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

BETSY LEHMAN CENTER for Patient Safety

EXECUTIVE SUMMARY MAY 2021

INTRODUCTION

Medical harm and other difficult events in patient care occur with frequency in Massachusetts and elsewhere in the country. In addition to the physical, emotional, and financial toll they can take on patients and their families, members of the health care workforce experience post-event complications ranging from loss of sleep and sadness to reliving the event or considering ways to shift their careers away from clinical settings.

In a new report, the Betsy Lehman Center outlines findings from surveys at seven Massachusetts hospitals in connection with a pilot program to implement a model of staff peer support. The surveys were designed to elicit perspectives on the emotional, physical, and work-related impacts of difficult events that occur in patient care.

Among the examples of difficult events cited by the survey respondents were unexpected adverse patient outcomes including deaths, medical errors, and challenging interactions with patients, families and other staff. Health care workers affected by the events included not just doctors and nurses, but other clinical and nonclinical staff such as members of administrative, transport, security, and other teams.

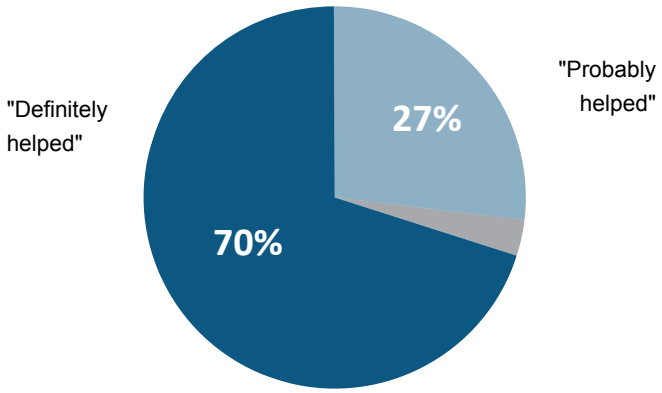
The survey data also add to the growing body of evidence that talking to a peer helps alleviate detrimental stresses that clinicians and staff experience in the aftermath.

OUR FINDINGS

- Frequency: 46% of clinicians and staff experienced a difficult event in the prior year, as did nearly one-third of associate practice providers and other clinical staff, along with 53% of security, 24% of administrative and 46% of other non-clinical staff. Of those who experienced a difficult event, 77% reported two or more such experiences within a year.
- Emotional impact: Only a small fraction of respondents said they experienced no emotional fallout from the difficult event that occurred. In fact, 60% said they were sad afterwards, 34% reported frustration and 31% anxiety. In addition, 41% lost sleep after the event and 33% of clinical and 28% of non-clinical staff said they experienced a loss of joy from their work. Several of the impacts, including frustration and anxiety, could persist for many months.
- Coping: The most common approach to managing emotions and other consequences from a difficult event was to talk to someone else. Of that group, 73% turned to a peer. Talking to a peer "definitely helped" 77% of those who used that coping strategy and another 27% thought it "probably helped." And, among respondents who had not recently experienced a difficult event, 66% said their strategy would be to talk to someone else.

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

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



METHODS

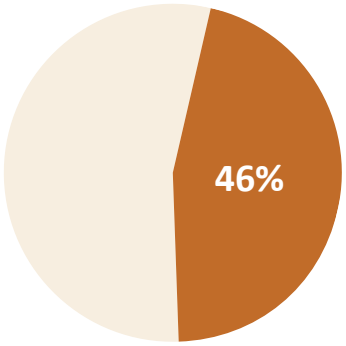
The surveys were conducted by the Betsy Lehman Center in late 2019 and early 2020 as part of a pilot project with seven hospitals committed to establishing programs that include the training of peers to act as peer supporters. Each hospital selected two units for the pilot: one that would institute a peer support program and one that would serve as a control unit. Complementary surveys of both C-suite leadership and the managers of those units was also administered. As of December 2020, about 120 peer supporters were identified and trained across the organizations.

CONCLUSION

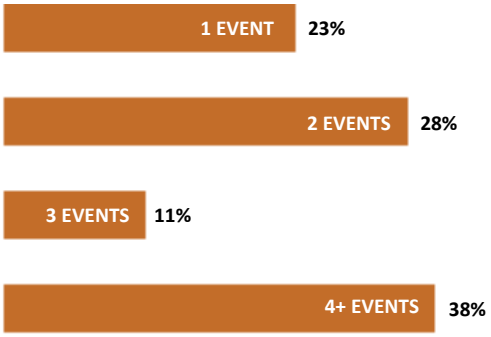
The survey data point to the potential benefits of more widespread implementation of peer support programs. But they also highlight barriers to adoption and use of peer support services. These include reluctance on the part of health care staff to acknowledge they need help after experiencing a difficult event and awareness about resources available to support them.

The pilot peer support program initiative is one aspect of a larger effort by the Betsy Lehman Center to address the emotional needs of health care professionals, staff, patients, and families when things go wrong in patient care.

ALMOST HALF OF STAFF EXPERIENCED A DIFFICULT EVENT



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



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