Difficult events in patient care impact all staff, but support from peers can help

RESEARCH REPORT MAY 2021

BETSY LEHMAN CENTER
for Patient Safety

INTRODUCTION

Tens of thousands of Massachusetts patients are injured each year by the medical care intended to heal them. A recent study documented the emotional, physical, and financial toll these events can take on individuals and their families, as well as the cost of medical errors to the state's health care system. Emotional consequences can linger for months or years, sometimes leading people to avoid seeking medical care.[1]

Medical harm events also affect the clinicians involved, as well as staff and others who interact with patients. Research over the last decade documents the difficulties health care professionals experience, ranging from guilt and fear of litigation to reliving the event or considering ending their medical careers.[2]

Peer-to-peer conversations and support are among the more effective ways to help clinicians and staff cope when something has gone wrong in a patient's care.[3] In addition, recent work by teams of researchers in two different health care systems found a link between peer and institutional supports for those impacted by adverse or difficult events with improved patient safety culture scores[4] and workforce well-being.[5]

Yet more information about peer support in medical settings is needed. Much of the literature focuses on physicians and/or nurses and does not address the experiences of other health care professionals and personnel. Studies are often confined to a single institution or health care system. In addition, there is limited information on individual coping strategies, organizational culture and supports, and gaps in leadership's knowledge of how its frontline personnel experience and manage difficult events.

In 2019, the Betsy Lehman Center began working with a group of Massachusetts hospitals to pilot self-sustaining peer support programs in their organizations starting in units where difficult events most frequently occur, such as emergency departments and intensive care units. It is one aspect of a larger effort by the Center to add structural supports to the health care system that help meet the emotional needs of health care professionals, staff, patients, and families from medical harm and other difficult events.

To develop a baseline understanding of staff experiences with difficult events and coping strategies, the Center conducted surveys at seven of the pilot hospitals with clinicians, staff and leadership in select units of the hospitals.

This report describes findings from the surveys and implications that will aid the development of peer support programs in hospitals and other health care organizations throughout the state.

Methods:

In 2019, the Betsy Lehman Center adapted a model for a structured peer support program developed by Medically Induced Trauma Support Services (MITSS)* for use in hospitals. The Center invited all hospitals in Massachusetts to apply to participate in a pilot initiative to test the program model by implementing it in their organizations.

The Center selected eight hospitals that had never offered a peer support program to participate in the first phase of the pilot. Each hospital identified two units: one that would institute the peer support program and one that would serve as a control unit.

Data was collected from select units at seven hospitals: Cooley Dickinson Health Care, Emerson Hospital, Lowell General Hospital/ Circle Health, MetroWest Medical Center, Newton-Wellesley Hospital, South Shore Hospital, Southcoast Health System

Seven of the eight hospitals administered a baseline survey of all English-speaking staff in both the intervention and control units to assess the prevalence of difficult events; the emotional, physical, and work impacts of these events; coping strategies; and perceptions of safety culture. A complementary survey of C-suite leadership and managers of the staff in the pilot and control units was also administered (full survey instruments are included in Appendix).

Surveys were administered between September 2019 and February 2020 and were open for 3-4 weeks each. There was an overall response rate of 22% for the staff survey (n=573) and 53% for the leadership survey (n=97).

*Medically Induced Trauma Support Services was a nonprofit founded in 2002 to develop support services for medical professionals in the aftermath of adverse and other traumatic events in patient care. Its founder, Linda K. Kenney, transitioned MITSS' work to the Betsy Lehman Center in 2018.

FINDING: Both clinical and non-clinical hospital staff experience difficult events with frequency

Nearly half of hospital staff responding to the survey said they had experienced a difficult event in the prior 12 months.

Of that group, more than three-quarters faced two or more such events in that same 1-year period; more than one third experienced four or more difficult events in a single year.

Almost half of the respondents who experienced an event described themselves as the direct care provider for the patient affected and an additional one third "helped respond" to the event.

But because teamwork plays a strong role in delivering complex care in the hospital units surveyed, difficult events in patient care can have a ripple effect that extends beyond the immediate direct care providers.

Not unexpectedly, about half of nurses and physicians reported experiencing at least one difficult event. But the same was true for members of the security team who work in the same units.

In addition to nurses and physicians, more than 1-in-3 who perform other clinical roles experienced at least one recent difficult event. These might include pharmacists, technicians, nursing assistants, personal care attendants or others involved in direct or indirect patient care.

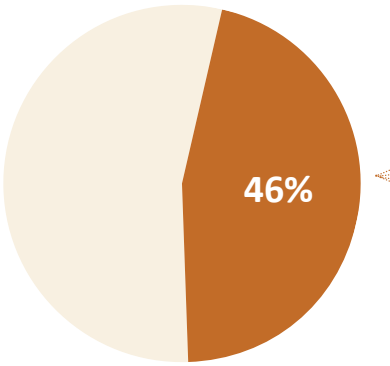
Nearly 1-in-4 administrative staff members and about half of other non-clinical staff in the units also experienced at least one difficult event in patient care. Non-clinical staff encompasses roles such as dietitians, chaplains, and members of the transport team.

WHAT IS A DIFFICULT EVENT?

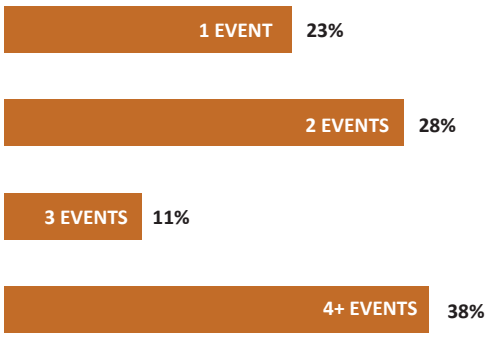
The survey used the following to describe a difficult event:

"In the course of routine patient care, there are some cases that may be especially difficult for staff. These cases may include unanticipated outcomes, medical error, challenging interaction with patients or family members, or more routine cases that trigger an emotional reaction due to a personal or professional connection (e.g. patient has a similar condition to the provider's family member; case reminds provider of an earlier case)."

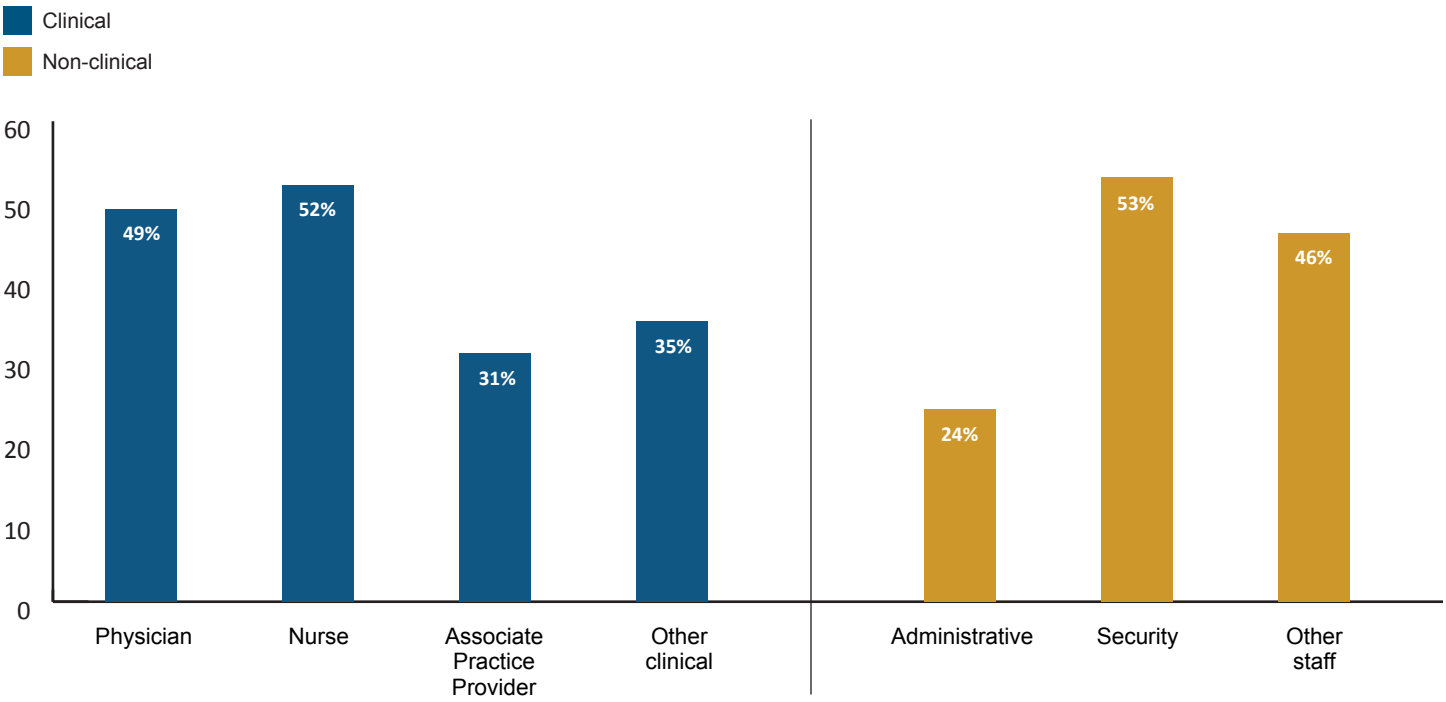
ALMOST HALF OF STAFF EXPERIENCED A DIFFICULT EVENT



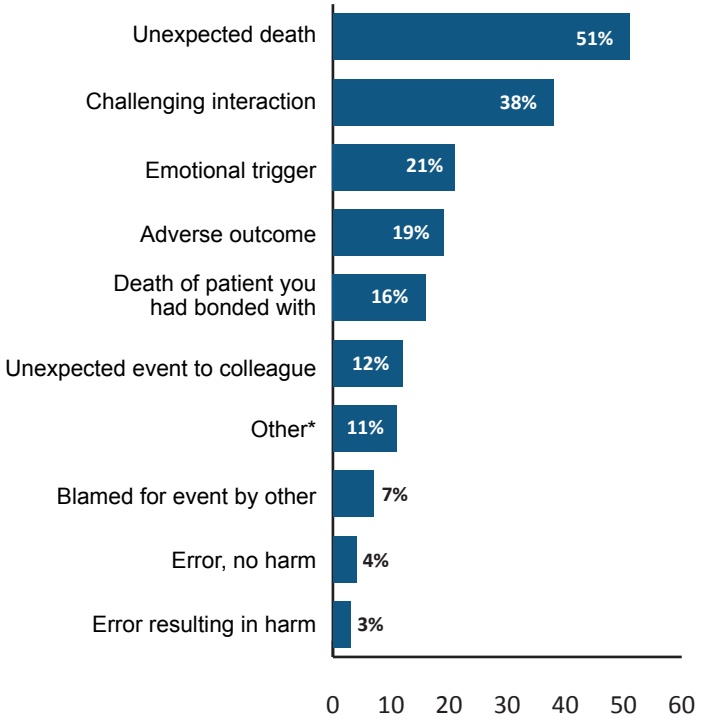
MORE THAN THREE-QUARTERS FACED 2+ SUCH EVENTS WITHIN ONE YEAR



ALL TYPES OF STAFF REPORT EXPERIENCING A DIFFICULT EVENT



MOST COMMON DIFFICULT EVENTS



*Examples of other events includes trauma to children or young people, drunk driver accidents, difficult interactions with other hospital staff members, patients seeking care due to severe violence (e.g. domestic abuse), not being able to help patients.

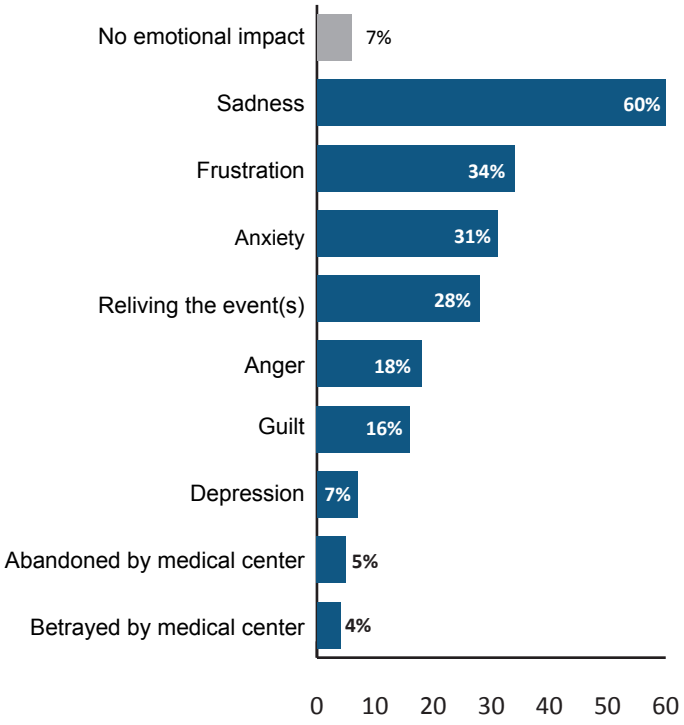
FINDING: Most clinicians and staff report emotional or physical impacts from difficult events

Only a small fraction of survey respondents said they experienced no emotional consequences in the aftermath of a difficult event in patient care. Sixty percent said they were sad after the event and close to one third reported frustration and/or anxiety. More than one quarter experienced moments where they relived the event. Nearly 1-in-5 respondents also cited feelings of anger and guilt.

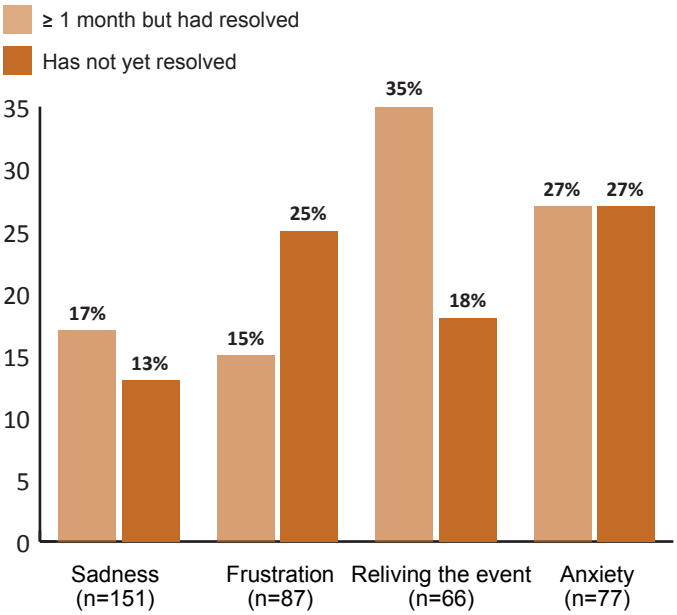
Emotional consequences from difficult events can linger for months. For half of those reporting anxiety, this feeling persisted for a month or more. Frustration also lasted, with 1-in-4 reporting that frustration from the incident they experienced had yet to dissipate.

Physical health can suffer as well. Four-in-10 had trouble sleeping and 1-in-4 felt muscle tension. Fatigue, indigestion, and a racing heartbeat were among the other physical symptoms they tied to the difficult event they had experienced.

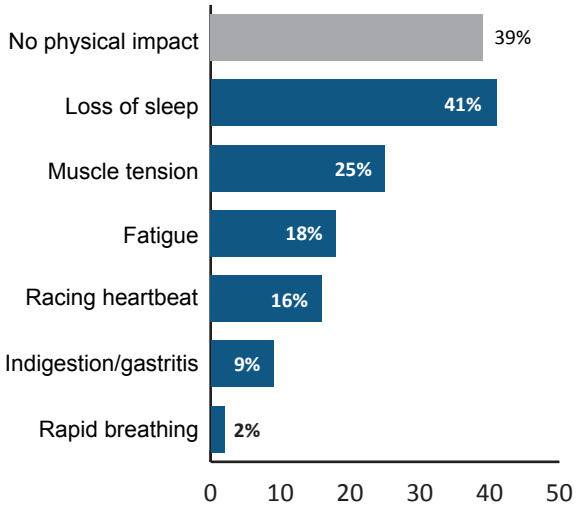
MORE THAN 90% REPORT AN EMOTIONAL IMPACT



MORE THAN HALF REPORT ANXIETY LASTS AT LEAST ONE MONTH



MORE THAN 60% REPORT A PHYSICAL IMPACT

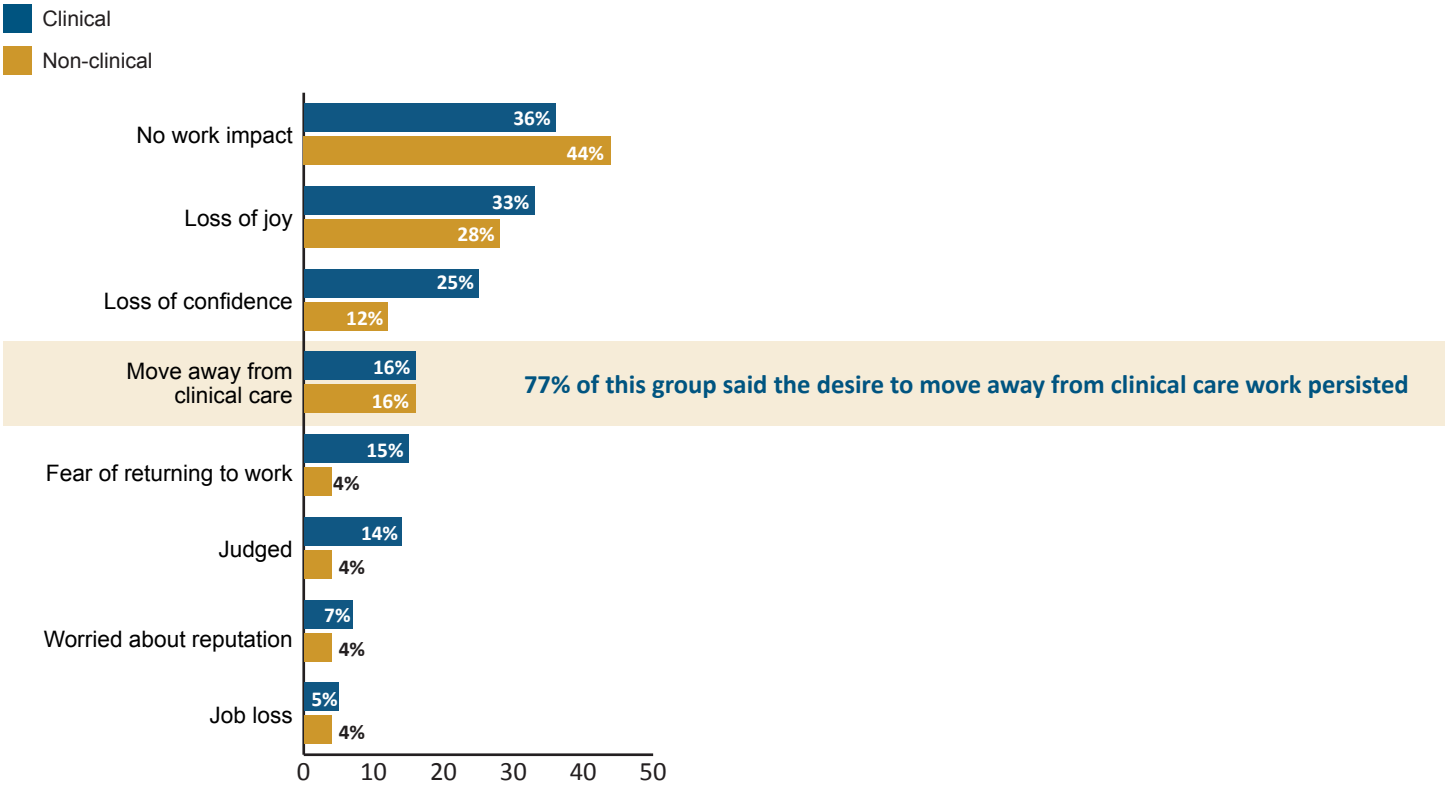


FINDING: Difficult events affect job satisfaction

The effect of these experiences on job satisfaction varied. More than one-third of clinical and more than 4-in-10 of non-clinical staff felt the difficult event did not alter their emotions about work. Among clinical staff, though, almost the same number indicated they derived less joy or meaning from their work in the aftermath of the event. Respondents also cited a loss of confidence, fear of being judged, and fear of going back to work.

About 16% of all survey respondents felt the desire to move away from clinical care in the aftermath of a difficult event. More concerning is that, for the vast majority of that group, their apprehensions about staying in a clinical care role persisted. Similarly, among those who indicated that they felt a lack of joy or satisfaction in their job after the event, about 4-in-10 said the feeling stayed with them. This was true both for events that had occurred three or more months before the survey and events that were more proximate to survey completion.

DIFFICULT EVENTS AFFECT JOB SATISFACTION AMONG BOTH CLINICAL AND NON-CLINICAL WORKERS



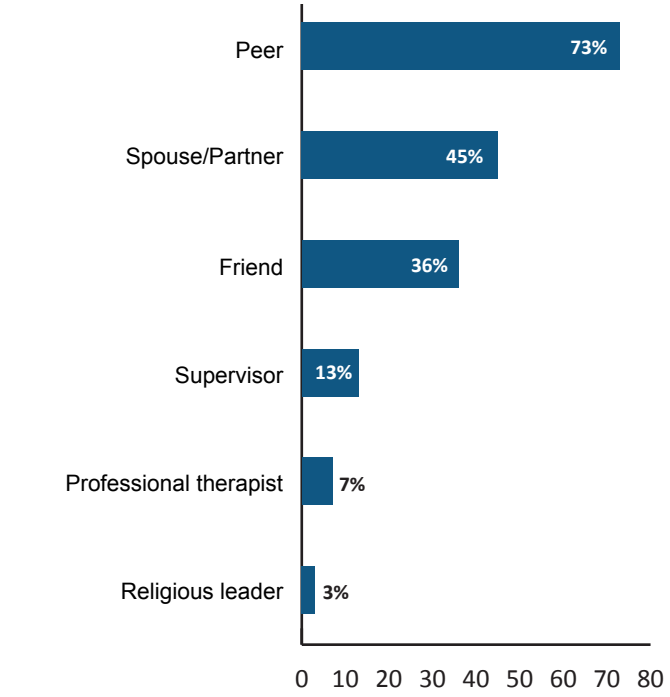
FINDING: Talking informally to a peer is a common strategy for coping with difficult events

Among clinicians and staff who experienced a difficult event, the most common approach to managing their feelings was to talk, informally, to someone else about the event. Other common coping mechanisms included a multidisciplinary debrief at the hospital, as well as physical exercise and yoga or meditation.

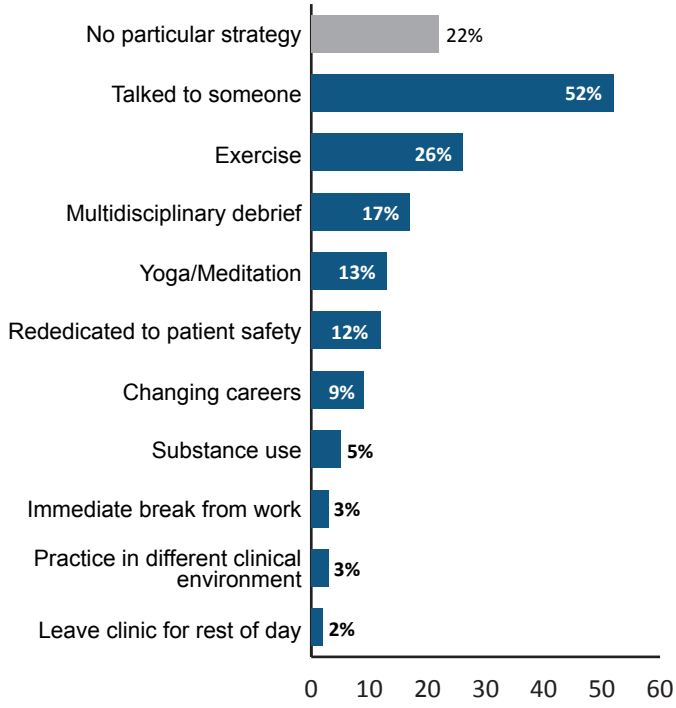
The majority of both clinical and non-clinical staff talked to a peer as a coping strategy. Almost half talked about the event with a spouse or partner and about one third confided in a friend. A much smaller percentage spoke with a supervisor and/or turned to a professional therapist or religious leader.

In addition, the majority of respondents who had not experienced a difficult event in the prior year suggested that talking to someone else would be a key way to cope with the experience. Those same respondents also indicated that multidisciplinary briefings, taking an immediate work break, and participating in a case review would also be worthwhile ways to cope in the aftermath of a difficult event.

OF STAFF WHO CONNECTED WITH SOMEONE, MOST TALKED TO A PEER



TALKING TO SOMEONE IS THE MOST DESIRED SUPPORT



FINDING: Talking informally to a peer helps staff recover and is associated with perceptions of a stronger safety culture

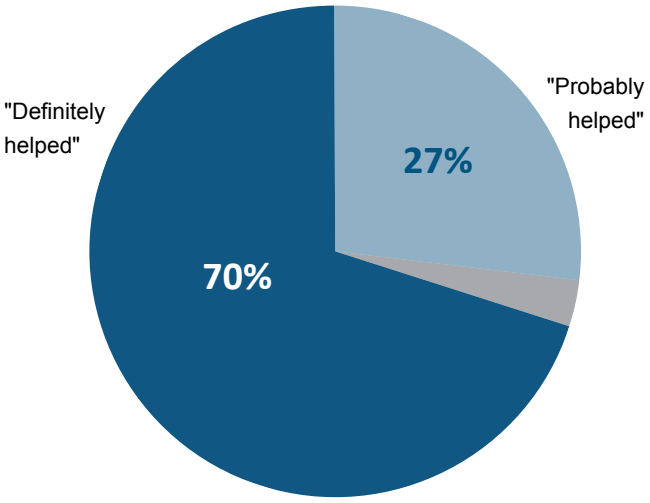
A sizable majority of physicians, nurses, other clinicians, and non-clinical staff who talked to a peer said it "definitely" helped them and another 27% said those conversations "probably" helped them cope with a difficult event.

In general, talking to a peer did not stave off physical, emotional, or work-related impacts from a difficult event, but these conversations often shortened the duration of negative consequences. Those who talked to a peer were less likely to report that frustration, muscle tension, loss of confidence, and loss of joy in work "never went away" compared to those who did not talk to a peer even when the event took place three or more months before the survey. As for "burnout," 46% of respondents who talked to a peer after a difficult event reported feeling burned out at least once a month compared to 53% of those who did not.

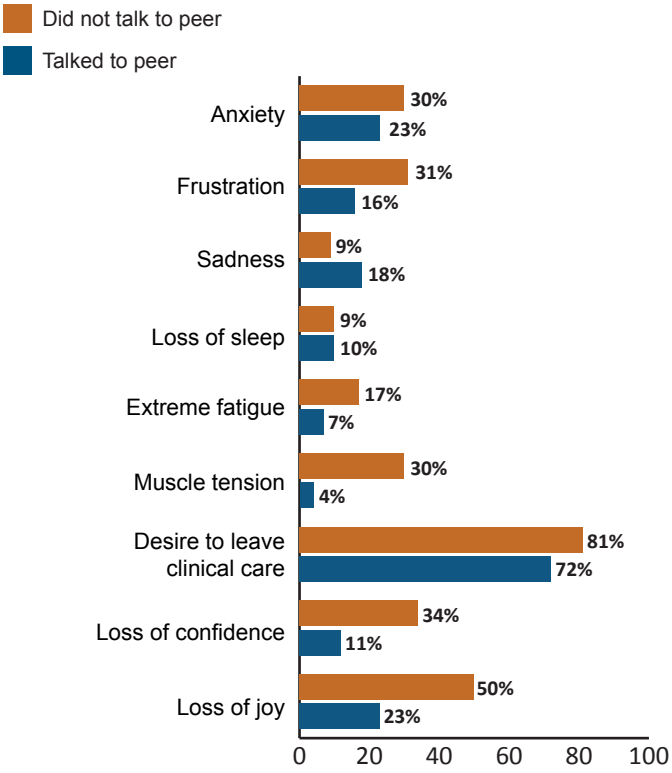
In addition, there may be a link between the choice to talk to a peer for help coping and staff members' perceptions of their organization's patient safety culture.

When asked a series of questions commonly used to measure safety culture, those who turned to a peer after a difficult event had a more positive impression of their organization's culture than respondents who did not seek out a peer after an event.

OF STAFF WHO TALKED TO A PEER, 70% REPORTED IT "DEFINITELY HELPED"



THOSE WHO DID NOT TALK TO PEERS EXPERIENCED LONGER-LASTING IMPACT



FINDING: Leadership's views of difficult events and their aftermath contrast with clinician and staff experiences

Separate surveys of the leadership of both the pilot and control units at each of the hospitals show that almost half of them underestimate the frequency of difficult events experienced by staff and nearly one quarter said they simply didn't know the extent of these experiences by staff.

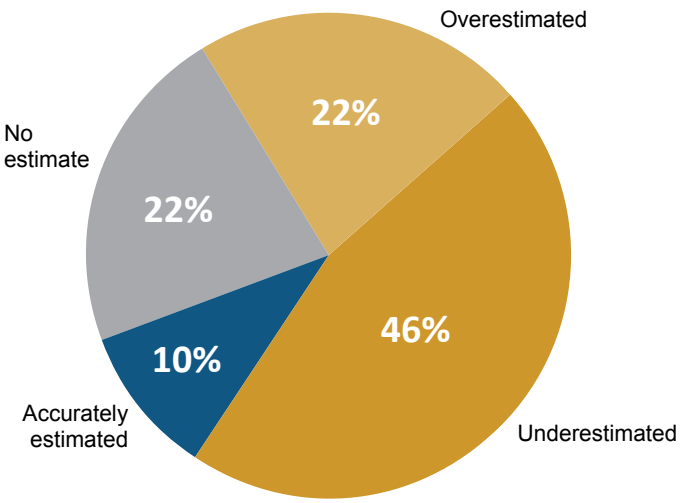
Almost half of leaders said they would not expect negative impacts to patient care and 4-in-10 assumed that staff took time off from work in the aftermath of an event. About one-third of leadership indicated they would "probably" or "definitely" rearrange elective procedures if needed to give teams a break after a difficult event and another third said they might consider it.

However, 97% of staff who reported experiencing an event said they did not take a break and 83% did not believe there were negative impacts to care for other patients in the immediate aftermath of a difficult event.

Leaders were also more likely than staff to believe that positive changes resulted from difficult events, such as triggering a rededication to patient safety work, serving as lessons for others in the organization, and catalyzing new systems or processes to avoid similar events in the future. Staff who reported experiencing an event offered a somewhat different view: half indicating that lessons learned from the event were highlighted for others in the hospital and one quarter suggesting that new systems or processes to prevent future events resulted.

Asked about existing resources that might help clinicians and staff cope with a difficult event, nearly half of staff said they were not aware of any such resources in their hospital while that number was closer to one third among leadership respondents.

ONLY 10% OF LEADERSHIP ACCURATELY ESTIMATED THE EXTENT OF STAFF EXPERIENCE WITH DIFFICULT EVENTS



DISCUSSION: Implications for peer support programs

Findings from these surveys align with other work demonstrating that engaging in conversations with colleagues is a common and helpful approach to coping with emotions that arise after difficult events in patient care.

A robust peer support program transforms these informal practices into a network of well-trained volunteers — equitably and appropriately distributed across the organization — who are equipped with emotional support skills and able to connect their peers with additional resources when needed.

Because only a few health care organizations in Massachusetts currently provide peer support services, the Betsy Lehman Center is actively working with a pilot group of hospitals to build self-sustaining peer support programs, initially in select units where difficult events most frequently occur, such as intensive care units or emergency departments.

As of December 2020, about 120 peer supporters were identified and trained across the organizations. Each hospital was working to increase awareness of the peer support resource in the selected units and two of the hospitals were expanding the peer support program into other units or departments.

In addition to the findings outlined above, these baseline survey data highlight potential barriers to adoption and use of peer support services. Two items, in particular, likely need attention from the outset when establishing or expanding a peer support program:

- Reluctance to seek help: Leadership and staff survey respondents indicated people working in hospitals may not think they need help after experiencing a difficult event in patient care.
- Awareness about resources: As noted in the previous section, respondents indicated a lack of knowledge of resources available in the aftermath of a difficult event.

Other potential barriers cited by the respondents were finding time to seek help and concerns about privacy.

Taken together, these perceptions suggest that consistent, positive and targeted communication about a peer support program will underscore organizational commitment to the program and seed its success.

CONCLUSION

Adverse and difficult events in patient care happen with frequency. They can affect anyone who works in a hospital, from members of the clinical team to personnel in administration, security, transport, and others who help respond to or witness an event.

The physical, emotional, and work-related effects are real and can persist for days, weeks, months, or longer.

Speaking with a peer is the most common informal strategy for clinicians and staff trying to cope with a difficult event in patient care. These conversations are associated with faster recoveries from a range of emotional, physical, and workplace consequences, including frustration, tension, and loss of confidence.

Peer-to-peer interactions after an adverse event are also correlated with a stronger sense of safety culture within a hospital.

These survey data confirm the use and efficacy of peer-to-peer conversations as a buffer against prolonged emotional, physical, and work-related impacts that stem from difficult events in patient care. They demonstrate the need for peer support opportunities that are accessible and visible across an organization, supported by leadership, and available to clinicians and non-clinicians alike.

APPENDIX

Sample and Survey Administration

The Betsy Lehman Center for Patient Safety invited all hospitals across Massachusetts to participate in a pilot program to add peer support as a resource for clinicians and staff. Eight hospitals that had limited or no experience with a peer support program were initially selected for the pilot. Criteria for inclusion in the pilot included leadership endorsement, hospital interest, and capacity to engage in the program's development. Seven hospitals elected to continue with the pilot and follow the model offered by the Betsy Lehman Center. That model includes an initial planning phase, establishment of a multi-disciplinary advisory committee, a 0.25 FTE program manager, survey participation, and training of a predetermined number of clinicians and staff as peer supporters among other elements.

Each hospital identified 1.) a single pilot unit that would train peer supporters and 2.) a control unit that would not train peer supporters for at least a year. A baseline survey of all English speaking staff in both pilot and control units assessed the prevalence of difficult events, the emotional, physical and work impacts of these events, coping strategies and perceptions of safety culture (full survey instrument is included in Appendix). The surveys were anonymous and conducted in advance of any training of peer supporters at the sites.

Between September 2019 and February 2020, each hospital's leadership team sent surveys by email to staff in the two units, along with a message encouraging them to complete it. Surveys were open for 3-4 weeks. Executive leadership and leadership of the pilot and control units received a similar survey to measure their perceptions of difficult events on staff. Unit leadership encouraged participation in the survey during meetings and staff received email reminders, usually on a weekly basis. Staff included clinicians responsible for direct patient care (e.g. physicians/nurses) as well as supplementary providers (e.g. respiratory therapists) and staff that may not have a direct patient role (e.g. security, administrative) in the units surveyed. Using the online survey tool SurveyGizmo (now Alchemer), all responses went directly to the Betsy Lehman Center; hospital leadership was unaware of which individuals did nor did not participate in the survey. A total of 2649 staff and 183 leadership members were surveyed.

Survey Design

Questions were adapted from previous research measuring the impacts of difficult events on staff as well as patients. Two committees advised the Betsy Lehman Center on development of the surveys. One advisory committee had expertise in peer support programs and the impact of difficult events on health care workers while the other advisory committee was comprised of researchers, methodologists and patient safety experts. Finally, cognitive testing of the survey was done with residents at a hospital and staff of the Betsy Lehman Center who were not involved in the peer support program.

Survey Questions

The length of the survey varied depending on a respondent's experience with difficult events. Those who reported experiencing a difficult event in the prior 12 months could choose to answer up to 56 questions. Respondents could answer or skip each individual question.

A total of 573 hospital staff completed the survey for a response rate of 22%. The range in response rates among hospitals varied from 10 to 34%. One hospital experienced change in personnel leading the pilot work as the survey was underway, likely affecting its response rate. Another hospital began the survey phase of the program just as COVID-19 was gaining a foothold in Massachusetts.

Separately, 97 leaders completed the survey for a response rate of 53% and a range of 18-95%.

SURVEY QUESTIONS: PEER SUPPORT PROVIDERS AND STAFF

The survey used the following to describe a difficult event: In the course of routine patient care, there are some cases that may be especially difficult for staff. These cases may include unanticipated outcomes, medical error, challenging interaction with patients or family members, or more routine cases that trigger an emotional reaction due to a personal or professional connection (e.g. patient has a similar condition to the provider's family member; case reminds provider of an earlier case).

- Does your institution offer services that could provide support for staff after these types of event/cases?
  ( ) Yes
  ( ) No
  ( ) Don't know
- Please describe the services offered:
- In the past 12 months, have you been involved in these event/cases? In the course of routine patient care, there are some cases that may be especially difficult for staff. These cases may include unanticipated outcomes, medical error, challenging interaction with patients or family members or more routine cases that trigger an emotional reaction due to a personal or professional connection (e.g. patient has a similar condition to the provider's family member; case reminds provider of a previous earlier case).
  ( ) Yes
  ( ) No
- If yes, how many?
  ( ) 1
  ( ) 2
  ( ) 3
  ( ) 4 or more
- How long ago did this event/case occur?
  ( ) 0 – 3 months
  ( ) 4 – 6 months
  ( ) 7 – 9 months
  ( ) 10 – 12 months
- Please describe the type of event/case (check all that apply).
  [ ] Unexpected death
  [ ] Death of a patient with whom you had bonded
  [ ] Adverse event or medical outcome
  [ ] Medical error without harm to patient
  [ ] Medical error with harm to patient
  [ ] Unexpected event that occurred to a colleague while at work (e.g. death, major injury)
  [ ] Challenging interaction with patient or family member
  [ ] Event that triggered emotional reaction based on previous experience
  [ ] Blamed for outcome by other healthcare professional
  [ ] Other:
- What was your involvement in the event/case?
  ( ) I was the direct care provider
  ( ) I responded to the event and helped
  ( ) I heard about it but was not directly involved
  ( ) It was my patient but I wasn't directly involved in the event
  ( ) Other:
  ( ) Don't know

- What was the degree of patient physical harm from the event/case?
  ( ) Death: Dead at time of assessment
  ( ) Severe harm: Bodily or psychological injury (including pain or disfigurement) that interferes significantly with functional ability or quality of life
  ( ) Moderate harm: Bodily or psychological injury adversely affecting functional ability or quality of life, but not at the level of severe harm
  ( ) Mild harm: Minimal symptoms or loss of function, or injury limited to additional treatment, monitoring, and/or increased length of stay
  ( ) No harm: Event reached patient but no harm was evident
  ( ) Unknown
- Which of the following would best describe the most significant emotional impacts on you from this event/case? Pick up to 3.
  [ ] It had no significant emotional impact on me
  [ ] Anger
  [ ] Sadness
  [ ] Guilt
  [ ] Reliving the events
  [ ] Anxiety
  [ ] Depression
  [ ] Frustration
  [ ] Abandoned by medical center
  [ ] Betrayed by medical center
  [ ] Other:
- For feelings of *anger*, how long did this emotional impact last?
  ( ) A few hours
  ( ) A day
  ( ) A week
  ( ) A month
  ( ) More than a month but I no longer experience that emotional impact from the error
  ( ) It has never completely gone away
- For feelings of *anger*, how strongly were you impacted?
  0 – 100
- For feelings of *sadness*, how long did this emotional impact last?
  ( ) A few hours
  ( ) A day
  ( ) A week
  ( ) A month
  ( ) More than a month but I no longer experience that emotional impact from the error
  ( ) It has never completely gone away
- For feelings of *sadness*, how strongly were you impacted?
  0 – 100
- For feelings of *guilt*, how long did this emotional impact last?
  ( ) A few hours
  ( ) A day
  ( ) A week
  ( ) A month
  ( ) More than a month but I no longer experience that emotional impact from the error
  ( ) It has never completely gone away
- For feelings of *guilt*, how strongly were you impacted?
  0 – 100

- For feelings of *depression*, how long did this emotional impact last?
  ( ) A few hours
  ( ) A day
  ( ) A week
  ( ) A month
  ( ) More than a month but I no longer experience that emotional impact from the error
  ( ) It has never completely gone away
- For feelings of *depression*, how strongly were you impacted?
  0 – 100
- For feelings of *reliving the events*, how long did this emotional impact last?
  ( ) A few hours
  ( ) A day
  ( ) A week
  ( ) A month
  ( ) More than a month but I no longer experience that emotional impact from the error
  ( ) It has never completely gone away
- For feelings of *reliving the events*, how strongly were you impacted?
  0 – 100
- For feelings of *anxiety*, how long did this emotional impact last?
  ( ) A few hours
  ( ) A day
  ( ) A week
  ( ) A month
  ( ) More than a month but I no longer experience that emotional impact from the error
  ( ) It has never completely gone away
- For feelings of *anxiety*, how strongly were you impacted?
  0 – 100
- For feelings of *frustration*, how long did this emotional impact last?
  ( ) A few hours
  ( ) A day
  ( ) A week
  ( ) A month
  ( ) More than a month but I no longer experience that emotional impact from the error
  ( ) It has never completely gone away
- For feelings of *frustration*, how strongly were you impacted?
  0 – 100
- For feelings of *abandoned by medical center*, how long did this emotional impact last?
  ( ) A few hours
  ( ) A day
  ( ) A week
  ( ) A month
  ( ) More than a month but I no longer experience that emotional impact from the error
  ( ) It has never completely gone away
- For feelings of *abandonment*, how strongly were you impacted?
  0 – 100

- For feelings of *betrayed by medical center*, how long did this emotional impact last?
  ( ) A few hours
  ( ) A day
  ( ) A week
  ( ) A month
  ( ) More than a month but I no longer experience that emotional impact from the error
  ( ) It has never completely gone away
- For feelings of *betrayal*, how strongly were you impacted?
  0 – 100
- For *other emotions*, how long did this emotional impact last?
  ( ) A few hours
  ( ) A day
  ( ) A week
  ( ) A month
  ( ) More than a month but I no longer experience that emotional impact from the error
  ( ) It has never completely gone away
- For *other emotions*, how strongly were you impacted?
  0 – 100
- Which of the following would best describe the most significant physical impacts on you from the event/case? Pick up to 3.
  [ ] It had no significant physical impact
  [ ] Loss of sleep
  [ ] Racing heart beat
  [ ] Extreme fatigue
  [ ] Indigestion/gastritis
  [ ] Muscle tension
  [ ] Rapid breathing
  [ ] Other:
- For the *loss of sleep* that you experienced, how long did the physical impact last?
  ( ) A few hours
  ( ) A day
  ( ) A week
  ( ) A month
  ( ) More than a month but I no longer experience that physical impact from the error
  ( ) It has never completely gone away
- For the *loss of sleep* that you experienced, how strongly were you impacted?
  0 – 100
- For the *racing heartbeat* that you experienced, how long did the physical impact last?
  ( ) A few hours
  ( ) A day
  ( ) A week
  ( ) A month
  ( ) More than a month but I no longer experience that physical impact from the error
  ( ) It has never completely gone away
- For the *racing heartbeat* that you experienced, how strongly were you impacted?
  0 – 100

- For the *extreme fatigue* that you experienced, how long did the physical impact last?
  ( ) A few hours
  ( ) A day
  ( ) A week
  ( ) A month
  ( ) More than a month but I no longer experience that physical impact from the error
  ( ) It has never completely gone away
- For the *extreme fatigue* that you experienced, how strongly were you impacted?
  0 – 100
- For the *indigestion/gastritis* that you experienced, how long did the physical impact last?
  ( ) A few hours
  ( ) A day
  ( ) A week
  ( ) A month
  ( ) More than a month but I no longer experience that physical impact from the error
  ( ) It has never completely gone away
- For the *indigestion/gastritis* that you experienced, how strongly were you impacted?
  0 – 100
- For the *muscle tension* that you experienced, how long did the physical impact last?
  ( ) A few hours
  ( ) A day
  ( ) A week
  ( ) A month
  ( ) More than a month but I no longer experience that physical impact from the error
  ( ) It has never completely gone away
- For the *muscle tension* that you experienced, how strongly were you impacted?
  0 – 100
- For the *rapid breathing* that you experienced, how long did the physical impact last?
  ( ) A few hours
  ( ) A day
  ( ) A week
  ( ) A month
  ( ) More than a month but I no longer experience that physical impact from the error
  ( ) It has never completely gone away
- For the *rapid breathing* that you experienced, how strongly were you impacted?
  0 – 100
- For the *other physical impact* that you experienced, how long did the physical impact last?
  ( ) A few hours
  ( ) A day
  ( ) A week
  ( ) A month
  ( ) More than a month but I no longer experience that physical impact from the error
  ( ) It has never completely gone away
- For the *other physical impact* that you experienced, how strongly were you impacted?
  0 – 100

- Which of the following would best describe the most significant impacts this event had on your emotions about work? Pick up to 3.
  [ ] It had no significant impact on my emotions about work
  [ ] Fear of being judged
  [ ] Fear of losing my job
  [ ] Doubted my professional abilities/loss of confidence
  [ ] Fear of going back to work
  [ ] Less job satisfaction/negatively impacted my joy and meaning from work
  [ ] Considered changing my job/position away from direct clinical care
  [ ] Worried about my reputation
  [ ] Worried about loss of wage or bonus
  [ ] Worried it would affect my promotion
  [ ] Other:
- For the *fear of being judged* that you reported, how long did this impact last?
  ( ) A few hours
  ( ) A day
  ( ) A week
  ( ) A month
  ( ) More than a month but I no longer experience that impact from the error
  ( ) It has never completely gone away
- For the *fear of being judged* that you reported, how strongly were you impacted?
  0 – 100
- For the *fear of losing my job* that you reported, how long did this impact last?
  ( ) A few hours
  ( ) A day
  ( ) A week
  ( ) A month
  ( ) More than a month but I no longer experience that impact from the error
  ( ) It has never completely gone away
- For the *fear of losing my job* that you reported, how strongly were you impacted?
  0 – 100
- For the *fear of loss of reputation* that you reported, how long did this impact last?
  ( ) A few hours
  ( ) A day
  ( ) A week
  ( ) A month
  ( ) More than a month but I no longer experience that impact from the error
  ( ) It has never completely gone away
- For the *fear of loss of reputation* that you reported, how strongly were you impacted?
  0 – 100
- For the *fear of being doubted in your professional abilities/loss of confidence* that you reported, how long did this impact last?
  ( ) A few hours
  ( ) A day
  ( ) A week
  ( ) A month
  ( ) More than a month but I no longer experience that impact from the error
  ( ) It has never completely gone away

- For the *fear of being doubted in your professional abilities/loss of confidence* that you reported, how strongly were you impacted?
  0 – 100
- For the *fear of going back to work* that you reported, how long did this impact last?
  ( ) A few hours
  ( ) A day
  ( ) A week
  ( ) A month
  ( ) More than a month but I no longer experience that impact from the error
  ( ) It has never completely gone away
- For the *fear of going back to work* that you reported, how strongly were you impacted?
  0 – 100
- For the *loss of job satisfaction* that you reported, how long did this impact last?
  ( ) A few hours
  ( ) A day
  ( ) A week
  ( ) A month
  ( ) More than a month but I no longer experience that impact from the error
  ( ) It has never completely gone away
- For the *loss of job satisfaction* that you reported, how strongly were you impacted?
  0 – 100
- For the *considered change of job* that you reported, how long did this impact last?
  ( ) A few hours
  ( ) A day
  ( ) A week
  ( ) A month
  ( ) More than a month but I no longer experience that impact from the error
  ( ) It has never completely gone away
- For the *considered change of job* that you reported, how strongly were you impacted?
  0 – 100
- For the *worry about your reputation* that you reported, how long did this impact last?
  ( ) A few hours
  ( ) A day
  ( ) A week
  ( ) A month
  ( ) More than a month but I no longer experience that impact from the error
  ( ) It has never completely gone away
- For the *worry about your reputation* that you reported, how strongly were you impacted?
  0 – 100
- For the *worry about loss of wage/bonus* that you reported, how long did this impact last?
  ( ) A few hours
  ( ) A day
  ( ) A week
  ( ) A month
  ( ) More than a month but I no longer experience that impact from the error
  ( ) It has never completely gone away

- For the *worry about loss of wage/bonus* that you reported, how strongly were you impacted?
  0 – 100
- For the *worry about your promotion* that you reported, how long did this impact last?
  ( ) A few hours
  ( ) A day
  ( ) A week
  ( ) A month
  ( ) More than a month but I no longer experience that impact from the error
  ( ) It has never completely gone away
- For the *worry about your promotion* that you reported, how strongly were you impacted?
  0 – 100
- For the *other impact* that you reported, how long did this impact last?
  ( ) A few hours
  ( ) A day
  ( ) A week
  ( ) A month
  ( ) More than a month but I no longer experience that impact from the error
  ( ) It has never completely gone away
- For the *other impact* that you reported, how strongly were you impacted?
  0 – 100
- Did you take time off work as a result of the event/case?
  ( ) Yes
  ( ) No
  ( ) Don't remember
- How long did you take time off work?
  ( ) A few hours
  ( ) A day
  ( ) A week
  ( ) A month
  ( ) More than a month but it no longer impacts absenteeism
  ( ) It still results in absenteeism
- Do you believe that this event/case negatively impacted the subsequent care you provided?
  ( ) Yes
  ( ) No
  ( ) Not sure
- How long did it negatively impact your care?
  ( ) A few hours
  ( ) A day
  ( ) A week
  ( ) A month
  ( ) More than a month but it no longer negatively impacts my care
  ( ) It still negatively impacts my care
- Do you believe that this event/case positively impacted the subsequent care you provided?
  ( ) Yes
  ( ) No
  ( ) Not sure

- How did it improve care? (Check all that apply).
  [ ] Rededicated commitment to patient safety
  [ ] Took action to put in systems/processes to avoid similar type of event in future
  [ ] Highlighted lessons learned from the case to others in organization
  [ ] Other:
- Please select the top 3 coping strategies you used to cope after the event/case.
  [ ] I didn't use any particular coping strategies
  [ ] I got emotional support or talked to someone
  [ ] Got an immediate break from work to recover
  [ ] Left the clinical area immediately for at least the rest of the day
  [ ] Practicing in a different clinical environment or type of case for awhile
  [ ] Participating in a multidisciplinary debriefing of the event
  [ ] I began or started using more substances (drugs/alcohol)
  [ ] I considered changing careers
  [ ] I thought about suicide/hurting myself
  [ ] I exercised
  [ ] Meditation, yoga or some other similar activity
  [ ] Rededicating myself to patient safety
  [ ] Other:
- If you got emotional support, from whom did you get it? (Check all that apply).
  [ ] A colleague or peer
  [ ] A friend
  [ ] My spouse
  [ ] A supervisor within the department
  [ ] A professional (psychologist, therapist)
  [ ] A religious leader
  [ ] Other:
- Was the support helpful?
  ( ) Definitely helped
  ( ) Probably helped
  ( ) Didn't change things
  ( ) Probably made things worse
  ( ) Definitely made things worse
- Why did you not seek out emotional support from a colleague or peer? (Check all that apply).
  [ ] Concerns about privacy
  [ ] Didn't think I needed it
  [ ] Will appear "weak"
  [ ] No formal peer support program offered
  [ ] Don't have enough time
  [ ] Concerns about malpractice/They have been told not to talk about it
  [ ] Fear of support being used as evidence in litigation
  [ ] Other

- For coping strategies you did not use, which of the following do you think would have helped after your event/case? (Check all that apply).
  [ ] I didn't need help
  [ ] Getting an immediate brief break from work to recover
  [ ] Being allowed to leave the clinical area immediately for at least the rest of the day
  [ ] Being assigned to a different clinical environment or type of case for a while
  [ ] A multidisciplinary debriefing of the event
  [ ] Getting emotional support by talking to someone
  [ ] Changing careers
  [ ] Help understanding the case review process
  [ ] Exercise
  [ ] Meditation, yoga or other similar activity
  [ ] Rededicated myself to patient safety
  [ ] Other:
- From whom would it have been helpful to get emotional support from?
  [ ] Spouse/partner
  [ ] Colleague or peer
  [ ] Supervisor
  [ ] Religious leader
  [ ] Professional counselor
- When was the last time you were involved in these event/cases? In the course of routine patient care, there are some cases that may be especially difficult for staff. These cases may include unanticipated outcomes, medical error, challenging interaction with patients or family members or more routine cases that trigger an emotional reaction due to a personal or professional connection (e.g. patient has a similar condition to the provider's family member; case reminds provider of a previous earlier case).
  ( ) 1 – 2 years ago
  ( ) 3 – 5 years ago
  ( ) > 5 years ago
  ( ) Never
- In general, do you believe that being involved in these event/cases negatively impacts subsequent care?
  ( ) Yes
  ( ) No
  ( ) Not sure
- How long does it negatively impact care?
  ( ) A few hours
  ( ) A day
  ( ) A week
  ( ) A month
  ( ) More than a month
- Do you believe that these event/cases positively impact subsequent care?
  ( ) Yes
  ( ) No
  ( ) Not sure
- How does it improve care? (Check all that apply).
  [ ] Rededicates our commitment to patient safety
  [ ] Actions are taken to put in systems/processes to avoid similar types of event in future
  [ ] Lessons learned from the case are highlighted to others in organization
  [ ] Other:

- Which of the following should health care institutions offer after these cases/events? (Check all that apply).
  [ ] Getting an immediate brief break from work to recover
  [ ] Being allowed to leave the clinical area immediately for at least the rest of the day
  [ ] Being assigned to a different clinical environment or type of case for a while
  [ ] A multidisciplinary debriefing of the event
  [ ] Talking to someone
  [ ] Help understanding the case review process
  [ ] Meditation, yoga or some other similar activity
  [ ] Exercise
  [ ] Other:
- Who would you prefer to talk to?
  ( ) A colleague or peer
  ( ) A friend
  ( ) A supervisor within the department
  ( ) A professional (psychologist, therapist)
  ( ) A religious leader
- Why do you think staff do not (or would not) take advantage of a peer support program following these cases/events? (Check all that apply).
  [ ] Concerns about privacy
  [ ] Don't think they need it
  [ ] Will appear "weak"
  [ ] Unaware of the resource
  [ ] Don't have enough time
  [ ] Don't perceive peer supporters as a peer
  [ ] Fear of retribution
  [ ] Other:
- I feel burned out from my work
  ( ) Never
  ( ) A few times a year or less
  ( ) Once a month or less
  ( ) A few times a month
  ( ) Once a week
  ( ) A few times a week
  ( ) Every day
- I have become more callous toward people since I took this job
  ( ) Never
  ( ) A few times a year or less
  ( ) Once a month or less
  ( ) A few times a month
  ( ) Once a week
  ( ) A few times a week
  ( ) Every day
- Staff will freely speak up if they see something that may negatively affect patient care
  ( ) Never
  ( ) Rarely
  ( ) Sometimes
  ( ) Most of the time
  ( ) Always

- Staff feel free to question the decisions or actions of those with more authority
  ( ) Never
  ( ) Rarely
  ( ) Sometimes
  ( ) Most of the time
  ( ) Always
- Staff are afraid to ask questions when something does not seem right
  ( ) Never
  ( ) Rarely
  ( ) Sometimes
  ( ) Most of the time
  ( ) Always
- Please give your work area/unit in this hospital an overall grade on patient safety.
  ( ) Excellent
  ( ) Very good
  ( ) Acceptable
  ( ) Poor
  ( ) Failing
- Your age
  ( ) 20 – 30 yrs
  ( ) 31 – 40 yrs
  ( ) 41 – 50 yrs
  ( ) 51 – 60 yrs
  ( ) 61 and older
- Years you have worked at the institution
  ( ) < 1 year
  ( ) 1 – 5 years
  ( ) 6 – 10 years
  ( ) > 10 years
- I describe my gender as
  ( ) M
  ( ) F
  ( ) Non-binary
- I describe my race as
  ( ) White
  ( ) Black or African American
  ( ) Asian
  ( ) Native Hawaiian or Other Pacific Islander
  ( ) American Indian or Alaskan Native
  ( ) Multi-racial
  ( ) Other
- I describe my ethnicity as
  ( ) Not Hispanic/Latino
  ( ) Hispanic/Latino
  ( ) Other:
- On what unit/department do you work?
  ( ) Mainly ED
  ( ) Mainly ICU
  ( ) Both ED & ICU (Equally split between the two)

- Staff type
  ( ) Nurse
  ( ) NP/PA, CRNA or other APP
  ( ) Attending Physician/Staff Physician
  ( ) Resident
  ( ) Respiratory Therapist
  ( ) Pharmacist
  ( ) Security
  ( ) Environmental services
  ( ) Administrative
  ( ) Other:
- Approximately what percentage of your work time do you spend at XXXXXX Hospital?
- Is there anything else you'd like to add about your experience with these events/cases?

SURVEY QUESTIONS: PEER SUPPORT LEADERSHIP

- Please enter your "Personal Identifier"
- Does your institution offer services that could provide support for staff after these types of event/cases?
  ( ) Yes
  ( ) No
  ( ) Don't know
- Please describe the services offered:
- What unit is your leadership position in?
  ( ) ED
  ( ) ICU
  ( ) C-suite
  ( ) Other:
- Approximately, what percent of your staff (clinical and support) do you think were involved in these event/cases? In the course of routine patient care, there are some cases that may be especially difficult for staff. These cases may include unanticipated outcomes, medical error, challenging interaction with patients or family members or more routine cases that trigger an emotional reaction due to a personal or professional connection (e.g. patient has a similar condition to the provider's family member; case reminds provider of a previous earlier case) in the last 12 months?
- Which of the following would best describe the most significant emotional impacts on staff from these event/cases? Pick up to 3.
  [ ] No significant emotional response
  [ ] Anger
  [ ] Sadness
  [ ] Guilt
  [ ] Reliving the events
  [ ] Anxiety
  [ ] Depression
  [ ] Frustration
  [ ] Abandoned by medical center
  [ ] Betrayed by medical center
  [ ] Other:
  [ ] Don't know
- For feelings of *anger* experienced by staff, how long does this emotional impact last?
  ( ) A few hours
  ( ) A day
  ( ) A week
  ( ) A month
  ( ) More than a month
  ( ) It never completely goes away
- For feelings of *anger* experienced by staff, how strongly are staff impacted?
  0 – 100
- For feelings of *sadness* experienced by staff, how long does this emotional impact last?
  ( ) A few hours
  ( ) A day
  ( ) A week
  ( ) A month
  ( ) More than a month
  ( ) It never completely goes away

- For feelings of *sadness* experienced by staff, how strongly are staff impacted?
  0 – 100
- For feelings of *guilt* experienced by staff, how long does this emotional impact last?
  ( ) A few hours
  ( ) A day
  ( ) A week
  ( ) A month
  ( ) More than a month
  ( ) It never completely goes away
- For feelings of *guilt* experienced by staff, how strongly are staff impacted?
  0 – 100
- For feelings of *reliving the event* experienced by staff, how long does this emotional impact last?
  ( ) A few hours
  ( ) A day
  ( ) A week
  ( ) A month
  ( ) More than a month
  ( ) It never completely goes away
- For feelings of *reliving the event* experienced by staff, how strongly are staff impacted?
  0 – 100
- For feelings of *anxiety* experienced by staff, how long does this emotional impact last?
  ( ) A few hours
  ( ) A day
  ( ) A week
  ( ) A month
  ( ) More than a month
  ( ) It never completely goes away
- For feelings of *anxiety* experienced by staff, how strongly are staff impacted?
  0 – 100
- For feelings of *depression* experienced by staff, how long does this emotional impact last?
  ( ) A few hours
  ( ) A day
  ( ) A week
  ( ) A month
  ( ) More than a month
  ( ) It never completely goes away
- For feelings of *depression* experienced by staff, how strongly are staff impacted?
  0 – 100
- For feelings of *frustration* experienced by staff, how long does this emotional impact last?
  ( ) A few hours
  ( ) A day
  ( ) A week
  ( ) A month
  ( ) More than a month
  ( ) It never completely goes away
- For feelings of *frustration* experienced by staff, how strongly are staff impacted?
  0 – 100

- For feelings of *abandoned by medical center* experienced by staff, how long does this emotional impact last?
  ( ) A few hours
  ( ) A day
  ( ) A week
  ( ) A month
  ( ) More than a month
  ( ) It never completely goes away
- For feelings of *abandonment* experienced by staff, how strongly are staff impacted?
  0 – 100
- For feelings of *betrayed by medical center* experienced by staff, how long does this emotional impact last?
  ( ) A few hours
  ( ) A day
  ( ) A week
  ( ) A month
  ( ) More than a month
  ( ) It never completely goes away
- For feelings of *betrayal* experienced by staff, how strongly are staff impacted?
  0 – 100
- For *other* emotions experienced by staff, how long does this emotional impact last?
  ( ) A few hours
  ( ) A day
  ( ) A week
  ( ) A month
  ( ) More than a month
  ( ) It never completely goes away
- For *other* emotions experienced by staff, how strongly are staff impacted?
  0 – 100
- Do you believe that the quality of care at your institution is *negatively* impacted by these event/cases?
  ( ) Yes
  ( ) No
  ( ) Not sure
- How long does it *negatively* impact care?
  ( ) A few hours
  ( ) A day
  ( ) A week
  ( ) A month
  ( ) More than a month
- Do you believe that these event/cases *positively* impact the care at your institution?
  ( ) Yes
  ( ) No
  ( ) Not sure
- How long does it *positively* impact care?
  ( ) A few hours
  ( ) A day
  ( ) A week
  ( ) A month
  ( ) More than a month

- How does it improve care? (Check all that apply).
  [ ] Rededicates our commitment to patient safety
  [ ] Take action to put in systems/processes to avoid similar type of event in future
  [ ] Highlights lessons learned from the case to others in organization
  [ ] Other:
- Do you believe that staff take time off because of these event/cases?
  ( ) Definitely
  ( ) Probably
  ( ) Maybe
  ( ) Probably not
  ( ) Definitely not
  ( ) Don't know
- Do you believe that you are losing staff because of these event/cases?
  ( ) Definitely
  ( ) Probably
  ( ) Maybe
  ( ) Probably not
  ( ) Definitely not
  ( ) Don't know
- What are the types of responses/actions desired by your staff after these cases/events? (Check all that apply).
  [ ] Getting an immediate brief break from work to recover
  [ ] Being allowed to leave the clinical area immediately for at least the rest of the day
  [ ] Being assigned to a different clinical environment or type of case for a while
  [ ] A multidisciplinary debriefing of the event
  [ ] Talking to someone
  [ ] Help understanding the case review process
  [ ] Meditation, yoga or some other similar activity
  [ ] Exercise
  [ ] Other:
- Who would staff desire to talk to?
  ( ) A colleague or peer
  ( ) A friend
  ( ) A supervisor within the department
  ( ) A professional (psychologist, therapist)
  ( ) A religious leader
- Would you be willing to cancel or delay elective surgery or procedures because the staff was involved in one of these events/cases?
  ( ) Definitely
  ( ) Probably
  ( ) Maybe
  ( ) Probably not
  ( ) Definitely not

- Why do you think staff do not (or would not) take advantage of a peer support program following these cases/events? (Check all that apply).
  [ ] Concerns about privacy
  [ ] Don't think they need it
  [ ] Will appear "weak"
  [ ] Unaware of the resource
  [ ] Don't have enough time
  [ ] Don't perceive peer supporters as a peer
  [ ] Fear of retribution
  [ ] Other:
- What is the *primary* desired outcome for a peer support program?
  ( ) Improving provider wellness related to acute stress
  ( ) Decreasing long term burnout
  ( ) Staff retention
  ( ) Improved quality of care after adverse events
  ( ) Enhanced reputation of the institution
- What percent of your staff do you believe feel burned out from work once a week or more?
  0 – 100
- What percent of your staff do you believe would say they feel the job has made them more callous toward people once a week or more?
  0 – 100
- Staff will freely speak up if they see something that may negatively affect patient care
  ( ) Never
  ( ) Rarely
  ( ) Sometimes
  ( ) Most of the time
  ( ) Always
- Staff feel free to question the decisions or actions of those with more authority
  ( ) Never
  ( ) Rarely
  ( ) Sometimes
  ( ) Most of the time
  ( ) Always
- Staff are afraid to ask questions when something does not seem right
  ( ) Never
  ( ) Rarely
  ( ) Sometimes
  ( ) Most of the time
  ( ) Always
- Please give these units in this hospital an overall grade on patient safety.
  ( ) Excellent
  ( ) Very good
  ( ) Acceptable
  ( ) Poor
  ( ) Failing

- What is your role in the institution?
  ( ) C-Suite
  ( ) Physician department leader
  ( ) Nursing leader
  ( ) Health Care Quality
  ( ) Support services (e.g. housekeeping, and security)
  ( ) Other:
- Please describe your role:
- Your age
  ( ) 20 – 30 yrs
  ( ) 31 – 40 yrs
  ( ) 41 – 50 yrs
  ( ) 51 – 60 yrs
  ( ) 61 and older
- Years you have worked at the institution
  ( ) < 1 year
  ( ) 1 – 5 years
  ( ) 6 – 10 years
  ( ) > 10 years
- I describe my gender as:
  ( ) M
  ( ) F
  ( ) Non-binary
- I describe my ethnicity as:
  ( ) Not Hispanic/Latino
  ( ) Hispanic/Latino
  ( ) Other:
- Is there anything else you'd like to add about your experience with these cases/events?

ENDNOTES

1. Betsy Lehman Center for Patient Safety. The Financial and Human Cost of Medical Error … and How Massachusetts Can Lead the Way on Patient Safety. https://betsylehmancenterma.gov/assets/uploads/Cost-of-Medical-Error-Report-2019.pdf. Published June 2019.
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