structure and the policies and the politics. So it's really hard,</p>	<p>Vulnerability clearly conveyed to her managers but no empathy in return. Another one-way street? Expectation of no emotion? Or that emotion is self-serving and not genuine? 'Playing the victim' is dismissive and harsh. Rejects any impact on the staff member.</p> <p>Conflicted feelings: yes a victim of the handling, but not of the event. Trained for challenging events. Experienced. But not expecting to be left high and dry at challenging times. Let down. Impersonal: NHS, the structure, the</p>
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<p>Victim of the structure Victim of the policies and the politics</p> <p>Coping with the incident Individual resilience</p> <p>Victim is emotive SV could be political Managers don't want to see staff as victims This is your job</p> <p>Staff are human</p> <p>Victim of poor behaviour Victim of lack of supportive policies Victim of policies not followed Victim of lack of correct process</p>	<p>because I feel like the — even if everything that happened with the Trust didn't happen, it's still losing that lady affected me in such a way mentally because it touched so close to home; I would have had time off work; I would have had sickness, but I feel like I would have coped. But I don't feel I would have coped because of the Trust; I feel I would have coped because that's me as an individual. So I think the term victim is very, it's very emotive, and I feel like it could become a very political term within the NHS, because I feel the managers don't want to see the staff as victims, because the mentality that I got was: you're not a victim; this is your job; this is what you are trained to do; you choose to do this. And that's right; yes that is right, 100%. I'm not a victim. I have put myself in that position. But I'm a human being, and there's only so much one person can accept. I feel like a victim of poor behaviour that has been allowed, of lack of policies that haven't supported staff, of lack of following policies that haven't supported staff, of lack of there being a correct process at that point that it all happened.</p>	<p>policies, the politics: a victim of the system. No structural back up.</p> <p>Staff have coping skills for incidents, but not for the added layer of poor management behaviour. Staff reliant on own skills and resources.</p> <p>Poor manager behaviour not only occurred but is allowed within the system. Not following policies equates to a further lack of support. No certainty in the process, no transparency. No framework for expectations staff can rely on.</p>
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Appendix L (continued)

Initial coding	Transcript Extract 2 (P5)	Initial reactions and comments
<p>Reputation damaged</p> <p>Efforts made to qualify</p> <p>Fear of losing everything</p> <p>Senior managers making fatal mistakes</p>	<p>P: No, my reputation is damaged. It has been, and as I said, this is about my reputation —. They have no idea of the effort that I put in to become a doctor, and how many nights I had to work, or how much effort I made, and my family and my dad and my mum. And I came to this country to improve myself, my position, and I could just — everything can just be lost, and my children, my wife, everything, because somebody has made the wrong decision. And these are not —, these are not stupid people. These are high up, senior management people, so they're not —. I don't care if somebody or my patient will say: you are stupid, because I'm fine, but these people they are above me...</p> <p>I: Yes.</p> <p>P: ... or they are making a decision; they shouldn't make these mistakes, and this is not a simple mistake. This is — it could have been a fatal mistake for my life, a fatal mistake.</p> <p>I: So what I'm hearing is, you were accused in a way, of either some mistake or lack of intervention...</p> <p>P: Yes.</p>	<p>Reputation is very important. Years of striving by an individual, dashed by managers.</p> <p>Risk of losing all that has been earned, gained, developed. Family resources are at risk. Sense of jeopardy and threat.</p> <p>Managers making the wrong decision – wrong for this P but not for them? Right for the organisation, to protect and defend and deflect responsibility?</p> <p>Potential for serious harm to P. 'Mistakes' of this kind – blaming someone found to be blameless - sound avoidable, but risk disaster for those implicated.</p>

<p>Different responses to clinicians</p> <p>Consultants are nothing</p> <p>Blaming staff</p> <p>Easy to blame ethnic minority staff</p> <p>Easy to label and target</p> <p>Ethnic minority staff not taken seriously</p>	<p>I: ... and actually the people in your view that have made the mistake are these senior people? They have made a big mistake, but nobody is responding to them in the same way?</p> <p>P: Yes, yes because I'm just a Consultant. I'm not a manager; I'm not the Chief Executive; I'm not the Clinical Director; I'm not the Head of Safety; I'm not a high up Legal Department Officer. So I'm nothing, and they are —. It's easy to find, it's easy — now I don't want to put it in a discrimination way, but it's easy to find somebody who has come to this country, not part of this country, okay, it's easy to blame. So I'm very easy to be labelled or targeted, whereas, if I was John Smith, probably, somebody would say: let's have him prove this, take it a bit more seriously. So I haven't been taken seriously, because I'm not John Smith, you know what I mean? I feel even this element of discrimination. I have felt it.</p> <p>I: Yes. So I'm hearing throughout this and in that aspect of your background as well, a sense of vulnerability, your livelihood at risk?</p> <p>P: Yes, yes.</p>	<p>No sanctions against the managers for making this mistake that could have cost P his job. High up managers sound protected (by the system?), no risk to their jobs or livelihoods.</p> <p>Hesitating to make accusations of discrimination, and yet feeling singled out by virtue of not having an English-sounding name.</p> <p>Being taken seriously does not depend on professional qualifications or experience but on fitting in, sounding/ being English?</p> <p>Feeling discriminated against: does this make it more likely to be singled out when things go wrong? Client has reported not having treated this patient, but pinpointed for an omission.</p>
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<p>Staff support the organisation Tiny part of the organisation Not counting Not valued</p> <p>Feeling desperate</p> <p>Not feeling protected</p> <p>Vulnerability Risk of false accusations</p> <p>Feeling extremely vulnerable</p>	<p>I: ... and that, to this point, hasn't really been taken into consideration?</p> <p>P: Yes. I'm for this organisation. I'm just a very tiny element. Now if I was John Smith or if I was Antony whatever, probably my element would be slightly bigger. Now this is just my — I'm starting to feel probably sometimes a bit desperate: why this? Is it because —? Why? I don't know, but obviously I don't feel protected and this word that you use, vulnerability, I use it because I said I can walk down the corridor, and somebody could shout out and say: oh this doctor looked at me in a bad way, and I feel —, because then obviously I won't have any kind of protection.</p> <p>I: So this incident, and really more the treatment after it, has made you feel more vulnerable on a longer term basis?</p> <p>P: Extremely.</p> <p>I: Is that correct?</p> <p>P: Extremely vulnerable, extremely vulnerable.</p>	<p>Positioning himself as supportive of the organisation. But not being supported in return, which he feels relates to his ethnicity.</p> <p>Not being able to understand why he has been singled out, and feeling the only explanation is ethnicity? Which leave him vulnerable to future accusations based not on facts. Sense of innocently going about his business and being accused of malintent, which the organisation will not protect him from.</p> <p>Feeling extremely vulnerable to future negative treatment by /lack of support from the organisation, because this is what he has experienced already</p>
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Appendix L (continued)

Initial coding	Transcript Extract 3 (P9)	Initial reactions and comments
<p>Policies are clinical or HR</p> <p>Driving a coach and horses through a policy</p> <p>Staff ignoring policy</p> <p>Staff not bothered</p> <p>Staff not checking</p> <p>HR disciplinary processes</p> <p>Retraining</p> <p>Written warning</p> <p>Regulatory referral</p> <p>Dismissal</p>	<p>I: And you've referred several times to policies, and I am understanding that correctly as the medical or clinical treatment policies?</p> <p>P: Yes, how you administer drugs, or how you manage particular bits of equipment, but I'm also talking about HR policies that go alongside that. So if somebody, like I said drove a coach and horses through this policy, totally ignored it, couldn't be bothered, didn't do the relevant checks, then you would be doing this investigation, and it could then trigger an HR process that could range from a written warning, first written warning with training and development, to a dismissal and a referral to the regulatory body.</p> <p>I: And if somebody hadn't driven a coach and horses through the policy and, as you say, there might have been a system issue...</p> <p>P: Yeah, yeah.</p> <p>I: ... how would it differ?</p> <p>P: Yes the investigation would be at the front end, and that would identify all of the factors. So I don't think anything is just</p>	<p>Principal understanding of the word policy is clinical SOPs or HR, which sounds here like disciplinary. All about what's required of staff or could be used to hold them to account.</p> <p>Interesting to start talking only about negative aspects: staff who are negligent, lazy, don't follow agreed processes. Why start there? Is that the main function of policy: to use against staff found wanting?</p> <p>HR processes: negative consequences and repercussions. No mention of supportive action.</p>

<p>Staff prone to flout policies Assumptions about individuals</p>	<p>unifactorial; it's always multifactorial. So there could be — so if somebody is prone to drive a coach and horses through things, and the system has holes in it, it would enable that more easily. And if somebody is genuinely sort of, what's the word, I suppose thoughtful and professional, but there are things that maybe allow a human error to occur. So we need to understand all of the elements, and fix all of them as best we can, and test it to make sure that it's as robust as it can be.</p>	<p>Reverting to the coach and horses idea. 'Careless' staff create chances for things to go wrong?</p> <p>Careful staff acknowledged: but still no mention of support. All about ensuring patient care is improved.</p>
<p>Thoughtful and professional staff</p>	<p>I: Thank you and are there policies — so this is a separate use of the word 'policy' — are there policies or schemes that you've known of to identify or support staff in these circumstances?</p>	<p>Possibility of being referred to OH and potential counselling: sounds a bit vague and uncertain.</p>
<p>Occupational Health support</p>	<p>P: Yes, I mean we have Occupational Health. So if you're working in practice, your employer will have an Occupational Health service, which, you know, you would offer that person: a referral to Occy Health, and a potential counselling sort of service. If somebody is a member of a Trade Union then I know, for example, the Royal College of Nursing has membership services where our members are able to access confidential counselling, a number of sessions, because, like I say, that emotional impact and mental health impact is huge. So we, I would be encouraging people to take those opportunities,</p>	<p>Fixed-term counselling from Trade Unions: depends on being a member, and on the counselling being offered meeting the need re duration and type. Recognition of the huge impact on staff emotionally.</p>
<p>Potential counselling</p>		
<p>Access to counselling via Union Fixed term counselling</p>		
<p>Huge emotional and mental health impact</p>		

<p>Staff learning and development needs Preventing recurrence</p> <p>Access to Occupational Health via manager or HR</p> <p>Duty of care until dismissed</p> <p>Healthcare professionals self-harming</p> <p>Fear of losing everything</p> <p>Policies not permitting access to colleagues Not allowed to discuss with anyone</p> <p>A lot for one person to carry Isolation</p>	<p>because talking it through and putting it into some sort of perspective —. And then there’s also, you know, using OD, Organisational Development Department: identifying what their learning and development needs might be going forward, to prevent a recurrence.</p> <p>I: And would these apply to all staff, this access to Occupational Health? Would that apply to everybody in an organisation that might have been involved?</p> <p>P: I would expect it to. I would ask them to talk to their manager or HR to get a referral to Occupational Health. Because I think with the duty of care — because until that person is dismissed, they are still an employee, and we have to —. You know, we are seeing an increasing number of nurses and well, healthcare professionals self-harming, because they find themselves in situations where they feel that they might lose everything. So you know, we can't treat that too lightly; especially when they're at home, and some of these policies say you can't come onto the premises; you can't contact any of your colleagues; you can't talk about this to anyone. I mean that's an awful lot for one person to carry, isn't it, in isolation, if you live on your own as well.</p> <p>I: Yes.</p>	<p>Acknowledgement of the need to talk incidents through.</p> <p>Reverting to talking about learning and improving. This seems the prime focus, at the heart of responses to incidents.</p> <p>Expectation that all staff would be referred to OH: but this is not the case as other Ps have confirmed. Having to go through a manager to get to OH is problematic: divulging personal aspects. Confidentiality? Also, other Ps have said no right to go to HR direct. 'Until that person is dismissed' – the 'duty of care' sounds like an official rubric: make sure steps have been followed? Recognition that staff self-harm, and may be banned from contact with colleagues creating a heavy burden: the system adds to the burden by the requirements? System could include a professional (in-house?) contact? Why this enforced isolation? What are the assumptions?</p>
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<p>Shame</p> <p>Sent home in disgrace Impact on staff</p> <p>Malicious allegations Investigations and suspension Exonerated</p>	<p>P: And if you're ashamed and you don't want to tell your family, because we're all proud of what we do every day, so to be sent home in disgrace, you're probably going to keep that all inside, which is not healthy.</p> <p>I: So, might somebody be sent home and then later exonerated?</p> <p>P: It has happened.</p> <p>I: Right.</p> <p>P: Particularly if there's an allegation, you know, if there's been an allegation of X, you know: he said/she said. We've had circumstances where members have been investigated, people have been suspended on the basis of an allegation, which when, properly investigated, and I've done a management investigation, and found that it was possibly a bit malicious.</p>	<p>Focus on feeling of shame: suggests guilt, or wrongdoing, or being cast out. Disgrace: is this the approach? Or a perception? If not healthy, why is this not challenged or adjusted?</p> <p>I'm thinking of P1.</p> <p>Malicious allegations are one thing, but other Ps have described their own managers and seniors blaming them without known malice, just to protect the organisation after a negative patient outcome, or in a retribitional way for challenging a manager.</p>
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Appendix L (continued)

Initial coding	Transcript Extract 4 (P13)	Initial reactions and comments
<p>Traumatic experiences</p> <p>Crying for a whole day</p> <p>Processing difficult experiences</p> <p>Junior staff managing overnight</p> <p>Responsibility for A&E</p> <p>No senior staff support</p> <p>Traumatic cardiac arrests</p>	<p>P: I would say that I probably found most sets of acute on-calls on night shifts quite traumatising, because there would be something pretty much every shift that wasn't satisfactory or that was, you know, verging on difficult. And I always used to get the end of every set of nights and I would essentially — usually I would cry for the day afterwards, because there was so much processing to do for all of the stuff that had happened. But there are specific events, like when I was an SHO. There were no Registrars on call overnight. So I'd been qualified for two years; so overnight as the medical SHO I was basically running all of the acute — so anybody that came in A&E, and A&E didn't have any Consultants on overnight at that time. And in fact they only had SHOs on. So it was the SHOs, most of whom who only had, like, one or two years' worth of training, who were running the A&E Department and the medical take. So you could —if you think the Registrar was on site, but was basically in bed. But the one incident that was really traumatic was when they put out a cardiac arrest call, because at that time — I think cardiac arrests are one of the things that are the most stressful, obviously — and they put out a cardiac arrest call, and I went to</p>	<p>Traumatic impacts arise every shift: Difficult situations. Build-up of stress and emotion. Near misses.</p> <p>High level of emotional response from someone self-describing as not someone who cries readily.</p> <p>Huge level of responsibility on junior doctors creating the likelihood of mistakes from pressure.</p> <p>Senior staff at home or asleep. Norms and expectations on juniors.</p> <p>Specific incidents causing traumatic responses: faced with a situation for which she had had no training. Other staff refusing to take over. No sense of</p>

<p>Managing events without training</p>	<p>A&E, because that's where it was, and they'd incorrectly put out an adult cardiac arrest call for a paediatric arrest. So actually when I got there, it was like — you will not be able to — but the tiny baby must have been like months old, and I'm not trained in paediatric resuscitation, and the only other person there was the A&E SHO, who was less experienced than I was, and the child's parents were stood there next to the child. And I arrived, and my Registrar — because he was on the arrest call — so he comes to the arrest, but he came in and said: I can't deal with this; it's a paediatric arrest, and I've got a baby, and he left. So basically it was me and this A&E SHO, trying to resuscitate this —. In some ways it was fortunate, because the baby was clearly dead. I think it had been, it had fallen. It was really tragic; the baby had fallen off a table, and it was clearly dead. So in some — that wasn't good, but in some ways it made it less traumatic for me, because I knew there wasn't really anything that we could do anyway. It was cold and it was stiff, so there wasn't —. So we kind of went through the motions, but I couldn't actually physically do anything, because I've never been taught how to put cannulas into babies or to do anything. So this poor A&E SHO and I were just trying to do compressions, and then they eventually put out a proper call and the paediatric team came, but it was sort of 20 minutes before they came.</p>	<p>teamwork or seniors taking responsibility.</p>
<p>Senior staff refused to assist</p>		<p>Description of a horrific, distressing experience: but delivered in a very matter of fact way.</p>
<p>Attempting to resuscitate a dead baby</p>		<p>Expected to manage: no training, no experience. Expectations versus resources: one-sided</p>
<p>Going through the motions</p>		
<p>Put into a situation without appropriate training</p>		

<p>Carry on No support Just back to the shift Traumatic</p> <p>Not recognising traumatic impact at the time Recurrent thoughts about past incidents</p> <p>Horrible experiences</p> <p>Desensitised</p> <p>Real trauma of watching awful things happen Having to absorb it</p> <p>No talk down</p> <p>Seniors concerned about safeguarding No concern from senior staff No empathy There was nobody there</p>	<p>And then we never really got any support or anything after that; basically, it was just back to the shift. That was pretty traumatic, and I don't think I really necessarily recognised it at the time, but I've thought about it a lot since; it comes up quite a lot I think. And I don't know how to sort of say how it has affected me, except that it's something that I recurrently think about. I don't necessarily currently think about it and feel very much; do you know what I mean? It's not like I break down. I just think about it a lot and it's just like: that was horrible, you know, in a 'how did that ever happen' sort of way. And I think that's my feeling about most of these things. It's just that kind of — maybe you get, there's a little bit of desensitising going on; I don't know. You know, in the sense that it is — maybe that's like a real trauma, because — I don't know. Maybe you know, if you think about people at war, when they're just watching all these awful things happen, and you have to kind of like absorb it. It just feels a bit like that, I guess. And then — so there was no real —, we didn't have any talk down, any —. I think I spoke to the Paediatric Consultant on the phone because she wanted to understand what had happened, but she was like, you know: this is clearly a safeguarding issue. But there was no like — at least I can't remember, there was any like: how are you doing? I'm very sorry that that happened to you. There was nothing, because</p>	<p>Not receiving support, in spite of the emotional nature of the event.</p> <p>Realising traumatic impacts after the event: not time to realise; norm of carrying on and coping; no opportunity to feel.</p> <p>Intrusive thoughts about past events. Reflecting on incidents where nothing more could have been done. Impact not acknowledged, including by the staff themselves? Desensitisation as a strategy for staff coping?</p> <p>Like being in a war - a strong analogy. PTSD arises from not being able to process traumatic events. Is this just expected?</p> <p>Senior staff concerned about rules and processes re the patient, but not about what their juniors have experienced. Sounds neglectful and uncaring. Duty of</p>
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<p>Lengthy traumatic events</p> <p>Bit of a talk to juniors</p> <p>No training how to talk to staff after fatal cardiac arrests</p> <p>Back to on-call straightaway after patient death 5 minutes' break refused Consultant said no time</p> <p>Asking for a cup of tea Consultant said no Expectation of carrying on No support</p> <p>Horrible No follow up</p>	<p>there was nobody there; there was nobody in the hospital. And another cardiac arrest later, an adult: it really was like 'ER' stuff, like kneeling on the trolley as people were wheeling him round. But the worst thing about that was that it obviously took a long time, and we resuscitated him for a long time. And at the end of it, I chatted it through with all of the juniors, I mean briefly, had a bit of a talk with them. But it's interesting that as part of being an ALS Instructor, they don't really — there is no instruction about how to talk people down after a cardiac arrest, or after an unsuccessful cardiac arrest. So I did a little bit of chat, but then I went back to the on-call, because I was doing the on-call. And I said to the Consultant: I just need like five minutes: yeah but you haven't got time; there are 12 patients waiting to be seen. So absolutely no —. I said: I just need a cup of tea, and he was like: no. There was no, absolutely no support for that at all. And he didn't even acknowledge how hard it had been. And I'm quite like — like I didn't turn up in tears, you know; I just — because that's just not what I do. And it was in the middle of a busy day shift, but it was really horrible. But there was no follow up from that at all. And he died, which just erm, yeah.</p> <p>I: The patient died?</p> <p>P: Yeah, yeah.</p>	<p>care..? Who is caring for staff and on what basis? Duties not reciprocal?</p> <p>More description of traumatic and frightening situations, with enormous responsibility, again delivered in a matter-of-fact way.</p> <p>Instructions and training are about the patient treatment, not about how to talk to other staff after an incident. No emotional elements in training? No acknowledgement of how it might feel or impact?</p> <p>This sounds awful: no empathy, concern, or support. Very small request for a 5 minute break after a patient death rejected: no awareness of the effect that might have, or how the staff member's safe functioning may depend on a few moments to regroup? Seems thoughtless, uncaring (duty of care?) and risky.</p>
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<p>Resuscitating patients inappropriately Inappropriate expectations</p> <p>Cardiac arrest during a caesarean</p> <p>Saving lives</p> <p>Can't recall many cardiac arrests although traumatic</p> <p>One medical Registrar on-call for whole hospital</p>	<p>I: And did you know that?</p> <p>P: Yeah, yeah, because when you are — yeah, yeah, he died; we stopped resuscitating him, yeah. I mean and you get used to it. Most cardiac arrests —, that changed over time actually, because more and more over time there were appropriate sort of DNARs [Do Not Attempt Resuscitation] put in place. So people — you would be resuscitating clearly inappropriate people. And it's interesting — I can't, you know, I don't know how many cardiac arrests I've been to, and I can't really remember any of the others specifically, really, apart from one that was an obstetric one, a lady, who arrested during a caesarean, but she was fine; we sorted her out; she came back. So I remember that one. But all the others, I can't really remember them, to be honest, which is, you know; you'd think they would be quite big and traumatic. And then I suppose the other traumatic thing was when one of the patients, in my very final year as a Registrar, just before I became a Consultant. But they used to have overnight — when I was there, they had one medical Registrar on call for the whole hospital. So you would cover all of the medical wards, all of the acute admissions. Obviously the juniors would see — there were quite a lot of junior doctors — but if there was anything for those patients that came through A&E that</p>	<p>Having to get used to patient deaths. Having to attempt resuscitation on patients inappropriately: rules followed, no concern for the impact on the staff member of pointless interventions.</p> <p>Forgetting traumatic incidents: interpreted as not affected? Or trauma just buried ready to emerge later or be compounded?</p> <p>So much responsibility for one staff member: traumatic effects developing from having to choose which patients to prioritise care for. Inadequate staffing as</p>
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<p>Impatience with emotionally affected staff Not feeling empathy System not set up for empathy</p> <p>No give in the system Everyone has to get on with it</p> <p>Clinically supportive</p> <p>Risk of showing empathy Staff might fall apart</p>	<p>the juniors but, if anything, if they started to crumble, I would just get annoyed, not outwardly with them, but inside I was going: ‘for goodness sake, we’ve got to get through this’. Do you know what I mean? I didn’t feel particularly kind towards them, because it just wasn’t set up for that sort of behaviour. There was no give in the system for anybody to not be able to just get on with it. I think — and I can’t remember a specific example but, you know I always got very good feedback from the juniors about being supportive. So I would always answer their calls. I would always take everything they said seriously, and if they were worried about somebody I would go and see the patient. So I was never rude to them, but I would not go out of my way to make sure they were okay, I don’t think, because it was too dangerous. [Laughs] It was, like, you just didn’t know where that would lead; it would just lead to the whole on call just falling apart.</p> <p>I: So too dangerous because people would crumble, because it would be emotionally nice? Do you mean too dangerous in that way?</p> <p>P: Yeah.</p> <p>I: Right.</p>	<p>Awareness that she was not always emotionally supportive to her junior staff: feeling the organisational pressure to continue and carry on.</p> <p>Norms perpetuated: lack of emotional concern for her then passed on to her own staff because of insufficient time and staff</p> <p>Support being more about clinical information, less about being emotionally supportive or kind.</p> <p>Too dangerous to be kind: colleagues might require a lot of support or collapse, and there was no available time. Resources seem a big part of this picture.</p>
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<p>Risk of having to take time to support colleagues No spare time available for support</p> <p>Working with different staff No relationships in on-call shifts</p> <p>No continuity of relationships</p> <p>No opportunity to check on staff later No follow up on impacts</p> <p>Not the culture to seek colleagues out to check up on them</p>	<p>P: Yeah, yeah, and that you know, you would end up with like two hours out of the on call, where you actually didn't have two minutes. D'you know what I mean?</p> <p>I: Yes, I do.</p> <p>P: And because we were always working with lots of — this is one of the problems, the issues, that you were always working with different people. So, you — it wasn't like your team. So I wasn't on call with the people who I was spending my day to day job with. So there wasn't the continuity, in the sense that you could check in the next day really with them. They would just disappear, and you wouldn't see them. So we didn't really have that follow up. And I can't remember ever like specifically seeking them out to check that they were okay. It was just not the culture of how it was, not how it was.</p>	<p>On-call shifts not having a basis in existing relationships undermines being supportive: no culture of checking in on affected staff. Moving on, next shift, new people. Transience and no further action. No management follow up or responsibility for the effects on staff of their normal work.</p> <p>Not the culture: no scope, time, opportunity for challenging the cultural norms or doing things differently. Staff coping and responding on their own, in their own time.</p>
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