Transcript

Video: Results of the Pan Canadian Survey of Healthcare Workers View on the Second Victim Phenomenon

Minutes:58:26

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MS. GINA PECK: Good afternoon, everybody, and welcome to the Canadian Patient Safety Institute's Creating a Safe Space webinar series, supporting the psychological health and safety of healthcare workers. This, our second episode, focuses on results on the pan-Canadian Survey of Healthcare Workers' Views on the Second Victim Phenomenon. Our guest speakers will explain the approach taken to obtain front-line provider's views on and experience with second victim phenomenon, then help us understand the results.

My name is Gina Peck, project coordinator and technical host for today's call. I would like to welcome you on behalf of our partners, the Mental Health Commission of Canada, Ontario Tech University, and Chatham Health Kent, Chatham Kent Health Alliance. If you miss part of this webinar or want to share your learnings with others on your team or in your organization, please know that it is being recorded and will be available on our website within the next week. We will also list the upcoming webinars in the series at the end of our hour today.

Please write your questions in the Q&A box on your screen, or chat them directly to me or to Margaret. They will be compiled and provided to our speakers at the end of the call. If you run into any, any IT difficulties, please connect with me in the chat box, and I will try to assist you as best I can.

In today's session, we will begin with Markirit Armutlu who joined the Canadian Patient Safety Institute in 2017 as a senior program manager and is the lead for the psychological health and safety of healthcare workers program. Welcome, Margaret, to the webinar. Over to, to open the discussion on creating a safe space.

MS. MARKIRIT ARMUTLU: Thank you, Gina. Gina, if we can advance the, the slides. Let me just see if we can go.

MS. PECK: Yep, you have the presenter ball. You should be able to advance now.

MS. ARMUTLU: Thank you. I'm having some issues on my end, but I think we can read can redial this. Okay, so I'm hoping that you are, you can see what I see here. It's the, I'm presenting the speakers on the slide. Gina, can you confirm that you can see that on your end?

MS. PECK: Yep, you're good, Markirit.

MS. ARMUTLU: Okay, so thank you everyone, for joining us today, and I'm really thrilled to welcome our guest speakers. We do have with us today Dr. Brenda Gamble, who's associate dean and associate professor from the faculty of Health Sciences at the Ontario Tech university. Brenda's research interests include, quality and patient safety in the medical, in the medical laboratory, health workforce interprofessional practice and education, the -- technologies, and the development of simulations for classroom and clinical settings.

And we also have Dr. Myuri Manogaran. Myuri received her PhD in population health at the University of Ottawa. She's working as a data and research analyst at the Royal College of Physicians and Surgeons of Canada in the Health Policy and Advocacy Unit. Myuri has also worked as a policy analyst with the Health Human Resources Division of the Healthcare Programs and Policy Directorate at Health Canada.

Brenda and Miri are collaborating with us in the research study that you will hear about today, and today's webinar will, actually, start with Gary Deroo, who is a pharmacy clinical practice leader at Chatham Kent Health Alliance. Gary has been a hospital pharmacist for 25 years. For the first 20 years, he has served as pharmacy clinical practice leader and staff pharmacist at Chatham, at the Chatham Health, Chatham Kent Health Alliance. Gary will share his personal experience after being involved in a serios medical error and provide insights into how to improve the outcomes of caregivers who are involved in similar situations.

And so what I'm going to do is just to share with you a bit about essentially why psychological health and safety of the healthcare worker has become a priority for CPSI and outline some of our current projects that we have underway in this area.

So, the Canadian Patient Safety Institute works with governments, health organizations, leaders, and healthcare providers to inspire extraordinary improvement in patient safety and quality. In line with its 2018-2023 Strategic Direction, CPSI works to contribute evidence to inform policies and standards that best support patient safety at the organizational and health system levels, and to embed patient safety requirements in regulations, standards and accreditation. In developing the national program for the psychological health and safety of healthcare workers, CPSI has partnered with the Mental Health Commission of Canada, and has brought together experts from across the country to address the various needs of healthcare providers who are traumatized by events during the provision of care, known as the Second Victim Phenomenon.

Now, we have, over the course of this work, looked up the term Second Victim, and you will note, as we describe the survey to you, as Mary and Brenda describe the methodology and the results of the survey, in that, for the results of that particular survey, we were looking at healthcare providers who were impacted by being on the sharp end of a patient safety event. However, as we proceeded with this work, and you'll see as we move along with webinar three and webinar four, and please join us for those webinars, that the term second victim has broadened, and we are going to be introducing a different term moving forward that really encompasses healthcare providers' experience, and the stress and anxiety that healthcare providers experience within the healthcare environment, in the work environment.

So, our work over the course of the past few years have looked at the developments, and have produced a beautiful document about confidentiality and legal privilege of peer-to-peer support programs. Our first webinar presented that work. Today, we will hear about, we will hear about the survey on the perceptions of healthcare providers, and we will present, in webinar three, you'll hear more about Global Environmental Scan of Peer Support Programs. We will, we are also working on communion guidelines on and recommendations for best practices for peer support programs, and we have collaborated with the Mental Health Commission to develop a comprehensive tool kit for peer support programs in Canada, and we will be launching, in the fall, an expert advisory committee for peer support programs, and what's that, a community of practice for peer support programs to really, on an ongoing basis, to be available and to support

organizations who are in the process of implementing such a program.

Our intent is to really, with all this, influence practices, policy makers, and standards in this area, so we're really thrilled there's a lot of great work that's being done and we welcome to join us in the webinars on these dates, so the first webinar was launched on May the 15th, and today's webinar, again, will be on the survey, and then we've got the next two coming up, and so you'll see here, these are the webinars that will come up, so webinar number three will be on the global environmental scan on June the 20th, and webinar number four, our fourth webinar, will be really to launch our best practices, guidelines for peer-to-peer support programs and our toolkit.

So, with that, I want to proceed to introduce to you Gary, and we will hand over the presenter's tool to Gary, who will speak to you about his learning objectives and proceed with his presentation, so over to you, Gary.

MR. GARY DEROO: Thanks so much for the introduction. So, my role at my facility is a dual role, a bit. It's, for the most part, a frontline staff pharmacist role, with a little bit of clinical practice leader tossed in there at times, and so, as part of my front-line work, I do a fair bit as a frontline pharmacist, and this is the keyboard that I use, at least for the last five years or so to do my pharmacy work at the hospital. You can see in the middle there is my H key, and in our pharmacy system, the H key is a very powerful key. With one keystroke, we can put a medication on hold, and with two keystrokes, we can take a medication off of hold. And a couple of years ago, I forgot to hit H on my keyboard, and that was part of a sequence of events that ended in a patient's death, and so I'm here today to share some of the experience for me that followed, and hopefully to give you a few tips on how to reduce the impact of incidents like these, both for yourself, if you're even in this unfortunate situation, and for the people around you.

So, you've probably seen a picture like this related to this topic in the past. it's an attempt to sort of show you what it feels like to be at the sharp end of a medical incident, and it's really hard to sort of capture the magnitude and the gravity of that experience with a simple photo. For me, the first few days after the, after the patient's death were frankly pretty horrible, probably some of the worst days of my life, actually, and I felt really flooded with emotions,

which is really what this image is trying to portray. I couldn’t even put a name to all of the emotions that were in there. They would sort of come over like a wave. They didn't necessarily have any sort of triggers or pattern. They would just sort of come unexpectedly and disappear just as unexpectedly at times. And as I said, it was hard to put a name on all of the bundle of emotions that was happening for me at the time. There was definitely some, you know, some profound sadness in there, and definitely some fear. I was scared of being sued. I was scared of my college getting involved. Fortunately, one of the things I was never really scared of was how my organization, my hospital was going to react. I had worked long enough with the folks in quality risk and patient safety to know that these sorts of incidents were handled with the appropriate amount of sort of care and compassion, so I'm very thankful that, that was never really one of my concerns. But, the first few days, despite all of that, were pretty terrible.

So, about a week in, or so, I could tell I wasn't doing very well. I wasn't really getting much help of any kind, at that point, partly by my own decision making, and so I started to try to take care of myself, as best I could, and so I started to try to do some sort of self-induced art therapy. I'm not normally a painter, but I thought maybe this was a way to start processing some of this experience, and so what you see here on this slide is a painting that I did. It's got three panels, and it's an attempt to describe sort of the physical symptoms I was having at the time, and so the first panel is sort of a feeling I would get in my stomach on my way to work, the second panel maybe when I was parking in the parking lot at work, and most days, I could manage to keep it in between those two panels and manage to work, and on two or three occasions, I ended up sort of in what that third panel is trying to describe, where I made it into the building, made my way into someone's office who I felt comfortable with and sort of just completely fell apart and ended up having to leave for the day.

Prior to this incident, I would have said I was a pretty mentally healthy guy. My thought, my sort of thoughts and feelings were pretty well in balance. I could use my sort of thinking to control most of my emotions. I've always been a bit of a heart on my sleeve kind of guy, but I always did that sort of by choice, and during this experience, it wasn't like that at all. If I, if you had asked me prior to this experience whether you thought I was well equipped to handle this kind of thing, I probably would have said, it would be

difficult, but I think I have good, you know, strategies and coping mechanisms to manage that, and I was, well, very wrong. It's probably pretty cliché to say, but you really don't know how you're going to react in these sorts of situations until they actually happen to you, and so this sort of balance that you see on the screen got, got tipped, heavily in the favor of the emotional side of things, and so it, there were times that I felt my thinking part of my brain and my emotional part were sort of completely at odds with one another, and it definitely was the emotional side that was winning. Any sort of coping mechanisms that I would have used in the past weren't working very well. I had this, like I said, this sort of wave of emotions that would come and go, and I didn't seem to have any sort of control over it whatsoever, and that was a weird experience for me. I was not really accustomed to sort of not being able to think my way out of things. It was odd to know what the right thing is to do. The logical part of my brain is still working. It knew what all the right things were to do, but all my decisions ended up being based on sort of the feelings I was having at the time instead of by any sort of logic, that was kind of broken at the time.

This is another piece of art that I did around that same time, about a week, or maybe two weeks in, and it's an attempt to show sort of the, the effect of comments that people tried to help me with. People that cared greatly about me did their best to try to say things that they, that, to help me feel better and so this is sort of a pictorial of how effective those were, and so on the right side of the screen, you can kind of see that big blue mess. That was sort of my emotional state at the time, and then the sort of logical symbols that you see on the left kind of represent logical arguments that people tried to use to help me feel better. And so they would say things like, like all logical arguments, like, well, this could have happened to anyone, it wasn't all your fault, someone else you know, should have caught that error, and the truth was, as you can see, they kind of collected in a pile here on the image. Those sorts of logical arguments weren't very helpful, and for the most part, people didn't know what to say to try to help, and those sorts of arguments were the sort of natural instinct of folks to try to help, to try to convince you, or convince me, sort of not to feel the way that I was feeling, and as you can see, those weren't terribly effective. And I, I came to realize it, you know, it wasn't the logical part of my thinking that was, or the logical part of my brain that was

broken, it was the emotional part, and I think that's why these logical arguments, for the most part, aren't very effective, and now that I've had some training on how to help folks in this scenario, I know there are things that I can say that are more helpful.

So, I got offered my hospital's EAP or assistance program early on, and I refused it actually. It seemed very scary to me, for reasons that now I, don't make a whole lot of sense. So, I was worried, you know, that I would be a bunch of red tape or that I would need a bunch of doctor's notes, and I was sort of scared of all of that part happening, and again, the logical part of my brain is telling me, hey, this is, you know this is the right thing to do. You know you need to go talk to somebody, but the logical part of my brain was losing that battle at the time, and my emotions, being scared of the process and beings cared to talk to somebody that I wasn't comfortable with or had never met, all of those things were sort of driving my decision making at the time, and so I ended up refusing that kind of help, and so instead, I sort of started seeking out my own help, and I met with a couple of people at the hospital here who I was comfortable with, who I had a lot of respect for, who I knew were good at handling folks in these sorts of situations, and so I started talking with them.

And one of those people sort of shared a similar experience that she had, had, and not in a way of sort of minimizing my experience or trying to compare the two experiences, but just to say, here, I kind of know what that's like. Why don't I tell you what happened to me? And that helped a bit, actually. It, it made me feel less alone, because there's a great sense of aloneness, at least for me, during the experience, despite being surrounded by people who were trying to help, there was this feeling of being alone, and so sort of finding someone who I could connect with, so, made me feel better And a second person that I talked to didn't try to convince me not to feel the way that I was feeling. They said things like, I wish this was different for you, or I'm sorry you had to go through this, and sort of reflected back the feelings that I was already having, and that was helpful, as well. And I distinctly remember her saying at one point, you know, this has really shaken you to your core, and that really kind of nailed my experience. And I remember for the feeling, for the first time really that someone really understood what was going on for me, and that sort of connection with someone understanding you in that experience felt great.

So, I continued to work through this experience. I sort of removed myself from direct patient care for a period of time. I sort of poured myself into a project that I was working on, and most days, I managed to get a fair bit of work done, some more than others, and there was sort of gradual improvement. As the weeks went by, I was not having those feelings quite as frequently, and not having them as powerfully, but it took forever, or seemed to take forever, and it got frustrating, honestly, at times, because it was so unpredictable. I wanted some sort of pattern or trigger that I could control, and there wasn't anything I could wrap my hands around, and my usual strategies weren't working. It wasn't resolving as quickly as I wanted it to, and so that part got sort of frustrating at time because I didn't seem to be able to make any headway.

I had some other interesting symptoms that cropped up. This is a photo of a two-lane highway, and I remember having an experience where I was driving to my parent's place on a highway just like this, and I got stuck behind a car that was doing, I don't know, like 10 ow 20 kilometers an hour below the speed limit, and in the past, I would have you know, safely passed that kind of car, but I had this risk aversion that accompanied this experience, and I, I could not pass this slow moving car. I had this distinct sense that if I pulled into the passing lane and I saw an oncoming car no matter how far in the distance it was, I was probably going to lose it, and so I just stayed stuck behind this slow moving vehicle for, I don't know, 15 or 20 minutes before it finally turned.

Another symptom that I had was something I ended up calling responsibility fatigue. So, normally, I'm a super involved dad and I'm involved in all my kids' stuff, making sure everything gets done, and for a period of time, I had an awful time, trying to be involved in that sort of thing, even things as simple as making sure the dishwasher got emptied or permission slips got filled out, it was, it was all I could do to keep all of my own stuff together, and no matter how much I wanted to be as helpful as I normally was, I just simply, it felt completely overwhelming, and so even though I wanted to do those things and it felt bad not to do those things I, I simply was not able to be as helpful as I normally was.

This sort of thing felt really great. That's not me, by the way, but it could have been. I'm an introvert by nature, and so I sort of recharge by having time to myself, and this kind

of sort of quiet, sort of moment felt really good. What I came to realize later is, when do you do this you sort of risk excluding the people around you that can help you, like your family and your friends, and I think I probably did an element of that, but that was sort of my experience at the time.

Eventually months later, I ended up feeling really burnt out, ended up taking a week off of work, I started seeing a social work counselor, and that's when things really started to turn around for me, because I finally started to get some of the things that I've now learned that people ought to get in the first 24 to 48 hours, instead of months later.

There was a couple opportunities that I had to be part of the disclosure process and meet with the patient and the family, and that was an incredibly difficult thing to do. Again, my logical thinking was telling me that, that was the right thing to do, but it was incredibly difficult to get myself into that room because I felt so scared about the whole process. I'm so glad I did, though, and it's one of the takeaways that I share when I present this kind of material at my hospital's orientation, is that being part of the disclosure was a big piece for me because, when, months' later, when the hospital met with the family, I wasn't present, but the family mentioned that I was sort of one of the highlights of their stay and that after the incident had occurred, I was sort of compassionate and honest and forthright and obviously cared about what had happened and did my best to sort of manage the situation after the fact. I was very thankful I had sort of managed to get into the disclosure process.

SO, even in the early days, as people were trying to help me, I already knew that I wanted to be able to do these sorts of things in the future, so long before I heard of sort of second victim phenomenon or peer support, I was already imagining, you know, what we could do at our facility, have a list of people that maybe had some training, who would be willing to talk to folks, who were having these experiences, and the person who was affected might be able to even pick somebody from the list that they were comfortable with to avoid that sort of whole fear of strangers piece, and so then, I sort of started to dig more into the topic, learned more about peer support, and I started getting involved in trying to make this better for my own facility and for other facilities.

Then, significantly later, I heard that my own hospital was developing a peer support program, and I immediately got involved and, and so I've had the opportunity to help some folks in those moments, and that's a really rewarding experience.

That's not me, either. I only wish I looked that cool, but I like this picture. It sort of describes for me how I feel now, sort of after the fact. I'm not sure if I'm a weaker person or a stronger person. I'm definitely a different person. There's some sort of longstanding effects of this experience. One of those is that sort of rock solid control I had over my emotions isn't what it once was, but I've also developed a big, obviously, big compassion for this topic, and so gain, in my hospital orientation, I do my best to help people prepare themselves by sort of helping them think about medical error as a system problem instead of a people problem, and also, to give some sort of emotional first aid strategies to help them take care of the people around them, if it ever happens to them. I also took part in producing an ISMP or Institute for Safe Medication Practices newsletter a while back that sort of highlighted second victim phenomenon and some strategies for facilities on how to do a better job of managing that in their buildings.

And so, I'd like to close by saying thank you. I'm really appreciative to share the sort of human element of this topic in a way that’s tough to deliver on paper. I've been waiting for quite a while for this kind of opportunity to sort of share this, to be part of making this situation better for folks, and so I, I'm thankful to the coordinators for giving me the opportunity.

MS. PIKE: Gary, thanks so much. It's Gina here, back again, and to articulate your story for us is nothing short of amazing. Thank you so much. Your story really touched me, and I really do admire your bravery in sharing that with us today, so thank you. For those on the line, if you have any questions for Gary, please add them to the chat box or Q&A box, and we will invite him to answer them in the session at the end of the call. That being said, I'm going to now pass it over to Myuri, who was introduced at the top of the hour. Myuri, I'm going to give you the presenter ball. You'll be able to advance your slides, and I will pass it over to you. Can you hear me, Myuri? Your line is now unmuted. Thank you. Thank you.

MS. MYURI MANOGARAN: Thank you, Gina, for the introduction. I'll just advance my slide there. Okay, so thank you again, Gina, for the introduction and facilitating this session. So, the purpose of this presentation is to provide an overview defining the National Survey on Healthcare Workers' Views on the Second Victim Phenomenon, and before I start, I would like to acknowledge my research colleague, Dr. Brenda Gamble, who is on the line, as well as the members of the Canadian Patient -- - Institution, who are also a part of this study and provided support. So, quick outline of the presentation, I will go through the objectives of the study and the approach that was undertaken, the demographics of the respondents, key findings, and end off with conclusions from the study, as well as recommendations.

On to the objectives, over the last decade, the Second Victim Phenomenon has been identified as a serious issue for frontline healthcare providers, with the severity of this issue potentially impacting their well-being, as well as the safety of the patient. So, the purpose of this study was to determine the extent of the Second Victim Phenomenon in Canada, and the resources that are currently available to support healthcare providers across the nation.

Onto the approach, a national, self-administered online survey of all front line healthcare providers - - administered towards the front of 2018. We used a validated survey instrument called the Second Victim Experience and Support Tool to identify second victim occurrences and support resources. In addition to this, data was collected related to the respondent demographics, employment characteristics, and educational history. We also had four open ended questions on second victim support.

So the data analysis for this study, we used multi-descriptive statistics, and the results were analyzed by professional groups, sectors, and years of experience to determine if the view differed within professional groupings or by the demographics, and these responses were grouped and analyzed by themes, based on the open ended questions that we had asked at the end of the survey.

So, on to the demographics, who responded to our survey? We had a total of 390 frontline healthcare professionals completing this survey. Of the 290 frontline healthcare professionals, the majority of the respondents of this survey indicated residing in the province of Ontario. Nunavut and the Northwest Territories had the least amount respondents,

and Medical Radiation Technologists represented the highest group to respond to our survey. SO, as mentioned previously, the largest amount of respondents were from the Medical Radiation Technologist groups, which as followed by the nursing groups at 10 percent, physicians at nine percent and pharmacists at eight percent. In terms of the area of practice, the majority of the respondents indicated working in the acute care sector, and this is around 69.2 precent of our respondents. In terms of the years of experience, 65 percent of the respondents indicated, indicated having more than 12 years of experience in the field, and this is followed by 11 percent each for those having nine to 12 years of experience and six to eight years of experience.

So, onto the findings, in terms of involvements in a patient safety event and the impact from that event, 58 percent of our respondents indicated that they had indeed been involved in a serious patient safety event impacting one of their patients. 32 percent indicated that a patient safety event caused them to experience anxiety, depression or wonder if they would be able to continue to do their job in the last 12 months. So, of the 32 percent that I had mentioned previously, who indicated experiencing some form of symptoms, post the patient safety event, 89 percent of them indicated not receiving any kind of second victim support at their institution, and 35 percent of participants indicated being not satisfied with the amount and type of support that they received, if they did receive any.

So, our respondent were presented with some statements to rate, pertaining to the psychological distress of experiencing a patient safety event, so looking at the table here and the first statements they represented at, more than 50 percent of respondents agreed that they experienced embarrassment from these instances, and that the occurrence made them fearful of future occurrences. When presented with statements on physical distress, majority of respondents disagreed with having experienced most of the symptoms on the list. However, 37.8 percent agreed that the mental weight of their experience was indeed exhausting, and this may suggest that the psychological symptoms after experienced a patient safety event are experienced stronger by healthcare professionals in comparison to the physical symptoms.

So, of the 123, or the 35 percent who indicated experiencing anxiety, depression or wondering if they are able to continue their jobs, due to patient safety events, 89 percent of them did not receive any second victim support at their

institutions, so that's the circle there in red. Only 6.5 percent of victims indicated receiving second victim support at their institution.

So, when asked in the short answer questions, the top three types of second victim support that were received by respondents, and again, this is the 6.5 percent group were support from their employment assistance programs, discussions with their managers, and discussions with their colleagues. Here are some quotes to support the top three, the top three supports that were listed by the respondents. We have a medical radiation technologist who said, we have an employee and family health program that I have utilized a few times. Discussion with manager and colleagues about event and impact on myself and the client's family, this was said by a physical therapist, and then a nurse had indicated that follow-up with manager, support from colleagues and counseling through EAP.

Of those who received support in the last 12 months, 35 percent of participants indicated not being satisfied with the amount and type of support they received. The respondents indicated there being no acknowledgment of the incident, ignorance, as well as being subject to inappropriate jokes or bullying by the manager or team members. Here are some quotes to support it. I know the second one's a big longer, so I'm going to focus on the first one for, in consideration of time. This is a quote that was provided by a medical radiation therapist, or technologist. My manager at the time made inappropriate jokes about the incident, and offered zero support, including not mentioning how to get in touch with any form of employee assistance. Now, the latter one is from, by a physician who, pretty much in summary said, they're traumatized by the institution's blatant avoidance of actually investigating the situation, but they talk a bit about how the institute had reacted to the situation, as well as the support that they received, or the acknowledgement received.

There was a question asking about what were the types of support that respondents had, would like to receive in the event of facing a second victim incident. Of the seven types of support that were presented to them, the majority of respondents identified having a respected peer to discuss the details of what happened as being very desirable, and this was 82.8 percent of the respondents. This was followed by having a specific, peaceful location that is available to

recover and re-compose also being ranked as desirable, at 76.7 percent.

So, when respondents were asked to identify the type of Second Victim Support they would like to receive, the top support that was highlighted by respondents were confidential support, both on and off site, peer support from their colleagues, support and or conversation with their manager, and time off immediately after an incident, and here are some quotes to support, to support the top five or the top four supports that were discussed. In addition, respondents were asked what they would do differently if they were supporting a peer based on their experience, so being available, in both time and space, encouraging discussion and asking what support they wanted, being empathetic and understanding, and encouraging them to seek help were the top most stated types of support, and the following slide has some more quotes from the healthcare providers, for instance, one from our physicians that said, when a colleague recently experienced a difficult patient situation I called her to say that I was available to talk if she needed it, and a nurse encouraged reaching out for help, even if they feel fine, as well as sharing the experience with colleagues, and then the last quote was from a medical radiation technologist, who said to listen, understand, enact policies and processes to support safer work practices, learn from the incident, and let them know that they are not alone.

So, while the majority of respondents provided comments on how they would support a peer who has experienced a patient safety event, there was also other, some form of backlash for supporting a peer, and stated being reluctant to do it again. Some also stated their own personal hardships as a barrier to helping a peer. So, for instance, in the first one, from a medical laboratory technologist, I just can't. I don't have the time at my workplace to support my coworkers in this way. I can say a nice word or give a quick hug, but then we have to move on with the work, but then we have to move on with the work. That is its own form of trauma inflicted on staff, expecting staff to be in attendance and focused on work when they are experiencing their own personal hardships. And then a pharmacist, I did support a peer and a colleague and got blamed for doing so. I don’t know what I would do differently. I didn't believe we genuinely have a no blame culture in hospitals. Still too much fear. The respondents were asked for advice in terms of the best support of guidance possible to a team member who was emotionally impacted following a patient safety incident, and the top

forms of support that were advised by the respondent included confidential support for everyone involved in the incident, debriefing, acknowledgement of the situation and sympathy, actively listening, follow up and face to face support. And again, here are some more quotes to support the last slide. The best thing to do is to listen openly and non-judgmentally from a physician. A respiratory therapist said, have someone available and checking in often, not just immediately after. Another physician mentions that debriefs are helpful, but not just leaving it after the debrief. Revisit in a few weeks or months to see if things are going okay, there has been any impact to work or if they need more support, and an occupational therapist mentioned acknowledge the impact. Make it easy for persons to seek help, not just in nursing, but across professions. So, conclusions and recommendations, based on the data collected, it is evident that the majority of frontline healthcare professions that have experienced a patient safety event are not receiving second victim support at their institution. Although 35 percent indicate not being satisfied with the support they received, their written responses indicated otherwise, asking for the support, understanding, and empathy for their peers and managers undergoing such an experience. This data and interviews with healthcare managers will help to understand how to support our healthcare professionals.

In terms of recommendations, this survey is the first phase for identifying existing current support systems and assessing the needs of second victims. A follow-up to this study, as I mentioned assessing earlier, a follow-up on the view of healthcare managers and leaders will help to understand what these leaders need in order to be able to support their team members in need of second victim support. As well, with the high number of respondents from MRTs or medical radiation technologists, follow up with the MRTs via focus groups or key intimate interviews to delve deeper to what the concerns are and where they are stemming would also be of benefit.

That concludes my presentation, and just before ending, I would like to thank the Canadian Patient Safety Institute for the opportunity to work on this study. It was a, it was a great experience and definitely we, I'm sure we all learned a lot from this. I'd also like to acknowledge the Ontario Tech University for supporting and facilitating this study, as well. Thank you.

MS. PECK: Great, thank you, Myuri, and of course to your colleague Brenda for putting this presentation together for us today, and of course, Gary. All the presentations were wonderful. We thank you all, and of course, thanks to my colleague Markirit for inviting such terrific spokespeople to lend their insights. We do have some comments in the chat box. First of all, we wanted to, Kareen wanted to say thank you to Gary for such an honest, authentic presentation of a challenging personal experience. It was well presented. Sherry says the same thing, thanks for sharing your story with us, Gary, and Kelly says, thank you, Gary, for the transparency and the courage to share your story. I think you're an incredible ambassador for physician wellness. Your messaging about the impact for second victim on the mental health of frontline staff is compelling, very inspiring.

So, the chat box is open. I'm going to keep an eye on that. We'll also keep an eye on the Q&A Box. I did have one question that came in. Gary, you're a pharmacist, and when you talk about risk aversion, I know it's kind of, it's kind of a broad question, and it would be different for everybody, but how long did it take you to be confident in your role at work again?

MR. DEROO: Interestingly, if you recall that sort of picture I did with the cardboard, that big blue mess on the righthand side, a month later, with the help of a social work counselor, I determined was almost entirely grief, and I never actually suffered greatly from the piece that people often do, which is guilt. And I, and I'm, I think the reason that is, is because going into this incident, for years, I had been sharing the message of just culture, and through hundreds and thousands of incidents that I've reviewed over the years, I've extremely rarely thought that it was the practitioner that was at fault. It's almost always the system that's the problem, and so when it came sort of my turn to be in this experience, it, it wasn't very long before I sort of let myself off the hook in that regard. I thought of myself as unlucky, and that's how I sort of spoken to folks in the past in similar experiences, and continue to speak to them now. It's not the people, for the most part, that are the problem. I had a crippling amount of grief, but guilt and concern that I was a poor practitioner was something that I was spared, and I sort of deliver that message at my hospital orientation, as well. I try to encourage people to develop in themselves and around them the idea of just culture, and a systems approach to medical error, because I really think

that's what helped me sort of not suffer that portion of it when it came to be my turn.

MS. PIKE: That's wonderful. Good insight and great information to share with the group. I do have, let's see, another question here from Laura. Thank you for sharing your story. I work in addictions. I wanted to ask you, do you consider the disclosure process similar to a reconciliation process, or are the two different? As we do our accreditation, I wanted to understand the difference?

MR. DEROO: I'm not sure, actually, what a reconciliation process is. For me, I had an opportunity to meet with the family sort of after the event had happened, but before the patient had died, and so I had an opportunity to be part of explaining what had happened, to apologize for my part of it, and to sort of help develop the plan of care moving forward, and so for me, that was my sort of involvement in the disclosure process. I can't say how that differs from what a reconciliation process is like.

MS. PIKE: Perfect, perfect. Well, thank you, again, for that insight, Gary. I think, Laura, if you have any additional questions or a little bit of further-up to your question, you can certainly send it to me, and we'll see if we can get some information for you. Myuri, there is a question for you. I will get you to unmute your line. Was there a difference between the professional groups in their experiences or perceptions when it came to the survey?

MS. MANOGARAN: Thank you, Gina. We did look into that, and there's not much of a difference between the professional groupings. However, because we had such a high number of respondents from the medical radiation technologist group, we were just suspicious that maybe that, that was indicating they were having a different experience and that could have skewed the result, so as a result of that, we did look deeper into the results, separating that group out and separating them into a different group, and it turns out that there wasn't much of a difference. There were some categories in the psychological stress where the group that did not include the MRTs had more of the, they agreed with more of the symptoms, or they were experiencing more of the psychological symptoms versus the MRTs, so that's what I could say to that.

MS. PIKE: Great, thank you for that response. And just to go back a little bit more, Myuri, it might have been mentioned a little earlier in the presentation, but somebody, somebody

asked, how long did it take to distribute the survey, and what, how long did it take you to compile the data?

MS. MANOGARAN: Okay, so the survey was in distribution, I believe there was about four to five months that we had the survey out. In order to compile the data together, with data cleaning, and to do the data analysis an everything, it was about a couple of months, that it - - too.

MS. PIKE: Great, thank you for that. We do have another comment in the chat box. I don't see a question in it, but it says, thank you for the presentation. A group of colleagues and myself have recently been published in JMRS as we investigated the effects of the SVP in radiation therapists. Our results were very similar to yours. Spreading awareness is a great first step. That came in from Suzanne. Thank you, Suzanne, for that.

MS. MANOGARAN: Yes.

MS. PIKE: Indeed. Gary, over to you, another question, would you suggest peer support being received by similar professional peer groups, or, or of similar experience?

MR. DEROO: I think at times that can be helpful in that what, I think one of the big benefits of the peer support process is that personal connection piece. If someone can sort of appreciate at least at some level what your experience has been, that might be more easily done at times by someone of your similar profession. At the same time, I don't think it's required. If you have people with the right training or the right skillset, anyone can do these things well. There was a group of us that went for - - incident stress management training, and virtually anyone can do that work. There's some pretty simple steps to help folks who are experiencing emotional trauma or difficulty, and I think anyone can help in those moments, regardless of what their profession is.

MS. PIKE: Great, thank you for that. It is very good advice, for sure. What would be the difference, Gary, question for you again, between peer supporter and EAP program, in your opinion?

MR. DEROO: For me early on, the difference was in the comfort level I had with it. The EAP program, again, it felt scary to me for reasons that I realize aren't logical now. But at the time, it felt very scary, because there, I felt like there would be some sort of process involved, and paperwork and red tape and checkups by, you know, human resources or

occupational health, all things that felt scary to me at the time, and simply the fact that I'd be talking to somebody who I didn't know. Again, I knew that, that was the right thing to do, but the emotional part of me didn't want that at all, so I think the difference with peer support is that you have somebody, hopefully, that you have a relationship with already, and I think that can facilitate just getting to talk for the first time.

MS. PIKE: Yeah, I think we all have access to those EAP programs, but it's like you say, having that personal connection, somebody that you have confidence in that, that you can speak to, as a peer support, really does make quite a difference, for sure.

MR. DEROO: And I think there's a role, there is definitely a role for the EAP program. I think it might come later. I think in the first couple of days, or even a week or two, you, I think the peer support program enables connection with that, held faster. I think the EAP program can kick in later, potentially, after that sort of initial shock period is sort of passed.

MS. PIKE: Right, right. I do have, sorry, Myuri?

MS. MANOGARAN: Sorry, I was just going to quickly add in this discussion about the EAPs and peer support program, I also think that, as one of the things we realized is part of the survey, a lot of people commented on the EAP support programs taking a lot of time to kick in, so you know, there's a longer process to getting, requesting the service and whatnot, so I think while waiting for that gap, or waiting for it, I also guess it seems like it's also, for lack of words, is systematically, like, for lack of a better work, it might just, I guess that's another reason why people just want to turn to peer support programs. It's more readily available and you're able to make that connection. As you mentioned, I just wanted to throw that in, that other sort of level there.

MS. PIKE: No, that's great, Myuri. Thank you for that, for sure. I did have another question come in, Gary. You talked about the disclosure process. Can you elaborate on that a little more?

MR. DEROO: So, I sort of described the opportunity that I had to go in and speak to the family, and as I said, it was a very, very challenging thing to do. I think if folks are going to be asked to be part of that process, they're going to need more than just convincing to go. I wanted to do the right

thing, and it was incredibly scary all at the same time. The emotional part of my brain was sort of telling me to run away as far and as quickly as possible, and so it took everything I could to get into the room a couple of times to have those conversations. So, again, I'm so thankful that I did, because I think in the long run, practitioners will feel sort of much better about the overall experience, if they've had the opportunity to be part of that process. It's just incredibly difficult to do early on.

And similarly when we have sort of process reviews, at least at hospitals on what happened and what we can do differently to prevent these kinds of errors in the future. Similarly, it was very difficult to get to that sort of meeting, as well, for the very same reasons. I knew it was the right thing to do. I've been to those before. I know that they're handled well, and still, it very difficult to overcome the fear to get in there, and so I think folks, if they're going to be asked to be part of that process, as well, need emotional support to get there, not sort of logical convincing that it's the right thing to do, because they probably already know that.

MS. PIKE: Well, thank you so much for sharing those insights. I do know that we're getting close to the top of the hour. I want to respectfully thank you Gary, Gary Deroo, Dr. Myuri Manogaran, and of course Dr. Brenda Gamble for sharing your time and expertise. Thanks to all of your for attending the call today, for taking the time to attend. I know that the voice on the end of the line isn't the usual one. My colleague Christopher Thrall, who's our communications officers, is out sick today, so I apologize for my shortcomings. He's certainly the communications expert and I usually stay behind the scenes doing the technical aspect, but thank you all for sticking around and hearing these very, very valuable insights. I'd like to thank our partners today, the Mental Health Commission of Canada, Ontario Tech University and Chatham Kent Health Alliance. Just a little note to advise you of this, if you want to continue the conversation started in the discussion, int eh chat box, please feel free to send me an email directly. I will forward your comments and any additional questions you may have that either were unaddressed or we didn't get to today. We'll send them on to our speakers and try to get back to you with responses. You should get an email from me today following up with this webinar. It should go directly into your inbox, and if everything goes according to plan, you also should get a link to the document that Gary alluded to earlier. We will be

posting a recording of this webinar to the CPSI website. It should take about 7 to 10 days for that to be uploaded. So, thank you all again. We invite you to join us for the next two webinars in the series, which continue on June 20th, with a global environmental scan of peer to peer support programs, and then the series ends on September 20th with the Canadian Best Practices for Peer to Peer Support Programs and the launch of the Peer to Peer Support Tool Kit. I can't thank you all enough for joining us today. Have a wonderful day and hopefully we'll see you again soon. Thanks, everybody.

[END OF TRANSCRIPT]