patient safety learning

Staff Support Guide

a good practice resource following serious patient harm

Part of the *Safety for All* campaign

SAFETY FOR ALL

patient safety learning

SAFER HEALTHCARE BIOSAFETY NETWORK

The *Safety for All* campaign is focused on driving awareness of the interrelationship between healthcare worker safety and patient safety. It not only highlights how poor healthcare worker safety standards and practice impact adversely on patient safety, but also champions the need for a systematic and integrated approach to improve safety practice in both healthcare worker safety and patient safety. By doing so, the sum becomes greater than the individual parts.

We are calling on the government and leaders in the health and social care sector to recognise that patient safety is to some degree dependent on the delivery of effective healthcare worker safety (and vice versa). Also to implement nationwide standards, practice and structures on patient safety culture which take account and, where possible, align and combine both patient safety and healthcare worker safety.

The campaign is run by Patient Safety Learning and the Safer Healthcare and Biosafety Network and financially supported by industry: B. Braun, BD, Edwards Lifesciences and Stryker.

Contents

Introduction

As healthcare has become more effective it has also become increasingly complex, with greater use of new technologies, medicines and treatments. In this complicated environment there are many different ways in which avoidable harm can potentially occur. Errors can have life-changing consequences and in the worst cases result in the death of a patient.

In recognition of this, it is vital that we create an environment with an open and fair culture, that enables patient safety issues to be raised, discussed and resolved and which ensures incidents of avoidable harm are responded to with empathy, respect, rigour and action for improvement. To achieve this, we need to ensure that patient safety incidents are reported consistently and that staff and patients feel safe and supported in doing so.

Whilst the first priority of any avoidable harm will be to support patients and their families, staff directly and indirectly involved should also be provided with the support they need following an incident and subsequent investigation.

This support guide and resource focuses on what needs to be put in place for staff. It will also shortly be available online and in expanded form, with individual guidance for staff members, managers and organisations. (See Appendix.)

This guide seeks to address two key questions:

1. How can we support staff involved in serious incidents better, so that these can be more effectively investigated and result in learning and improvement?
2. How can we ensure that where staff are an unintended contributor to avoidable harm they are treated fairly and empathetically?

There is no simple 'one size fits all' approach. What is required varies in practice depending on the incident itself and the personal and emotional response of the staff member involved.

However, the process following a serious incident has a number of common steps where the right information and support, given at the right time and in the right spirit, can have a significant impact on the staff member.

This guide outlines what good practice support looks like for a staff member following a serious safety incident, and through the subsequent investigation and aftermath.

It has been written not just for staff members involved in serious safety incidents, but also their line managers and senior leaders seeking to improve their organisation's approach and handling of them. It is intended to:

- Help staff feel safe to speak about serious incidents and confident that they will receive appropriate support recognising the personal impact that this may have on them
- Foster an environment of openness and discussion of patient safety incidents; consequently supporting a culture of learning and acting on their findings.

This guide has been produced by Patient Safety Learning and the Safer Healthcare and Biosafety Network, as part of the *Safety for All* campaign, supported by an Expert Advisory Group of patient safety leaders, clinicians and those with direct experience of supporting patients and staff following avoidable harm.

Step-by-Step Guide: flow chart

Knowledge of incident

- Appropriate senior person informed
- Immediate support offered
- Next steps indicated
- Incident logged

Incident investigation

- Staff member informed of investigation / review
- Well-being support provided
- Support in preparation given
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- Draft report shared
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Post-investigation

- Ongoing / long-term support for staff provided
- Personal training needs met
- Learning and improvement facilitated

Step-by-Step Guide

1 Knowledge of incident

1.1

Appropriate senior person informed – enabling the incident to be reported in a timely and appropriate manner.

- Providing the staff member with guidance on who to report to and when, meaning that they will know immediately who to contact, including out of hours. If the person is their line manager, they will need to know who to approach in the event that their line manager is unavailable.
- Giving them the time and space to sit quietly and write down everything that happened while events are still fresh in their mind. This will stand them in good stead when the incident is subject to investigation / review at a later date.
- It is advisable that the staff member completes any outstanding patient records before they leave the hospital on the day of the incident.

Step-by-Step Guide

1.2

Immediate support offered – ensuring the staff member has the support required.

- Giving the staff member an opportunity to speak to someone about the incident, as well as access to a 'wobble room' and other forms of immediate support (e.g. help in getting home safely; contacting a family member, if required; access to an employee assistance line or buddy scheme). This reinforces the organisation's commitment to supporting staff in the event of a serious incident.
- In early conversations with the staff member there should be a focus on how they would like to be supported:
  - They should know that they don't have to give an immediate answer; rather that there are people who can provide individualised support that meets their needs, alongside a recognition that their needs may change over time.
  - There should be a supportive and empathetic approach that ensures the staff member is able to sit down with someone who will take them through what to expect, while listening to their fears and concerns.
- As a minimum, the staff member will need a copy of the Trust's Serious Untoward Incidents policy, plus guidance on how to document their recollection of events, along with information on how to access advice from their relevant Royal College website, Trade Union, etc.
- In the event that they need time off, or it is important that staff are supported by trained managers, supervisors and/or HR professionals who can ensure they have the necessary information and support, as well as instil confidence in the process.
- Plans should be in place to provide cover for staff who need time off, to help counter any increased anxiety concerning the potential impact of this on colleagues and patients.
- Expected standards of behaviour, along with their associated values, should be reinforced to other members of staff to help ensure that the colleague involved in the incident is not subject to gossip or offhand, insensitive comments.

Step-by-Step Guide

1.3

Next steps indicated – providing the staff member with clarity about the process to be followed.

- The staff member will need to know as soon as possible whether an investigation / review will be undertaken and if referral to another agency may be warranted (e.g., Police; Medical Examiner; etc) so that they can prepare and be prepared.
  - Information provided should include the systems, controls and barriers in place, so that there is awareness of system resilience.
- The staff member should be provided with information to demonstrate and assure them that the process will be fair and balanced.
- They should receive a checklist of potential next steps to help prompt questions if the Trust has not provided the expected information
- Key things the staff member may want to know are:
  - Who will be informed?
  - When the patient will be told, in compliance with Duty of Candour?
  - What category of incident will be assigned?
  - What immediate steps the staff member may need to take?
  - How to deal with media interest?
  - How to deal with working relationships and any communication issues?
- It may be appropriate for the staff member to notify their trade union or professional body representatives.
- The staff member will need to know:
  - The 'Just Culture' toolkit to be employed to inform assessment of whether there is a systemic issue, or possible personal culpability
  - Whether any HR processes will be invoked (e.g. referral for medical assessment; suspension pending investigation / review; disciplinary processes; etc).

1.4

Incident logged – ensuring the incident is appropriately recorded.

- The staff member will need to know their responsibility in relation to the logging of the incident on the Trust's reporting system and to whom they must report for these purposes (e.g., relevant senior manager; divisional head; risk lead; etc)

Step-by-Step Guide

2 Incident Investigation

2.1

Staff member informed of investigation / review – providing the staff member with the information they will need to engage fully with the investigation / review.

- To ensure the staff member will know what to expect, and when, and that they can contribute effectively, they will need to know:
  - The start date and probable timescale, including key milestones.
  - The type of investigation / review and process to be followed.
  - The contribution expected – written recollection of events, interview, etc.
  - The terms of reference.
  - When / how patients and / or their family will be engaged and involved
  - Who will be doing the investigation / review.
  - The behavioural standards expected to ensure a fair and balanced process.
  - How the investigation fits into Patient Safety Incident Reporting Framework (PSIRF) arrangements.
  - What sources of evidence will be used; who else will be interviewed and / or giving statements; referral to clinical notes; what information is in the public domain.
  - How they will be kept informed of feedback on the investigation process in a timely and empathetic way, taking into account their individual needs, what they want, and are emotionally able to receive.
  - How to deal with any internal questions and / or challenges.
  - How to prevent damaging working relationships.
  - What category of incident will be assigned, especially any potential change to the category.
  - Staff should expect the lead investigator to be compassionate, supportive and emotionally intelligent. These are the characteristics required of someone leading a learning response.

Step-by-Step Guide

2.2

Well-being support provided – making support available to the staff member throughout the process. It is vital to recognise the importance of civility in engagement with colleagues and those involved in the incident.
It is often micro-aggressions that impact on how people feel about managing incidents.

- Organisations with a commitment to supporting staff involved in a serious safety incident will provide:
  - Access to someone neutral to talk to, plus signposting to others for counselling and mentorship.
  - Support that has the staff member's well-being, including information on who to turn to if they do not feel supported (e.g., HR; Freedom to Speak Up Guardian; independent manager; etc).
  - Support should come from trained line managers, psychologists and / or well-being leads. Where necessary, support in managing external interest (e.g., from the media).
- Consideration should also be given to making support available for other staff involved in the investigation, as well as listening to their thoughts or concerns about the review / investigation process.

2.3

Support in preparation given – ensuring the staff member is able to fully contribute to the investigation or review process.

- The staff member will need guidance on the format of a written recollection of events, as well as clarity about the process and any ethical considerations and advice / information on the investigative methodology. It is helpful for them to have a discussion with the investigator about their recollection of events.
- The staff member's union or professional body will be able to provide advice on writing a recollection of events.
- At this stage, it is helpful for the staff member to be aware of and supported in relation to any wider issues relating to the investigation.
- The staff member will need the details of who to turn to for support in responding to any media enquiries or social media publicity.

Step-by-Step Guide

2.4

Contribution to investigation / review made – consideration of the staff member's participation in the process.

- The staff member's contribution will be most informative and insightful if they are given advice on open disclosure and feel confident and supported. This will also help ensure that their contributions are transparent and not influenced by others (e.g., through coaching).
- They will not feel supported if the tone of an interview they attend is interrogative.
- They should be invited to bring a friend or colleague and to reschedule if they feel unable to cover everything on that particular day.

2.5

Draft report shared – providing initial opportunities to feedback.

- Giving the staff member the opportunity to check their contribution to the draft report for factual accuracy will help ensure that the process is fair and transparent.
- The staff member should be provided with an update on the timescale for the completion of the final report.

2.6

Final investigation / review report shared – ensuring staff member involved is fully aware of the outcome.

- To be effective, the support provided to the staff member in the final stages of the investigation and at the point of report publication will mean:
  - Keeping them informed about when the report will be published and whether in the public domain; whether staff will be named; whether a 'right to reply' will be afforded to them; and whether any further process is required.
  - Reminding them of the help that might be available from their professional organisation.
- Note that staff often feel particularly vulnerable and anxious in the period between the draft and final report publication.

Step-by-Step Guide

3 Post-investigation

3.1

Ongoing / long-term support for staff provided – recognising that the need for support does not necessarily end once the investigation / review has finished.

- Where it is wanted, the availability of agreed and regular psychological support from a person with appropriate expertise can help minimise the longer-term effects on the staff member. This may include providing updates on the patient and family situation from the patients perspective.
- Employee assistance schemes are helpful sources of confidential and impartial support.
- Participating in reflective practice can be a useful element of the recovery process.

3.2

Personal training needs met – ensuring that any areas identified in the investigation or review are followed up.

- This step is not applicable in every situation.
- The staff member will need support to acquire any knowledge or skills improvement to strengthen practice.

3.3

Learning and improvement facilitated – recognising and acting on opportunities to share learning to improve patient safety.

- Organisational support to staff involved in serious safety incidents, plus systems to encourage personal reflection (in the context of wider organisational learning from the incident) are key to helping all staff impacted by a serious safety incident to recover and learn:
  - Staff should be given the opportunity to share their experience and reflections with others, such as line managers and peers, to inform healing
  - System improvement plans from the investigation or review should be actioned.
- Mechanisms should be in place to collect and share learnings – to reinforce a just and learning culture.

Appendix

Example: online, expanded version of Staff Support Guide

Serious safety incident research: sources, findings and recommendations

Example: online, expanded version of Staff Support Guide

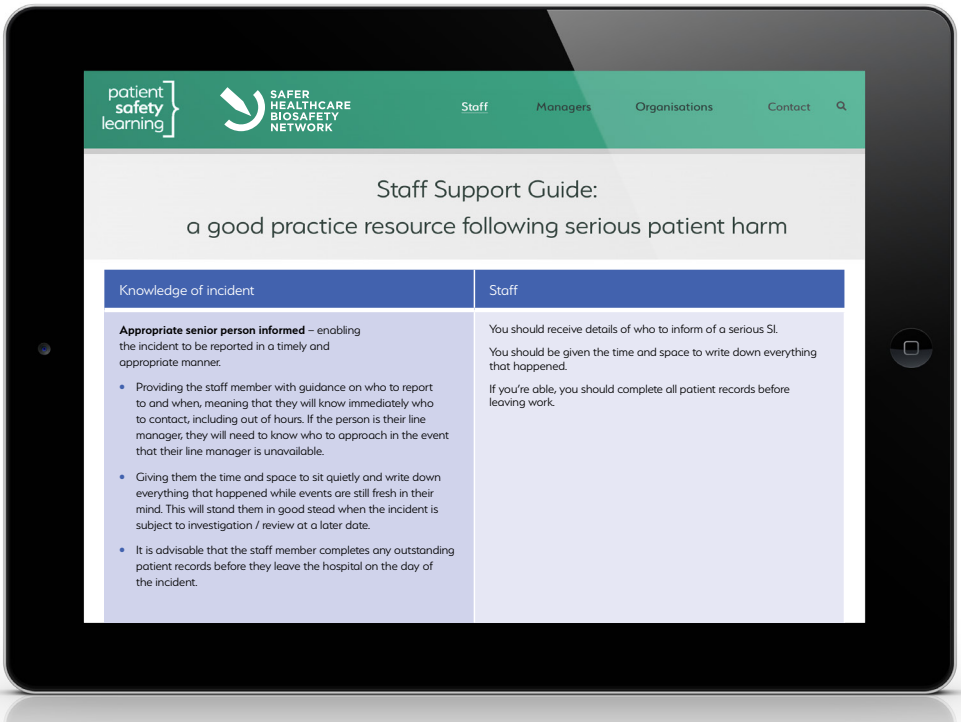
Online expanded version

In order to further help staff, managers and organisations apply good practice, Patient Safety Learning is expanding the Support Guide with the development of a web-enabled app.

This will provide easily accessible and detailed practical guidance focused not just on staff involved in serious harm, but also their managers and organisations. It will describe in more personalised form the support needed by staff, as well as the necessary accompanying managerial and organisational approach, resources and advice.

We are planning to launch this free app during the summer and will be exploring how organisations might be able to customise its implementation across their Trusts.

We intend to update regularly both the app and this guide in order to provide a state-of-the-art knowledge repository, as well as the very latest examples of where such guidance has been successfully implemented.



Serious safety incident research: sources, findings and recommendations

Aims and objectives

The aims of this research are to determine current practice in how staff are treated when they are involved in a serious safety incident, as well as provide evidence-based recommendations for improvement. These have informed the development of this Staff Support Guide and recommended step-by-step process. This will be updated periodically by Patient Safety Learning to ensure that staff, managers and organisational leaders have access to the latest thinking, information and guidance.

Summarised on the following pages are examples of good practice and successful implementation; challenges, failures, or examples of poor practice to be addressed; and recommendations for action.

Contents

Staff impact / impact on staff

Source	Authors' key findings	Authors' conclusions, recommendations and examples of good practice
Supporting Second Victims: Breaking the Cycle of harm (2019) Rebecca Lawton	Staff who are involved in serious incidents often enter a vicious cycle of loss of confidence, anxiety and burnout, leading to greater risk of further incidents.	Support should be offered in the short, medium and long term. A rapid response is necessary. Support from colleagues, supervisors and managers is essential. Develop incident investigation processes that support staff and facilitate learning for the team.
The natural history of recovery for the healthcare provider 'second victim' after adverse patient events (2009)	Staff involved in a serious incident often become what they describe as 'second victims'. The paper provides empirical data collected from affected staff and makes recommendations for recovery and moving on from a serious incident.	Frontline supervisors and peers could be trained to provide immediate and targeted support especially during the early stages.
When healthcare harms – who cares? Blog by Joanne Hughes (2020) Joanne Hughes	When staff are involved in an incident of patient harm, they may lose trust in their own ability and the systems they work in to keep patients safe, and they may worry about their future.	Staff need care and support in order to recover themselves and, crucially, so that they feel psychologically safe and are fully supported to be open and honest about what has happened.
Safety Incident Supporting Our Staff (SISOS): A second victim support initiative at Chase Farm Hospital (2019) Carol Menashy	Account of a young doctor involved in a serious incident.	An example of good practice from Chase Farm Hospital, which operates a 24-hour staff support unit for those involved in serious incidents.

Staff Impact / Impact on Staff

Source	Authors' key findings	Authors' conclusions, recommendations and examples of good practice
Perceptions of institutional support for 'second victims' are associated with safety culture and workforce well-being (2020) Sexton et al.	A study to determine whether healthcare worker assessments of good institutional support for staff involved in safety incidents were associated with institutional safety culture and workforce well-being. It found that perceived institutional support for healthcare workers was associated with a better safety culture and lower emotional exhaustion.	Investment in programmes to support staff involved in safety incidents may improve overall safety culture and staff well-being.
The emotional impact of medical error involvement on physicians: a call for leadership and organisational accountability (2007) Amy D. Waterman et al.	Many physicians experience significant emotional distress and job-related stress following serious errors and near misses.	Authors suggest that these issues will only be adequately responded to when institutions commit resources to patients, physicians and other involved hospital staff involved in serious safety incidents.
Healthcare workers as second victims of medical errors (2011) Albert Wu, Hanan Edrees and Lori Paine	Involvement in medical errors often provokes intense emotional distress that seems to considerably increase the risk of burn-out and depression. The evidence suggests a reciprocal cycle of these symptoms and future suboptimal patient care and error.	Given the significant burden on physicians' health, well-being and performance associated with medical errors, healthcare institutions and clinical leaders should accept accountability and provide staff with formal and informal systems of support.

Staff Impact / Impact on Staff

Source	Authors' key findings	Authors' conclusions, recommendations and examples of good practice
Suicide by clinicians involved in serious incidents in the NHS: a situational analysis (2014) Strobl et al.	Evidence exists that errors are common in clinical practice and that physicians often deal with them in dysfunctional ways. However, there is no general acknowledgment within the profession of the inevitability of medical errors or of the need for practitioners to be trained in their management.	Further investigation is needed into the circumstances of suicides by clinicians involved in patient safety incidents or whilst under investigation. Support for clinicians under investigation (regardless of the reason) is recommended.
Lessons for leadership and culture when doctors become second victims: a systematic literature review (2019) Willis et al.	A study of suicides of clinicians involved in incidents and investigations, by ascertaining the burden of such suicides and the support systems available, which found that a pressurised NHS cannot afford to take its eyes off staff well-being.	Despite relevant initiatives and services in place, there are considerable gaps in both knowledge and practice.
Suffering in silence: a qualitative study of second victims of adverse events (2013) Susanne Ullström et al.	Poor organisational culture and leadership negatively influences and hinders doctors who make mistakes. Doctors often carry unresolved trauma for several years causing them to constantly relive an event.	Unchecked, unresolved trauma can lead to poor relationships with colleagues and impact greatly on their ability to sleep and performance at work.

Staff Impact / Impact on Staff

Source	Authors' key findings	Authors' conclusions, recommendations and examples of good practice
Medical error, incident investigation and the second victim: doing better but feeling worse? (2012) Albert Wu and Rachel C Steckelberg	Healthcare workers are often impacted by medical errors and experience many of the same emotions and/or feelings as the patient and family members involved. Signs and symptoms are similar to those in acute stress disorder, including initial numbness, detachment and even depersonalisation, confusion, anxiety, grief and depression, withdrawal or agitation, and re-experiencing of the event.	Hospitals' guidelines for handling adverse events should be backed up by an institutional policy on open disclosure. Institutions should offer training in the difficult task of communicating with patients and their families in the aftermath of an adverse event. Basic education about the law and legal process surrounding adverse events should also be offered (which may reduce some of the anxiety about possible legal action).
Second Victim – Yorkshire Quality and Safety Research Group and the Improvement Academy (Last Accessed June 2022)	Information on the concept of a 'second victim', based largely on Albert Wu's original definition. Also references the need for a Just Culture. Includes some primary data in the form of surveys of healthcare workers. Presents their original Occupational Staff Support Model – broadly similar to the manual.	There are three possible outcomes after an adverse event (Changing direction; Agent of Change; Continuing Practice). The gold standard should be to support staff to be self-compassionate, self-accepting, hopeful and forward looking, rather than feeling isolated and just surviving, or that they should no longer practice.

The importance of maintaining a just and learning culture following serious incidents / no blame

Source	Authors' key findings	Authors' conclusions, recommendations and examples of good practice
Moving from a Blame Culture to a Just Culture – Seven Key Elements (2020) Phil Taylor	Healthcare organisations that prioritise workforce well-being will be better placed to put lessons learnt from the coronavirus pandemic into practice.	Seven recommendations made to shift from a 'blame' culture to a 'just' culture following serious incidents.
Just and Learning Culture: A New Way of Caring (2019) Merseycare NHS Foundation Trust	In 2016, Merseycare NHS Foundation Trust embarked on a journey towards a just and learning culture. This provides an overview of a substantial programme of work and describes their progress and the results they achieved.	Whilst changing from a retributive 'blame' culture to a restorative 'just' culture may be challenging, it can be done – to the benefit of patients and staff.
Being fair: supporting a just and learning culture for staff and patients following incidents in the NHS (2019) NHS Resolution	This draws on NHS Resolution's unique dataset to explore best practice in response to incidents resulting from claims across the system. It aims to help the NHS to create an environment to better support staff when things go wrong and to encourage learning from incidents.	
Just Culture and Its Critical Link to Patient Safety (2012) The Institute for Safe Medication Practice	Shares key questions to help organisations assess their progress toward creating a Just Culture and provides a national snapshot of where hospitals stand regarding certain aspects of a Just Culture.	

The importance of maintaining a just and learning culture following serious incidents / no blame

Source	Authors' key findings	Authors' conclusions, recommendations and examples of good practice
Annie's Story: How a systems approach can change safety culture (2020) MedStar Health	An example of how healthcare organisations seeking high reliability embrace a Just Culture in all they do. When patient harm occurs, caregivers involved are often devastated along with the patient and family, yet many have had to navigate this storm alone.	A systems approach in our healthcare workplace, along with a Just Culture, cultivates the sharing of knowledge and helps prevent patient harm from occurring altogether.
The 'Just Culture': why it is not just, and how it could be (2020) Paul Stretton	A Just Culture is still seen primarily as a linear mechanism to apportion liability. Within our complex healthcare organisations, this approach is inadequate.	There should be a focus on learning, rather than liability, with a presumption of good intention until proven otherwise. This more compassionate and respectful approach can help to move healthcare organisations towards a Just Culture and create an atmosphere of trust.
Just Culture case study template (2014) St Joseph Health	A template used by St Joseph Health, in the USA, to guide you through a Just Culture scenario.	Presents an example of how to approach developing a Just Culture in a healthcare organisation.
Managing accidents using retributive justice mechanisms: When the Just Culture policy gets done to you (2020) Derek Heraghty, Andrew Rae, Sidney Dekker	Examines the impact the use of retributive justice mechanisms within the accident analysis process has on both the individual and the organisation. It analyses the perceptions of those involved in five accidents where retributive justice mechanisms were used.	Retributive justice mechanisms used as part of the accident analysis process negatively impacts three key areas: (1) the mental health of the individual; (2) organisational learning; and (3) organisational performance.

The importance of maintaining a just and learning culture following serious incidents / no blame

Source	Authors' key findings	Authors' conclusions, recommendations and examples of good practice
Safety-II and Just Culture: Where now? (2020) Steven Shorrock	Safety-II defines safety not as avoiding those things that go wrong, but as ensuring that things go right. Safety-II views the human not as a hazard, but as a resource necessary for system flexibility and resilience.	Rather than focusing only on justice, or even fairness, Just Culture should focus on a mindset of trust, mutual understanding and openness, as well as language that is non-blaming.
Flight Safety Foundation: Just Culture Manifesto (2020) The Flight Safety Foundation	Only a very small proportion of human actions is criminally relevant (criminal behaviour, such as substance abuse or misuse, grossly negligent behaviour, intention to do harm, sabotage, etc.). Mostly, people go to work to do a good job; nobody goes to work to be involved in an incident or accident.	Following serious incidents, there is a need for support and fairness for those involved and affected, and learning for organisations, industry and society as a whole. In the absence of intentional wrongdoing or gross negligence, these obligations should not be threatened by adverse responses either by organisations or States.
Why isn't After Action Review used more widely in the NHS? (2021) Judy Walker	After Action Review (AAR) is a tried and tested, evidence-based approach that increases learning after events but, despite the clear benefits to patient safety and team resilience, its use in the NHS is still more limited than it should be.	AAR is one of the best mechanisms to both foster and drive a culture of learning and improvement, but the simplicity of the AAR process itself should not blind you to the need to be very considered in how you mitigate and manage the barriers in a clinical setting.

The importance of maintaining a just and learning culture following serious incidents / no blame

Source	Authors' key findings	Authors' conclusions, recommendations and examples of good practice
Nonpunitive response to errors fosters a Just Culture (2017) Juliet Battard	Non-punitive response to errors is a primary dimension of a hospital's patient safety culture that we can measure through staff surveys. This article describes a successful hospital nursing staff initiative that resulted in an improved non-punitive environment as measured by responses on the Agency for Healthcare Research and Quality Hospital Survey on Patient Safety Culture.	Armed with knowledge of the benefits of nonpunitive response to errors and tangible actions to create a nonpunitive environment, we can cultivate a strong and just safety culture.
From a blame culture to a Just Culture in healthcare (2009) Naresh Khatri and Lanis Hicks	A prevailing blame culture in healthcare has been suggested as a major source of an unacceptably high number of medical errors. A Just Culture has emerged as an imperative for improving the quality and safety of patient care. However, healthcare organisations are finding it hard to move from a culture of blame to a Just Culture.	Healthcare organisations need to build internal human resource management capabilities to bring about the necessary changes in their culture and management systems and to become learning organisations.

The importance of maintaining a just and learning culture following serious incidents / no blame

Source	Authors' key findings	Authors' conclusions, recommendations and examples of good practice
Fair and Just Culture, Team Behavior, and Leadership Engagement: The Tools to Achieve High Reliability (2006) Allan Frankel, Michael Leonard, and Charles Denham	In the last ten years the science of patient safety has become more sophisticated, with practical concepts identified and tested to improve the safety and reliability of care. There are excellent examples of institutions applying Just Culture principles, Teamwork Training, and Leadership Walk Rounds – but to date, they have not been comprehensively instituted in healthcare organisations in a cohesive and interdependent manner.	The authors suggest that there are the mechanism and tools available to institute a Just Culture in healthcare organisations, with the main barriers to this remaining in their practical implementation and introducing them in a cohesive and interdependent manner.
Being fair supporting a just and learning culture for staff and patients following incidents in the NHS (2019) NHS Resolution	A just and learning culture is the balance of fairness, justice, learning – and taking responsibility for actions. It is not about seeking to blame the individuals involved when care in the NHS goes wrong. It is also not about an absence of responsibility and accountability. A resilient organisation helps staff work safely every day. Resilience also provides the ability for an organisation to sustain its operations under both expected and unexpected conditions.	We should adopt a balanced approach to safety, so that we learn from when things go wrong and learn from when things go right. Examples given include: • organisations to adapt and adopt a 'Just and Learning Culture Charter' • a restorative approach • the importance of having informal conversations at the very beginning, with a focus on learning rather than formal investigations which tend to focus on finding who is to blame.

The importance of maintaining a just and learning culture following serious incidents / no blame

Source	Authors' key findings	Authors' conclusions, recommendations and examples of good practice
Sidney Dekker's Restorative Just Culture checklist (2020) Sidney Dekker	Restorative Just Culture aims to repair trust and relationships damaged after an incident. It allows all parties to discuss how they have been affected, and collaboratively decide what should be done to repair the harm.	A Restorative Just Culture, not a retributive Just Culture, is recommended.
A Just Culture after Mid Staffordshire (2014) Sidney Dekker and Thomas Hugh	Using published evidence in the safety literature, the authors examined the distinction between our need to understand what happened, the practical need for preventing recurrence, and the age-old philosophical need to explain suffering.	To promote safety and quality, we should be sensitive to the differences between understanding, satisfying demands for justice, and avoiding recurrence.
Berwick review into patient safety (2013) Department of Health and Social Care	Recommendations to improve patient safety in the NHS in England.	Recommendations for: 1. The Overarching Goal 2. Leadership 3. Patient and Public Involvement 4. Staff 5. Training and Capacity-Building 6. Measurement and Transparency 7. Structures 8. Enforcement 9. Moving Forward.

The importance of maintaining a just and learning culture following serious incidents / no blame

Source	Authors' key findings	Authors' conclusions, recommendations and examples of good practice
The importance of critical incident reporting – and how to do it (2015) Tim Fetherston	Traditionally, the response has been to blame those involved and to fail to put systems in place which help to guard against similar problems and errors occurring in the future. All too often, therefore, the same errors have been made repeatedly. 'This all means that healthcare staff tend not to report mistakes or 'near misses' (errors or disasters that have been narrowly avoided), fearing that if they do so they will be blamed and punished. And this in turn means that senior medical, nursing and management personnel do not get the information they need in order to make the service safer.'	Recommendations around setting up an effective reporting system.

Candour / transparency

Source	Authors' key findings	Authors' conclusions, recommendations and examples of good practice
Regulation 20: Duty of Candour (2017) Care Quality Commission	The legal duty of candour is a general duty to be open and transparent with people receiving care from you. The regulation was put in place by the Care Quality Commission in 2014, to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment.	Sets out specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and making an apology.
Robbie Powell: Time for Truth, Justice and Accountability (2021) Sharon Hartles	In this article Sharon Hartles looks at the tragic case of the death of Robbie Powell and the work of his parents, Will and Diane, in their relentless pursuit for truth, justice and accountability. It looks in detail at the events around and after Robbie's death and their campaign for an individual legal Duty of Candour for healthcare professionals.	Talks about the possibility of the extension of the legal duty of candour to individual healthcare professionals, not just NHS organisations

Candour / transparency

Source	Authors' key findings	Authors' conclusions, recommendations and examples of good practice
Openness and honesty when things go wrong: the professional duty of candour (2015) Nursing and Midwifery Council	This guidance from the Nursing and Midwifery Council complements the joint statement from the healthcare regulators and gives more information about how to follow the duty of candour principles.	Every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. Healthcare professionals must also be open and honest with their colleagues, employers and relevant organisations, and take part in reviews and investigations when requested. They must also be open and honest with their regulators, raising concerns where appropriate. They must support and encourage each other to be open and honest, and not stop someone from raising concerns.
The Duty of Candour – where are we now? (2020) Peter Walsh	This summarises what progress has been made since the introduction of the organisational and professional duties of candour, but also questions what difference they have made.	There is a need for a central training and awareness campaign to support the implementation of the duty of candour in England and a review of the legislation and guidance is well overdue.
Regulating the duty of candour. Requires improvement (2018) Action against Medical Accidents (AvMA)	A report by AvMA on Care Quality Commission inspection reports and regulation of the duty of candour.	Even where problems were found with trusts' compliance with the duty of candour this still did not lead to recommendations to address the issue.

Candour / transparency

Source	Authors' key findings	Authors' conclusions, recommendations and examples of good practice
A review into the quality of NHS complaints investigations where serious or avoidable harm has been alleged (Last Accessed June 2022) Parliamentary and Health Service Ombudsman (PHSO)	Review of complaints procedures at selected NHS Trusts. Serious incidents are not being reliably identified by Trusts. The PHSO judged 28 of the cases the authors looked at to be serious enough to lead to a serious incident investigation, but only eight had been treated as such by the NHS.	Better recognition, value and support of the role of NHS complaints managers and investigators is needed. Broad principles of a good investigation, building capability and capacity need to be championed at a local level whilst also allowing for flexibility and proportionality. Learning from investigations needs to be shared in order to improve the capability of the local NHS.
The patient safety leader of the future (2019) Adam Burrell	Recommendations on how the NHS can improve its patient safety record in the future. Often when things have gone wrong, it is because organisations have failed to be transparent about the problems that they are facing.	The leaders of patient safety must be able to be torchbearers for safety and humble enough to admit when the right standards are not being met.

Candour / transparency

Source	Authors' key findings	Authors' conclusions, recommendations and examples of good practice
Factors associated with disclosure of medical errors by housestaff (2011) Andrea Kronman, Michael Paasche-Orlow, Jay D Orlander	Attributes of the organisational culture of residency training programmes may impact patient safety. Training environments are complex, composed of clinical teams, residency programmes and clinical units. The authors examined the relationship between residents' perceptions of their training environment and disclosure of, or apology for, their worst error. While 31% reported apologising for the situation associated with the error, only 17% reported disclosing the error to patients and/or family.	Factors in the learning environments of residents are associated with responses to medical errors. Organisational safety culture can be measured and used to evaluate environmental attributes of clinical training that are associated with disclosure of, and apology for, medical error.
Improving the Patient, Family and Clinician Experience After Harmful Events: The 'When Things Go Wrong' Curriculum (2010) Sigall Bell, Donald Moorman, Tom Delbanco	The emotional toll of medical error is high for both patients and clinicians, who are often unsure with whom – and whether – they can discuss what happened. Although institutions are increasingly adopting full disclosure policies, trainees frequently do not disclose mistakes, and faculty physicians are underprepared to teach communication skills related to disclosure and apology.	The authors developed an interactive educational programme for trainees and faculty physicians that assesses experiences, attitudes and perceptions about error, explores the human impact of error through filmed patient and family narratives, develops communication skills, and offers a strategy to facilitate bedside disclosures.

Candour / transparency

Source	Authors' key findings	Authors' conclusions, recommendations and examples of good practice
Patients' and Physicians' Attitudes Regarding the Disclosure of Medical Errors (2003) Gallagher et al.	Fieldwork via focus groups of US physicians into attitudes towards disclosure of SIs. Physicians may not be providing the information or emotional support that patients seek following harmful medical errors.	Physicians should strive to meet patients' desires for an apology and for information on the nature, cause, and prevention of errors. Institutions should also address the emotional needs of practitioners who are involved in medical errors.
Disclosure of Adverse Events and Errors in Surgical Care: Challenges and Strategies for Improvement (2014) Lauren Lipira and Thomas Gallagher	Academic journal article on disclosure and Just Culture principles.	Participation in communication and resolution programmes, integration of Just Culture principles, surgical team disclosure planning, refinement of informed consent and morbidity and mortality processes, surgery-specific professional standards, and understanding the complexities of disclosing other clinicians' errors all have the potential to help surgeons provide patients with complete, satisfactory disclosures.

Candour / transparency

Source	Authors' key findings	Authors' conclusions, recommendations and examples of good practice
Managing the after-effects of serious patient safety incidents in the NHS: an online survey study (2013) Anna Pinto, Omar Faiz, Charles Vincent	Examines the current state of practice in English NHS Trusts in relation to the communication of serious patient safety incidents to patients and families, and support for all parties involved. Finds an awareness of the importance of being open is high among patient safety managers in English NHS Trusts, but there is still considerable scope for improvement in the management of the after-effects of patient safety incidents.	More research is needed on patients' and healthcare professionals' preferences for support after patient safety incidents.

Whistleblowing / whistleblower

Source	Authors' key findings	Authors' conclusions, recommendations and examples of good practice
'Whistleblowing': a definition for reflection in Speak Up Month (2021) Steve Turner	This blog offers a definition of whistleblowing and discusses its importance.	The post makes a number of recommendations for appropriate circumstances where staff should feel able to 'blow the whistle'.
NHS Dirty Secrets: Bullying, Cover-ups, Discrimination, Favouritism, Whistleblowing (2020) John England	First-hand accounts of patients that have experiences of avoidable harm and cover-ups, and staff (including the author) that have experienced detriment for speaking up. An analysis of cover-up cultures in the NHS with examples given as to the methods used to support the hiding of issues, such as patient deaths, from public scrutiny.	
The lifecycle of the whistleblower (2020) Roger Kline	This article describes the 'lifecycle' of a whistleblower and the stages and steps that they will go through.	Provides an outline of the experience of whistleblowing and indicates areas and highlights areas of difficulty that cannot be addressed by whistleblowing policies.
The right – and duty – of NHS staff to speak up (2020) Hugh Wilkins	Blog post noting barriers to whistleblowing faced by NHS staff, such as disciplinary action, detriment to career prospects, and isolation in the workplace. Provides reflections on where whistleblowing has failed in the NHS.	Emphasises the importance of the NHS People Plan putting in place clear measures to tackle barriers to whilstleblowing.

Whistleblowing / whistleblower

Source	Authors' key findings	Authors' conclusions, recommendations and examples of good practice
Whistleblowers' Support Scheme (2020) NHS England and NHS Improvement	Information on the Whistleblowers' Support Scheme to aid staff whose career prospects have suffered as a result of raising concerns of public interest.	An example of good practice.
Public Concern at Work – The Whistleblowing Commission. Report on the effectiveness of existing arrangements for workplace whistleblowing in the UK (2013) Trades Union Congress	Reports on attitudes towards whistleblowing and various codes of practice.	Includes 26 recommendations to improve the effectiveness of workplace whistleblowing in the UK.
'I don't want to hear anything bad' – whistleblowing in health & social care (2019) Steve Turner	Personal account of whistleblowing in England and challenges faced by whistleblowers, such as loss of careers, marginalisation and victimisation in the workplace.	There needs to be an individual duty of candour (duty to tell the truth); an end to self-regulation in healthcare and elsewhere; and recognition of the value to society of those who risk everything to fight for justice and truth.

Whistleblowing / whistleblower

Source	Authors' key findings	Authors' conclusions, recommendations and examples of good practice
An Office of the Whistleblower is needed to ensure people who speak up are protected (2020) Mary Robinson MP	Whilst there are laws in place to protect whistleblowers, the overwhelming evidence is that they have failed to address the principal issues they face. The author states that politicians have a duty to confront the most difficult things, including the barriers to justice and the fear of retaliation that make it impossible or futile for people across all sectors to speak up safely.	A system that works with whistleblowers, instead of against them, would serve to protect employees and would empower them to do the right thing. Although the UK was the first in Europe to introduce legislation with Public Interest Disclosure Act 1998, we are in danger of falling behind global best practice. Recommends the creation of an Office of the Whistleblower to ensure people who speak up are protected.
Whistle in the Wind: Life, death, detriment and dismissal in the NHS. A whistleblower's story (2020) Peter Duffy	First-hand account of consultant surgeon who was dismissed for blowing the whistle to the Care Quality Commission. Via avoidable deaths and errors, cover-ups, misuse of public funds, bullying, abuse and victimisation, the author charts out in searing detail his demotion, punishments and exile from both family and NHS and the subsequent brutal legal process that followed his illegal dismissal.	Provides examples of failures in the NHS underlining the importance of whistleblowing.

Whistleblowing / whistleblower

Source	Authors' key findings	Authors' conclusions, recommendations and examples of good practice
We all want a culture of speaking up, don't we? So, why isn't it happening? (2020) Anonymous	A blog giving personal reflections on the times when the author has spoken up about patient safety issues and the responses they had when they raised them, based on Sir Robert Francis' six principles for Trusts to follow in his review of speaking up in NHS Trusts in 2015.	The blog sets out where the author believes the NHS is coming up short against Sir Robert Francis' speaking up principles and calls for action to address this gap.
Wrongdoing and whistleblowing in healthcare (2018) Johanna Pohjanoksa, Minna Stolt, Riitta Suhonen, Helena Leino-Kilpi	Describes healthcare professionals' experiences of observed wrongdoing and potential whistleblowing acts regarding them.	The whistleblowing process should be further developed, and ethically effective programmes and interventions should be developed for increasing whistleblowing and preventing wrongdoing in healthcare.

Whistleblowing / whistleblower

Source	Authors' key findings	Authors' conclusions, recommendations and examples of good practice
Whistleblowing and patient safety: the patient's or the profession's interests at stake? (2011) Stephen Bolsin, Rita Pal, Peter Wilmshurst, Milton Pena	Encouraging the medical profession to report poor care and to report incidents that occur in their practice has been problematical in modern healthcare, although there are notable exceptions. This article discusses why a change in the attitude of the profession is required, what the benefits will be and how it can be achieved. It gives account of different roles played by different parties in the process of whistleblowing and their respective significance in the process. The authors believe that only by open public scrutiny will constructive change be cemented into exemplary clinical practice.	The profession, through the GMC or BMA Council, should commission a Consultation Group on Reporting Poor Care to examine the consequences to all parties from incidents of reported poor care. The Government should consider establishing a Health Select Committee Review of Whistleblowing that would make impartial recommendations to Government and the profession. The Government should consider setting up and resourcing a National Whistleblowing Centre similar to that in the US.
NHS whistleblower in West Suffolk will 'never be the same again' (2021) The Guardian	Empirical account of nurse who faced bullying and harassment after reporting on malpractice by a colleague.	Provides an example of poor practice by an NHS Trust in relation to whistleblowing.

Well-being / staff well-being

Source	Authors' key findings	Authors' conclusions, recommendations and examples of good practice
How are you feeling NHS? Toolkit (2020) NHS Employers	The toolkit sets out contributors to decreased emotional well-being and shows you how to encourage improvements. This easy-to-use resource has been developed with NHS staff to: • help bridge a gap in understanding and enable us to talk openly and regularly about emotional health • assess the impact emotional well-being has on ourselves, our colleagues and on our patients • enable us to action plan to enable more good days than bad.	Good practice resource to support staff well-being.
Healthcare staff well-being, burnout, and patient safety: A systematic review (2016) Hall et al.	This study looked at whether there is an association between healthcare professionals' well-being and burnout and patient safety. The authors found that poor well-being and moderate to high levels of burnout are associated, in the majority of studies reviewed, with poor patient safety outcomes such as medical errors,	Further prospective studies should be carried out, including research in primary care, and there should be a clearer definition of healthcare staff well-being.

Well-being / staff well-being

Source	Authors' key findings	Authors' conclusions, recommendations and examples of good practice
Suicide by female nurses: a brief report (2020) National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH)	This report, authored by the NCISH, was commissioned by NHS England/NHS Improvement in response to a report by the Office for National Statistics that identified female nurses as having a risk of suicide 23% above the risk in women in other occupations. Although prevalence of experiencing adverse life events within three months of death was similar across the groups, female nurses were reported to have more workplace problems (18%). More than half (60%) of female nurses who died were not in contact with mental health services.	More detailed studies to help identify priorities for prevention. Improved access to mental healthcare in nurses, as in many groups. Further study of self-poisoning among female nurses, to inform prevention measures. Further exploration of cases of death by suicide relating to female nurses, including examining the specific effects of workplace, financial and personal problems.
Impact of feeling responsible for adverse events on doctors'personal and professional lives: the importance of being open to criticism from colleagues (2004) O. G. Aasland and R. Førde	This study sought to investigate the impact of adverse events that had caused patient injury and for which the doctor felt responsible, and the experience of acceptance of criticism among colleagues.	More acceptance of criticism of professional conduct may not only prevent patient harm, but may also give more support to colleagues who have experienced serious patient injury.

Well-being / staff well-being

Source	Authors' key findings	Authors' conclusions, recommendations and examples of good practice
Residents' Responses to Medical Error: Coping, Learning, and Change (2006) Kirsten Engel, Marilynn Rosenthal and Kathleen Sutcliffe	This explored the significant emotional challenges facing resident physicians in the setting of medical errors, as well as their approaches to coping with these difficult experiences. The authors found that medical errors have a profound impact on resident physicians by eliciting intense emotional responses. For the great majority of residents, their ability to cope with these events was dependent on a combination of reassurance and opportunities for learning. Interactions with medical colleagues and supervisory physicians were critical to this coping process.	Resident education must support the development of constructive coping skills by facilitating candid discussion and learning subsequent to these events.
Too Many Abandon the 'Second Victims' Of Medical Errors (2014) Matthew Grissinger	Account of a suicide by a nurse following medical error. Discusses importance of support for staff following a serious incident.	Support initiatives for staff involved in serious incidents need to be established and widely communicated so that staff members are aware of available resources, are receptive to accepting help, and know how to access assistance.

Well-being / staff well-being

Source	Authors' key findings	Authors' conclusions, recommendations and examples of good practice
Supporting physicians and staff involved in adverse events (2021) Alberta Health Services	Alberta Health Services make the case that after an investigation of an event, it's important to touch base with the healthcare team and everyone involved so they can get some closure. They provide tips on how to support staff involved in serious safety incidents.	Good practice examples of support for staff involved in serious safety incidents.
WHO Charter: Keep health workers safe to keep patients safe (2020) World Health Organization	Sets out the connection between healthcare worker safety and patient safety and the importance of considering the two concepts side-by-side.	Sets out five steps to improve health worker safety and patient safety: • Establish synergies between health worker safety and patient safety policies and strategies • Develop and implement national programmes for occupational health and safety of health workers • Protect health workers from violence in the workplace • Improve mental health and psychological well-being • Protect health workers from physical and biological hazards.

Well-being / staff well-being

Source	Authors' key findings	Authors' conclusions, recommendations and examples of good practice
Psychological impact and recovery after involvement in a patient safety incident: a repeated measures analysis (2016) Eva Van Gerven et al.	Study conducted into the Belgian health service on the impact of serious incidents on staff well-being. Effects of being involved become more severe in line with the severity of the incident. Effects are more pronounced in female staff, amongst other findings.	Healthcare organisations should anticipate the need to provide their staff with appropriate and timely support structures that are tailored to the healthcare professional involved in the incident and to the specific situation of the incident.

Methods of analysis including Root Cause Analysis and SEIPS

Source	Authors' key findings	Authors' conclusions, recommendations and examples of good practice
Patient Safety Incident Response Framework (Last Accessed June 2022) NHS England and NHS Improvement	New Patient Safety Incident Response Framework (PSIRF) outlines how providers should respond to patient safety incidents and how and when a patient safety investigation should be conducted.	Provides a high-level good practice framework for responding to serious patient safety incidents in the NHS.
Safety Engineering Initiative for Patient Safety – SEIPS (Last Accessed June 2022) Developed by Professor Pascale Carayon and colleagues in the University of Wisconsin, the SEIPS framework is partly based on Donabedian's well-known Structure-Process-Outcome model of healthcare quality.	SEIPS is arguably the best known and most published systems-based Human Factors framework in healthcare worldwide. SEIPS is strongly grounded in a Human Factors-based systems approach	Provides a systems-based model for approaching patient safety incident investigation.
Learning from Adverse Events (2020) Chartered Institute of Ergonomics and Human Factors	This document explores human factors in incident prevention and management.	The report sets out nine key principles organisations can apply to capture the human contribution to such events.
Root Cause Analysis (2019) Healthcare Quality Quest	Summary explanation of what root cause analysis is and how it can be applied.	Details of a tool that can be used in patient safety incident investigations.
Root cause analysis: Why we need to change the focus (2020) Anonymous Patient Safety Manager	Blog from a patient safety manager asking why the NHS spends so much time generating root cause analysis reports, rather than focusing on what changes should happen afterwards to current systems and processes.	Analyses how root cause analysis reports are currently used in the NHS and considers how we could change are approach to improve patient safety.

Methods of analysis including Root Cause Analysis and SEIPS

Source	Authors' key findings	Authors' conclusions, recommendations and examples of good practice
Root cause analysis gone wrong (2018) Mohammad Farhad Peerally and Mary Dixon-Woods	A blog which discusses a case where a hospital planned to perform a root cause analysis to investigate an adverse event, which resulted in an individual blamed, but no interventions to prevent similar errors or address systems issues were ever implemented.	Incident investigation following an adverse event requires an organisational safety culture that fosters open dialogue surrounding medical errors to maximize organisational learning. Root cause analysis is only one of many methods of incident investigation. Newer methods promote a systemic view of incident investigations and analysis. Incident investigations in healthcare need to be conducted by professionals skilled in human factors engineering and systems thinking, alongside expert clinicians and frontline staff. The recommendation phase should receive more attention. Corrective actions need to be congruent to the causal factors they are trying to address and monitored for successful implementation and risk mitigation. Some problems identified through root cause analysis cannot be solved by individual organisations, but require coordinated efforts across the entire healthcare system.

Methods of analysis including Root Cause Analysis and SEIPS

Source	Authors' key findings	Authors' conclusions, recommendations and examples of good practice
A review of significant events analysed in general practice: implications for the quality and safety of patient care (2009) John McKay, Nick Bradley, Murray Lough and Paul Bowie	A voluntary educational model in the west of Scotland enables general practitioners (GPs) and doctors-in-training to submit significant event analysis reports for feedback from trained peers. The authors reviewed reports to identify the range of safety issues analysed, learning needs raised and actions taken by GP teams.	This technique could be used to investigate and learn from a wide variety of quality issues, including those resulting in patient harm.
Training healthcare professionals in root cause analysis: a cross-sectional study of post-training experiences, benefits and attitudes (2013) Paul Bowie, Joe Skinner and Carl de Wet	Despite the limitations of the root cause analysis evidence base, healthcare authorities and decision makers in NHS Scotland – similar to those internationally – have invested heavily in developing training programmes to build local capacity and capability, and this is a cornerstone of many organisational policies for investigating safety-critical issues. However, there has been no systematic attempt to follow up and evaluate post-training experiences of root cause analysis-trained staff in Scotland.	RCA-trained staff should be provided with continuous development opportunities and performance feedback.

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