

Patient Safety & Staff Support; Voices From The Frontline

Dr. Thomas Conway¹, Lucy Barnard², Eloïse Blanquet², Dr. Rohana Ramachandran¹

¹General Paediatric Department, Evelina Children's Hospital, London
²GKT School of Medicine, King's College London

Why is this important?

In Paediatric Medicine, patient safety issues including complaints and serious incidents represent one of the most emotive clinical situations in which staff can find themselves. This makes compassion towards them all the more important.

Critical incident investigation in healthcare has been shown to have significant psychological impact across the MDT. It can induce anxiety, depression and even in some cases PTSD which can negatively impact on the attitudes and behaviours of practitioners towards their patients.

It is therefore vital that we recognise the importance of support for staff which will contribute to continued high quality care.

What is PSIRF?

The Patient Safety Incident Response Framework replaces the Serious Incident Framework (2015) and aims to integrate **compassionate engagement** of those involved, **considered and proportionate responses** and **supportive response systems**.

Objectives

Our project seeks to **explore personal experiences** around the investigation of clinical incidents and gather suggestions from those involved to **improve engagement and learning**. The intention is to inform changes to support implementation of the Patient Safety Incidence Response Framework (PSIRF).

Methods

An initial survey with 24 respondents sent to inpatient and emergency departments of a tertiary children's hospital found the majority of staff felt unsupported, their views unheard and that there was a lack of information concerning outcomes of investigations.

A subsequent focus group was set up with 12 members of the MDT to review survey results and discuss next steps. It was felt a help booklet would be well received.

A follow up survey offered to staff across inpatient, emergency and intensive medicine departments. The 62 responses were anonymous. Respondents were asked the following:

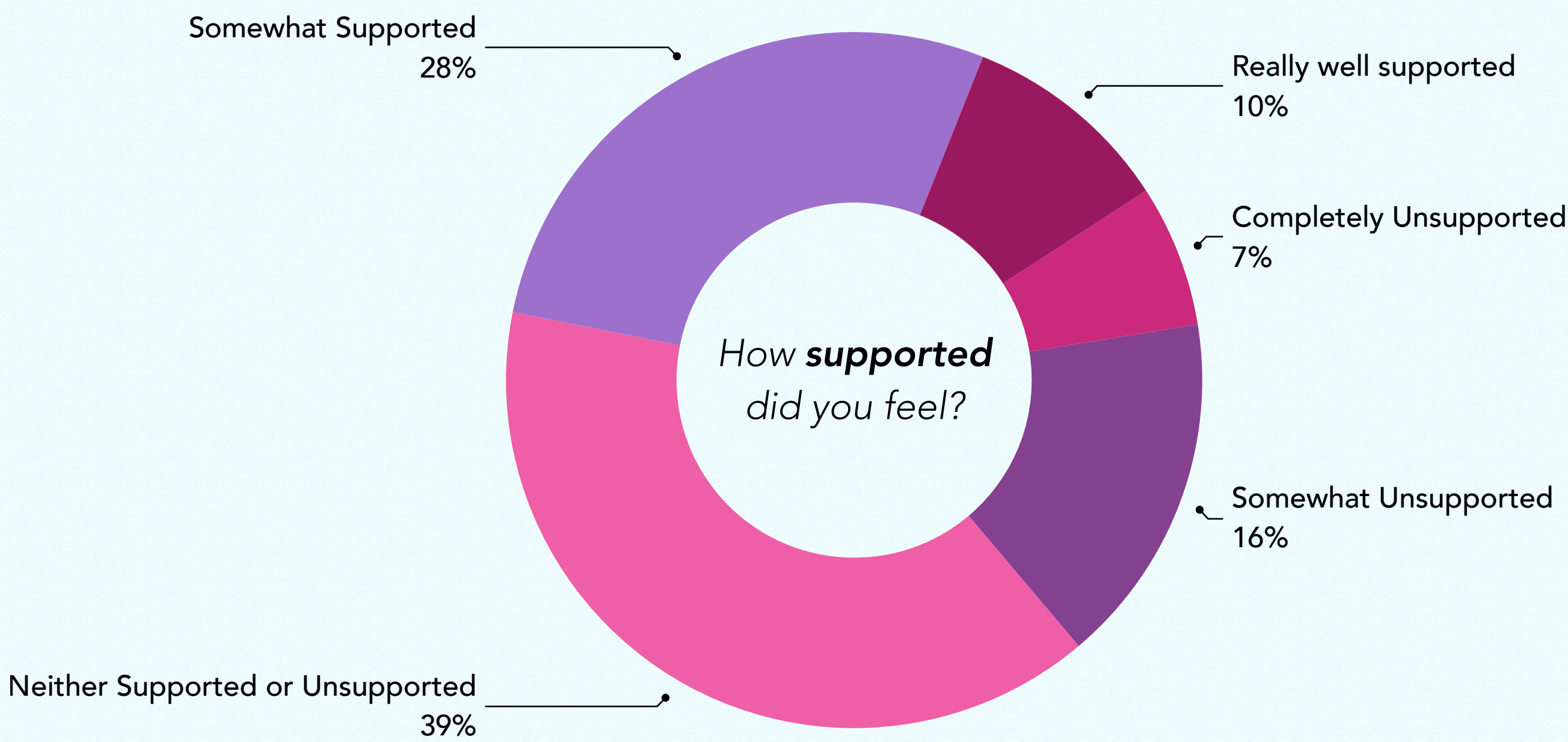
- One word to capture the **emotions felt** when involved in an investigation.
- Score **how clear the purpose was** to them and **how supported they felt**.
- Were they **listened to and involved** in generating learning that arose.
- Did they change their practice and what three actions would they suggest to **improve staff experience**.
- Would they value an **information booklet** and what content would they want it to include.

At the end of the survey there was an optional free text section for further suggestions.

Results

62 staff from Paediatric Medicine, Paediatric Surgery, PICU and NICU responded to the survey. Doctors accounted for 49%, Nurses for 43% and Allied Health Professionals for the remaining 8%.

Emotions felt about investigations



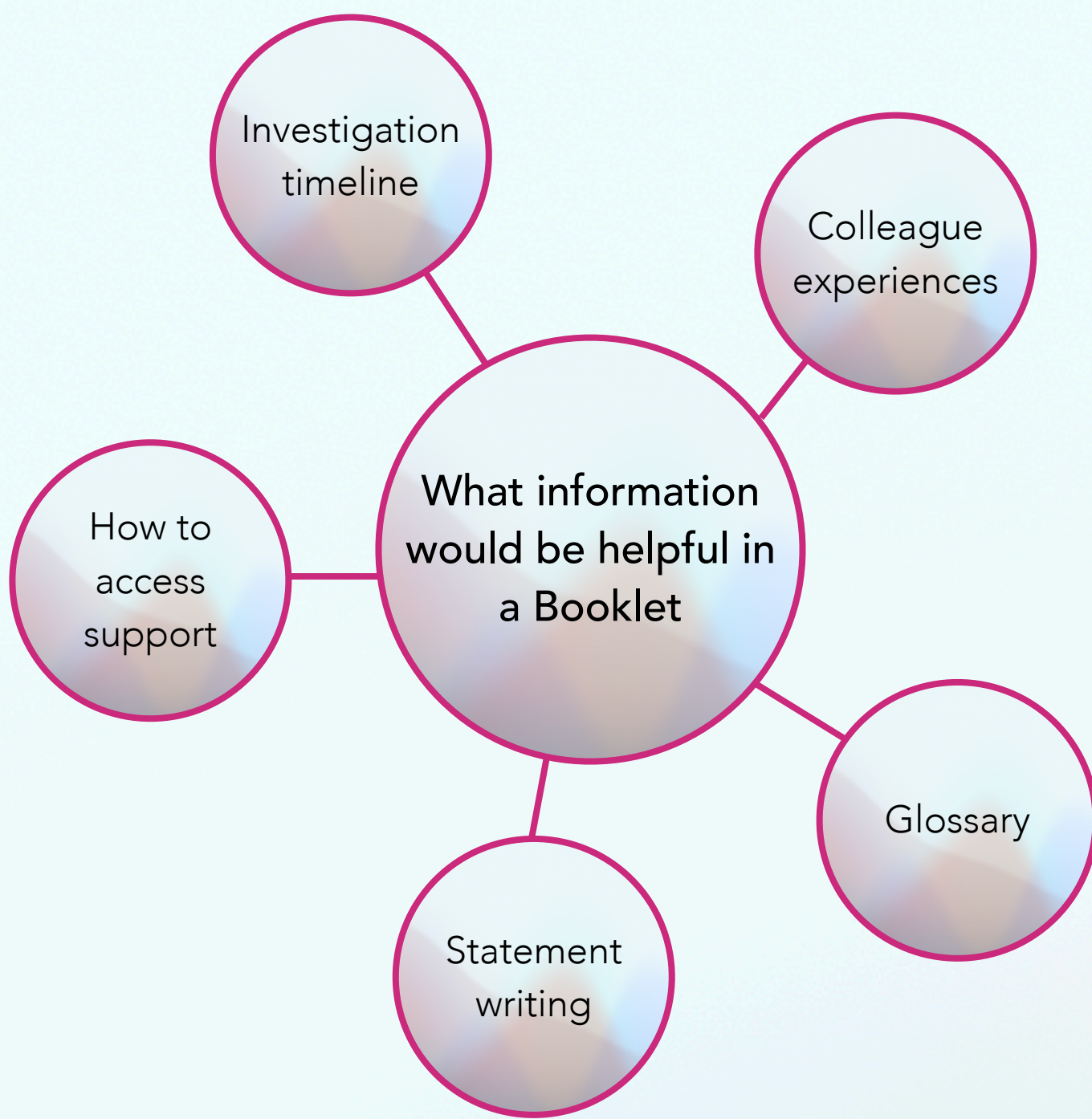
Staff unclear about purpose of investigation.

Top actions for ensuring a positive experience

1. Mentorship / Supervisor / Easily accessible pastoral support
2. Education and guidance
3. Emphasis on positive learning outcomes and supportive culture
4. Importance of 'safe-space' debriefs for all involved



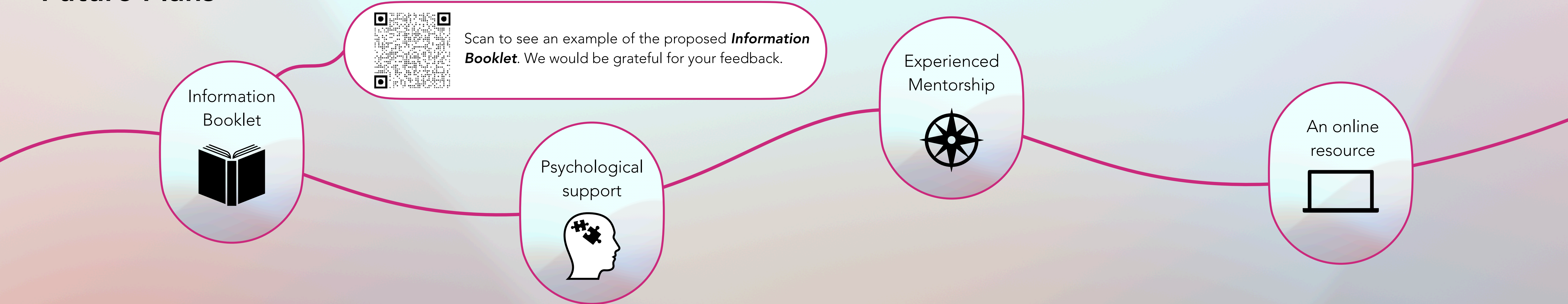
Staff would find an information booklet useful.



Conclusions & Analysis

The findings support the changes advised in the PSIRF framework. They also identified emotions and anecdotes which will be a valuable component of the proposed staff resource. It was felt that it would be useful to have an advice booklet including clear signposting to resources such as *statement writing support*, *investigation timelines* and how to access *local and national support networks*. In any event improvements need to be made to improve the personal experiences of staff involved and better support them through this process. By doing this, engagement in the process will be better and learning outcomes likely more effective. It is important to remember that improving safety and encouraging a culture of learning should always go hand in hand.

Future Plans



References

1. de Boer J (Coby), Lok A, van't Verlaat E, Duivenvoorden HJ, Bakker AB, Smit BJ. Work-related critical incidents in hospital-based health care providers and the risk of post-traumatic stress symptoms, anxiety, and depression: A meta-analysis. *Social Science & Medicine*. 2011 Jul;73(2):316–26. doi:10.1016/j.socscimed.2011.05.009
2. Oster NS, Doyle CJ. Critical incident stress and challenges for the emergency workplace. *Emergency Medicine Clinics of North America*. 2000 May;18(2):339–53. doi:10.1016/s0733-8627(05)70129-2
3. Patient Safety Incident Response Framework [Internet]. NHS; [cited 2024 Feb 22]. Available from: <https://www.england.nhs.uk/patient-safety/incident-response-framework/>

*This project and proposed resources are yet to be approved by the hospital.

Contacts for feedback: tconway@nhs.net rohana.ramachandran@gstt.nhs.uk