Creating
a Safe Space

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**Strategies to Address the
Psychological Safety of
Healthcare Workers**

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Disclaimers

This publication is provided as information only. All examples are provided as illustrations. This publication is not to be used as a substitute for legal advice. It is not an official interpretation of the law and is not binding on the Canadian Patient Safety Institute (CPSI).

Foreword

Chris Power, CEO | Canadian Patient Safety Institute

I started out in healthcare with the long-term goal of becoming a doctor. However, in nursing I found a profession that kept me constantly connected to patients and their families. I knew it was where I could have the greatest impact on their lives. I didn't really think much about the impact they could have on mine – especially if someone came to harm while in care. Harm within the healthcare system has such a real, permanent effect on the lives of patients and their families. And while I speak every day about the consequences of patient safety incidents for patients, only rarely do we talk about the effect these incidents have on providers as well.

The Canadian Patient Safety Institute was established in 2003 as the result of a rallying cry by dedicated healthcare providers working within the healthcare system who couldn't experience one more incident of a patient getting harmed. Patient safety incidents are the third highest cause of deaths in Canada. According to our studies, over the next 30 years, 12.1 million people will be harmed within the Canadian healthcare system.

The Canadian Patient Safety Institute has issued an urgent call to action to demonstrate what works and strengthen commitment to patient safety in Canada. Best practices need to be translated into sustainable, committed standard practices for practitioners and providers at all levels of the health system. And at each level, people need support.

Nurses, doctors, and other healthcare providers are human. When mistakes happen – or when the worst possible outcome presents itself after a procedure – the impact on these care providers can affect their work, their lives, and the safety of their patients. I would have appreciated a non-judgmental, peer-to-peer support program when I was practicing. The questions raised in relation to the confidentiality of peer-to-peer support are well worth discussing.

We hope the conversations already happening around the world about provider support will continue. The ultimate goal for all of us is to build a healthcare system in which every patient experience is safe, and healthcare providers are supported.

The Canadian Patient Safety Institute is proud to partner with the Safe Space Working Group to help make this goal a reality. Let's challenge the status quo together.

An ever-growing body of evidence demonstrates that health professionals feel emotionally distressed after a patient safety incident (PSI)[1-4], and there is an emerging recognition of the potential negative impact on both the health professionals' health[5-11] and on patient safety[12-13]. As a result of this recognition, healthcare organizations are seeking ways to support health professionals who are emotionally traumatized after a PSI.

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Introduction

Introduction

Working in healthcare can be emotionally distressing [1-4]. There is a general recognition among both academics and healthcare organizations of the importance of emotional support for healthcare workers, especially because of the very real potential for the profession's negative impact on both the workers' physical and mental health[5-11] and on patient safety[12-13]. As a result of this recognition, there has been an impetus within the patient safety movement and healthcare organizations to find ways to support healthcare workers.

While patients and families will always be the first priority in healthcare, workers also need to be supported as a result of what they experience in their profession. Peer support programs (PSPs), where healthcare workers can discuss their experiences in a non-judgmental environment with colleagues who can relate to what they are going through, are now seen as a useful approach to helping them cope. A number of support programs are emerging in the US and Canada, as healthcare organizations are beginning to recognize that this is an appropriate and valuable service for their staff.

This manual provides a comprehensive overview of what peer support is available in Canada and internationally. Most importantly, it provides best practice guidelines, tools and resources, to assist policy makers, accreditation bodies, regulators and healthcare leaders assess what healthcare workers need in terms of support, and to create PSPs to help them improve their emotional well-being and allow them to provide the best and safest care to their patients.

The components of this manual include:

1. A survey of Canadian healthcare workers: Their views on the experience of a patient safety incident and the support they need. Through a pan-Canadian survey conducted in partnership with the University of Ontario Institute of Technology (UOIT), we sought input from healthcare workers themselves to determine what support they needed and where the gaps were across Canada.

2. Global environmental scan of peer support programs: Report on a scoping review of peer support practices across Canada, the US, and globally, based on global literature research led by the IWK Health Centre. The aim was to gather knowledge from international literature around the world so that we could learn from those who had established or studied healthcare PSPs.

3. Creating a safe space: Confidentiality and legal privilege for peer support programs: This document was informed by a team of lawyers, physicians and a patient advocate who had extensive experience with the issue of confidentiality in healthcare. It is a key resource for organizations who are planning a PSP, as it gives clear explanations about what is and is not privileged information, and how best to strengthen confidentiality.

4. Creating a safe space: Best practices for workplace peer support programs in healthcare organizations: This document was created in collaboration with a team of Canadian healthcare experts in the field of PSPs, whose experience and understanding of how to establish a PSP was vital to developing the comprehensive and informative document. These guidelines provide a step-by-step approach to help healthcare organizations succeed by building leadership support from the beginning, establishing a committed team of healthcare workers to initiate the PSP, clearly identifying the goals of the program and clarifying policies, processes and responsibilities before

the program is launched. The guidelines also make recommendations on how to recruit and train peer supporters and how best to ensure the spread and sustainability of the program.

5. [Creating a safe space: Peer support toolkit](#): We undertook a thorough environmental scan to uncover as much relevant educational and informational material as possible to facilitate the development of peer support programs across Canada. This toolkit is an excellent source of information for healthcare workers, leaders, regulators and policymakers templates, and includes examples and recommendations for anyone who is embarking on creating a new PSP.

CPSI's position

CPSI is committed to improving patient safety in Canada and does so through a number of initiatives. Each of our endeavours is part of a comprehensive strategy to keep patients safe including the Patients for Patient Safety Canada program, which recognizes the wealth of experience and knowledge members of this program can share to improve patient safety and *Safer Healthcare Now!* interventions. These interventions facilitate the implementation of best practice. We also developed substantial resources with our partners such as the *Canadian Disclosure Guidelines*, *Communicating After Harm in Healthcare* and the *Patient Safety and Incident Management Toolkit,* which provide practical strategies and resources to manage PSIs openly and effectively while engaging patients throughout the process.

This manual is no exception. It is our hope that by fully exploring how best to support healthcare workers, we will contribute to system safety by providing tools and resources to everyone who makes up the system – patients, families, workers and healthcare leaders – that allow them to learn, collaborate and improve care for patients.

The following guiding principles underpin the development of this manual:

1. It is important that healthcare workers have a psychologically safe environment that provides them with an opportunity to speak confidentially to a peer about their experiences:

    • it will help them cope with emotionally traumatic experience; and

    • it will improve patient safety since health professionals will be in a healthier emotional state to care for their patients safely.

2. These support programs are not intended to affect transparency about the facts surrounding patient safety incidents or other distressing events, or to withhold material facts surrounding events from patients and families, but rather to provide a safe space to help health professionals cope with traumatic and stressful events.

3. Those promoting PSPs should be transparent to prospective participants about what can and cannot be kept confidential. This is an important way to align expectations and avoid further negative experiences.

4. Advocacy for, or the establishment of, a PSP does not in any way lessen the importance of reporting patient safety incidents and other events for quality improvement efforts. It also does not diminish the importance of disclosing the facts around the incidents and events to patients and families, and other incident management activities.

Definition of a Peer Support Program

Peer support is a supportive relationship between people who have a lived experience in common [14]. Co-workers who have had similar experiences can provide support and referral assistance through peer support, improving the mental health of their peers and helping them towards recovery, empowerment, and hope[15]. Peer supporters are trained to provide compassionate support and resources or referrals, but because they are not trained professionals, they do not diagnose mental health injuries or recommend specific treatments.

There are many variations in the meaning and/or composition of a PSP in healthcare. This disparity is likely the result of the grassroots nature of PSPs, where each organization develops and implements a program that is suited to their structure and adapted to the specific needs of their staff. At the heart of any PSP, however, is the desire to embed and sustain a psychologically safe environment where those who are part of the healthcare organization feel supported by their peers and the organization when they experience distress at work.

For the purposes of this document, we have defined a PSP as follows:

A peer support program includes any program that provides non-clinical emotional support to health professionals (and in some cases other individuals who work, volunteer or train at organization) who are experiencing emotional distress and this support is provided by a peer. The need for emotional support can be the result of:

1. A patient safety incident: an event or circumstance that could have resulted, or did result, in unnecessary harm to a patient. There are three types of patient safety incidents:

    - **Harmful incident:** a patient safety incident that resulted in harm to the patient (replaces "preventable adverse event");

    - **Near miss:** a patient safety incident that did not reach the patient and therefore no harm resulted; and

    - **No-harm incident:** a patient safety incident that reached the patient but no discernible harm resulted.

2. A critical incident or trauma: "Any sudden, unpredictable event that occurs during the course of carrying out day-to-day duties or activities that poses physical or psychological threat to the safety or well-being of an individual or group of individuals" (as per SickKids definition in their Trauma Response and Peer Support Policy). Examples include:

    - unexpected death of a patient;

    - suicide of a colleague;

    - a workplace accident resulting in critical injury to a staff member;

    - internal or external disaster;

    - mass casualty situations;

    - life-threatening illness, injury or untimely death of staff or co-worker;

- natural or man-made disasters; and

- any incident charged with profound emotion.

3. Other work-related stress (**excludes** issues related to Human Resources such as job action or performance). Examples include:

- work environment;

- assault, harassment, or violence involving staff or patient and/or family;

- workplace conflict;

- workplace re-organization or downsizing;

- complaints/lawsuits;

- cumulative stress;

- work-life balance issues;

- compassion fatigue;

- vicarious trauma; and

- events that attract media attention.

Box 1.0: A note on the term "second victim"

Albert Wu coined the term "second victim"[5] and many others subsequently adopted the term to describe a health professional who experience a PSI. The first victim is the patient who was harmed, while the second victim is the health professional who is traumatized by the event.

The use of the term "second victim" has been heavily debated in healthcare. For one, this label often does not resonate with healthcare workers as the term implies weakness, and this is not a characteristic they associate with themselves[11]. Also, the label "victim" implies healthcare workers do not have a role to play in the incident, and that something has been done *to* them which they had no control over. Patients and families do not always appreciate the term either, as calling the health professional a victim has the potential to lessen the impact of the incident on the patient.

In addition, the term "second victim" refers exclusively to the distress healthcare workers feel following a patient safety incident. However, there are a variety of situations that may lead to damaging emotional impact on healthcare workers[16]. One study evaluating the impact of a peer support program for healthcare professionals noted that the majority of the incidents for which they sought support were not related to medical error[17]. For 80 of the encounters, 45% included death of a patient and 21.3% involved a patient safety incident; the remainders of calls were about other difficult situations, such as difficult decisions, burnout, staff assault, interpersonal conflict among staff and others[17]. The RISE programme notes: "Hospital workers face many challenges following the occurrence of stressful, patient-related events. A few of those involve medical errors, but the large majority are simply related to the extraordinary stresses incumbent in the job" [17].

Another reason to question the use of the term "second victim" is that creating a label for what is a normal and healthy psychological reaction to a distressing situation risks pathologizing the healthcare worker's experience and further stigmatization.

When it came out in 2000, the term "second victim" was very useful, especially because it brought attention to the impact of PSIs on health professionals and set us on a path to recognize the traumatic experience of PSIs in healthcare. However, the label is no longer useful nor widely accepted.

Considering the reservations both healthcare workers and patients have for the term "second victim," the reality that the distress experienced by healthcare workers goes beyond the distress they feel after a patient safety incident, and the importance of not pathologizing what is a normal reaction, CPSI is electing not to use the term "second victim" and indeed not to label the experience at all. Instead, we will refer to the emotional distress experienced by a healthcare worker.

The term *second victim* is still used in literature and many support programs throughout Canada and abroad. The term *second victim* will be used in this document when referring to external programs or work where this terminology has been used.

Background

Healthcare workers function in an increasingly complex and technical environment, often under tremendous time pressures and growing demands for resources, where they are working interdependently with others in systems that are not always effective, all the while striving to provide the best of care for their patients. At the same time, they carry an added emotional burden of the risk of something going wrong, and the potential of a patient safety incident where the patient is harmed or almost harmed. They work within a system full of ambiguity, uncertainty, and morally complex choices.

Within this environment, there are a number of specific causes of emotional distress, as suggested in the definition of peer support. For example, a healthcare professional may feel emotionally traumatized after a sudden or unexpected bad outcome, a patient safety incident, the loss of a patient with whom they feel close, workplace conflict, or when dealing with multiple trauma cases.

Healthcare workers can experience strong emotional, physical, cognitive, or behavioural responses to events or to the stress of the workplace. Signs and symptoms that someone may be reacting to workplace conditions may include the following[15]:

Table 1.0: Signs and Symptoms

Physical	Emotional	Cognitive	Behavioural
Sleep disturbances	Numbness	Intrusive thoughts or images	Increase or loss of appetite
Fatigue	Feeling overwhelmed or helpless	Poor concentration	Crying spells
Dizziness and weakness	Guilt	Impaired decision-making	Increased alcohol consumption
Increased heart rate and blood pressure	Grief or depression	Difficulty doing calculations	Withdrawal
Chills	Loss of emotional control	Disrupted thinking	Change in activity
Nausea and vomiting	Anger	Blaming	Irritability
Muscle tremors and/or twitches	Panic or fear		Change in personality

Individuals seeking support might be experiencing distress in the form of anxiety, depression, post-traumatic stress disorder (PTSD), chronic work-related stress, and burnout or compassion fatigue. They may not always need professional help, but simply need someone to talk to who understands what they are going through.

Peer support is rooted in the belief that "…hope is the starting point from which a journey of recovery must begin[18]." Peer supporters can inspire this hope by not treating their peers like a victim, but by helping them leverage their own resilience and discover their own sense of empowerment, recover their self-esteem, learn new coping skills and experience personal growth.

A PSP can foster a supportive culture and provide timely access to mental health support. It can be a safe way for healthcare workers to talk about their experiences and challenges with someone who is empathetic and can understand what they are going through because they have "been there." A peer supporter draws from their own experience to help their colleagues get through the immediate consequences of emotional distress and help them process what they are going through in a positive manner. The Mental Health Commission of Canada maintains that connecting with another person who has lived with similar problems, or is perhaps still doing so, can be a vital link for someone struggling with their own situation[19]. When healthcare workers are able to quickly share their experiences in a safe, trusting, accepting, and validating environment, it can reduce the risk of more traumatic or cumulative stress.

The BCEHS outlines the following benefits and outcomes in their overview of healthcare worker support models[20].

Healthcare worker support models can:

- Humanize mental health challenges and take them outside the medical realm;

- Promote socialization, reducing feelings of isolation and alienation that can be associated with mental health conditions;

- Help people gain control over their symptoms and reduce hospitalization;

- Foster hope and recovery;

- Help people learn coping skills and improve resilience;

- Promote a better understanding of mental health issues and services for all within an organization;

- Create opportunities for increased employee engagement;

- Help peers reach life goals and improve quality of life; and

- Provide rewards and further healing for the peer supporter through the experience of listening to and helping others.

There are a number of challenges to setting up a PSP in a healthcare organization, not the least of which is that healthcare workers often have a difficult time reaching out for help. Asking for help or seeking mental health care is stigmatized as a sign of weakness[11,12,13]. According to de Wit et al., "… the very act of admitting you need help after a traumatic event carries its own powerful stigma in a culture that embraces the illusion that perfection can be achieved, and that falling short of this impossible standard is a sign of personal defect[12]." Further, some health professionals may not want to risk their credentialing bodies finding out that they sought mental health care[13]. Healthcare workers are also reticent to seek help because they fear being judged negatively by their colleagues, do not trust the confidentiality of the process, or lack confidence in the value of the support.

It is important that a PSP be built with this challenge in mind, and thus be planned and executed carefully and deliberately.

Summary

CPSI is committed to improving patient safety by improving the well-being of healthcare workers. As we undertook this PSP project, we endeavoured to access all relevant resources to ensure that the product was comprehensive, and evidence based.

We hope that this manual is both useful and practical for healthcare leaders, managers and frontline workers who are about to embark on a new PSP or who have begun the process and are looking for recommendations, resources, and innovative ideas.

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**Section 1: Survey of
Healthcare Providers'
Perceptions related to the
Second Victim Phenomenon**

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Section 1: Survey of Healthcare Providers' Perceptions related to the Second Victim Phenomenon

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Section 1: Survey of Healthcare Providers' Perceptions related to the Second Victim Phenomenon

A Survey of Canadian Healthcare Workers: Their views on the experience of a patient safety incident and the support they need

Introduction

This section of the manuscript entitled Creating a Safe Space: Strategies to Address the Psychological Safety of Healthcare Workers is a key component of the Canadian Patient Safety Institute (CPSI) initiative to improve support to healthcare workers after a patient safety incident (PSI). The study was undertaken by a research team at the University of Ontario Institute of Technology (UOIT), in collaboration with CPSI to uncover what Canadian healthcare workers need in terms of emotional support after a PSI. The purpose of this study was to determine the perceptions of Canadian healthcare workers on their experiences of a PSI, and the support they received or wished to receive. This survey undertaken within this research will serve as a basis for identifying existing current support systems and assessing the needs of Canadian healthcare workers.

Methods

UOIT conducted a national self-administered online survey of healthcare workers in 2018. The details of the methodology used are detailed in the following sections.

Sample

The sample was identified based on an email listserve provided by CPSI. After excluding individuals on the listserve who did not fit the description of a frontline healthcare worker, the survey was sent to 750-850 individuals. However, due to the low response rate, the survey was later sent out through healthcare professional associations asking them to distribute the survey to their members. Not all associations were able to do so, however; many had policies in place regarding the number of surveys or studies they would send to their members.

Questionnaire

The questionnaire incorporated components from the validated Second Victim Experience and Support Tool (SVEST) instrument[2], including questions about psychological and physical distress, and about desired forms of support. It also included items on variables related to demographics, employment characteristics and educational history (See Appendix 1). The SVEST is used to collect responses on psychological and physical symptoms after a PSI, and the quality of support resources available [1]. The

desirability of possible support resources is also measured [1]. The SVEST has been assessed for content validity, internal consistency, and construct validity and confirmatory factor analysis[1]. The research team collaborated with the CPSI team to obtain feedback regarding the questionnaire and to make modifications (e.g., demographic, workplace characteristics, etc.) to reflect the Canadian health care environment. The researchers responsible for creating the SVEST gave permission to use the instrument.

In addition to the questions on the SVEST, open-ended questions were added to obtain information on:

- whether they had received support after a PSI in the past 12 months and, if yes, what type of support they received;

- what type of support they would like to receive;

- what they would do differently for a peer based on their experience; and

- what their advice is in terms of providing support.

Data collection

The self-administered electronic questionnaire was developed using the platform MachForm, which was hosted on a secure server at UOIT. The electronic questionnaire was distributed June 2018 by an email invitation in collaboration with the CPSI to maintain confidentiality of the sample. Arrangements were made by the CPSI to have the email invitation sent to the sample population. The email invitation included the consent form, explanation of the study, contacts for further information, and a link to the questionnaire. Participation was completely voluntary. To participate in the study and to indicate consent, participants were required to click on the link provided in the email invitation which took them to the questionnaire. Upon completion of the questionnaire, respondents were asked to click on a link to submit the completed questionnaire.

This was an anonymous survey and no personal identifying information was collected. If anyone felt uncomfortable answering any of the questions they were not required to provide a response.

Once the questionnaire was completed, the raw data was stored on a secure server at UOIT. The UOIT research team did not have access to the email addresses. The data was strictly anonymous. Access to the raw data was limited to the research team. Individual responses were kept confidential and only grouped and aggregated study data will be presented in any presentations, publications, or de-briefings.

Data analysis

The analysis included descriptive statistics, factor analysis, and an analysis of variance. The data was analyzed by professional group, sector, and years of experience and, in relation to questions #20 and #21, to determine if views differ within professional groups.

Responses were grouped and analyzed by themes based on the open-ended questions asked in the survey (ex. type of support received, type of support wanted, etc.).

Ethics

Approval was obtained from the Research Ethics Board at the UOIT.

Results

Demographics of the Respondents

A total of 390 self-identifying frontline healthcare workers responded to this survey. Those disciplines who responded included dietitians, medical laboratory technologists, medical radiation technologists, nurses, occupational therapists, paramedics, pharmacists, physical therapists, physicians, respiratory therapists and other. Table 1.1 presents the response rates of each discipline.

Table 1.1: Respondents by Professional Designation
(N= 390)

Professional Designation	Number of Respondents	Response rate
Medical Radiation Technologist (MRT)	229	58.7%
Nurse	39	10.0%
Physician	37	9.5%
Pharmacist	32	8.2%
Respiratory Therapist	24	6.2%
Medical Laboratory Technologist	10	2.6%
Paramedic	8	2.1%
Physical Therapist	6	1.5%
Dietitian	4	1.0%
Occupational Therapist	2	0.5%
Other	1	0.3%

Respondents were also asked to identify the area of practice relevant to their current work. Table 1.2 displays the breakdown of respondents by area of practice with the majority of respondents (69.2%) identifying acute care as their current area of practice.

Table 1.2: Respondents by Area of Practice
(N=390)

Area of Practice	Number of Respondents	Response Rate
Acute Care	270	69.2%
Primary Care	53	13.6%
Community Care	44	11.3%
Long-Term Care	14	3.6%
ALL*	5	1.3%
Other	4	1.0%

*The category "ALL" consists of respondents indicating working in all four areas of practice.

The majority of respondents to this survey reside in the province of Ontario (32.3%). The smallest number of participants was from Nunavut and the Northwest Territories (0.3% each). The breakdown of the respondents by their province of residence is presented in Table 1.3 below.

Table 1.3: Respondents by Province of Residence
(N= 390)

Province of Residence	Number of Respondents	Response rate
Ontario	126	32.3%
Alberta	88	22.6%
British Columbia	49	12.6%
Manitoba	33	8.5%
Nova Scotia	30	7.7%
New Brunswick	26	6.7%
Saskatchewan	21	5.4%
Quebec	9	2.3%
Prince Edward Island	4	1.0%
Newfoundland & Labrador	2	0.5%
Northwest Territories	1	0.3%
Nunavut	1	0.3%

Table 1.4 presents a breakdown of respondents by years of experience in healthcare. The majority of respondents indicated having 12 years or more of experience in healthcare. This was followed by 6-8 years and 9-12 years of experience in healthcare (11.0% and 10.8% respectively).

Table 1.4: Respondents by Years of Experience in Healthcare
(N=390)

Years of Experience in Healthcare	Number of Respondents	Response Rate
12 years or more	253	64.9%
6-8 years	43	11.0%
9-12 years	42	10.8%
3-5 years	35	9.0%
2 years or less	17	4.4%

Involvement in a Patient Safety Event

Of the 390 who responded, 58% indicated that they have been involved in a serious patient safety event[i] impacting one of their patients and 32% indicated that a patient safety event caused them to experience anxiety, depression or wondering if they were able to continue to do their job in the last 12 months (See Table 1.5).

Table 1.5: Involvement in a Patient Safety Incident Involvement in a Patient Safety Event (N=390)

	Number of Respondents	Response Rate
Have been involved in a serious patient safety event impacting one of their patients	225	57.7%
A patient safety event caused them to experience anxiety, depression or wondering if they were able to continue to do their job	123	31.5%

Due to the disproportionately higher number of MRT respondents, these numbers were further analyzed to assess for any skew in the results. For the purpose of this analysis, MRTs were compared to a group of respondents with the next highest response rates (Nurses, Physicians, Pharmacists and Respiratory Therapists). The results are presented in Tables 1.6 and 1.7 below.

Table 1.6: Involvement in a Patient Safety Event - MRTs (N=229)

	Number of Respondents	Response Rate
Have been involved in a serious patient safety event impacting one of their patients	106	46.3%
A patient safety event caused them to experience anxiety, depression or wondering if they were able to continue to do their job	57	24.9%

Table 1.7: Involvement in a Patient Safety Event – Nurses, Physicians, Pharmacists and Respiratory Therapists (N=132)

	Number of Respondents	Response Rate
Have been involved in a serious patient safety event impacting one of their patients	97	73.5%
A patient safety event caused them to experience anxiety, depression or wondering if they were able to continue to do their job	53	40.2%

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[i] The term "patient safety event" was used instead of the term "patient safety incident" in the SVEST tool. Although CPSI has adopted the term "patient safety incident" in all its documents, the term "patient safety event" will be used in this document to protect the integrity of the results.

Based on the results in Table 1.6 and 1.7, it is evident that the group of healthcare workers in Table 1.7 shows a much higher positive response rate of 73.5% when asked whether they have been involved in a serious patient safety event impacting one of their patients. This indicates that this group of healthcare workers is more likely to experience a serious patient safety event compared to MRTs which make up a larger portion of our sample. The same is true for the second statement about their experience of anxiety, depression, or ability to continue to do their job: the group of healthcare workers have a much higher positive response rate compared to the MRT group.

The next sections will outline some of the effects healthcare workers experience after a patient safety event. Each section presents the results from the scale questions and are supplemented with the qualitative responses.

Psychological Distress

Respondents were asked to rate their agreement with statements about psychological distress. Over 50% of those who responded to this question agreed that they experienced embarrassment from these instances and 54.3% indicated that the experience has made them fearful of future occurrences. Although not the majority, 39.9% said they felt miserable as a result of the experience, and 41.3% felt deep remorse.

Table 1.8: Psychological Distress - All respondents

	Disagree	Neither	Agree	NA	Total (N)*
I have experienced embarrassment from these instances	104 (35.6%)	7 (2.4%)	153 (52.4%)	28 (9.6%)	292
Experience has made me fearful of future occurrences	95 (31.5%)	15 (5.0%)	164 (54.3%)	28 (9.3%)	302
Experience has made me feel miserable	143 (47.2%)	13 (4.3%)	121 (39.9%)	26 (8.6%)	303
I feel deep remorse for past experience	123 (42.0%)	15 (5.1%)	121 (41.3%)	34 (11.6%)	293

*Total (N) excludes those who did not respond.

Separating out the MRTs from the rest of the data, it is interesting to note that over 50% of the MRT respondents disagreed that the experience made them feel miserable (55.6%) or deep remorse for the past experience (51.2%).This is in contrast to the results obtained from the group of respondents presented in Table 1.10. This group of respondents agreed with all the statements over 50% of the time.

Table 1.9: Psychological Distress - MRTs

	Disagree	Neither	Agree	NA	Total (N)*
I have experienced embarrassment from these instances	70 (44.0%)	0	67 (42.1%)	22 (13.8%)	159
Experience has made me fearful of future occurrences	72 (42.1%)	0	76 (44.4%)	23 (13.5%)	171
Experience has made me feel miserable	95 (55.6%)	0	56 (32.7%)	20 (11.7%)	171
I feel deep remorse for past experience	83 (51.2%)	0	50 (30.9%)	29 (17.9%)	162

*Total (N) excludes those who did not respond.

Table 1.10: Psychological Distress - Nurses, Physicians, Pharmacists and Respiratory Therapists

	Disagree	Neither	Agree	NA	Total (N)*
I have experienced embarrassment from these instances	26 (23.4%)	6 (5.4%)	74 (66.7%)	5 (4.5%)	111
Experience has made me fearful of future occurrences	20 (18.5%)	13 (12.0%)	71 (65.7%)	4 (3.7%)	108
Experience has made me feel miserable	40 (37.0%)	9 (8.3%)	54 (50.0%)	5 (4.6%)	108
I feel deep remorse for past experience	32 (29.6%)	9 (8.3%)	63 (58.3%)	4 (3.7%)	108

*Total (N) excludes those who did not respond.

Physical Distress

The majority of those who responded to this question disagreed with having experienced most of the physical distress symptoms in the list. However, 37.8% agreed that the mental weight of their experience was exhausting. This may suggest that the psychological symptoms after experiencing a patient safety event are experienced more often by healthcare workers in comparison to physical symptoms.

Table 1.11: Physical Distress - All respondents

	Disagree	Neither	Agree	NA	Total (N)*
The mental weight of my experience is exhausting	125 (33.1%)	84 (22.2%)	143 (37.8%)	26 (6.9%)	378
My experience can make it hard to sleep regularly	163 (43.1%)	72 (19.0%)	115 (30.4%)	28 (7.4%)	378
The stress has made me queasy or nauseous.	170 (45.0%)	77 (20.4%)	103 (27.2%)	28 (7.4%)	378
Thinking about the experience makes it difficult to have an appetite	182 (48.1%)	82 (21.7%)	88 (23.3%)	26 (6.9%)	378

*Total (N) excludes those who did not respond.

Table 1.12 displays the data for this subset of question for MRTs alone. The results are very similar to the overall respondent data presented in Table 1.11 with the majority of the respondents disagreeing with all of the statements referring to the experience of physical distress after a patient safety event.

Table 1.12: Physical Distress - MRTs

	Disagree	Neither	Agree	NA	Total (N)*
The mental weight of my experience is exhausting	83 (37.1%)	46 (20.5%)	74 (33.0%)	21 (9.4%)	224
My experience can make it hard to sleep regularly	106 (47.3%)	42 (18.8%)	53 (23.7%)	23 (10.3%)	224
The stress has made me queasy or nauseous.	108 (48.2%)	44 (19.6%)	49 (21.9%)	23 (10.3%)	224
Thinking about the experience makes it difficult to have an appetite	116 (51.8%)	44 (19.6%)	42 (18.8%)	22 (9.8%)	224

*Total (N) excludes those who did not respond.

Considering the responses from the nurse/physician/pharmacist/respiratory therapist group, a slight difference in responses can be noted. This group of respondents agreed that the mental weight of their experience was exhausting (43.8%) and that their experience of the patient safety event made it hard to sleep regularly (41.4%).

Table 1.13: Physical Distress - Nurses, Physicians, Pharmacists and Respiratory Therapists

	Disagree	Neither	Agree	NA	Total (N)*
The mental weight of my experience is exhausting	35 (27.3%)	34 (26.6%)	56 (43.8%)	3 (2.3%)	128
My experience can make it hard to sleep regularly	48 (37.5%)	24 (18.8%)	53 (41.4%)	3 (2.3%)	128
The stress has made me queasy or nauseous.	50 (39.1%)	29 (22.7%)	45 (35.2%)	4 (3.1%)	128
Thinking about the experience makes it difficult to have an appetite	55 (43.0%)	32 (25%.0)	38 (29.7%)	3 (2.3%)	128

*Total (N) excludes those who did not respond.

Support

Of the 123 who indicated experiencing anxiety, depression or wondering if they were able to continue their job due to a patient safety event, 89% of them did **_not_** receive any support at their institution (Table 1.14). Only 6.5% of respondents indicated receiving support at their institution. Very similar results are seen when the data is separated between the MRT group and the comparison group (Tables 1.15 and 1.16).

Table 1.14: Experienced an incident in the last 12 months vs Received support in the last 12 months - All respondents

	Receiving support in the last 12 months		
		No (N=358)	Yes (N=14)
Experienced an incident in the last 12 months (N=123)	No (N=267)	248 (92.9%)	6 (2.2%)
	Yes (N=123)	110 (89.4%)	8 (6.5%)

Table 1.15: Experienced an incident in the last 12 months vs Received support in the last 12 months - MRTs

		Receiving support in the last 12 months	
		No (N=218)	**Yes** (N=3)
Experienced an incident in the last 12 months	**No** (N=172)	166 (96.5%)	1 (0.6%)
	Yes (N=57)	52 (91.2%)	2 (3.5%)

Table 1.16: Experienced an incident in the last 12 months vs Received support in the last 12 months - Nurses, Physicians, Pharmacists and Respiratory Therapists

		Receiving support in the last 12 months	
		No (N=117)	**Yes** (N=8)
Experienced an incident in the last 12 months	**No** (N=79)	68 (86%)	4 (5.1%)
	Yes (N=53)	49 (92.5%)	4 (5.1%)

Type of Support Received

Those respondents who received support in the past 12 months were asked to specify the type of support that they received. The top three types included support from EAP, discussions with their manager, and discussion with their colleagues.

- "We have an employee and family health program that I have utilized a few times." – Medical Radiation Technologist

- "Discussion with manager and colleagues about event and impact on myself, client's family." – Physical Therapist

- "Follow-up with manager, support from colleagues, counselling through EAP." – Nurse

- "Discuss situations with Unit manager and trusted peers. I also go to an outside professional counselor on my own time." - Pharmacist

Satisfaction with Support Received

Of those who received support in the last 12 months, 35% of participants indicated being **_not_** satisfied with the amount and type of support that they received. In addition, some respondents indicated there was no acknowledgement of the incident, or that they were subject to inappropriate jokes or bullying by the manager and/or team members.

- A medical radiation technologist stated "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."

- A physician responded "I am also traumatized by the institution's blatant avoidance of actually investigating the situation and dealing with it in an ethical and transparent way. I have been forced to be an important bystander whose patients have been hurt by malpractice committed by other members of the treatment team who have not been held accountable. I was not directly involved in the incident, but tried to advocate for my patient who was a young adolescent, only to see not only nothing happened, but the nurse involved continued to repeat her medically unsound actions on-going with no attempt by hospital to stop it. They did not want to deal with the nurses or their union and it was easier to just look away and ignore me."

Desired Supports

Respondents were asked to identify their desired forms of support (See Table 1.17). 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 desirable (82.8%).The support that ranked second (76.7%) was having a specific peaceful location available to recover and recompose.

Table 1.17: Desired Supports

	Undesirable	Neutral	Desirable	NA	Total (N)*
Confidential 24 hours support	36 (9.5%)	87 (23.0%)	245 (64.8%)	10 (2.6%)	378
Opportunity to meet my counselor at my hospital	54 (14.3%)	95 (25.1%)	212 (56.1%)	17 (4.5%)	378
Discussion with manager/supervisor	47 (12.4%)	86 (22.8%)	232 (61.4%)	13 (3.4%)	378
Employee Assistance Program (EAP)	35 (9.3%)	53 (14.0%)	281 (74.3%)	9 (2.4%)	378
A respected peer to discuss	11 (2.9%)	43 (11.4%)	313 (82.8%)	11 (2.9%)	378
A specified peaceful location	20 (5.3%)	57 (15.1%)	290 (76.7%)	11 (2.9%)	378
Ability to take time away immediately	23 (6.1%)	58 (15.3%)	287 (75.9%)	10 (2.6%)	378

*Total (N) excludes those who did not respond.

When asked to describe further the type of support that they would like to receive, the top supports that were highlighted by respondents were confidential support (on and off site), peer support from their colleagues, support and/or conversation with their manager, and time-off immediately after an incident.

- "Time away from the workplace immediately after a serious incident to process what has taken place and my response to it." – Nurse

- "Real time available online or telephone counsel or support" – Respiratory Therapist

- "Open discussion with my supervisor about the repercussions of the incident. And the opportunity to discuss with close peers about what may have contributed to the incident and how to prevent in the future. I do not think that talking to an outsider would be beneficial (at least for me)." – Pharmacist

- "Support from management and supervisors, less of a "blame culture"." – Medical Radiation Technologist

Support for a Peer

In addition, respondents were asked what they would do differently if they were supporting a peer based on their experience. The most common types of support respondents noted were being available (time and space), encouraging discussion and asking what support they wanted, being empathetic and understanding, and encouraging them to seek help.

- "When a colleague recently experienced a difficult patient care situation, I called her to say that I was available to talk if she needed it." – Physician

- "Provide time and space to meet with that colleague in a non-judgmental way to indicate support. To receive structured training/ education about how to support and approach my colleague OR at least be able to provide resources to quickly point the way to this peer. To practice kindness and support from the whole team/ person perspective." – Pharmacist

- "Encourage reaching out for help, even if they feel "fine" Sharing the experience with colleagues." – Nurse

- "Listen, understand, enact policies and processes to support safer work practices, learn from incidents, and let them know they are not alone." – Medical Radiation Technologist

While the majority of respondents provided comments on how they would support a peer who has experienced a patient safety event, there were others who experienced a backlash for supporting a peer and who stated they would be reluctant to do so again. Some also stated their own personal hardships as a barrier to helping a peer.

- "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. 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." – Medical Laboratory Technologist

- "I did support a peer and 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." – Pharmacist

Advice on How to Support

The respondents were asked their opinions about what would be the best support or guidance for a team member who is emotionally impacted following a patient safety event. The top forms of support suggested by the respondents 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.

- "The best thing to do is to LISTEN openly and non-judgmentally." – Physician

- "Have someone available and checking in often. Not just immediately after." – Respiratory Therapist

- "Debriefs are helpful, but not just leaving it after the debrief - revisit in a few weeks/month to see if things are going okay, if there has been any impact to work, if they need more support." – Physician

- "Acknowledge the impact; make it easy for persons to seek help - not just in nursing but across professions." – Occupational Therapist

- "Confidential support from whomever is involved in the disclosure." – Physician

Conclusion
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The results obtained from this study provide us with some insight into the effects of the PSIs on our healthcare workers. In particular, the results from this study further stress the psychological impact of PSIs over physical distress. These results support that healthcare workers who have experienced a PSI need to be supported emotionally[4, 6]

One significant finding is the number of survey respondents who experienced a PSI within the past 12 months but did not receive support. Of the respondents indicating they experienced a PSI, only 6.5% indicated they received support. Overall, 89.4% responded they did not receive any support. Without a supportive team, healthcare workers will have more difficulty coping with the incident and making a full recovery[4].

Respondents clearly indicated that peer support would be one of the most valuable types of support after a PSI. They also indicated that support from managers/supervisors and institutional support was important. At the same time, respondents expressed concern over support from higher authorities, with some respondents even indicating they were afraid to approach them for help. A large survey of physicians in the United States and Canada found that 90% of physicians indicated that hospitals and healthcare organizations failed to support them when coping with the trauma of a PSI [5].

In our survey, not only did respondents clearly indicate they wanted more support from their institution and higher authorities, but they also wanted to receive from them empathy and acknowledgement of what they are experiencing. These findings are supported by Denham (2007) who states that healthcare workers who have experienced a patient safety incident need to immediately be made aware that their peers respect and support them, that they remain a trusted and valued member of the team, and that they are supported by their higher authorities [3].

As a final note, a very high number of MRTs responded to this survey. Considering they made up for 59% of the respondents, their high interest in completing the survey warrants further investigation; for example, it might indicate that this group is affected by PSIs and used this survey as a method of voicing their

concerns over how healthcare workers are supported after such incidents. It would be worthwhile to follow-up with the MRTs via focus groups or key informant interviews to delve deeper into what these concerns are and where they are stemming from.

The results from this survey emphasize the importance of creating an awareness of the need for support after a PSI amongst frontline healthcare workers, higher authorities, and institutions. CPSI hopes that healthcare organization will pay attention to what healthcare workers are expressing through this survey, and make use of the tools, resources and guidelines in the Creating a Safe Space: Strategies to Address the Psychological Safety of Healthcare Workers to develop support programs for their own workers.

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Creating
a Safe Space

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**Section 2: Global Environmental
Scan of Healthcare Worker
Support Models**

Acknowledgements

Section 2: Global Environmental Scan of Healthcare Worker Support Models

Disclaimer

This publication is provided as information only. All examples are provided as illustrations. This publication is not to be used as a substitute for legal advice. It is not an official interpretation of the law and is not binding on the Canadian Patient Safety Institute (CPSI).

Section 2: Global Environmental Scan of Healthcare Worker Support Models

Introduction

There were two scans completed for this paper – one in 2018 and the second in 2020. The Canadian Patient Safety Institute (CPSI) determined that it would be valuable to conduct an environmental scan of national and international literature. In 2018, researchers at IWK Health Centre were funded by an IWK Health Centre "Category A Research Grant" to conduct a scoping study to explore how health professionals are supported after a patient safety incident – with particular focus on peer support programs. The IWK researchers collaborated with CPSI to write this section about the findings from their study.[ii]

The IWK Health Centre study explored the range and context of interventions used in Canada and internationally to support health professionals emotionally in the workplace. The researchers considered qualitative and quantitative evidence, as well as policies, presentations, manuals, and brochures. Specifically, the objectives were to:

- describe peer support programs that address the impact of patient safety incidents (PSIs) on health professionals;

- describe the target audience of the intervention; and,

- report the intervention outcomes for health professionals and the organization as a whole.

CPSI also collaborated with the IWK team to conduct an additional survey of healthcare organizations in Canada that were known to have established or were in the process of establishing a Peer Support Program.

In 2020, the Mental Health Commission of Canada (MHCC) funded an update of the environmental scan, broadening the scope of search to all healthcare worker support models and were not limited to peer support programs. The MHCC and HealthCare*CAN* consulted with healthcare organizations across Canada to define what unique chronic stressors exist in the healthcare sector. Two additional psychosocial factors, unique to healthcare, were identified:

- Protection from moral distress: a healthcare work environment where staff are able to do their work with a sense of integrity that is supported by their profession, employer, and peers; and
- Support for psychological self-care: a healthcare workforce where staff are encouraged to care for their own psychological health and safety.

The scan included healthcare worker support models that have pertinence within the COVID-19 pandemic. The main research question for the 2020 scan was: What healthcare worker support models have

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[ii] The scientific findings from the IWK research, in an article entitled "Organizational interventions to support second victims in acute care settings: a scoping study" will be published in a peer-reviewed journal.

been implemented across Canada and internationally in long term care, primary care, home care and acute care? Two researchers from CPSI completed the 2020 environmental scan.

The tables below are separated by international and Canadian models for health worker support models.

Methods

2018 Environmental Scan

The 2018 study focused on peer support programs for healthcare providers. For the 2018 scan the researchers performed a scoping study using the Arskey and O'Malley framework[1] to characterize the range and context of interventions used to psychologically support health professionals.

 The following scientific databases were searched:

- PubMed (November 2018);
- Embase via Elsevier (September 2017);
- Cumulative Index of Nursing and Allied Health (CINAHL) via EBSCOHost (September 2017);
- PsycINFO via EBSCOHost (September 2017);
- The Cochrane Central Register of Controlled Trials (CENTRAL) via Cochrane Library (September 2017); and,
- Web of Science Core Collection via Clarivate Analytics (September 2017).

All titles and abstracts that appeared relevant were selected for full text review. Two reviewers independently reviewed the full text articles to determine whether they described a program to support health professionals emotionally. During full-text screening, the text and reference lists of included papers were also screened for mentions of "second victim" support programs that were not found in the search. The researchers contacted authors of included studies to request further information about their programs.

Additionally, the following organizations were contacted to ask about documentation relating to any emotional support programs for health professionals of which they were aware, as well as additional contact information:

- Institute for Healthcare Improvement (IHI);
- Canadian provincial patient safety and quality councils;
- The Joint Commission;
- Agency for Healthcare Research and Quality (AHRQ);
- National Patient Safety Foundation;
- Canadian Medical Practice Association (CMPA);
- National Patient Safety Agency;
- Accreditation Canada;
- Royal College of Physicians and Surgeons of Canada;
- College of Nurses (Canadian provincial Colleges);
- Canadian Nurses Association;
- Canadian Pharmacists Association;
- Canadian College of Family Physicians;
- Canadian Medical Association; and,

- Resident Doctors of Canada.

The data were collated and summarized in a chart and programs were categorized and analyzed for common themes and characteristics. The search strategy for the 2018 scan favoured identifying peer support programs that are published in peer reviewed journals. This field of study is growing rapidly, and we expect that there are many other programs that have yet to be published in the peer reviewed domain or are in the development phase. Some programs may be found exclusively on organizational intranets and protected access domains. The need to ensure confidentiality in this sensitive domain introduces a barrier to producing outcomes-oriented research.

CPSI identified and surveyed a number of Canadian peer support programs that have either been established or are in the process of being established. The organizations surveyed included:

- Critical Incident Stress Program (CISP), British Columbia Emergency Health Services (BCEHS) and member of the BC First Responders' Mental Health Committee;
- Occupational & Critical Incident Stress Management (OCISM) (Health Canada – providing services to nurses working in First Nations communities across Canada);
- Peer Support and Trauma Response Program (The Toronto Hospital for Sick Children – SickKids);
- Peer Trauma Response Team Program (Alberta Health Services);
- Programme d'aide aux médecins du Québec (PAMQ)/Quebec Physicians' Health Program (QPHP); and,
- Second Victim Peer Support (Michael Garron Hospital);
- St Michael's Hospital, still in development phase;
- Chatham-Kent Health Alliance, still in development phase; and,
- Second Victim Guidance Team (Central Health, Newfoundland and Labrador).

We do not expect that this is an exhaustive list of peer support programs in healthcare organizations in Canada. As we promote and expand our reach across the country, we will no doubt continue to discover other programs and organizations that support healthcare workers emotionally.

Through the survey and one-on-one interviews, we collected data about how and why the organizations implemented a PSP, details about the mandate, scope and policies, along with information about training, confidentiality and evaluation. Much of the information gathered in the survey and interviews is expanded on in the "Best Practices for Workplace Peer Support Programs in Healthcare Organizations" section of this manuscript, but we include in this section an overall summary of the Canadian landscape. The survey questions are in Appendix 1.

Finally, a toolkit was developed to support healthcare leaders and policy makers to develop, implement or improve a workplace peer support program for healthcare providers. It includes tools, resources and templates from organizations across the globe who have successfully implemented their own peer support programs for healthcare providers. This toolkit was developed in partnership with the Mental Health Commission of Canada. Programs and materials from 24 organizations were included in the 2018 toolkit. While a thorough search was conducted in 2018, CPSI decided to expand the search with an evidence-based systematic method to ensure we captured a full breadth of resources.

2020 Environmental Scan

For the updated 2020 version the scope of the study was broadened to include psychological safety models for healthcare providers, which included psychological self-care supports and supports that address moral distress and may be preventative in nature, i.e. programs that seek to foster moral resilience, or consist of interventions available for healthcare providers experiencing moral distress. In addition, due to the COVID-19 pandemic the study included a search of resources and tools that were put into place during the COVID-19 context (e.g. addressing moral distress during the pandemic). The Arskey and O'Malley framework was also used to guide the selection and analysis of the psychological supports.

Multiple searches were conducted using the following databases: Medline(R) ALL (Ovid), Embase (Ovid), PsycInfo (Ovid), and CINAHL Plus with Full Text (EBSCO). Searches employed both controlled vocabularies, such as Medical Subject Headings (MeSH), and keywords representing concepts such as: (psychological distress OR burnout) AND (program OR intervention), with additional searches including terms on (Covid-19 OR 2019-nCov) OR (patient Safety OR patient Harm). The search for the scientific literature covered articles published between January 1, 2010 and May 15, 2020. No limiters were used, and strategies were adapted for each database. Searches were complemented with a grey literature search.

All titles and abstracts that appeared relevant were selected for abstract review and entered into Covidence©. Two CPSI reviewers independently reviewed the abstracts to determine whether they described a program to support psychological self-care, moral distress and peer support for healthcare providers. Any discrepancies were resolved by consensus. The included abstracts were provided by the CPSI librarian and underwent a second review for inclusion. The inclusion criteria for the search are as follows:

- French and English language
- Healthcare workers including those working in long term care, primary care, home care and acute care
- International and Canadian healthcare worker support models including peer-to-peer programs, toolkits, crisis intervention systems, domains, packages, rapid response models, and any other services that address healthcare worker psychological health and safety through protection from moral distress and supports for psychosocial self-care both in usual circumstances and during the 2020 COVID-19 pandemic.

During full-text screening, the text and reference lists of included papers were also screened for resources and models for psychological self-care, moral distress and peer support for health care providers that were not found in the search. Authors of included studies from the first and updated scans were contacted to request further information about their programs and to identify any additional tools, programs, and resources. They were specifically asked about the process taken to develop their programs, the barriers they faced and the measures of success (if available). The goal was to find programs that had been evaluated and if possible, sustained.

When the environmental scan was updated, the research team employed targeted surveys by way of calls and emails to the organizations offering healthcare worker support models with insufficient information online. These informal surveys were used to gather information about programs, resources and tools on psychological well-being including moral distress and psychological self-care along with peer support for healthcare providers. The following organizations were contacted:

- Institute for Healthcare Improvement (IHI)
- The Joint Commission
- Agency for Healthcare Research and Quality
- National Patient Safety Foundation
- Canadian Medical Practice Association
- National Patient Safety Foundation
- Accreditation Canada
- College of Nurses
- Canadian Nurses Association
- Royal College of Physicians and Surgeons of Canada
- Canadian Pharmacists Association
- Canadian College of Family Physicians
- Canadian Medical Association
- Resident Doctors of Canada
- Canadian Agency for Drugs and Technologies in Health
- Global Patient Safety Network
- The International Council of Nurses
- Canadian Alliance for Mental Illness and Mental Health

- Canadian Federation of Mental Health Nurses
- National Initiative for Eating Disorders
- Canadian Foundation for Healthcare Improvement
- Menno Place
- Sinai Health System
- BC Emergency Health Services
- BC Children's Hospital
- HealthCareCAN
- Providence Health Centre
- Montfort
- Michael Garron Hospital
- Saskatchewan Health Authority
- Vancouver Island Health Authority
- Covenant Health
- Sick Kids
- Alberta Health Services
- St. Joseph's Health Care London
- Eastern Health, Health Sciences Centre
- Nova Scotia Health Authority

Again, this was not expected to be an exhaustive list of international and Canadian organizations. We collected the following information about existing and global support programs, tools and resources and tools that promote the psychological safety and well-being of healthcare workers including psychological safety and moral distress. The online survey also included questions to help us identify any potential collaborators and advice about our search (e.g. terms to search). The survey questions for the 2020 scan are in **Appendix 2.**

In addition, the toolkit was updated to reflect the broadened scope of the 2020 environmental scan. The updated toolkit supports healthcare leaders and policy makers to develop, implement or improve a workplace healthcare worker support program, with an emphasis on psychological self-care and reducing moral distress. It includes tools, resources, and templates from organizations across the globe who have successfully implemented their own healthcare worker support programs. This toolkit was developed in partnership with the Mental Health Commission of Canada.

Two strategies were used to update the toolkit. First, developers of the programs identified in the 2018 and 2020 environmental scans were contacted to provide any additional program materials, such as training resources, policy documents, promotional materials, agendas/schedules, testimonials, and templates. Second, a systematic grey literature search was conducted to identify any additional resources, such as background information, fact sheets, work sheets, podcasts, news articles, webinars, etc. that address the general well-being, psychological self-care, and moral distress of healthcare workers. These searches yielded resources from 37 additional organizations/programs.

Findings

For the 2018 scan, 5,634 titles and abstracts were screened. The researchers identified 21 organizational programs that support health professionals emotionally. They identified two broad types of interventions: peer support programs [2-7] and proactive education [5, 8-12]. Proactive education included curricula and toolkits intended to increase knowledge and awareness about the concept of the "second victim" (a term still widely used, but as we explain in the introduction to this manuscript, one CPSI has chosen to eschew) as well as coping strategies. Some programs included elements of both peer support and proactive education [13-19].

For the 2020 update, a second literature search was conducted with a broader search strategy. In this second iteration, 4103 titles and abstracts were screened independently by two CPSI researchers who found some overlap with the findings form the 2018 environmental scan. Of these 3762 were excluded due to irrelevancy. The remaining documents were uploaded into Covidence© by the CPSI librarian. After review of the full documents for relevancy 28 studies were included in the study and added below.

The following tables 2.1 and 2.2 including findings from both the 2018 and 2020 scan outline various international and Canadian models, toolkits, programs and resources for protecting and improving the psychological health and wellbeing of healthcare providers including those for proactive education and curriculum, peer support after a patient safety incident, and psychological health and well-being including psychological self-care and moral distress. Each of the tables includes information about the program, its mandate and scope of support, the clients/audiences of the program, the process taken for implementation, the barriers to implementation and the measures of success. If possible, the measures of success were included to provide evidence of program effectiveness. In addition, it should be noted that although the healthcare worker support programs have specific mandates and scopes of support, programs may have indirect effects on other important psychosocial factors among healthcare workers. For example, peer support programs may provide support and resources that address moral distress and improve psychological self-care.

International Healthcare Worker Support Models

There are many excellent and innovative programs to address the psychosocial factors specific to the healthcare workforce. Yet many healthcare organizations do not know where to go for support or have trouble accessing evidence-based programs in ways that are timely, responsive to their needs and adaptable to their context. There is a need for more information sharing about programs that work. There also needs a more comprehensive, upstream, and better coordinated approach to supporting healthcare workers' mental health across Canada. In this effort, educational programs and peer support programs were identified in the 2018 environmental scan, and programs that aimed to enhance psychological self-care and reduce moral distress were identified in the 2020 environmental scan.

In the 2018 environmental scan, several international educational programs and peer support programs were identified. In some instances, educational interventions were bundled with peer support programs to promote their peer support programs and raise awareness about the second victim phenomenon "to normalize the behaviour of seeking support after an adverse event" [14]. For example, RISE used a website,

promotional videos, internal publications, screensavers, presentations to targeted departments and unit-level champions to promote knowledge about second victims and the RISE peer support program[17]. YOU Matter and forYOU educated staff to facilitate staff ability to identify and provide initial support to a second victim [13,16]. The educational mandate of PeerSupport (formerly SWADDLE) was broader than program awareness and initial staff support [15,19]. PeerSupport promoted resilience through seminars and "resilience rounds" to discuss compassion fatigue and mindfulness[19]. One peer support program – Battle Buddies - was developed to provide supports during the COVID-19 pandemic and provides a stepped approach for rapid deployment.

Some programs reached out to health professionals automatically in response to a specific event in the organization, while other programs depended on self-referral or referral by a colleague or administrator. One program, the Clinician Peer Support Program, described multiple paths by which it was activated: self-referral, referral by a peer supporter or referral by patient safety or risk management staff [14]. In the Physicians Insurance Peer Support Program, clinicians are contacted by peers who are trained by the claims department to provide support before or during litigation[5]. All but one program did not mandate participation in the program. Participation in Healing Beyond Today was mandatory for staff [2], as it was created in response to a specific significant patient safety incident. Some, like RISE and forYou, were premised on a stepped care model, whereas the level of resource intensity and effectiveness are provided as needed by the healthcare professional. Several of the programs had several stages for implementation including YOU Matter, which was implemented over the course of four years. The barriers to program implementation included stigma, confidentiality, a lack of awareness of the program, and the additional work time required for completion.

In the 2020 environmental scan, programs that focused on developing strategies and techniques for developing psychological self-care and reducing moral distress were identified. Psychological self-care encompasses a variety of behaviours and strategies including improving physical health through nutrition and exercise, better work-life balance, positive thinking and self-talk, and building social support networks. Other strategies for lowering stress such as yoga, meditation, and journaling, were also identified. The most common psychological self-care strategy found in the literature were facilitated workshops and learning sessions to reduce burnout (e.g. Burnout Program) and/or on techniques to improve well-being and reduce stress including mindfulness, meditation, yoga, and so forth. The programs focused on reducing burnout, anxiety, stress and compassion fatigue and improving resilience. Finally, the 2020 environmental scan included programs developed to assist healthcare workers with reducing moral distress. Several of the programs include the reduction of moral distress within their mandate or scope of support.

Table 2.1 provides an overall summary of the international healthcare supports for psychological health, including those designed for peer support, psychological self-care and to reduce moral distress. Note that many of the tools and resources from these support models are available in the Creating a Safe Space Toolkit.

Table 2.1: International Healthcare Worker Support Models

Location	Program Name	Short description	Mandate/ Scope of Support	Clients/ Audience	Process for Implementation	Barriers	Measures of Success
University of Missouri Health Care (MUHC), Missouri, US	forYOU [16, 20,21]	The forYOU team provides 24/7 confidential support and emotional first aid to clinicians, address unique needs through a 3-tier model of support, and increase institutional awareness of "second victims".	Peer Support (Emotional first aid after unanticipated or stressful / traumatic events)	Clinicians and Hospital Staff	Three-tiered model of support. Tier 1: local/departmental support and response to promote identification and awareness of second victims. Tier 2: guidance and support of identified second victims by specially trained peer supporters. Tier 3: access to professional services (e.g., chaplaincy, EAP, social work, and clinical health psychologists). Training is provided for peer supporters.	Information not found	Information not found
Methodist Hospital of Indiana, Indiana, USA	Healing Beyond Today [2]	Healing Beyond Today is a Critical Incident Stress Debriefing (CISD)-based program launched after a PSI in the NICU to help transition return to work. Sessions included sharing of feelings and grief to assist with self-forgiveness, return to work, and creating a vision for the future.	Post critical Incident (transition back to work)	"Second victims" of a particular PSI	Developed and implemented following a specific critical incident. Attendance was mandatory for all unit staff, and invitations were extended to ancillary personnel. Sessions were held off-site, away from the site of the PSI event.	Information not found	Information not found

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Location	Program Name	Short description	Mandate/ Scope of Support	Clients/ Audience	Process for Implementation	Barriers	Measures of Success
Johns Hopkins Hospital Maryland, USA	Resilience in Stressful Events [17,22] (RISE)	Multidisciplinary team of peer supporters activated through paging system to provide 24/7, confidential psychological support after a critical incident. The RISE team page backs ~30 minutes, arranges meeting in next 12 hours to provide psychological first aid and resources that may be helpful. After encounter, peer supporter activates debriefing session.	Peer Support Unanticipated patient event, stressful situation, or patient-related injury	Health professionals	Implementation takes place over 4 phases: 1) Developing RISE program, 2) Recruiting and training of peer responders, 3) Launching RISE pilot, and 4) Launching RISE hospital-wide. Program operated by existing resources in the hospital and relied on volunteered time of hospital staff. Training for peer supporters is a two-day workshop.	Barriers include lack of awareness of program, overcoming blame culture, additional staff time needed to handle adverse events. Staff concerns about confidentiality, risk of exposure to legal consequences.	Most of the peer responders were able to offer additional resources to staff, believed interactions were successful, and were able to meet staff's expectations.
Scott & White Medical Center, Texas, USA	Staff Well-being Assistance During Difficult Life Events [19,23] (SWADDLE)	1:1 ongoing peer support provides psychological first aid and referral to outside resources. Based on the Scott three-tiered model of staff support. Program provides prevention education for compassion fatigue, secondary	Peer Support	Health professionals	Peer support initiated following adverse incident, claims, litigation, and board complaints/ disciplinary action.	Information not found	Information not found

Location	Program Name	Short description	Mandate/ Scope of Support	Clients/ Audience	Process for Implementation	Barriers	Measures of Success
		traumatic stress, and burnout. Resilience Rounds are scheduled bi-monthly; these have both a didactic educational component, as well as a facilitated, confidential 20-30-minute group discussion. Also, train in "high-risk" areas in psychological first aid. A licensed behavioural health clinician was also hired to assess escalating psychological crises and fast-track psychiatric referrals.					
Washington University School of Medicine, USA	Washington University School of Medicine Clinician Peer Support Program[14]	Trained peers provide psychological support to clinicians after PSIs. Peer supporters work with clinicians to enhance resiliency by identifying and encouraging positive coping strategies.	Peer Support	Clinicians (defined as physicians, residents, fellows, physician assistants, nurse practitioners,	The program was developed with the support of the Washington University School of Medicine, WUSM Faculty Practice Plan and respective risk management and General Counsel departments. Self-referral, referral by a peer supporter, or by patient safety staff or risk management staff.	Program addresses barriers such as lack of time to seek assistance, fears about confidentiality, negative impact on career, and mental health stigma.	Information not found

Location	Program Name	Short description	Mandate/ Scope of Support	Clients/ Audience	Process for Implementation	Barriers	Measures of Success
		Peer supporters are trained to focus on the clinician's emotions and well-being, not on the event itself. No notes are kept, and clinicians are assured that all conversations are confidential.		and certified registered nurse anesthetists)	Training program provides evidence-based information on the emotional and functional impact of PSIs, information on positive coping mechanisms and clinician resiliency, and on established warning signs/known risk factors for depression and/or suicide.		
Nationwide Children's Hospital, Ohio, USA	YOU Matter[13]	A peer support program that is available 24/7 for psychological support after a critical incident. Interventions based on the Scott 3-Tiered model of Staff Support [16]. Encounter forms accessed through SharePoint and include only non-identifying data. This website also contains meeting minutes, lists of resources, and promotional materials.	Peer Support	Health professionals	Program was implemented over 4 years, beginning with better understanding "second victims" and brainstorming supports. After needs of hospital were assessed, a pilot study was conducted and evaluated, and peer support training curriculum was developed. Next, marketing materials were created, and the program was rolled out in clinical and non-clinical units/staff. As program developed, more staff support hired. Evaluation and feedback continue for improvement. The program was managed, and information distributed through SharePoint (an online platform)	Information not found	Information not found

Location	Program Name	Short description	Mandate/ Scope of Support	Clients/ Audience	Process for Implementation	Barriers	Measures of Success
					Peer support training consists of 4.5 hours of didactic lectures, small group work, and discussion.		
Cohen Children's Medical Center, New York, NY, USA	Helping Our Peers Endure Stress (HOPES) Program [24, 25]	24/7 peer support in response to critical incidents. HOPES team can be activated by anyone within the division. Three types of interventions are available depending on the type, urgency, and intensity of the situation. These interventions are: Defusing – occurs within hours, acknowledges experience, educates about possible reactions, plans for immediate future, and assesses need for higher level of mental health care. Debriefing – occurs	Peer-Support & Psychological Self-Care	Following a critical incident, anyone within the division can activate HOPES.	HOPES was designed for a specific division of a medical center and the HOPES staff resembles the composition of the division itself, allowing peer representation. A mission statement, core values, team structure, team membership, on-call/dispatch and activation procedures are developed. Program is promoted during staff meetings, morning briefs, teaching sessions, and through posters and signs. For continuous improvement and sustainability, administrative support, financial support, and record keeping is needed. Participation in program is voluntary and staff are not required to attend.	Program addresses concerns of confidentiality.	As of July 2020, the influence of the program on burnout was being analyzed. Culture change noted in division – greater acknowledgement of impact of critical incidents, greater support-seeking, and surveying of emotional needs.

Location	Program Name	Short description	Mandate/ Scope of Support	Clients/ Audience	Process for Implementation	Barriers	Measures of Success
		24-72 hours after less severe incident or as follow-up to more severe incident. Aim to return to baseline functioning by allowing emotional expression and offering concrete psychological self-care strategies. One-on-one – 24/7 availability of HOPES staff member for perspective and support.					
University of Minnesota Medical Center, Minnesota, USA	Battle Buddies [26]	A peer support program designed for rapid deployment during COVID-19. First, everyone assigned peer support through a 'Battle Buddy'. 2 co-workers work together to check in with each other, recognize stressors and resiliency factors, and develop individualized stress	Peer Support & Psychological Self-Care (Stress inoculation, burnout, PTSD symptoms, developing adaptive responses)	Healthcare workers	Designed to be implemented quickly during a sudden, high-stress event such as a pandemic. Form a Steering Committee of key faculty in relevant departments. This committee is responsible for the administration of the program. Steering committee meets with department/unit leaders to customize the program. Following, three levels of program are implemented, and Steering Committee conducts weekly drop-	University of Minnesota Medical Center, Minnesota, USA	Information not found

Location	Program Name	Short description	Mandate/ Scope of Support	Clients/ Audience	Process for Implementation	Barriers	Measures of Success
		inoculation plans. Second, a mental health consultant is assigned to each unit for unit-level support to aid implementation and conduct group sessions. Third, individual support is offered to individuals who requires professional assistance with higher-level mental health needs.			in meetings for continued evaluation, feedback, and making changes to program where appropriate.		
2017 Resident Wellness Consensus Summit in Las Vegas, Nevada, US	Resident Educator Toolkit [10]	Three toolkits developed for educators. Includes the second victim syndrome toolkit (4 modules), mindfulness and meditation toolkit (3 modules), and positive psychology toolkit (2 modules) Toolkits provide educators necessary resources, reading materials, and lesson	Psychological Self-Care (Positive Psychology, "Second Victim Syndrome")	Residents	The curriculum was designed to be flexible in implementation to meet needs of trainees/departments. The curriculum can be implemented as a year-long program or a module can be reduced to a single 45-minute session.	Information not found	Information not found

Location	Program Name	Short description	Mandate/ Scope of Support	Clients/ Audience	Process for Implementation	Barriers	Measures of Success
		plans to implement didactic sessions in their residency curriculum.					
Alicante-Sant Joan Health District Alicante, Spain	Mitigating Impact in Second Victims (MISE)[12]	A virtual program that was designed to education about "second victims", emotional reactions, and coping strategies. The website was structured in two packages: demonstrative and informative. The informative package offers information about basic patient safety concepts. The demonstrative package offers descriptions of emotional consequences of PSIs and recommendations for actions following PSIs. On average, it took 5	Psychological Self-Care ("Second Victim", communication)	Frontline Healthcare Professionals	Information is provided in several formats: narrated PowerPoints, PDFs, text, images, demonstrative videos, and a mobile app. An external evaluation was conducted of the website and the focus/content of the program was evaluated by Patient Safety experts.	Barriers identified include lack of manager preparation, lack of feedback, lack of training, and fear of repercussions.	1) HCW demonstrated increased knowledge of PSIs, consequences of PSIs, and what to do following a PSI after the program.

Location	Program Name	Short description	Mandate/ Scope of Support	Clients/ Audience	Process for Implementation	Barriers	Measures of Success
		hours to complete with twelve 30-minute sessions.					
2017 Resident Wellness Consensus Summit in Las Vegas, Nevada, US	Resident Wellness Curriculum [9]	The curriculum was designed to address psychological support and wellness of residents. It includes a seven-module "Self-Care Series". Other modules include a two-module introduction to wellness; a two-module section on physician suicide and self-help; a four-module "Clinical Care Series" focusing on difficult workplace situations, wellness in the workplace, and dealing with medical errors and shame.	Psychological Self-Care +Suicide Prevention, Wellness Culture, Medical Mistakes, Clinical Care	Residents	The curriculum was designed to be modified to meet the needs of trainees. For example, sections can be re-arranged or omitted, or the resources can be emailed to residents for self-study.	Information not found.	1) Empowerment and engagement increased in residents who participated in bi-weekly 1-hour curriculum sessions compared to residents who did not take part in the curriculum. 2)Burnout, emotional exhaustion, and depersonalization scores decreased among residents who took part in program.

Location	Program Name	Short description	Mandate/ Scope of Support	Clients/ Audience	Process for Implementation	Barriers	Measures of Success
Beth Israel Deaconess Medical Centre, Harvard Medical School Massachusetts, US	When Things Go Wrong [8]	Curriculum was developed to educate about adverse medical events and effectively communicate with and apologize to patients and their families and improve and standardize disclosure practices. A second curriculum was developed to train instructors of the curriculum. Curriculum includes baseline assessment of experiences, attitudes, and perceptions; interactive curriculum using filmed patient narratives; implementation strategy for real-time disclosure.	Psychological Self-Care +Apologizing to patients, disclosure, communicating with patients	Physicians, Residents, Students, and Healthcare Educators/ Faculty	The curriculum was launched with two tracks, "Teach the Trainee" for students, residents, and fellows and "Teach the Trainee" for faculty. Disclosure procedures of adverse incidents are established, and ongoing evaluations are conducted.	Fear of reaching out to supervisors/clinical teachers and receiving poor evaluations, power discrepancies, and receiving additional work to their already busy schedules.	1) Many trainees (79%) and faculty physicians (92%) reported that the curriculum would affect their own practice.
Cleveland Clinic, Ohio, USA	Code Lavender: Holistic Rapid	An interdisciplinary peer support program that provides emotional support.	Peer Support & Psychological Self-Care	Patients, families, hospital personnel	To implement the program, it is advised to conduct an internal assessment, form partnerships for team development, obtain	Lack of administrative support was identified as a barrier.	Information not found.

Location	Program Name	Short description	Mandate/ Scope of Support	Clients/ Audience	Process for Implementation	Barriers	Measures of Success
	Response	Triggers include unexpected death, death or illness of staff or long-term patients. First response in 30 minutes, with repeated check ins over next 72 hours. Services offered include massage, spiritual care, Reiki, Healing Touch, aromatherapy, and access to EAP.		(clinical and non-clinical)	leadership buy-in, advertise the program, measure outcomes, and train team members.		
Army Medical Center, USA	The Care Provider Support Program (CPSP)[27]	A psychological support program aims to reduce burnout by developing coping skills through self-awareness activities and energy management. Curriculum includes a 1 to 2-hour intervention involving discussion groups, education on stress and resilience, and interactive	Psychological Self-Care +Burnout	Military and Civilian Healthcare Workers	Annual CPSP training is required for military and civilian health professional staff. Training takes place at a military training facility.	Information not found.	1) Burnout scores decreased 30 days after the CPSP training.

Location	Program Name	Short description	Mandate/ Scope of Support	Clients/ Audience	Process for Implementation	Barriers	Measures of Success
		participation.					
Royal College of Surgeons in Ireland, Centre for Positive Psychology and Health, Dublin, Ireland	Attention-Based Training (ABT)[28]	The virtual-based psychological support intervention is designed to reduce burnout, as well as improve other psychological (stress, anxiety) and physiological (sleep, heart rate) outcomes. The 8-week program is available for free by RCSI. Curriculum includes small weekly manuals accompanied by 1-hour webinars (originally live webinars, saved for future access). Webinars can be accessed for free on YouTube.	Psychological Self-Care +Stress, Anxiety, Physical Symptoms	Healthcare Workers	Curriculum is available for free and is open access. PDF handouts contain educational information as well as YouTube links to videos reviewing information and practicing psychological self-care techniques.	Barriers considered when developing program: time, physical access, name of program (e.g., "mediation" may be inflammatory for some groups", and modifying participation (e.g., use breathing instead of mantra).	1) Burnout, stress, and anxiety decreased after the program and results were sustained for 2 months. 2) Physiological improvements were noted after the program, such as improved resting heart rate, heart rate variability, and sleep.
University of Kentucky, Lexington, Kentucky,	hCATS (health Colleges Advancing	The program is a weekend retreat that focuses on teaching techniques of	Psychological Self-Care + Resilience	Health professions students, faculty, and	The camp was part of a healthcare student education curriculum. It was implemented with administrative support from	Availability of content experts to lead each seminar, funding for physical retreat	1) Program evaluations by participants indicate knowledge gains in the habits and practices of

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Location	Program Name	Short description	Mandate/ Scope of Support	Clients/ Audience	Process for Implementation	Barriers	Measures of Success
USA Originally held at Shaker Village outside Lexington, KY	Team Skills) to CPR (Cultivating Practices of Resilience) Camp [29]	psychological self-care and resiliency, develop positive relationships, ways to combat stress, and implement a team to sustain resiliency practices. Didactic sessions for recognition of workforce stress, attention to work-life balance, and the science of mindfulness practices. Interactive activities include yoga, mindful eating, mindful hiking, body scan, diaphragmatic breathing, reflective music and art, GATHA practices, guided imagery, labeling thoughts and loving-kindness practice.	and Burnout	healthcare professionals who team to provide patient care.	the university, trained and certified facilitators, and in non-clinical environment.	space, meals, facilitators, KORU certification for facilitators. (This was originally funded by a grant).	resilient people, strategies for building resilience and coping with stress/burnout in self and others, and work-life balance.
Mayo Clinic, Rochester, MN, USA	Stress Management and	The program teaches psychological self-care strategies to develop	Psychological Self-Care +Mindfulness,	Healthcare Workers	The program is mandatory for all Mayo Clinic physicians, nurses and medical students.	Program addresses time and commitment barriers by being	1) Anxiety, stress, and burnout decreased and scores on resilience,

Location	Program Name	Short description	Mandate/ Scope of Support	Clients/ Audience	Process for Implementation	Barriers	Measures of Success
	Resiliency Training (SMART) Program[30, 31,32]	mindfulness and reduce stress and burnout. The program is founded on raising awareness about the physiological and psychological basis of stress and improving attitude through gratitude, compassion, acceptance, higher meaning, and forgiveness. The program is a single 90-minute session (available in different formats) and a commitment to daily SMART practices, which can be as short as 5 minutes.	Stress, Burnout			practical to implement in a single session and realistic strategies that can be easily incorporated in a busy lifestyle.	happiness, and mindfulness increased following the SMART program.
The Ohio State University Wexner Medical Center, Columbus,	MINDBODY STRONG Cognitive Behavioral Therapy Program[33, 34]	MINDBODYSTRONG is a cognitive behavioral skill-building program that addresses physical and psychological self-care, and coping strategies and	Psychological Self-Care +Resiliency, Job Satisfaction, Stress, Anxiety	Newly Licensed Nurses	Information not found.	Information not found.	1) Anxiety and healthy lifestyle behavior scores improved in HCW in the program compared to HCW who did not, and results were sustained for 3 months.

Location	Program Name	Short description	Mandate/ Scope of Support	Clients/ Audience	Process for Implementation	Barriers	Measures of Success
Ohio, USA		problem solving. The program delivered in 8 weekly sessions that focus on three themes: caring for the mind (CBT, problem solving, coping strategies, etc.), caring for the body (diet, exercise, etc.), and building skills (positive self-talk, self-esteem building, sleep diary, etc.).					2) Depression and job satisfaction scores improved in HCW in the program compared to HCW who did not, and results were sustained for 6 months.
Ohio State University College of Medicine, Ohio, USA	Mindfulness in Motion (MIM)[35, 36]	MIM is a psychological support program that focuses on mindfulness practices and techniques, including yoga and music relaxation based on weekly prompts to focus on. The program is an 8-week long program that includes a 2-hour retreat and 1-hour weekly group	Psychological Self-Care +Resiliency, Mindfulness, Stress	Nurses	Program takes place on site location during work hours. Implementation takes place over 6 steps: 1) Characterize high stress work environment, 2) determine appropriate location/time/interest, 3) obtain institutional support, 4) take baseline assessment, 5) conduct MIM, and 6) evaluate program.	Requires institutional support to replace staff while they attend sessions during work.	1) HCW improved in resiliency and work engagement immediately following participation. 2) In comparison, HCW who did not take part in MIM did not show any differences in resiliency and work engagement.

Location	Program Name	Short description	Mandate/ Scope of Support	Clients/ Audience	Process for Implementation	Barriers	Measures of Success
		meetings. Clients are also assigned to practice 20 minutes of meditation daily.			The protocol for the program can be found at this link: http://www.jove.com/video/52359		
Australian Catholic University, Melbourne, Victoria, Australia	PAR (Promoting Adult Resilience) Program [37]	PAR is a customizable, psychological support program that teaches communication and stress management skills to improve relationships, decrease conflict, and reduce stress. Program is available in different schedules and can also include booster e-mails sent in between and after sessions to encourage engagement and practicing skills. Curriculum is taught via PowerPoints, group discussions and activities, and workbooks.	Psychological Self-Care +Stress, Communication	Nurses	Program delivered by trained facilitators. Program developers supervise sessions.	Information not found.	1) Coping self-efficacy and behavioral regulation improved directly after the program. 2) Stress improved after the program and results were sustained for 3 months.

Location	Program Name	Short description	Mandate/ Scope of Support	Clients/ Audience	Process for Implementation	Barriers	Measures of Success
Emerald, Queensland, AUS	Mindful Self-Care and Resiliency Program [38, 39]	The program educates clients about resiliency, mindfulness concepts, and basic practices of psychological self-care. The program includes a 7-hour in-person session, and clients are given a manual covering all the material in the session and assigned at-home exercises.	Psychological Self-care +Burnout, Psychological Strain, Negative Affect, Self-Awareness	Healthcare Workers	Process of implementation not specified. Clients voluntarily participated in program.	Due to time commitment issues, the clients were unable to attend follow-up sessions.	1) Physicians reported increased psychological self-care, as well as increased self-awareness and improved interactions. 2) Reduced burnout, negative affect, and psychological strain after the program.
Queensland Health, AMA Queensland, AUS	Wellness in the Workplace (formerly Resiliency on the Run Program)[40]	The customizable, psychological support program addresses mindfulness, developing strategies for handling burnout and compassion fatigue, self-empowerment, mindful communication techniques and communicating through difficult work	Psychological Self-Care +Resilience, Interpersonal Relationships, Mindfulness	Healthcare Workers	The program is conducted by a qualified psychiatrist. Sessions take place during available teaching time and was available at no cost to participant.	Program addresses communication barriers to getting help by teaching strategies for communicating through difficult situations and asking for help.	1) Most HCW in the program improved in psychological distress and burnout scores and results were sustained for 3 months. 2) No changes in distress and burnout scores in HCW who did not take part in the program.

Location	Program Name	Short description	Mandate/ Scope of Support	Clients/ Audience	Process for Implementation	Barriers	Measures of Success
		situations, and practical tips on getting help. The program is available in various formats, such as face-to-face, over video conference, 2x90-minute workshops, 1x3-hour workshop, and more. Each session is 90-minutes.					
Arthur G. James Cancer Hospital and Richard J. Solove Research Institute, Columbus, Ohio, US	THRIVE[41]	THRIVE is a psychological support program that focuses on developing psychological self-care strategies. The goal is to learn at least one psychological self-care strategy that works for client and they continue to use following training. Program includes 8-hour retreat, followed by 6-weeks of group support on a social	Psychological Self-Care	Certified nurse practitioners, educators, facilitators, managers, nurses)	The retreat is conducted on medical campus grounds away from typical work areas. Group facilitators are trained and have personal experience in the program. Groups should not exceed 24 participants. Voluntary participation in program.	The program requires large time investment (~6 weeks).	1) After the program, resiliency increased, and burnout and secondary trauma decreased. 2) Resiliency results were sustained for 6 months. 3) Staff turnover rate lower among HCW who attended the program compared to HCW who did not.

Location	Program Name	Short description	Mandate/ Scope of Support	Clients/ Audience	Process for Implementation	Barriers	Measures of Success
		media platform with 3 ten-minute exercises a week, and ending with a 2-hour wrap-up session. Psychological self-care strategies include yoga, self-massage, aromatherapy, mindfulness, improving sleep, breathing techniques, and guided imagery for career timelines. The social media group encourages ongoing practice and social support. The wrap-up session focuses on reviewing psychological self-care techniques and commitment to the lessons.					
Al Amal Mental Health Complex, Riyadh and	Burnout Prevention Program[42]	The program is a culturally tailored, psychological support program that educates participants about	Psychological Self-Care	Mental health nurses	Process of implementation not specified. Clients voluntarily participated in	Information not found.	1) Burnout scores decreased 3 months after program. 6 months after program, burnout scores increased slightly, but

Location	Program Name	Short description	Mandate/ Scope of Support	Clients/ Audience	Process for Implementation	Barriers	Measures of Success
Ar'ar, Saudi Arabia		burnout, burnout prevention, and psychological self-care strategies (e.g., communication and social skill training, breathing exercises, and muscle relaxation techniques). Program includes two 6-hour workshops led by nurses in same field as participants. Program modified to address cultural considerations in a Saudi context (e.g., language, customs, values, traditions, and etiquette).			program.		were still less than they were before the program. 2) Burnout scores did not change for nurses who did not take part in program.
Psychiatric hospital, Germany	Mental Health Intervention Program[43]	A psychological support program that addresses psychological self-care, work-related problems, problem solving, cognitive strategies for relaxation and self-	Psychological Self-Care + Stress, coping, self-efficacy	Healthcare workers	Program attended while off duty. HCW attended program voluntarily.	Information not found.	1) Stress scores decreased after the program and results were sustained at 6 months following the intervention. 2) Resiliency, self-efficacy, and emotional regulation improved at 6

Location	Program Name	Short description	Mandate/ Scope of Support	Clients/ Audience	Process for Implementation	Barriers	Measures of Success
		support, conflict management, communication, hospital culture, and social support. Content is taught in twelve weekly 1.5 – 2-hour sessions and are conducted by certified instructors. Training sessions utilized videos, group discussions, exercises, and home assignments.					months following the intervention compared to baseline scores. 3) Final course evaluations demonstrated overall satisfaction with relevancy and value of material, as well as increased knowledge of psychological self-care techniques.
University of Maryland School of Medicine, Baltimore, MD, USA	Healing Pathways[44, 45]	The psychological support course is designed to teach psychological self-care strategies and utilize mentoring to improve psychological well-being of healthcare workers. Clients learn relaxation techniques, develop and maintain self-care strategies (e.g., yoga, Reiki, Writing for Wellness,	Psychological Self-Care +Stress, Compassion Fatigue	Healthcare workers	Information not found.	The course requires significant time and money to participant.	1) Stress, exhaustion, coping, and mindfulness scores improved significantly following the program and results were sustained for 1 month.

Location	Program Name	Short description	Mandate/ Scope of Support	Clients/ Audience	Process for Implementation	Barriers	Measures of Success
		etc.). Curriculum includes weekly 1-hour meetings plus 1-hour lecture for 6 weeks, 2 full days of Reiki, and weekly discussion board posts. Class materials, lectures, and discussion board posts available on Canvas (online learning platform).					
Duke Center for Healthcare Safety and Quality, Duke University Health System, Durham, North Carolina, USA	Three Good Things (3GT) Intervention [46]	The 3GT is a virtual-based program designed to encourage psychological self-care and positive psychology. The program requires participation over 2 weeks. Every night, clients are sent a survey to respond toa prompt and select an emotion that best fits a positive moment from	Self-Care + Burnout, Depression, Subjective Happiness, Work-life balance	Healthcare workers	The program is a daily web-based intervention that is low-cost and does not require significant time to complete. The program begins on a Monday for improved rate of completion.	Lack of time to complete daily participation was identified as a barrier.	1) Acceptable feasibility – many clients expressed satisfaction and desire to take part in program again. 2) Emotional exhaustion, happiness, and depression improved after program and results were sustained for 12 months. 3) Work-life balance improved following

Location	Program Name	Short description	Mandate/ Scope of Support	Clients/ Audience	Process for Implementation	Barriers	Measures of Success
		that day. Clients have the option to share their responses anonymously and at the end of the survey are shown the previous day's log of approved responses.					program and results were sustained for 6 months.
Southeastern U.S. Healthcare System (organization not specified)	Transcendental Meditation Program[47]	The psychological support program is designed to enhance resiliency and reduce burnout using meditation and psychological self-care strategies. The program consists of an introductory class, prep-lecture, personal interview, 4 consecutive days of 90-120 minutes of personal and group instruction of TM technique, twice daily 20-minute meditation sessions, and personal and group	Psychological Self-Care +Resilience, Burnout, Compassion Fatigue	Nurses	Information not found.	The program requires significant time commitment. Nurses working 12-hour shifts reported difficulty attending weekly meetings and practicing meditation daily. Costs up to $960 USD to participate.	1) Increased compassion satisfaction and resiliency following the program. 2) Decreased burnout and secondary traumatic stress scores following the program.

Location	Program Name	Short description	Mandate/ Scope of Support	Clients/ Audience	Process for Implementation	Barriers	Measures of Success
		meetings every two weeks.					
Hazrat Fatima Hospital, Tehran, Iran	Group Cognitive Behavioral Therapy Intervention[48]	The cognitive-behavioral based program focuses on the interaction of physical, cognitive, and behavioral processes, recognizing emotions and behaviors, outcomes and consequences, evaluating beliefs, and logically analyzing and challenging beliefs. Ten 1.5 – 2-hour group cognitive-behavioral therapy sessions were held once a week over 2.5 months. Sessions taught by a clinical psychiatrist. The material is taught using group discussion and participation,	Psychological Self-Care +Burnout	Nurses, head nurses, and supervisors.	Participation in the program took place during work hours with permission and coordination from the hospital's nursing director. To motivate participation, time spent in program were counted towards in-service training hours and points received counted towards annual evaluation. Participation was voluntary.	Information not found.	1) Job burnout, depersonalization, and individual performance improved after participating in program and results were sustained for 1 month. 2) In comparison, no improvements were measured among HCW who did not take part in program.

Location	Program Name	Short description	Mandate/ Scope of Support	Clients/ Audience	Process for Implementation	Barriers	Measures of Success
		PowerPoint lectures, and homework assignments.					
Digital E-Learning Package	Psychological Wellbeing for Health and Care Workers: Mitigating the impact of COVID-19 on Psychological Wellbeing [49]	The e-package was designed for rapid development and deployment to psychologically support HCW during COVID-19. Learning sections, resources, and toolkit were developed to educate users about the psychological impact and consequences of the pandemic, normalize psychological responses to stress, and provide information and support to encourage users to seek help.

Sections include psychological impact, psychologically supportive teams, communication, social | Self-Care and Moral Distress | Healthcare workers, healthcare academics, healthcare students | The e-package is open to the public, open access, and does not require human support.

Though not tailored to a specific HCW profession, the e-package can be individually tailored by selecting sections of interest.

Package can be accessed at this link:

https://www.nottingham.ac.uk/toolkits/play_22794#resume=1 | Information not found. | Based on pre-defined criteria of success, the program demonstrated successful:

1) Delivery (users able to access the link, accessed the full package)

2) Engagement (users understood toolkit, gained sufficient knowledge, used knowledge in work and life, perceived information to be useful in future)

3) Implementation (practical and relevant to use across professions, not costly or timely to use, positive perceptions of program, easy to use). |

Location	Program Name	Short description	Mandate/ Scope of Support	Clients/ Audience	Process for Implementation	Barriers	Measures of Success
		support, psychological self-care, managing emotions, and further resources. Takes approximately 2 hours to complete the whole e-package.					
Georgia State University with Children's Healthcare of Atlanta, Atlanta, GA, USA	Nursing Know-How: Skills in Working with Pediatric Chronic Pain [50]	The psychological support program aims to increase knowledge and strategies to address psychological self-care and moral distress. Program consists of 4 modules, that focuses on understanding pain in patients, improving positive communication, collaborating and listening with co-workers to combat moral distress, and self-care strategies. The program is a single 90-minute small-group session, and each module is	Psychological Self-Care and Moral Distress	Nurses	The intervention took place during a regularly scheduled 2-hour staff meeting. Modules were facilitated by two clinical psychologists. Participation was voluntary.	Effectiveness of program may have been compromised by lack of follow-up for adherence and maintaining enthusiasm, as well as not having institutional support.	1) Program demonstrated feasibility - all nurses completed the program and material was relevant. 2) High satisfaction ratings immediately after program, though not sustained 3-months after. 3) Increase in knowledge of psychological self-care and psychosocial influences, and improvements in self-compassion, burnout, and general health.

Location	Program Name	Short description	Mandate/ Scope of Support	Clients/ Audience	Process for Implementation	Barriers	Measures of Success
		approximately 20-minutes. Sessions include educating, demonstrating, and practicing each module. Laminated posters were made available for each module and posted in the units.					
University of Aberdeen, Aberdeen, Scotland, UK	Caring for the Caregivers[51]	The intervention is a generic Mindful-Self Compassion training program that focuses on kindness, care, and understanding. The program takes place over 8 weeks, with 2.5-hour workshops per week and on-the-job mindfulness practice.	Psychological Self-Care +Compassion Fatigue, Resiliency	Nurses	Information not found.	Clients reported having difficulty practicing mindfulness strategies for various reasons (e.g., sleepy, external pressure).	Self-compassion, mindfulness, and resiliency scores improved following the program.
Oxford Brookes University, Oxford, UK	Taking Care of Yourself to Take Care of Others[59]	The program is a resilience enhancement program that focuses on developing positive relationships, maintaining positive	Psychological Self-Care +Resilience enhancement	Forensic Nurses	Each session is conducted by two facilitators. Sessions were conducted during protected time at work.	Information not found.	Self-reported resiliency and self-confidence improved following the program.

Location	Program Name	Short description	Mandate/ Scope of Support	Clients/ Audience	Process for Implementation	Barriers	Measures of Success
		outlook and hardiness, life-balance and psychological self-care, spirituality, and identifying and planning for resiliency. The program consists of 6 full-day workshops over 12 weeks.					
University of Virginia School of Nursing, Charlottesville, VA, USA	Emergency Resiliency Initiative (ERI)[52]	ERI is an emergency-department-specified mindfulness-based program that focuses on psychological self-care and mindfulness/ meditation. The program consists of three 90-minute sessions available in different formats. Each session consists of a lecture followed by meditation or compassion practice. Participants also practice meditation twice a week either	Psychological Self-Care +Mindfulness, Compassion	Emergency Department Nurses and Patient Care Technicians	Hours spent in the program counted towards unit staff meetings and participants were offered complimentary dinner before each session.	Sessions were held after work, which was difficult for a lot of HCW to attend.	Emotional exhaustion and personal accomplishment improved after the program.

Location	Program Name	Short description	Mandate/ Scope of Support	Clients/ Audience	Process for Implementation	Barriers	Measures of Success
		individually, through an app, or with a group on the unit during the first hour of the shift.					
Siteman Cancer Center at Barnes-Jewish Hospital, St. Louis, MO, USA	Compassion Fatigue Resiliency Program for Oncology Staff Nurses [53, 54]	The psychological support program aims to educate participants about compassion fatigue, stress, and negative consequences. The program develops resiliency through psychological self-care, self-regulation, connection, and self-validation.

The program consists of four 90-minute sessions and a 4-hour psychological self-care retreat. | Psychological Self-Care

+Compassion Fatigue, Resiliency | Oncology Nurses | Participants were paid their salary rate for time spent in the sessions. | Time demands of the program were identified as a barrier. | 1) Negative reactions to events were improved following the program and results were sustained for 6 months.

2) Secondary trauma improved 6 months after the program. |
| Hacettepe University Oncology Hospital and the Gazi | Psycho-drama-based Psychologi-cal | The psychological support program was developed to enhance empowerment and decrease burnout in | Psychological Self-Care

+Empowerment, | Nurses | Information not found. | Time demands were identified as a barrier. | 1) Psychological empowerment and workplace empowerment scores improved following the program |

Location	Program Name	Short description	Mandate/ Scope of Support	Clients/ Audience	Process for Implementation	Barriers	Measures of Success
University Health Research and Application Center, Ankara, Turkey	Empower-ment Program[55]	nurses through psychological self-care and positive coping strategies. Participants are educated about coping strategies and cognitive distortions, as well as taught psychological self-care/relaxation strategies, empathy, and dispute resolutions. Each session includes an interactive role-play scenario and a certified psychodramatist offers feedback and enhance awareness of communication patterns, emotions, ideas, and behaviors about the theme and scenario. The program consists of 2-hour sessions that took place once a	Burnout				and results were sustained for 3 months. 2) Burnout scores decreased following the program and results were sustained for 3 months. 3) Nurses who did not take part in the program did not change in empowerment or burnout scores.

Location	Program Name	Short description	Mandate/ Scope of Support	Clients/ Audience	Process for Implementation	Barriers	Measures of Success
		week for 10 weeks in small groups.					
Isfahan University of Medical Sciences, Iran	Moral Empower-ment Program[57]	The program is a workshop designed to decrease moral distress. Sessions cover definition, symptoms and consequences of moral distress, and strategies for overcoming moral distress such as asking for emotional and spiritual support, self-expression, problem-solving skills, and moral group meetings. The workshops utilized PowerPoint lectures and small group sessions of sharing personal experiences. Program consists of two 6-hour workshops.	Moral Distress	Nurses	Program was the subject of a pilot study. An ethics committee and hospital authorities approved the implementation of the workshop and its evaluation. Clients voluntarily participated in the workshop.	Cited barriers noted in other studies, including physician dominance, lack of understanding and respect from physician, clinical rounds without the presence of nurses.	1) Burnout scores decreased 1 month after nurses took part in program. 2) In comparison, burnout scores did not change for nurses who did not take part in program.

Location	Program Name	Short description	Mandate/ Scope of Support	Clients/ Audience	Process for Implementation	Barriers	Measures of Success
Shiraz Heart Center, Shiraz, Iran	4A Model Intervention[58]	The psychological support program is designed to decrease moral distress by educating participants about moral distress, how to address it using the 4A model, and organizational strategies. Program consists of two 4-hour sessions that utilizes lecture, group discussions, and role play.	Moral Distress	Critical Care Nurses	Information not found.	Information not found.	1) Significant and sustained decrease in moral distress after the intervention. 2) No decrease in moral distress in group that didn't take part in program

Canadian Healthcare Worker Psychological Support Models

In 2018, CPSI sought out Canadian healthcare organizations that already had extensive experience developing and implementing programs and resources for the psychological health and well-being of healthcare workers including peer support and psychological supports to address moral distress and inform psychological self-care. For the 2018 scan, representatives from the organizations participated in a working group to develop the document, took part in group and individual discussions, and filled out a survey (see Appendix 1). For this reason, much of the knowledge from these Canadian organizations is collated in the Best Practices Guidelines for Peer to Peer Support Programs.

The following points summarize some of the common themes about peer support programs (PSP) that emerged from the Best Practices Guidelines for Peer to Peer Support Programs working group:

- A peer support program includes any program that uses peers to provide non-clinical emotional support to health professionals (and in some cases other individuals who work, volunteer or train at organization) who are experiencing emotional distress. For a fuller definition, see the PSP definition in the introduction to manuscript.

- The main driver for initiating a PSP in these organizations was the recognition of the importance of mental health and wellness for individuals in their workplace, and a commitment to improve it. However, the catalyst for initiating a program in a healthcare organization varied somewhat among organizations.

- Although PSPs in healthcare are becoming recognized as a crucial service, it is still a worthwhile endeavour to establish the need for a PSP in the organization.

- However, the idea for a PSP was initiated, it is important to assemble a strong organizational planning team to carry it through to implementation.

- Establishing a clear goal for the PSP is a key contributor to the success of a program.

- It is imperative that the PSP has foundational support from those in the organization who will contribute to its success.

- The process of implementing a PSP is often underestimated by people who are keen and have good intentions to help their colleagues. However, if this team of individuals with good intentions has a conviction that a PSP is crucial to the well-being of their colleagues, uses an informed selection, recruitment and training process for peer supporters, and is willing to work through some of the steps described in the Best Practices Guidelines for Peer to Peer Support Programs, they will have an excellent chance of success.

- One of the most important steps in establishing a PSP is to institute a policy that outlines exactly what the program is, how it is structured, and how it will be implemented.

- Healthcare worker support models should, if possible, be inclusive rather than exclusive, that is, be open to all levels and all groups of clinical or non-clinical staff, and also include volunteers,

students, trainees or anyone who might be affected by a critical incident, experiencing stress or affected by emotional trauma in the workplace.

- Three key decisions need to be made in operationalizing the PSP: How is a worker connected to the PSP? What types of issues are supported? What is the process once the PSP is activated?

- It is important to clearly outline the responsibilities of managers and supervisors, who often have an important role in encouraging an individual to seek support or referring them to the PSP.

- Confidentiality is the cornerstone of the policy and of the PSP. [See the Confidentiality section]

- The peer supporters of a PSP are an integral component of the program, and the most important factor for its success. As such it is crucial that those implementing a PSP pay close attention to selecting, training and supporting them.

Canadian programs to support psychological safety by providing peer support, developing psychological self-care, and reducing moral distress were located by the two scans (see Table 2.2). Like the international models, the Canadian programs were implemented after a critical incident or, like the Critical Incident Program in BC are provided as part of a provincial psychological safety initiative. Other programs offered in Canada provide psychological health and well-being through educational materials (e.g. the 5 Factor Resilience Workbook), apps (e.g. Shift-Well) and workshops (ARISE).

Table 2.2: Canadian Healthcare Worker Support Models

Institution / province or territory	Program name	Short description / Links	Mandate / Scope of Support	Clients	Process	Barriers	Measures of Success
Michael Garron Hospital, ON	Second Victim Peer Support (est. 2014)	As part of its wellness strategic plan to foster a healthy workplace environment, the MGH began developing a Second Victim Peer Support Program to provide strong support to individuals who have experienced traumatic situations. Their program aims to provide 24-hour care to staff and physicians who are experiencing a normal reaction to a stressful event or outcome. The goal is to help healthcare team members understand what is known about this phenomenon and help	Peer Support	All staff (both clinical and non-clinical), physicians and volunteers, or anyone who is directly involved or witnesses an incident, or anyone who experiences a long period of high-stress or repeated exposure to emotional trauma.	3 levels of implementation: peer support for "second victim", departmental leadership to support and offer resources to unit, and hospital response for support and employee assistance program. Process after event: 1) Provide a "safe zone" to express thoughts and reactions to enhance coping. 2) Once patient is out of immediate danger, allow care provider to step away for a short time.	Lack of consistency in communication and execution of programs between departments, staffing shortages/unavailability of psychotherapists, and reverting to old processes during stressful periods were identified as barriers.	Currently being evaluated.

Institution / province or territory	Program name	Short description / Links	Mandate / Scope of Support	Clients	Process	Barriers	Measures of Success
		them quickly return to work. Toolkit Resources: • Providing Care and Support for our Staff (Brochure) • Second Victim Peer Support: Caring for Our Own (Peer Support Training Module) • Emotional Support Handout (Handout/Promotional Material) • Emotional Support Response Team: Guiding Principles for Leadership (Leadership Training Module) • Emotional Support Response Pilot: Director/Manager Update (PowerPoint)			3) Provide one-on-one peer support and explore normal reactions and feelings. 4) Provide assurance that he or she is experiencing a normal reaction. 5) When a whole team has been traumatized, arrange with manager for a team debriefing session within 24-72 hours of the event.		

Institution / province or territory	Program name	Short description / Links	Mandate / Scope of Support	Clients	Process	Barriers	Measures of Success
		• COVID-19 Tiered Approach to Physician Support					
British Columbia Emergency Health Services (BCEHS), BC	Critical Incident Stress (CIS) Program Est. 2015	Toolkit Resources: • BCEHS CIS Program Logic Model • Psychological Supports for Employees (FAQ) • Tackling Occupational Stress Injuries – The BCEHS Experience (Slide deck) • Critical Incident Stress Program Policy • Critical Incident Stress Program – Volunteer Peer Team Orientation Manual	Peer Support	All current employees of BCEHS are eligible for the program. Students are offered initial support and referred to community resources.	The program was developed following changes in the public safety industry. 1) Standard for Psychological Health in the Workplace was adopted under HR. 2) BCEHS developed a steering committee and assigned a program manager. The committee produced policies, defined peer response, and outlined activation procedures. 3) The program is continuously evaluated, monitored,	Barriers identified include challenges with recruiting and supporting volunteer employees, accessibility and credibility of community-based practitioners, demonstrating fiscal return on investment, changing "old leadership" thinking, and sustainable education and continued	Near the end of 2018, there were 1017 activations and 140 volunteers were trained.

Institution / province or territory	Program name	Short description / Links	Mandate / Scope of Support	Clients	Process	Barriers	Measures of Success
					and adapted. Start with leadership and involve key players (e.g., operations directors, unions, logistics and supports directors, HR, safety officers, learning and development).	culture shifting activities.	
The Toronto Hospital for Sick Children – SickKids ON	SickKids Peer Support and Trauma Response Program Est. 2018	Acknowledging that compassion fatigue, burnout, second victim distress and traumatic stress are common issues that affect healthcare professionals, SickKids launched the Peer Support and Trauma Response Program. The aim is to promote prevention, staff resiliency and effective coping strategies. The program offers	Peer Support	Available to anyone who holds a SickKids badge (e.g. staff, physicians, trainees, researchers, scientists, volunteers)	The program is accessible 24/7, 365 days a year. Staff may contact the program by phone, through a dedicated, confidential email box or attend the Peer office located by the Occupational Health Clinic. The program also has an established after hours on-call paging process. Support is activated at	A (healthcare) cultural environment of over performance and self-criticism lending to some collective mistrust and fears regarding: - individual exposure and vulnerability, - reservations pertaining to the optics of accepting help	1,045 peer interventions/activities at Year 1 in 2018; 2,995 at Y2 in 2019; and, 10,133 in Q1 of 2020 Key metrics track variables of utilization KPI on corporate scorecard Activities /interventions are tracked by each

Institution / province or territory	Program name	Short description / Links	Mandate / Scope of Support	Clients	Process	Barriers	Measures of Success
		hospital-wide interpersonal 1:1 peer support as well as CISM (Critical Incident Stress Management) response following distressing and traumatic events. Peers consist of physicians as well as clinical and non-clinical staff whose role is to provide confidential support, to listen, inspire, gently challenge and encourage while helping colleagues deal with stress and personal concerns. There are currently over 85 active peers on the team. Toolkit Resources: • Trauma Response and Peer Support Policy • Scope of Manager, Peer Support			the discretion of the individual. Staff typically self-refer; however, people leaders also consult with respect to supporting staff mental health issues or have initiated outreach for an employee with consent. CISM support is provided following an event upon request of staff or leadership. Otherwise, intervention is mandated by hospital policy and is activated following certain events (e.g., death of staff, "second victim" events, codes resulting in adverse outcomes, etc.). The program operates	- declining support based on the perception that stress is the nature of the work and there is no entitlement to feel traumatized or stressed Lack of awareness and understanding regarding the qualitative difference between a medical debrief to review operations and a psychological debrief offering decompression; a "hot debrief" (operational) is in-the-moment and more aligned with the timing and	peer over four spreadsheets on a weekly basis < 1% attrition within the peer network over 2.5 years

Institution / province or territory	Program name	Short description / Links	Mandate / Scope of Support	Clients	Process	Barriers	Measures of Success
		Program Role			under Occupational Health & Safety Services	demands of personnel and does not require significant coordination as CIS Defusing/Debrief might	
Chatham-Kent Health Alliance, Ontario	Peer Support Group Est. 2019	The decision to develop a program was in response to an organizational goal of providing a psychologically safe workplace. The program is situated within occupational health and can be triggered by the affected individual, a concerned co-worker or by leadership. Peer-supporters are staff members who were nominated by their managers, and then volunteered to be trained supporters in the	Peer Support	Staff, physicians, volunteers and students	1) All staff, volunteers, and students are informed of CISM program and signs, symptoms, and management of CIS. 2) Peer support is activated automatically in certain cases (e.g., hostage taking, line of duty death, homicide, or suicide of staff, etc.). Peer support can also be activated for other cases (e.g., near misses, adverse events, etc.). 3) PSP can be activated by affected	Information not found.	Information not found.

Institution / province or territory	Program name	Short description / Links	Mandate / Scope of Support	Clients	Process	Barriers	Measures of Success
		program. Toolkit Resources: • Critical Incident Street Management Policy • Critical Incident Stress Management: Peer Support Guide • Critical Incident Stress Management: Peer Support Group Brochure			individual, coworker, or leadership. 4) Once activated, employee contact is established. 5) Peer supporter provides confidential support and will offer additional resources if needed. 6) A follow-up is scheduled and conducted. 7) Information on how often PSP is activated, methods of activation, and themes for activation are recorded for statistical purposes.		
Central Health, NL	Second Victim Guidance Team Expected	The program is in development as of July 2020. The program was initiated because caring	Peer Support	All employees, physicians, volunteers (directly), patients and	Information not found.	Information not found.	Information not found.

Institution / province or territory	Program name	Short description / Links	Mandate / Scope of Support	Clients	Process	Barriers	Measures of Success
	est. 2020	for the second victim is considered an important part of an integrated system for managing adverse events and establishing a just culture. As of publication, the program is still in development, but they have completed the following: • Pilot training in two high risk areas 2016 • Guidance team established 2017 • Management competency training 2018 • Training and Peer Support program TBD		families (indirectly)			
Alberta Health Services AB	Peer Trauma Response Team Program	The program was initiated to help mitigate the burnout employees were experiencing as a result of critical incidents occurring in the	Peer Support	Alberta Health Services employees (full-time, part-time,	Under Workplace Health and Safety Leadership, an advisory committee provides support to the Peer Trauma	Information not found.	Information not found.

Institution / province or territory	Program name	Short description / Links	Mandate / Scope of Support	Clients	Process	Barriers	Measures of Success
	Est. 2001	workplace. The goal is to provide an opportunity to normalize the group or individual who experienced a critical incident, or who encounter traumatic events in the workplace that may cause physical or mental stress. The program objectives are to lessen the impact of a critical incident and to accelerate recovery, and includes education regarding prevention, recognizing signs and symptoms of critical incident stress and understanding how to access the support. Toolkit Resources: • Peer Trauma Response Team Logic Model • Peer Trauma		and casual)	Response Team Program. The committee develops vision through standardizing processes and tracking of program, assist with peer training, disseminate and exchange knowledge, schedule meetings, develop materials (e.g., training manuals, promotional materials, etc.), and provide additional supports. AHS provides training and recruitment support, intervention reporting, changing management support, and communication support. This facilitates information sessions, development of peer resources, peer training, data		

Institution / province or territory	Program name	Short description / Links	Mandate / Scope of Support	Clients	Process	Barriers	Measures of Success
		[Response Team Network Committee - Terms of Reference](#) • [Peer Trauma Response Team - Applicant Package](#) • [Peer Trauma Response Team Incident Report Form](#)			collection, and the ability to reach peers, clinicians, AHS leaders, and frontline operations.		
St Michael's Hospital ON	TBD Est. 2019	As of July 2020, the program is still in development. The hospital undertook a multi-phase, user-centered approach to create an organization-wide second victim support program. The next step is to develop an organizational response that will support individuals experiencing stress from patient-care encounters either immediately, or	Information not found.	TBD	Information not found.	Information not found.	Information not found.

Institution / province or territory	Program name	Short description / Links	Mandate / Scope of Support	Clients	Process	Barriers	Measures of Success
		shortly after the event. The organizational program will supplement existing debriefing and support programs developed at the unit level and enhances the existing the EAP and OMA physician health programs.					
Canadian Medical Association, Ottawa, ON	Wellness Connection Est. 2020	The program was developed as a virtual platform for peer support during COVID-19 for physicians and learners. The program recognizes the need for peer support during the pandemic and the lack of current infrastructure and opportunity to provide peer support. The program seeks to inform how to provide peer support, provide virtual group sessions focused on COVID-19, and	Peer Support	Physicians and learners seeking to support their peers or receive peer support themselves in the CMA's Community Engagement Platform.	Program is launching in two phases, which will allow time for evaluation and improvement of the second launch following the first.	Information not found.	To be evaluated. Expected outcomes include creating positive relationships, a supportive community, sharing challenges and coping strategies, reduce loneliness and isolation, normalize stress reactions, and provide training, practice, and

Institution / province or territory	Program name	Short description / Links	Mandate / Scope of Support	Clients	Process	Barriers	Measures of Success
		connect physicians and learners on a national platform. Moving forward, the program aims to expand on issues beyond COVID-19, develop and enhance peer-supporter training sessions, and build a network of supporters. The platform includes virtual group support sessions (formal sessions, drop-in sessions, and topic specific sessions), a gratitude space for sharing feelings and stories, and education content for training resources. Initiative overview: PDF					implementation resources for peer support.

Institution / province or territory	Program name	Short description / Links	Mandate / Scope of Support	Clients	Process	Barriers	Measures of Success
Health Canada	Occupational & Critical Incident Stress Management (OCISM) Est. 1991	The program provides services to nurses working in First Nations communities (nursing stations, health centres, home and community care) and zone/ regional offices, including FNIHB / Transferred / Band-employed / Agency / student nurses. The goal of the program is to safeguard nurses' wellbeing after a critical incident, to help them maintain/return to health, to prevent/ reduce occupational stress injuries, promote nurses' resilience, accelerate normal recovery, and minimize absenteeism. OCISM is specialized for nurses only and acknowledges the isolated locations these nurses work in.	Psychological Self-Care	Nurses working in First Nations communities across Canada	OCISM is one of 4 components of the Employee Assistance Services, part of the Regions and Program Bureau of Health Canada. OCISM is funded through a Memorandum of Understanding with the First Nations and Inuit Health Branch (FNIHB). OCISM service relies on nurses, most of whom are in Winnipeg. No other information of implementation was found.	Challenges in evaluation as a result of lack of available and relevant data.	1) Between 2009-10 and 2012-13, the number of requests for OCISM services increased from 1,842 to 2,940, ~ 60% increase. This may indicate increased of awareness in program. 2) Critical Incident calls to OCISM ranged from 30 to 50 calls. 3) According to Health Canada (HC), self-report of self-awareness, coping skills, mental and physical health, and productivity improved.

Institution / province or territory	Program name	Short description / Links	Mandate / Scope of Support	Clients	Process	Barriers	Measures of Success
		Toolkit resources: • OCISM Tips for coping for individuals directly involved in a traumatic event • OCISM Tips for coping for individuals involved in sustained, high intensity work • OCISM Tips for Family, Friends and Co-workers of individuals involved in a traumatic event • OCISM Tips for supervisors and managers of employees involved in a traumatic event • OCISM Tips on Coping following a traumatic Event • OCISM Brochure					

Institution / province or territory	Program name	Short description / Links	Mandate / Scope of Support	Clients	Process	Barriers	Measures of Success
Quebec	Programme d'aide aux médecins du Québec/ Quebec Physicians' Health Program (est. 1990)	In the 1970's, firmly convinced that physicians experiencing problems should not be ostracized but rather given peer support to help them find solutions, the then secretary general of the Collège des Médecins du Québec (the Québec College of Physicians), began providing peer-to-peer support to colleagues grappling with health problems. From these beginnings in 1990, an independent peer support program, the PAMQ/QPHP, was introduced in Quebec. The PAMQ/QPHP is an independent, not-for-profit organization, where physician advisors provide assistance on a confidential basis to colleagues affected by	Psychological Self-Care +Psychia-tric illness, sexual misconduct, substance abuse	All Quebec-based physicians including students, trainees, residents, staff and those who have retired have access to the program	Information not found.	Information not found.	Information not found.

Institution / province or territory	Program name	Short description / Links	Mandate / Scope of Support	Clients	Process	Barriers	Measures of Success
		any type of situation or illness. All the situations observed by the PAMQ/QPHP are deemed as having the potential to cause psychological impacts to physicians which could ultimately jeopardize the quality of care provided to patients. Toolkit Resources: • Analysis of the Effectiveness of Employee Assistance Programs: The Case of the QPHP • Quebec Physicians' Health Program • Annual Report of the PANG Program - Rapport Annuel 2017-2019 (French Only) • During a workplace					

Institution / province or territory	Program name	Short description / Links	Mandate / Scope of Support	Clients	Process	Barriers	Measures of Success
		crisis - is it possible not to react www.pamq.org					
St. Michael's Hospital, Toronto, ON, Canada	ARISE[56]	ARISE is a wellness intervention designed to enhance reduce burnout through psychological self-care and wellness. The program curriculum includes: 1-day workshop focused on resilience-focused activities and psychological self-care techniques ; Half day workshop on other wellness and family and employee assistance programs available through the hospital; Closed Facebook group is made available for optional peer support for	Psychological Self-Care +Burnout, Peer Support	Healthcare Workers	Information not found.	Information not found.	1) Burnout scores decreased 1 month following the program. 2) In comparison, those who did not participate in program did not change in burnout scores. 3) Nurses reported that they would use psychological self-care techniques and use resources outside of the workshop.

Institution / province or territory	Program name	Short description / Links	Mandate / Scope of Support	Clients	Process	Barriers	Measures of Success
		3 months after the workshops. Five 90-minute guided mindfulness sessions that are held live over Zoom (videoconference).					
BCEHS in partnership with the Ministry of Health, the BC Ministry of Health, and TELUS, Vancouver, BC	Shift-Well: An app for shift scheduling and psychological self-care	The Shift-Well app is a virtual resource that was developed to address motivation in first responders to access and utilize psychological self-care resources. The app was made in the context of first responder casual and shift work, and to increase motivation to access psychological self-care resources. The app provides a calendar for shift work, a section called "My Plan" that allows employees to establish psychological self-care goals and	Psychological Self-Care +Shift work, Sleep, Resilience	First Responders at BCEHS – paramedics, dispatchers	To be implemented late 2020. The app will be available to download for BCEHS first responder employees. TELUS will release a similar app for the general public in late 2020.	Barriers identified included developing a program for a population with a diverse background (education, level of service, context) and mobile work environment, as well as protecting employee confidentiality through the app.	To be evaluated by BC Ministry of Health around late 2020/early 2021.

Institution / province or territory	Program name	Short description / Links	Mandate / Scope of Support	Clients	Process	Barriers	Measures of Success
		schedule them into their shift calendar, as well as a learning section that can be accessed to learn more about psychological self-care, sleep, and resiliency and a key contacts section to access support at the hospital. The app was developed to work alongside the 5 Factor Resilience Workbook listed in the row directly below.					
Vancouver Psych Safety and Consulting Inc. & BCEHS, Vancouver, BC	5 Factor Resilience Workbook	The 5 Factor Resilience Workbook was developed to enhance resiliency for long-term, sustained career success and to complement the Department of National Defense Road to Mental Readiness (R2MR) program, which enhances "readiness" or	Psychological Self-Care and Moral Distress +Resilience	First Responders at BCEHS – paramedics, dispatchers	The workbooks will be available in hard copies as well as online to allow mobile workers (paramedics) to access the workbook on their phones in late 2020. BCEHS counselors will be provided workbooks, and	Barriers identified included developing a program for a population with a diverse background (education, level of service, context) and	To be evaluated by late 2020/early 2021.

Institution / province or territory	Program name	Short description / Links	Mandate / Scope of Support	Clients	Process	Barriers	Measures of Success
		the ability to successfully enter a stressful work environment. Vancouver Psychological Safety and Consulting Inc. identified 5 resilience factors in first responders and developed a workbook to address them. It was important to develop a program that was made within the context of work for paramedics and dispatchers, as this population is different from other HCW positions.			workbooks will be provided to new employees at orientation and made available to current employees.	mobile work environment.	
Mental Health Commission of Canada Ottawa, On.	The Working Mind (TWM) Healthcare	TWM is a training program that aims to promote mental health in the workplace and reduce stigma of mental illness specifically in a healthcare setting. The program educates	Psychological Self-Care +Stigma, Resiliency	Healthcare and Healthcare Facility employees (front-line nurses, physicians,	Courses available online through the MHCC website: Link	Information not available.	Information not available.

Institution / province or territory	Program name	Short description / Links	Mandate / Scope of Support	Clients	Process	Barriers	Measures of Success
		participants about mental health/illness, signs and symptoms of mental illness, reduce stigma and negative attitudes towards people with mental health problems in a healthcare setting, support colleagues with mental health issues, and maintain mental health and improve resilience. Two courses are available: one course for employees (4 hours) and a second course for managers (8 hours). Each course offers videos and case studies, trained facilitators, and participant reference guides.		support staff, etc.)			

Institution / province or territory	Program name	Short description / Links	Mandate / Scope of Support	Clients	Process	Barriers	Measures of Success
	Crisis Response Virtual Training	The Crisis Response Virtual Training courses were developed for essential workers to better understand and address their mental health and the mental health of their team. Caring for Yourself (2 hours) is a course designed to educate participants about mental wellness, recognizing worsening mental health issues, practical actions to help with stress, and when to reach out for help. Caring for your Team (3 hours) is a course designed to educate participants about self and team's mental wellness, recognizing worsening mental health issues in self and in team, practical actions to	Psychological Self-Care +Coping strategies	Essential Workers (including healthcare workers)	Courses available for free on MHCC website: Link	Information not available.	Information not available.

Institution / province or territory	Program name	Short description / Links	Mandate / Scope of Support	Clients	Process	Barriers	Measures of Success
		help with stress, and resources to help the team. This course also includes materials from the Caring for Self-course. The program was specifically designed to address unique challenges of essential workers during COVID-19. It is a free, virtual-based program.					

Conclusion

There are many excellent and innovative programs to address the psychosocial factors specific to the healthcare workforce. Yet many healthcare organizations do not know where to go for support or have trouble accessing evidence-based programs in ways that are timely, responsive to their needs and adaptable to their context. There is a need for more information sharing about programs that work. There also needs a more comprehensive, upstream, and better coordinated approach to supporting healthcare workers' mental health across Canada.

Innovations in healthcare worker support models too often remain as isolated pockets of excellence. By sharing what was learned from the updated scoping study and survey, we aim to provide a broad overview of the variety of interventions used in Canada and throughout the world. Our hope is that this will support healthcare organizations in their own design and implementation of worker support models, so that they might address and improve the psychological safety, wellbeing, moral distress and psychosocial self-care of healthcare workers.

There are other observations. Many of the programs and resources need to be tailored to the needs of different departments/units/hospital cultures including particularly stressful departments, like ER, pediatrics, and oncology. There is also a need for the evaluation of the programs. For many reasons this is a challenge (e.g., confidentiality, participation, etc.) but it is important to know the success of the program and to make changes where needed. Pre- and post-tests with large samples using relevant indicators of success are needed to better understand the effectiveness of the programs.

Limitations: The challenge of synthesizing findings from the scan and survey is that there are many ways to define, implement and assess psychological supports. It is clear that there is a broad impetus internationally to improve the psychological health and well-being of healthcare workers and others who work and train in healthcare organizations. There is also recognition that there is a need to train peers to support one another emotionally and provide resources and tools for organizations to improve the psychological health and safety of healthcare workers through psychological self-care and reducing moral distress. Finally, the search for resources and tools was conducted in the spring of 2020; therefore, we did not capture many resources on mental health supports during the COVID-19 pandemic.

We hope this document provides those seeking to establish or improve on their own psychological health and well-being to create a successful program that is tailored to the specific needs of their healthcare organization.

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Creating
a Safe Space

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**Section 3: Confidentiality
of Peer to Peer Support
Programs in Healthcare
Organizations**

cpsi·icsp Canadian Patient Safety Institute
Institut canadien pour la sécurité des patients

Acknowledgements

Section 3: Confidentiality of Peer to Peer Support Programs in Healthcare Organizations

Disclaimers

This publication is provided as information only. All examples are provided as illustrations. This publication is not to be used as a substitute for legal advice. It is not an official interpretation of the law and is not binding on the Canadian Patient Safety Institute (CPSI).

Section 3: Confidentiality of Peer to Peer Support Programs in Healthcare Organizations

Introduction

....

Peer-to-peer support programs, where health professionals can discuss their experience with a PSI in a non- judgmental environment with colleagues who can relate to what they are going through, are now seen as a potentially useful approach to helping health professionals cope with the PSI. A number of support programs are emerging in the US, and Canadian organizations are beginning to recognize that this – along with other types of support such as Employee Assistance Programs and trauma crisis teams – is an appropriate and valuable service for their staff. It is also well recognized that such programs will improve patient safety since health professionals will be in a healthier emotional state to care for their patients safely and be able to more effectively participate in PSI reviews and disclosures.

One of the first challenges many organizations confront in exploring the feasibility of such a support program is the ambiguity surrounding what type of legal protections may be available against disclosure of these communications in legal proceedings like malpractice actions or professional disciplinary hearings, or in employment or college disciplinary proceedings. With these guidelines, the Canadian Patient Safety Institute (CPSI) endeavours to clarify the legal privilege and professional confidentiality considerations of implementing peer-to-peer support programs for health professionals who are emotionally affected by a PSI. We hope that this work will help healthcare organizations create psychologically safe support programs, assist health professionals who are seeking support to understand what is protected and what is not, enable patients to gain insight into health professionals' experience, and encourage policy makers to consider what might need to change – including enhanced protections for these communications – to ensure health professionals are supported after a PSI.

CPSI priorities

CPSI is committed to improving patient safety in Canada and does so through a number of initiatives. Each of our initiatives is part of a comprehensive strategy to keep patients safe: from the Patients for Patient Safety Canada program, which recognizes the wealth of experience and knowledge members of this program can share to improve patient safety, to *Safer Healthcare Now!* interventions that facilitate implementation of best practices. We also have substantial resources we have developed with our partners such as the Canadian Disclosure Guidelines, Communicating After Harm in Healthcare and the Patient Safety and Incident Management Toolkit which provide practical strategies and resources to manage PSIs openly and effectively while engaging patients throughout the process.

The present guidelines are no exception. We recognize that there is a significant need to support health professionals as well as patients and families on their journey from harm to healing. It is our hope that by taking this first step towards supporting health professionals through a PSI, we will contribute to system safety by providing tools and resources to everyone who makes up the system – patients, families,

providers and healthcare leaders – that allow them to learn, collaborate and improve care for patients.

The following guiding principles underpin the development of this document:

1. It is important that health professionals have a psychologically safe environment that provides them with an opportunity to speak confidentially to a peer about their experience of a PSI because:

    - it will help them cope with what can be an emotionally traumatic experience; and

    - it will improve patient safety since health professionals will be in a healthier emotional state to care for their patients safely, and to participate more effectively in PSI reviews and conversations with patients.

2. These support programs are not intended to affect transparency about the facts surrounding PSIs or withhold material facts surrounding PSIs from patients and families, but rather to provide a safe space to help health professionals cope with traumatic and stressful events. The emotional trauma, not the PSI, should be the primary focus of these programs. Practically, however, it will not always be possible to provide effective support if the events cannot be discussed at least in part. The balance between these interests requires careful consideration.

3. Those promoting peer-to-peer support programs should be transparent to prospective participants about what can and cannot be kept confidential. This is an important way to align expectations and avoid further negative experiences.

4. Advocacy for, or the establishment of, a peer-to-peer support program for health professionals who experience a PSI does not in any way diminish the importance of reporting patient safety incidents for quality improvement efforts, disclosure of the facts around patient safety incidents to patients and families, and other incident management activities.

Background

Many efforts have been made in recent years to improve patient safety and decrease the number of patient safety incidents in the health system. These efforts have resulted in a vast number of quality improvement and patient safety initiatives and programs that have significantly raised awareness of the importance of patient safety and made a positive impact on patient care.

PSIs do continue to occur, however, with data showing that harmful PSIs range between 3% and 16% of all hospital admissions[1,2,6,14]. It is the reality of a health professional's work environment that they are subject to ongoing risk for PSIs[15]. The nature of a health professional's work is that they are constantly making decisions – sometimes of extreme gravity – that affect patients' lives and where there are unfortunately risks for miscalculations, misdiagnoses, misinterpretations or missteps – sometimes with serious consequences[16].

Emotional distress after PSIs

A significant number of studies conducted over the past few years confirm that health professionals feel emotionally distressed after a PSI[1-10], whether they are involved directly or indirectly. A systematic review by Seys et al[1] indicates that between 10% and 43% of health professionals are affected by PSIs, with one study reporting 40.8% of health professionals feel moderately severe harmful effects and 2.5% describe a severe impact on their personal lives.

Feelings health professionals describe include shame, humiliation, guilt and remorse. Their self-esteem is eroded, and they are filled with self-doubt, self-blame and feelings of inadequacy. They might fear punishment, job loss, patients' anger or colleagues' judgement. They can experience psychological symptoms such as panic, anxiety, grief and depression[6,18,19].

Sydney Dekker's (2013) book entitled Second Victim: Error, Guilt, Trauma, and Resilience[11] provides a comprehensive picture of the emotional reactions experienced by individuals who are involved in PSIs, and why they need support. He notes that the psychological journey some health professionals experience after a PSI can be traumatizing, and if they are not offered the help they need, this will erode his or her ability to cope with the experience. Dekker cautions that the trauma can even lead to posttraumatic stress disorder (PTSD) that leads to "emotional, social, behavioural, cognitive, and somatic consequences that can reverberate for a long time and that people are not well equipped to handle by themselves" (p. 17).

To understand why health professionals are so deeply affected by PSIs, it is helpful to understand who they are, and the environment in which they work.

The source of emotional distress

Health professionals are in the business of healing, and doing harm is the antithesis of what they aim to achieve. They feel pressure to be perfect in a situation where it is generally impossible to be perfect. It has been said that health professionals are trained in a culture of perfection[22] where the expectation is that, once they are finished their training, the work they do will be flawless. Their expectations for error-free care are unrealistically high[22].

Health professionals work within a highly complex and technical system under circumstances that are mentally and physically demanding. They are also often under incredible time pressures to make decisions without complete information, and they are working interdependently with others in systems that are not always effective all the while convinced that PSIs are always avoidable and that they are expected to be perfect. In actuality, health professionals work within a system full of ambiguity, uncertainty, and morally complex choices, where PSIs are inevitable[23].

At the same time, PSIs are rarely considered inevitable – they are essentially considered anomalies in healthcare[11]. Despite the inevitability of PSIs, where healthcare professionals are often simply inheritors of those PSIs and at the sharp end of a complex series of failures, there is a pervasive belief among health professionals that all PSIs are preventable[24,25].

A note on the term "second victim"

Albert Wu coined the term "second victim"[5] and many others, including Sydney Dekker[11,15,22,23], adopted the term to describe a health professional who experience a PSI. The first victim is the patient and family / caregiver who was harmed, while the second victim is the health professional who is traumatized by the event.

Dekker and Wu's work on exploring the nature of the emotions of individuals who experience PSIs has brought attention to the impact of PSIs on health professionals and has made a significant contribution to our understanding of these emotions. However, CPSI has chosen to avoid using this term, as this label often does not resonate with health professionals. Also, the label "victim" implies health professionals do not have a role to play in the incident, and that something has been done to them over which they had no control. Finally, calling the health professional a victim has the potential to demean the impact of the PSI on the patient.

Rather than adopting another term or label, which risks pathologizing health professionals and implying they are psychologically abnormal or unhealthy, we choose to refer to the effect rather than the individual: a health professional who experiences a PSI and who may be emotionally affected by it.

Just culture of safety and systems thinking: The ideal

Recognizing that PSIs should be an opportunity for learning and providing safer care for patients, many healthcare organizations and patient safety experts have explored how the healthcare system might create a more open and transparent environment. A number of efforts have been made to try to help health professionals understand that many of the PSIs that occur are often not due to any individual mistake, and very rarely because of negligence or incompetence. This has led to the development of just culture and systems thinking, where employees are encouraged to report and disclose PSIs without fear of inappropriate reprimand or punishment.

Disclosure of PSIs is a key building block of this just culture of safety and is a way of demonstrating to patients that they can trust healthcare professionals and organizations to be honest and open about harmful incidents, and to learn from these events to prevent them from recurring. It is also a health professional's ethical duty and responsibility to tell the truth, promoting personal accountability and continuous learning[26].

A culture of silence and individual blame: The reality

Despite this attention to a just culture of safety and disclosure, creating an open and transparent environment and moderating shame and blame continues to be an enormous challenge[3,4,20]. Health professionals continue to be unwilling to talk – and therefore learn – about harm or close calls.

Within this culture of blame, it is understandable why health professionals often choose to remain silent; they would likely hesitate to openly share information about PSIs because they fear punishment from their employers or judgment from their peers. This blame culture leads to underreporting of PSIs in healthcare; studies indicate that leadership is aware of less than 5% of the PSIs in their system, while front line staff members know about all of them[1].

Rise of support programs

As healthcare organizations continue work towards creating a just culture of safety, there is a growing recognition that health professionals can be emotionally traumatized after a PSI but might have difficulty seeking or finding help. There is also a recognition that unless health professionals are supported psychologically after a PSI, there is a risk that efforts to improve patient safety will be compromised[12,13,28]. As de Wit et al.[12] note: "we cannot deliver the safest possible care unless we foster an environment in which healthcare workers have a safe place to grapple with the impact of their involvement in adverse events" (p. 858).

White et al.[13] note that the distress from PSIs has the potential to worsen productivity, quality, and safety. Van Gerven et al.[28] note that improving healthcare professionals' work life wellness is considered a critical aspect of optimising health system performance. Finally, Pratt, Kenney, Scott and Wu[29] maintain that "failure to care for second victims could lead to a vicious cycle of adverse events, burnout, poor care, and more adverse events" (p. 238).

Seys et al.,[17] also notes the following defensive changes after a PSI, which can have a negative effect on patient safety:

- More likely to keep error to themselves;

- Avoidance of similar patients;

- Feeling less confident with patient/family, getting more worried, less trusting of others' capability;

- Avoiding further contact with patient/family;

- Thoughts about leaving practice;

- Change in health professional-patient relationship; and

- Ordering more tests, afraid of making another error.

There has recently been a growth of peer-to-peer support programs where health professionals can openly discuss PSIs in a safe, non-judgmental environment, thereby helping them deal with the emotional consequences of a PSI[26]. There is evidence that, in the first moments after a PSI, health professionals may need to talk to a colleague and feel respect and empathy from others[30]. These programs rely on volunteers from within the healthcare system who participate in training programs to provide support for their colleagues who are from similar professions and specialties as their own[12].

Many organizations offer assistance through some form of Employee Assistance Program (EAP), but the effectiveness of these programs for helping health professionals cope with their PSI experience is uncertain: "the low appeal of EAP may relate to a lack of tailoring to the needs of healthcare workers involved in adverse events, a lack of relevant training for EAP staff, or the use of non-clinician support providers who may lack credibility with healthcare workers"[13] (p. 38). It is clear that it would be difficult, if not impossible, for non-clinicians to grasp the full extent of the physical, psychological, and emotional impact of the experience of a PSI[21,29].

A few peer-to-peer support programs have been initiated in the US, such as the Resilience in Stressful Events (RISE) program at the Johns Hopkins Hospital, the Medically Induced Trauma Support Services (MITSS) program in Boston, the Centre for Professionalism and Peer Support at the Brigham and Women's Hospital, and the forYou program at the University of Missouri Healthcare (MUHC).

In Canada, there is much interest in exploring how best to support health professionals experiencing stressful events in the workplace. To-date, several organizations have developed support programs, including:

- Critical Incident Stress Program (CISP), British Columbia Emergency Health Services (BCEHS) and member of the BC First Responders' Mental Health Committee

- Occupational & Critical Incident Stress Management (OCISM) (Health Canada providing services to nurses working in First Nations communities across Canada)

- Peer Support and Trauma Response Program (The Toronto Hospital for Sick Children – SickKids)

- Peer Trauma Response Team Program (Alberta Health Services)

- Quebec Physicians' Health Program (QPHP)

- Second Victim Peer Support (Michael Garron Hospital)

- Second Victim Guidance Team (Central Health, Newfoundland and Labrador)

For more information on these programs and guidelines on how to set them up, refer to <u>CPSI Best practices</u> for workplace peer support programs in healthcare organizations.

Challenges of providing emotional support to health professionals

There are a number of challenges to providing support for health professionals who experience a PSI, not the least of which is their reticence to seek support. A large reason for this reticence is their shame, or their unwillingness to admit their fallibility; asking for help or seeking mental health care is stigmatized as a sign of weakness[11,12,13]. According to de Wit et al. "the very act of admitting you need help after a traumatic event carries its own powerful stigma in a culture that embraces the illusion that perfection can be achieved, and that falling short of this impossible standard is a sign of personal defect"[12] (p. 857). Further, some health professionals may not want to risk their credentialing bodies finding out that they sought mental health care[13]. Health professionals are also reticent to seek help because they fear being judged negatively by their colleagues, do not trust the confidentiality of the process, lack confidence in the value of the support, and worry about the implications for litigation.

The following table describes factors that impede disclosure of PSIs as described by Kaldjian et al.,[31] providing an overall summary of reasons for helplessness – such as lack of control or confidentiality – and fears and anxieties including fear of legal liability or loss of reputation.

Table 3. 1: Factors that impede disclosure of PSIs

Helplessness	Fears and Anxieties
Lacking control of what happens to information once it is disclosed	Fearing legal or financial liability
Lacking confidentiality or immunity after disclosure	Fearing professional discipline, loss of reputation, loss of position, or loss of advancement
Lacking institutional and collegial support after disclosure or a professional forum for discussion	Fearing patient's or family's anger, anxiety, loss of confidence, or termination of physician-patient relationship
Believing error reporting systems penalize those who are honest	Fearing the need to admit actual negligence
Lacking feedback after reporting PSIs or a sense of ownership in the quality improvement process	Fearing the need to disclose an error that cannot be corrected
Lacking time to disclose PSIs	Fearing the possibility of looking foolish in front of junior colleagues or trainees
Feeling helpless about PSIs because one cannot control enough of the system of care	Fearing negative publicity
	Fearing the possibility of 'fallout' on colleagues
	Feeling a sense of personal failure, loss of self-esteem, or threat to one's identity as a healer

Because of these factors (explained further in Kaldjian et al.[31]), the existing culture of silence, and health professionals' reticence to acknowledge their fallibility, it is clear that if health professionals were to seek support, confidentiality would be of utmost importance.

In addition, because there is also a possibility that PSIs might lead to litigation, health professionals are also concerned that what they share with others – in this case with a colleague in a support program – might be used as evidence in a civil proceeding or in employment or college disciplinary proceedings. As noted by de Wit et al.[12] "this burgeoning movement faces an obstacle, though, given the uncertainty over whether discussions conducted as part of supporting Second Victims will be deemed admissible as evidence in malpractice litigation or other disciplinary proceedings" (p. 853).

Legal privilege and confidentiality for these communications is therefore important to explore, as health professionals giving and receiving support should understand whether and to what extent these communications can be legally protected, and how committed these programs and organizations will be to fostering that protection. With this knowledge, they can then be clear about what type of information should be shared, how best to support each other, and ensure that the support is appropriate and helpful.

Defining Confidentiality and privilege

Before examining whether communications shared within a peer-to-peer support program are protected, it is important to outline the difference between confidentiality and privilege.

Whereas confidentiality involves the ethical duty of an individual not to disclose information without consent (e.g. the right of a client to not have the information that was shared with the therapist disclosed without proper release), privilege is a type of legal protection that prevents the introduction of information or communications into evidence in a trial or other legal proceeding[32]. In other words, within a peer-to-peer support program, those providing the peer support might be bound by an ethical duty not to disclose information deemed confidential, but this information may not be privileged.

Privilege is the right to refuse to disclose evidence, which has the effect of denying a judge, jury, or other adjudicator information that might help find the truth; therefore, the law demands that privilege be justified by some compelling societal interest[33]. If information is not privileged, then a plaintiff's lawyer could successfully seek to obtain access to the communications[33]. Privileges can apply to a class or category (such as lawyer-client privilege) or can be applied on a case-by-case basis if certain criteria are met[iii].

[iii] For the case-by-case privilege to be applicable, a person wishing to claim the protection of the privilege bears the burden of establishing that four criteria (called the "Wigmore criteria") are satisfied:

(1) the communication must originate in a confidence that it will not be disclosed;
(2) the element of confidentiality must be essential to the full and satisfactory maintenance of the relationship between the parties;
(3) the relationship must be one which should be sedulously fostered in the public good; and
(4) if all these requirements are met, the court must consider whether the interests served by protecting the communication from disclosure outweigh the interest at getting at the truth and disposing correctly of the litigation[33,34].

Satisfaction of the final criterion is the most difficult to meet for any person claiming case-by-case privilege, as the judge must find that the benefit of disclosure for litigation is less than the damage that it would cause to the relationship[33]. Since the aim of the litigation process is to find the truth, it is most likely that the courts will side with those seeking to disclose information from the court[33].

When communications about PSIs are protected

CPSI, along with all patient safety champions, encourages transparency and openness about PSIs, providing health professionals the opportunity to learn from PSIs, ensuring healthcare is improved and made safer. In fact, to reinforce this message, CPSI's Canadian Disclosure Guidelines[27] includes a set of "guiding principles" in the introduction.

Guiding Principles

The following guiding principles underpin the development and use of the Canadian Disclosure Guidelines:

Patient-centered healthcare: An environment of patient-centered healthcare fosters open, honest and ongoing communication between healthcare providers and patients. Healthcare services should be respectful, supportive and take into consideration the patient's expectations and needs at all times.

Patient autonomy: Patients have the right to know what has happened to them in order to facilitate their active involvement and decision-making in their ongoing healthcare.

Healthcare that is safe: Patients should have access to safe healthcare services of the highest possible quality. Lessons learned from patient safety incidents should be used to improve the practices, processes and systems of healthcare delivery.

Leadership support: Leaders and decision makers in the healthcare environment must be visible champions of disclosure as part of patient-centered healthcare.

Disclosure is the right thing to do: "Individuals involved at all levels of decision-making around disclosure must ask themselves what they would expect in a similar situation[1]."

Honesty and transparency: When a harmful incident occurs, the patient should be told what happened. Disclosure acknowledges and informs the patient, which is critical in maintaining the patient's trust and confidence in the healthcare system.

The key takeaway from these principles is that disclosure is the right thing to do for patient safety, for the patient and for the health professional.

There are situations, however, when certain information about PSIs might be kept confidential or when it is protected by privilege. The reason for protecting this information is not to hide the truth; rather, it is to allow PSIs to be explored openly and transparently by the healthcare team so that the team may learn from the incident and improve patient safety. If these communications were not protected, or privileged, there would be a chilling effect on the robust discourse that must occur in order to improve care following a patient safety incident.

The following sections describe examples where information is protected.

Lawyer-client privilege

As with any lawyer-client relationship, information a health professional might share with his or her lawyer about a patient safety incident would be protected by this class or categorical privilege. Although this is an example of privileged communication, it would not apply to peer support programs because no legal advice is being sought from or provided by a lawyer.

Quality Assurance Committees

Throughout Canada in every common law province and territory, legislation protects information that is generated from certain quality assurance activities[33,35]. This is generally referred to as "statutory privilege" or "statutory prohibition" which comes from legislation, not 'common law' (judge- or Court-made law) and not from the relationship of the parties sharing the information. Its scope is restricted to the circumstances intended by the legislation; it cannot be waived, as a privilege or confidentiality can be waived. It is widely accepted that without this guarantee of confidentiality, healthcare professionals would not freely participate in all quality assurance activities for fear of potential liability[36]. Consequently, the quality assurance activities would not be as effective, and the quality and safety of patient care would be compromised[36].

The Canadian Medical Protective Association[37] explains that the quality assurance committees are not intended to preclude other patient safety initiatives:

> "The reporting of critical incidents or adverse events to hospital quality assurance or peer review committees is generally part of a much broader initiative aimed at identifying and addressing systemic problems and improving patient safety. The ultimate goal of quality assurance activities is to critically review these incidents and to evaluate the effectiveness of the institution's practices and procedures in order to improve patient safety overall. It is generally accepted that, in order for quality assurance programs to be successful and effective, physicians and other health professionals must have satisfactory assurances that the reporting and subsequent investigation of such information will not be used or disclosed outside of the quality assurance process (either to patients or to other hospital departments or committees). If physicians and other healthcare providers are not confident that quality assurance information and documentation will be protected, they may be reticent or even unwilling to participate in the process."

While the specifics are different in each province/territory, the statutes generally follow the same model, keeping quality assurance proceedings, reports and investigations from being disclosed or used in court[34]. For example, section 9 of the Alberta *Evidence Act*[38], which resembles legislation in other jurisdictions, reads as follows:

> 9 (2) A witness in an action, whether a party to it or not, is not liable to be asked, and shall not be permitted to answer, any question as to any proceedings before a quality assurance committee, and is not liable to be asked to produce and shall not be permitted to produce any quality assurance record in that person's or the committee's possession or under that person's or the committee's control.

> Quality assurance committees are generally defined as committees appointed by regional health authorities or hospital boards, established under provincial legislation, or designated by ministerial order and prescribed in regulations[34].

Protection of quality assurance activities is typically accompanied by a statutory prohibition against disclosure of quality assurance information in legal or professional proceedings.

It is interesting to note that recent changes to legislation in Ontario – the Quality of Care Information Protection Act (QCIPA) – could be considered indicative of a trend towards more openness for any investigations or activities around PSIs. In particular, the following statements[39] show clear support for using caution when invoking QCIPA:

- The intent of QCIPA remains valid, and a modified version of the legislation should be retained. However, the legislation should be amended to clearly indicate that when QCIPA is invoked, patients and families must be fully informed about the results of the investigation, including what happened, why it happened and what measures (if any) the organization intends to take to prevent future incidents. This should be done in a way that respects the confidentiality protections of QCIPA.

- The current variation in how QCIPA is used across Ontario hospitals needs to be addressed. QCIPA should only be invoked when the nature of the contributing causes to a critical incident is unclear and there is the need for considerable discussion and speculation about the causes of the incident. Ontario hospitals, with the help of Patients for Patient Safety, the Canadian Medical Protection Association, Health Quality Ontario and others, should learn from each other and develop clear guidance about the circumstances under which QCIPA should be invoked to investigate a critical incident, and when it should not be invoked.

QCIPA represents a more nuanced kind of legislative privilege/prohibition that could be adopted in other jurisdictions in the future.

Apology Act

Although the Apology Act is not directly related to privilege in a peer-to-peer support program, it is another instance where communications surrounding a PSI – an apology to a patient about a PSI – cannot be taken into account in determining fault or liability in a legal proceeding.

To date, eight Canadian provinces and one territory (British Columbia, Alberta, Saskatchewan, Manitoba, Ontario, Nova Scotia, Prince Edward Island, Newfoundland and Labrador, and Nunavut) have adopted "apology legislation," either as stand-alone legislation or incorporated in Evidence Acts. In these provinces, an apology to a patient for an error is not admissible as evidence of liability in legal proceedings.

The main objective of apology legislation is to reduce health professionals' concerns about the legal implications of expressions of sympathy, including apologies.

An apology is an expression of sympathy and regret and a statement that one is sorry. The words "I'm sorry" are known to foster increased respect and improved relationships between patients, families and healthcare professionals.

Legal privilege in a peer to peer support program

Considering the definition of legal privilege, along with the above scenarios where communications about PSIs would be privileged or otherwise protected, it is unclear whether communications that occur within a peer-to-peer support program could be privileged at present or subject to a statutory prohibition against disclosure at present, since:

- They do not occur within a client-lawyer relationship;

- They are typically not communications taking place within or related to the activities of a quality assurance committee; and,

- To date there has not been a Canadian court decision to determine whether Wigmore privilege would protect the confidentiality of peer support communications.

The risk of a peer supporter being legally compelled to disclose is still therefore unknown. However, once it becomes known to patients, families and lawyers that these communications may be happening, it is reasonable to expect that there will be a curiosity about their relevance that could prompt inquiries. On the other hand, should anyone seek disclosure, they must have grounds for believing the information within the peer-to-peer support program is relevant or potentially relevant before a court will compel disclosure[34].

The fact that peer-to-peer support programs may not be protected by privilege does not necessarily mean organizations should be discouraged from implementing such an initiative – although it might make the implementation of a peer-to-peer support program more challenging. There are steps that organizations can take however to maintain confidentiality, if not privilege, so that health professionals might be free to discuss their emotions about traumatic events.

Recommendations for implementing a confidential peer to peer support program

All evidence gathered about the emotional impact of PSIs on health professionals' points to the importance of supporting them through what can be a traumatic experience. It is critical that leaders in healthcare organizations pay attention to the impact of PSIs, and initiate peer-to-peer support programs that will improve employee wellness and in doing so improve patient safety. Health professionals themselves need to understand the importance of seeking emotional support for the distress they experience so that they are better able to cope with their emotions in a timely manner, to offer themselves the opportunity for an earlier and fuller resolution of the physical and psychological trauma arising from the incident. In caring for themselves they will be able to provide better care to their patients and at the same time decrease the likelihood of a PSI.

The risk of peer support information being disclosed is unknown. The research conducted for these guidelines has demonstrated that there is no guarantee that the information shared within a peer-to-peer support program would be privileged; however, the benefit to the health care providers and their future patients may be more important than concerns about disclosure of conversations. In addition, the fact that

these discussions may not be privileged does not mean they cannot be confidential, and every step should be taken to ensure this confidentiality.

There are a number of excellent resources available to help organizations implement a peer-to-peer support program:

- Hirschinger LE, Scott SD, Hahn-Cover K. Clinician support: Five years of lessons learned[40].

- Edrees H, Connors C, Paine L, Norvell M, Taylor H, Wu AW: Implementing the RISE second victim support programme at the Johns Hopkins Hospital: a case study[41],

- Krzan KD, Merandi J, Morvay S, Mirtlallo J: Implementation of a "second victim" program in a pediatric hospital[42],

- Pratt S, Kenney L, Scott SD, Wu AW: How to develop a second victim support program: A toolkit for Health Care Organizations[29],

- Seys D, Wu AW, Van Gerven E, Vleugels A, Euwema M, Panella M et al: Health care professionals as second victims after adverse events: A systematic review[17].

To augment these resources, the following are a few recommendations for developing and implementing a peer-to-peer support program that will provide a psychologically safe environment for health professionals who experience a PSI and will mitigate risk of this information being used in a legal action.

Describing the program

Many health professionals are not aware of the psychological effect of a PSI until they experience it. It is therefore important to raise awareness about the traumatic emotional impact of PSIs through an education campaign that describes common reactions, behaviours and emotional consequences after a PSI, as well as ways to support the persons involved in the PSI[30,39].

Due to the challenges to implementing a peer-to-peer support program (as described above), not the least of which is a health professional's reluctance to seek help, it will be important for organizations to include the following messages in their description of the program:

- The program is confidential, and no documentation is maintained regarding the content of the discussion.

- The program aims to support health professionals through what is for many a traumatic experience.

- The program is an integral component of the organizational commitment to employee wellness and patient safety.

- The support offered by the program is not "therapy;" it is collegial support that comes from talking to someone who has "been there[21,44]."

It is normal to experience emotional and physical distress after a PSI, and it is critically important for individuals to seek support to cope with this distress.

Peer supporters are trained to offer emotional support, coaching and resources, not to review medical records or provide clinical feedback or opinions on the care provided[13].

As an example, the Brigham and Women's Hospital created a Centre for Professionalism and Peer Support[43] and quote an article by Van Pelt[44] which serves to create an understanding for the vision and purpose of the peer-to- peer support program:

> *The Peer Support Service bypasses the stigmas that limit the utilization of formal support services and offers care providers a safe environment to share the emotional impact of adverse events while serving as a foundation for open communication and a renewal of compassion in the workplace. As the breadth of stressors impacting healthcare professionals is revealed, the Peer Support service is being recognized as a vital hospital-wide service. It also appears to offer an important leap forward in the critical areas of patient safety and quality of care[44].*

Training peer supporters

As with any peer-to-peer support program, the peer supporters should receive training to ensure they are prepared to support their peers through an emotionally traumatic experience. This ought to include training for such skills as how to respond to distress calls, how to provide suicide first-aid, and how to give non-directive emotional support. Peer supporters must also be provided with training about what outside resources are available to peers in need[29,39,40].

As part of this training, it is important that the peer supporter understand their role in steering the conversation towards the emotional impact of the incident rather than opinions and speculations about what went wrong; the focus of the conversation should be on dealing with the emotional consequences of the incident[30]. In other words, what happened: the conversations within a peer-to-peer support program do not change the facts. The purpose of peer-to-peer support programs should not be to analyze what went wrong or who is to blame; rather the purpose should be to support the health professional emotionally and to assist the caller in processing the emotion and connecting with professional resources where appropriate. White et al.,[13] suggest that organizations can "minimize the risk of discoverability by assuming the clinician will discuss only their feelings as opposed to the facts surrounding the adverse event" (p. 38).

Peer supporter training should also include the practices and procedures for administering the confidential peer- to-peer support program including the logging of calls in a confidential manner (for statistical/cost evaluation purposes).

Other suggestions for maintaining confidentiality include ensuring:

- the organization establish Terms of Reference for the peer support program which incorporate confidentiality statements that parallel the first three Wigmore criteria (see footnote (i) on page 119 of this document);

- the organization establish the program under the umbrella of an existing privileged quality of care committee, or through the Risk Management office;

- peer supporters sign a confidentiality agreement;

- the identity of the peer supporters is not widely known;

- there is minimal documentation about those seeking support, and any documentation generated is marked "Confidential" and centrally stored in Risk Management or by the Quality of Care Committee;

- there is no record of telephone numbers;

- there is no documentation of the content of the conversations;

- health professionals are given the opportunity to make an anonymous telephone call; and

- there is a well-written policy documenting the purpose of the peer support program.

The challenge for organizations will be to provide effective services while maintaining confidentiality. It will be important for those developing the programs to find the right balance between confidentiality and personal support as the more confidentiality is maintained (with anonymous telephone calls, for example) the more difficult it will be to provide personal support that a health professional might need to cope with events.

Conclusion

The psychological trauma that health professionals undergo when they are involved in a PSI can be overwhelming and complex. It can have a significantly negative effect on their wellbeing and on their ability to care effectively for their patients. It is therefore important that healthcare organizations explore how best to support their workforce through what can be a very distressing experience.

Organizations will face an uphill battle in destigmatizing psychological support and overcoming health professionals' reluctance to share their feelings about PSIs. A peer-to-peer support program is a long-term initiative which should be expected to take five to ten years to become recognized, accepted and well utilized.

When implementing a peer-to-peer support program, organizations will also be faced with the challenge of assuring health professionals that they will be in a psychologically safe environment, and that every effort will be made to keep the information confidential.

In light of the fact that the communications within the support programs are not privileged at present, health professionals may need to be persuaded that the benefits of emotional peer support outweigh the risk of the communications being disclosed.

At the same time, everyone involved in the care of patients – including patients and families – will need to be reassured that a peer-to-peer support program does not in any way diminish the importance of other quality and patient safety improvement efforts, including the reporting of PSIs, disclosure and other incident management activities. Facts are facts, and health professionals are ethically bound to disclose PSIs, and confidentiality does not imply freedom from accountability[26]. There needs to be a clear message from everyone involved in the programs that they are not about keeping facts about patients' care from patients and others, but rather providing a safe space to help health professionals cope with traumatic and stressful events so that they might be in a healthier emotional state to care for their patients safely.

It is in the public's interest to support these peer-to-peer support programs because of their positive impact on the safety of subsequent patient care. Failing to provide this support might very well derail what could be one of the best paths to healing for health professionals who experience a PSI and obstruct what could be a valuable bridge to patient safety improvement[49].

Support for health professionals is an important component of a much larger incident management process that includes reporting, disclosure, analysis, learning, and quality improvement. Peer-to-peer support should be interwoven through this process. CPSI encourages organizations to design such programs with a commitment to confidentiality to the extent permitted by law.

CPSI promotes the disclosure of PSIs and continues to emphasize that these support programs are not about keeping facts about patients' care hidden, but rather helping health professionals cope with traumatic and stressful events so that they might be in a healthier emotional state to care for their patients safely in the future.

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Creating
a Safe Space

Section 4: Canadian Best Practice Guidelines for Peer to Peer Support Programs

cpsi·icsp Canadian Patient Safety Institute
Institut canadien pour la sécurité des patients

Acknowledgements

Section 4: Canadian Best Practice Guidelines for Peer to Peer Support Programs

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Disclaimers

This publication is provided as information only. All examples are provided as illustrations. This publication is not to be used as a substitute for legal advice. It is not an official interpretation of the law and is not binding on the Canadian Patient Safety Institute (CPSI).

Section 4: Canadian Best Practice Guidelines for Peer to Peer Support Programs

Introduction

It is clear from the results of the survey [see Section 1] and scoping review [see Section 2] that there is a great need for establishing peer support programs in healthcare organizations in Canada. The current literature [see Section 2] on mental health and wellness for health professionals also supports these findings, leading the Canadian Patient Safety Institute (CPSI) to make a strong recommendation to healthcare organizations to establish peer support programs for individuals in their organization who may be experiencing emotional distress.

Along with this recommendation, CPSI aims to support healthcare organizations that intend to establish a Peer Support Program (PSP). For this reason, we worked with Canadian experts in the field to develop this Best Practices section of the *Creating a Safe Space: Strategies to Address the Psychological Safety of Healthcare Workers*. These experts were recruited to be members of this working group because of their expertise in establishing their own peer support programs. Their collective wisdom shaped the direction and content of this manual; the members gave advice on important elements to include in our document, shared with us a multitude of resources and tools, outlined tips and lessons learned, and worked closely with us to develop key messages and recommendations to help organizations succeed with their PSPs.

The following are the program names (in various stages of development) and organizations of the working group members:

- Critical Incident Stress Program (CISP), British Columbia Emergency Health Services (BCEHS) and member of the BC First Responders' Mental Health Committee;

- Occupational & Critical Incident Stress Management (OCISM) (Health Canada – providing services to nurses working in First Nations communities across Canada);

- Peer Support and Trauma Response Program (The Toronto Hospital for Sick Children – SickKids);

- Peer Trauma Response Team Program (Alberta Health Services);

- Programme d'aide aux médecins du Québec (PAMQ)/Quebec Physicians' Health Program (QPHP);

- Second Victim Peer Support (Michael Garron Hospital);

- St Michael's Hospital, still in development;

- Chatham-Kent Health Alliance, still in development; and

- Second Victim Guidance Team (Central Health, Newfoundland and Labrador).

This is not an exhaustive list of peer support programs in healthcare organizations in Canada. There are other programs and organizations that support healthcare workers. For example, there are a number of health professional associations that offer peer support, and burgeoning initiatives such as the Schwartz Rounds™ that is now active in six centres in Canada. We uncovered a number of programs in our survey of peer support in Canada [see Section 2] and will no doubt continue to discover others as we continue our work in this area. We hope that this document will help bring together a community of practice where we can collaborate and learn from each other's experience.

It is important to note that these are guidelines only,

not a definitive step-by-step script; each

organization will necessarily customize their PSP

according to their own policies, culture and vision.

Purpose of the Best Practices section

The aim of this section is to provide a roadmap for healthcare organizations that are contemplating or are in the process of implementing a structured and formal workplace-based PSP program where employees, some with lived experience, are selected and prepared to provide peer support to other employees within their workplace (see definition p. 13 of the manual). This document was created to offer practical advice and outline key recommendations on how to develop the core elements for developing a comprehensive and sustainable approach to peer support. We aim for it to be beneficial to whoever initiates the program at any level: from the individual who identifies the need for peer support and wants to know how to get started, to organizational leaders who recognize the importance of supporting their staff and who need information to guide their process. It is important to note that these are guidelines only, not a definitive step-by-step script; each organization will necessarily customize their PSP according to their own policies, culture and vision.

There are valuable resources available already that provide guidance for the fundamentals of peer support programs in general. For example, Peer Support Canada provides certification for peer support, along with a number of resources on such topics as peer support competencies, training, code of conduct and core values.

In particular, the Mental Health Commission of Canada (MHCC)'s *Guidelines for the Practice and Training of Peer Support* (2013) provide comprehensive advice on a number of relevant topics, including:

- the value of peer support;
- guiding values and principles for peer supporters;
- skills, abilities and personal attributes of peer supporters; and
- guidelines for training peer supporters.

The British Columbia Emergency Health Services (BCEHS) adapted a great deal of this information, along with materials from the Critical Incident Stress Foundation, for their own program, and informed much of the content for the BC First Responders' Mental Health website. We will be referring to both the MHCC and the BC materials frequently throughout the text.

There is also knowledge to be gained from peer support programs for healthcare professionals that have been established for a number of years. The following programs, based in the United States, have several particularly useful documents and other resources that informed our work:

- Resilience in Stressful Events (RISE) second victim support programme at the Johns Hopkins Hospital;

- ForYOU team at the University of Missouri Health Care (MU Health Care);

- Medically Induced Trauma Support Services (MITSS) in Massachusetts; and

- The Center for Professionalism and Peer Support at Brigham and Women's Hospital in Massachusetts.

We do not intend to re-create such knowledge in this document; rather, our intention is to focus on fundamental considerations for establishing a peer support program within healthcare organizations, using examples and best practices gleaned from our experts and from other organizations with well-established peer support programs.

Throughout this text, we will be referring to two other sections of this manual that complement and reinforce the information here:

- Tools and Resources for Peer Support Programs: A comprehensive list of tools and resources that will help organizations implement a peer support program.

- Addressing Confidentiality for Peer-To-Peer Support Programs for Health Professionals: Clarifies the legal privilege and professional confidentiality considerations for a PSP.

Definition of Peer Support

As we have seen from the scoping review [see Section 1], there are many variations in the meaning and/or composition of a PSP. This disparity is likely the result of the grassroots nature of PSPs, where each organization develops and implements a program that is suited to their structure and adapted to the specific needs of their staff. At the heart of any PSP, however, is the desire to embed and sustain a psychologically safe environment where those who are part of the healthcare organization feel supported by their peers and the organization when they experience distress at work.

For the purposes of this document, the working group members agreed on the definition of a PSP as stated in the introduction to this manual, which is repeated on the next page for convenience (Box 4.1):

"Peer support is an important addition to SickKids as it gives staff an opportunity to connect with colleagues that "get it". It is not counselling or therapy. It is a chance to get some extra support. There is such value in talking through difficult moments. I enjoy being part of the Peer team as it always reminds me what dedicated and passionate professionals I am privileged to work with here at SickKids. This is not an easy place to work yet people come day after day and year after year to help (through whatever profession they are part of). Peer helps me connect with staff from all over as people not just professionals. I think that is important."

(Shaindy A. Child Life Specialist, Peer Supporter, SickKids)

Box 4.1: Definition of a Peer Support Program

A peer support program (PSP) includes any program that provides non-clinical emotional support to health professionals (and in some cases other individuals who work, volunteer or train at an organization) who is experiencing emotional distress and this support is provided by a peer. The need for emotional support can be the result of:

1. A patient safety incident: an event or circumstance that could have resulted, or did result, in unnecessary harm to a patient. There are three types of patient safety incidents:

    • Harmful incident: a patient safety incident that resulted in harm to the patient (replaces "preventable adverse event");
    • Near miss: a patient safety incident that did not reach the patient and therefore no harm resulted; and
    • No-harm incident: a patient safety incident that reached the patient but no discernible harm resulted.

2. A critical incident or trauma: "Any sudden, unpredictable event that occurs during the course of carrying out day-to-day duties or activities that poses physical or psychological threat to the safety or well-being of an individual or group of individuals" (as per SickKids definition in their Trauma Response and Peer Support Policy). Examples include:

    • Unexpected death of a patient;
    • Suicide of a colleague;
    • A workplace accident resulting in critical injury to a staff member;
    • Internal or external disaster;
    • Mass casualty situations;
    • Life-threatening illness, injury or untimely death of staff or co-worker;
    • Natural or man-made disasters; and
    • Any incident charged with profound emotion.

3. Other work-related stress (**excludes** issues related to Human Resources such as job action or performance). Examples include:

    • Work environment;
    • Assault, harassment or violence involving staff or patient and/or family;
    • Workplace conflict;
    • Workplace re-organization or downsizing;
    • Complaints/lawsuits;
    • Cumulative stress;
    • Work-life balance issues;
    • Compassion fatigue;
    • Vicarious trauma; and
    • Events that attract media attention.

Guiding values and principles of a peer support program

A valuable framework for those who are implementing a PSP is the MHCC's description of the primary values and principles of practice to which organizations should adhere. Below is an abridged version of those values and principles, as summarized by the BC First Responders' Mental Health.

Primary values

- Self-determination, self-resiliency and equality: the belief that each person knows the path towards recovery that is most suitable for them and that it is the peer's choice to engage in a peer support relationship.

- Self-compassion: the belief that empathy increases self-compassion, minimizes moral injury and reduces stigma around seeking help.

- Mutuality and empathy: the belief that all involved in the peer support relationship can benefit from the reciprocity and understanding that comes from lived experience.

- Recovery, hope and empowerment: the belief that there is power in hope and positivity and that these can aid in recovery.

Principles of peer practice

- Respect where each individual is in their journey towards empowerment and/or recovery and recognize that while peer supporters may have lived experience, the beliefs and healing paths of peers may not be the same as their own.

- Help peers normalize or destigmatize their distress, and encourage resilience through compassion and self-compassion.

- Help peers to determine their own direction. Work with peers to identify and explore options, and support them to take steps forward on their own rather than "helping" by doing it for them.

- Create a peer relationship that is open and flexible and maintain the focus on the peers and their needs. Ask yourself: "Are we in a safe place in the client's eyes?"

- Focus on positivity and on the peer's journey to a more hopeful, healthy and full life, rather than focusing on symptoms, diagnoses or objectives set by someone other than the peer.

- Share aspects of lived experience in a manner that is helpful to the client, demonstrating compassionate understanding and inspiring hope for recovery.

- Self-care is essential to the well-being of the peer supporter. Take care to recognize the need for health, personal growth, and resiliency when working as a peer supporter.

- Use communication skills and strategies to foster an open, honest, non-judgmental relationship that validates the peer's feelings and cultivates trust.

- Empower peers to find their path towards a healthier outcome, and encourage them to disengage from the peer support relationship when the time is right for the peer.

- Respect professional boundaries with the peer and with other professionals should they become involved. It might be useful to establish whether the relationship is a short term or long term one.

- Collaborate with others (community partners, mental health practitioners, leadership, other stakeholders) whenever appropriate.

- Know personal limits during crises and other times, and seek assistance when appropriate. Peer support work can be intense and experiences very challenging and as such, peer supporters need to understand the importance of taking care of themselves.

- Maintain high ethics and personal boundaries to avoid harming the peer or the reputation of peer support.

- Participate in continuing education and personal development to learn skills and strategies to assist in peer support work.

Building a program

The working group members for this section of the manual committed to offer practical advice and make concrete recommendations that would be valuable for individuals in healthcare organizations who were in the process of implementing a peer support program. We hope that by sharing their experience on how they developed their own peer support programs, and gleaning the most useful information from other key resources, we will help others who are establishing a peer support program.

Initiating the program

The main driver for initiating a PSP in the organizations is the recognition of the importance of mental health and wellness for individuals in their workplace, and a commitment to improve it. However, the catalyst for initiating a program in a healthcare organization varied somewhat among organizations.

For some organizations, the catalyst was a specific critical incident or trauma that had a significant emotional impact on staff, prompting the organization to take action so as to be prepared for future incidents and enhance the organization's response to them. In fact, more than one organization noted that the need for the PSP was driven by a critical incident.

For others, organizational leaders officially acknowledged that stresses and traumas were affecting the workplace – with one organization calling it a "trauma-infused environment" for example – and identified the need for emotional support for their staff and committed to promoting wellness. As an example, the RISE second victim programme at the Johns Hopkins Hospital was initiated because: "… patient safety leaders recognized a gap in the ability of the institution to provide consistent and timely support to second victims"[1]. The genesis of the peer support program at the Brigham and Women's Hospital was simply their "observation that clinical staff were suffering following adverse events"[2].

Some organizations implemented a PSP because they identified a rise in reports related to mental health such as the number of workplace violence incidents, absenteeism due to mental health illness, or the number of staff members accessing the Employee Assistance Program. In some cases, a PSP is initiated because of legislation; for example, many provinces are instituting presumptive legislation for paramedic

services related to occupational stress injuries. This change enables workers to access treatment more readily without have to prove their mental injuries were work related. The expectation of employers is that they are being proactive in managing occupational stress injuries through mitigation and early identification.

Other PSPs were created to support health and safety standards, organizational policies or national standards for a psychologically safe workplace, such as the National Standard for Psychological Health and Safety in Canadian Workplaces. Still others were prompted by unions requiring more mental health support for their members.

In whatever manner the need was recognized, the PSPs mostly grew organically without a clearly outlined process. Step- by-step, each organization put together the building blocks needed to establish a PSP. The following outlines the main building blocks.

Establishing the need

Although PSPs in healthcare are becoming recognized as a crucial service, it is still a worthwhile endeavour to establish the need for a PSP in the organization. Not only does it serve the purpose of substantiating the need for the program to organizational leaders and/or policy makers, but it will also provide valuable information about how best to deliver the program and identify the clients' needs.

The following are some of the tools and methods organizations use to assess needs:

- Questionnaires or "pulse" **surveys**, giving insight into potential clients' perspective of organizational support for their mental health (these were sometimes given out after a presentation about mental health). The MITSS program has a survey tool for clinicians and staff.

- **Interviews and focus groups** with frontline staff and with managers.

- **Management forum** where a presentation was made to all managers and senior executives, followed by a survey of management.

- **External review** of psychological health and safety.

- **Engagement survey** that assesses, for example, how staff rate the stress levels of their jobs, and how their emotional well-being and mental health are supported.

- **Environmental scan/gap analysis** of internal supports already in place (both formal and informal). The MITSS recommends that organizations include in the scan such resources as chaplaincy, social work, psychiatry, employee assistance programs. They also have an organizational assessment tool for clinician support. See Box 4.2 for an example of internal resources to assess.

- **Assessment of current response processes** for responding to critical incidents.

- **Assessment of key performance indicators** for short- and long-term illness should be examined, especially since mental health injuries can result in higher absenteeism and relapse.

- **Helping leadership recognize that early intervention is important,** and that if mental health is not recognized as a priority, this can result in moral injury, stigmatization and poor organizational morale.

- **Unit walkabouts and huddles** in identified high-risk areas, such as the emergency department and ICUs.

- **Review of data** in such areas as workplace violence and harassment, absences due to mental illness, referrals to the EAP or psychological interventions.

- **Pilot projects** to assess feasibility and value of PSP (for example, in one department or unit).

- **Review of standards** for mental health support (e.g. CSA Occupational Health and Safety, Mental Health Commission of Canada, Accreditation Canada, International Critical Incident Stress Foundation).

- **Literature reviews and background research** to gather knowledge on the importance of peer to support for health professionals.

Box 4.2: SickKids Hospital

Example overview of current services that support staff mental health:

- Occupational Health Clinic;

- Health Absence Management Program (HAMP);

- Wellness Program;

- Peer Support and Trauma Response Program;

- SickKids Mental Health Strategy;

- Peer Support and Risk Management Serious Safety Event Protocol;

- Customized mental health training during new nurse orientation period;

- SickKids Mental Health Resources for Staff website;

- Consultation with the Centre for Addiction and Mental Health (CAMH) Work, Stress and Health Program;

- Employee Assistance Program (EAP);

- Psychologist coverage in benefits plan;

- Incapacity in the Workplace policy;

- Prevention of Workplace Violence and Harassment policy;

- Other Human Resources programs and policies including the Engagement Survey;

- SickKids' Mental Health Management Model; and

- Classroom training for people managers on managing health, conduct and performance.

"There are not a lot of places to go for support, so it is very appreciated when it is offered."

(PAMQ/QPHP)

Assembling a team

Wherever the idea was initiated, it is important to assemble a strong organizational planning team to carry it through to implementation, in the form of a steering committee or working group. Members might include organizational leaders, managers and frontline staff from various clinical departments, as well representatives from human resources, occupational health and safety, patient safety/risk management teams, employee wellness teams, spiritual care teams, critical incident management teams, unions or provincial health authorities. Alberta Health Services suggests that team members might be nominated by their peers because they have certain skills or are seen as credible and respected. [See AHS Information for Leaders newsletter, Workplace Peer Support]

These teams – in the form of a working group or steering committee – are responsible for establishing the foundation of the PSP, including goals, policies, procedures and business plan. They might also be engaged in needs assessment/gap analysis, creating a work plan, strategic planning, and implementing, championing and evaluating the program.

"The best thing is feeling that I'm making a difference for

my colleagues in a way that is in tune with my values."

(PAMQ/QPHP)

> **Box 4.3: Examples of a PSP team**
>
> **SickKids**
>
> A steering committee was convened to develop a proposal for the implementation of a sustainable hospital-wide workplace peer support program. The working group included representatives from Occupational Health and Safety, Risk Management, Quality and Safety, Human Resources, Social Work, Facilities, Clinical Programs, Physicians and the Caring Safely project team and steering committee.
>
> **Johns Hopkins Hospital's RISE program**
>
> The PSP team included leaders in patient safety, risk management and clinical departments, who gathered to discuss "the magnitude and importance of the problem, current infrastructure to support healthcare providers, stories and experiences, and strategies to improve the system"[1]. They then put together a multidisciplinary "Programme Development Team" – including the director of patient safety, a physician faculty member, a risk manager, a patient safety researcher, a nurse manager and a hospital chaplain. to lead the strategic planning and implementation.
>
> **St. Michael's Hospital**
>
> An interdisciplinary group of healthcare and non-healthcare staff and trainees (i.e. physicians, nurses, social workers, clerical staff, security personnel) participated in two iterative design workshops facilitated by a design specialist. They and worked together to identify a program framework and prototypes, then test-drive and explore the feasibility of the design team's prototypes.

Identifying the goals

Establishing a clear goal for the PSP is a key contributor to the success of a program. This goal ensures that all levels of the organization understand the purpose and value of the PSP, and stay focused on what they are trying to accomplish.

The following are sample elements that might be embedded in the goals for a PSP, drawn from a selection of goals of established PSPs:

- safeguard the well-being of individuals at the organization;

- allow individuals time to collect themselves and reflect immediately following an incident;

- assist in the recovery of individuals who experience critical incident stress;

- help individuals maintain and/or return to health;

- prevent more serious occupational stress injuries and illness;

- provide reassurance and reduce the stigma of mental illness;

- promote resilience;

- provide referrals, resources and links to other support services, and activate appropriate psychological interventions as required;

- help individuals understand that their reactions are normal and expected;

- enable health professionals to continue to function effectively in the workplace; and

- reduce absenteeism.

Box 4.4: Sample Goals

PAMQ/QPHP

To prevent mental health problems among physicians, foster early identification and appropriate treatment of their problems, and help them stay in their job, or enter or re-enter the labour market.

RISE second victim support programme

To foster a culture in which all employees are resilient and mutually supportive before, during and after stressful events. To provide timely access to support employees' immediate needs to complement the services being offered by the existing employee assistance programme"[1].

Brigham and Women's Hospital

To provide a safe way for clinicians impacted by events to talk about their experience and emotions with someone who has empathy from having "been there"[2]. [see Brigham's FAQs]

MITSS

To assist affected individuals to process adverse medical events in a positive manner in order to move forward both personally and professionally[3].

St. Michael's Hospital

To provide immediate response to staff (medical and non-medical) and trainees who may be having emotional distress from being involved in a negative patient care interaction.

The goal of the program can be tied to long term outcomes for the organization, such as one that fosters a just culture of transparency or a resilient workforce, or to outcomes more specific to the program – such as one that provides emotional support to health professionals after a critical incident. They can also be linked with the "five rights of second victims" outlined by Denham[4]: treatment, respect, understand and compassion, supportive care and transparency and opportunity to contribute to enhancing the systems of care.

> **Box 4.5: Examples of Outcomes tied to the PSP**
>
> **Center for Professionalism and Peer support (Brigham and Women's Hospital)**
>
> We strive for three primary outcomes: to help the impacted clinician with emotional healing and wellness; to facilitate early reporting of adverse events, and to enable and promote compassionate and transparent disclosure and apology. [See the Center's Peer Support FAQs]
>
> **SickKids Hospital**
>
> By implementing policies and programs to enhance psychological health and safety and support mental well-being, we will improve staff and patient safety and productivity, and reduce the risk of errors, staff turnover, absenteeism, presenteeism (working while sick), second victim effect, and disability claims. Overall desired outcomes include the following:
>
> - Establish a sustainable program to provide support to staff members who are struggling with emotional distress or mental health conditions.
>
> - Create a safe environment at SickKids to encourage staff to seek assistance for emotional distress and mental health conditions.
>
> - Create a resilient and psychologically healthy workforce.

Partnering with leadership

It is imperative that the PSP has foundational support from those in the organization who will contribute to its success. This means getting buy-in from the organizational leadership, managers and those who will be served by the PSP.

Getting buy-in from senior leaders is not always as big a challenge as expected; in fact, our working group members often noted that "there was no argument" from senior leaders, as many already recognized that the need for a PSP was significant. In the same way, most managers also supported the PSP and were on board right away.

Still, there may well be resistance from leadership or management within the organization. Even the current climate of promoting the well-being of health professionals in the workplace does not mobilize senior leaders as much as it should. The RISE program at Johns Hopkins Hospital noted that one of the biggest challenges was the "limited awareness of the magnitude and importance" of the issues[1].

Some of the tactics used to bring senior leadership on board included:

- Providing evidence from a needs assessment or staff survey that clearly demonstrates the need for better emotional support as a result of workplace critical incidents.

- Clearly stated goals that demonstrated the benefits of the program to the organization (e.g. more resilient workforce, decreased absenteeism, improved patient safety).

- Assembling a team that was representative of relevant and various areas and levels of the organization.

- Sharing a video of a champion of mental health after a critical incident, thus humanizing an experience. CPSI's provider experience videos are powerful examples of such testimonials.

- Committing to clear lines of communications to senior leadership throughout the initial stages of the development of the program, and ongoing reporting to keep them apprised of its progress.

- Collaborating with the union(s) if applicable, ensuring they understand the purpose and benefits of the program.

- Educating leadership about the benefits of peer support whenever the opportunity arises (e.g. regular meetings, workshops, training sessions, manager and director forums, townhalls, HR community quarterly meetings, etc.).

- Creating a roadmap to take the organization from "we've never thought about having a peer support program" to a fully implemented and sustainable program.

- Provide a case study or story of a critical incident where staff were not supported (with a less than ideal outcome) and one where staff were supported (with a more positive outcome).

- Demonstrating return on investment (ROI) with data and statistics such as absenteeism due to mental health illness.

- Explain the importance of adhering to standards for mental health in the workplace.

The MITSS Clinician Support Tool Kit for Healthcare also provides a list of several resources under the headings "Internal Culture of Safety," "Organizational Awareness" and "Leadership Buy-in" that might help change the mindset of some more resistant leaders and staff, and prepare the organization for the establishment of a peer support program.

Once some of these steps have been taken, it is a good idea to take the time to assess leadership understanding and readiness before moving forward.

Operational policies and structures

Once the kernel of an idea begins to grow – whether it starts with an informal conversation, a reaction to a serious critical incident, or a formal organizational response to growing mental health issues among staff – it is time for the team to begin to formulate a strategic and/or organizational plan and implement the policies and build the structures required to build the foundation of a PSP.

A cautionary note expressed by our experts was that it is likely to take more time than expected to implement a PSP. Even the well-known RISE program at Johns Hopkins Hospital noted "there were relatively few calls in the first year of operation" and "the greatest challenge was getting staff members who could benefit from the programme to use it"[1]. Their suggestion is to "start slow and steady, and start with where people were at" and expect a few challenges along the way.

There are many questions to answer, and decisions to be made about such issues as who should own the program, how the program will be set up, how to recruit, train and compensate peer supporters, how staff will be connected or referred to the program, and how will the program be staffed and/or resourced.

The process of implementing a PSP is often underestimated by people who are keen and have good intentions to help their colleagues. However, if this team of individuals with good intentions has a conviction that a PSP is crucial to the well-being of their colleagues, uses an informed selection, recruitment and training process for peer supporters, and is willing to work through some of the steps described in this manual, they will have an excellent chance for success.

Instituting a policy

One of the most important steps in establishing a PSP is to institute a policy that outlines exactly what the program is, how it is structured, and how it will be implemented.

Some organizations began with existing policies – such as policies for employee wellness, just culture, occupational health and safety – and adapted them to include a PSP. These policies might include elements of peer support that are not yet formalized.

Others created a policy that was specific to the PSP. This process could be lengthy, with many iterations of the policy, especially as the concept of peer support or critical incident management might be new to those creating the policy, and many decisions have to be made about the mechanics of the program.

Below are suggestions for both the foundational and operational elements that might be included in an effective PSP policy, which was informed by the B.C. First Responders Mental Health Committee Developing a Peer Support Policy and the SickKids Trauma Response and Peer Support Policy, both available in our Tools and Resources section:

Foundational elements:
1. **Policy statement:** The policy statement should outline the purpose, goal and scope of the PSP, who is served by it and how it will benefit the organization.

2. **Definitions**: Provide a clear definition of peer support, how it will operate in your organization, and how it can assist health professionals who have mental health challenges. There might also be other terms you need to define, such as "peer supporters," "critical incident" or "mental health and well-being."

3. **Interventions:** Provide details of what type of interventions and services are available through the PSP (and what is not available, if this provides further clarification).

4. **Fit within organizational structure:** Clarify how the PSP is related to existing supports for staff and under what department or group will it be housed (e.g. employee assistance programs, human resources, wellness programs, occupational health and safety). The MITSS Clinician Support Tool Kit for Healthcare provides a number of examples for where the support program could be anchored, under the heading "Operational" on page 7. Wherever it is housed, our working group recommends that, to be most effective, peer support needs to operate autonomously (i.e. that it is a confidential safe space away from the operational arms of the organization) and be a core component of an organization's mental health system.

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5. **Resources:** Outline how the organization will commit to developing and maintaining a peer support program, including such elements as support for peer support members (including regular and ongoing training, and psychological oversight to gauge their health and resiliency), salaries for staff running the program, promotional materials, appropriate benefit resources, or secure privacy and communication equipment.

6. **Evaluation:** Determine the timeline for reviewing the policy, and for ensuring the PSP is achieving its purpose in supporting the mental health and wellness of health professionals. Identify the metrics that will be tracked to assess utilization and quality of programming.

7. **Communication** strategy both within the program and how program interfaces with hospital.

Operational elements:

1. **Clients:** Outline who will be supported, identifying precisely to whom and in what circumstances the policy will apply.

2. **Process:** Outline how the PSP will be activated, or how and when a worker will be connected or referred to a peer supporter.

3. **Responsibilities:** Explain the responsibilities of managers and supervisors as well as staff, peer supporters and peer program managers or coordinators.

4. **Confidentiality and documentation**: Provide details on how the PSP will maintain confidentiality.

It is important to put in place a plan to inform those who work at the organization about the policy, so that all are aware of the implementation of the PSP. This could be done through presentations or written literature on the program. Depending on the scope of peer support being offered, consider what training will be provided to raise awareness and understanding of peer support among all those in the organization who may access it (see section below on "Training").

The B.C. First Responders Mental Health Committee provides a underline for creating a policy that is specific to first responders, but can effectively be adapted to PSP for other health professionals.

The operational elements of the program will now be explored further.

Implementing the program

Clients: Who will be supported

There was clear consensus among our experts that a PSP should, if possible, be one that is inclusive rather than exclusive. This is to say that we suggest that PSPs be open to all levels and all groups of clinical or non-clinical staff, and also include volunteers, students, trainees or anyone who might be affected by a critical incident, experiencing stress or affected by emotional trauma in the workplace – as long as there are appropriate peer supporters available. As noted by one working group member, "our peer support program is open to anyone who wears a SickKids badge" or anyone who is identified as officially working at the organization.

Some of the organizations were targeted to a specific audience, but their PSPs were more inclusive than exclusive, and aimed to reach the broadest client base within their parameters. For example, the OCISM

notes that support is offered to all nurses working in First Nations communities including those employed by FNIHB, Band, agency, and nursing students.

Whatever the organization decides, a clear statement within the policy explaining who will be supported by the PSP is essential.

Process: How will the PSP be activated and followed through?

The process to determine how the need for support is identified or the PSP is activated can be challenging, but is a key element of establishing the structure and procedures for the program. Decisions will need to be made that are related to three key questions:

1. How is a worker connected to the PSP?

2. What types of issues are supported?

3. What is the process once the PSP is activated?

The following sections will provide advice and examples to help make those decisions.

How is a worker connected to the PSP?

There are many mechanisms that can connect a worker to a PSP. The most common mechanism is self-referral, where an individual calls a telephone number to reach the PSP directly. Some programs also have an email address for an individual to connect with the program, or have set up a paging system.

Box 4.6: Paging system in the RISE program

The RISE pager number and an intranet call button activate the RISE pager. The on-call RISE peer responder responds to the pager by calling back within 30 minutes, and planning a meeting (encounter) with the caller – ideally within the next 12 hours.

It is sometimes the case that a supervisor – such as a program director, manager, team lead or preceptor– will recognize that one of their staff members is in need of support. (see sections below on "Responsibilities of Managers and Supervisors"(p. 154) and "Other Training Considerations"(p. 172). Managers and supervisors can call the PSP themselves to alert them to the issue with the individual. In this case, some PSPs will arrange for a peer supporter to get in touch with the individual, at which point he or she will have the opportunity to accept or decline the service. In other PSPs, the peer supporters do not reach out to individuals when a call comes in from a concerned third party because of confidentiality issues or because the individual might not be open to talking when they have not been advised. In this case, the PSP will more likely assist the third party with their concerns regarding the colleague they are calling about and support them in helping the colleague access the PSP.

SickKids follows a process in the event that there is a referral for their PSP, as per their Peer Outreach flowchart.

The Center for Professionalism and Peer Support suggests that in cases where an individual is referred by someone other than themselves, the peer support call the individual and state: "I am calling as a peer supporter. I heard things didn't go well yesterday, and I'm calling to find out how you are doing. Would it be helpful to talk about your experience?"

Counsellors or therapists associated with the EAP or OH&S programs might also refer individuals to the PSP, or contact the PSP themselves to identify an individual who might benefit from their services. It is usually the case that the PSP will not be engaged unless the staff person has asked the individual if they can be referred.

A colleague of an individual might also call the PSP to talk about someone they are concerned about. The peer supporter might then give advice on how to talk to the colleague, or how to encourage them to contact the PSP themselves.

Another circumstance in which the PSP is activated is where there are many involved in an event who are traumatized or emotionally distressed. This might be a suicide by a staff member, an unexpected patient death or, in the case of first responders, during a disaster (such as wildfires or mass casualties, for example). Chiefs of staff, managers, supervisors or others involved in the management of such an event, and even sometimes staff who identify that many of their colleagues have been impacted by an event, decide to proactively activate the PSP. The PSP is therefore activated for a group of individuals, and results in a group intervention.

SickKids follows a clear process when a traumatic event occurs, as per their Peer Trauma Response flowchart.

Some organizations use proactive methods for engaging the PSP. For example, the PSP at one organization (SickKids) coordinates a morning safety call to capture what has occurred overnight as well as an evening safety call to get a pulse on what has transpired during the day to know how to intervene overnight. They look for out-of-the-ordinary outcomes that may have led to emotional distress, then check in with any individuals involved to make sure they are alright, refer them to appropriate resources such as the EAP or spiritual care team and /or activate a group intervention with the team involved. These proactive steps help mitigate risk of critical event by anticipating resource needs and deploying appropriate resources.

> "Once the program was established and proved its worth, we were able to focus on delivering excellent program services rather than justifying why it was needed."
>
> (OCISM)

BCEHS uses the standard International Critical Incident Stress Foundation (ICISF) list:

Figure 4.1: Top 9 CIS Triggers

Top 9 CIS Triggers
Suicide of a colleague
Line of duty death
Disaster or multi-casualty incident
Significant events involving children
Prolonged incidents ending in loss
Excessive media interest
Event with threat to staff safety
Serious on the job injury
Work on relatives or known victims

What types of issues are supported?

Individuals seeking support might be experiencing distress in the form of anxiety, depression, PTSD, burnout or compassion fatigue, which can result from a variety of emotional issues as described in the definition of a PSP [p. 13 of this manual]. It is important to be clear about what emotional issues will be supported by the PSP. The most effective way to determine this is to build from the definition of a PSP. It is especially important to be clear as to whether the PSP is for patient safety incidents only (as are many of the established programs in the US) or for other issues such as critical incidents/ traumas and other work-related stress as outlined in our definition of a PSP.

Box 4.7: OCISM

Example of proactive method for engaging the PSP:

OCISM

In the OCISM program, peer supporters review occurrence reports and proactively follow up to see how nurses are doing. They provide advice on self-care, and allow them an opportunity to discuss the event, with the purpose of averting a more serious response to a critical incident.

What is the process once the PSP is activated?

Once a call is made to the PSP, the next step is to assign a peer supporter to the case. Whether the call is channeled to a staff member of the PSP or to the peer supporter on call, these individuals are responsible for connecting a peer supporter to the individual in need. They will gather enough information about the individual and the incident so that they can create an action plan.

An important part of the plan for proceeding is identifying the most appropriate individual to match with the person in need. This might mean matching for profession or role, license level, years of experience, rural vs urban, work experience or gender, for example. In some cases, however, organizations have found that it is a peer supporter who knows little of the work of the affected group or individual who is a more objective – and helpful – resource. The assignment of a peer is therefore often managed on a case-by-case basis; what is important is that the peer matching creates a "safe place" for the individuals seeking help.

Box 4.8: Matching peers

Centre for Professionalism and Peer Support (Brigham and Women's Hospital)

It is often helpful for clinicians to feel the peer supporter has "been there" and understands the stakes. In other instances, speaking with a colleague from another discipline helps a clinician feel less judged or stigmatized… We avoid having a junior faculty member provide peer support to someone more senior; and it is also important that the peer supporter not be someone who, in other contexts is responsible for evaluating the clinician's performance.

[www.brighamandwomens.org/assets/BWH/medical-professionals/center-for-professionalism-and-peer-support/pdfs/peer_support_overview_and_faq.pdf]

In some organizations, individuals with formal mental health credentials – such as psychiatrists or psychologists or social workers– are assigned to clients with evidence of severe trauma.

Depending on the structure of the PSP, there may only be one or two peer supporters on call at the time, or the availability of peer supporters might depend on those who happen to be currently in the workplace.

It is also decided on a case-by-case basis when the intervention takes place. In a study done by the RISE program, the researchers found that the preference expressed by participants ranged from as soon as the event happened (12.7%) to within a few hours after the event (25.4%) to within a couple of days (48.2%) and after a week (8.1%)[1]. Most organizations try to get back to the individual in a timely manner, at least to connect and find out how urgent the need is.

Peer support is mostly provided in-person – or by telephone if the client prefers – in a suitable environment that is quiet and private.

It is recommended that support be rendered immediately, or as soon as possible after the PSP is activated[5]. Some peer support interventions might be a one-time support, and some might include follow-up or ongoing support if this is indicated or requested. It is also sometimes the case that peer supporters are there to provide immediate and urgent support, then connect the clients to other resources or supports as appropriate. Scott et al[6] suggests that there are three tiers of emotional support for a health professional: tier 1 is immediate emotional first aid to make sure the individual is okay; tier 2 is support from peer supporters; tier 3 is expedited referral to professional counselling.

Box 4.9: Sample process to activate PSP

Chatham-Kent Health Alliance

The following process is written into the Chatham-Kent Health Alliance policy, and is a useful example of the steps in a PSP once it is activated:

- When a need arises, a message is sent to all peer supporters through WhatsApp.

- Preference will be given to activating supporters who are currently in the workplace (i.e. before calling in team support who are not working)

- The on-call Peer Support Group member shall immediately upon request of services assess the nature of the incident, the needs of those involved, and the 5 T's (themes, targets, types, timing, team) so that appropriate action may be initiated.

- The on-call Peer Support Group member will begin a plan of action based on the 5 T's that may include scheduling a date and time with the individual(s) involved for various Peer Support Group services, or immediate referral.

- Periodically, the member(s) providing services will speak with fellow Peer Support Group team member(s) for a personal debrief to evaluate the services rendered and discuss any positive and negative feedback methods for improvement and anything that can help.

- No notes shall be taken during any intervention, but basic records should be attempted following the intervention.

Responsibilities of managers and supervisors

In the policy for the PSP, it is important to clearly outline the responsibilities of managers and supervisors, who often have an important role in encouraging an individual to seek support, or referring them to the PSP. They should not be left out of the organizational response to critical incidents.

Managers and supervisors need to be trained to recognize the signs of distress, and given clear instructions on how and when to refer their staff to the PSP (see the section on "Other training considerations"). The following is the BCEHS list of signs and symptoms of critical incident stress (CIS) to look for in a staff member [www.bcehs.ca/health-info/support-for-bcehs-family-members/critical-incident-stress/signs-and-symptoms-of-critical-incident-stress], which complements their leadership training about

the mental health and identifying when management responsibilities decrease and health care supports increase.

Figure 4.2: Top 10 CIS Signs & Symptoms
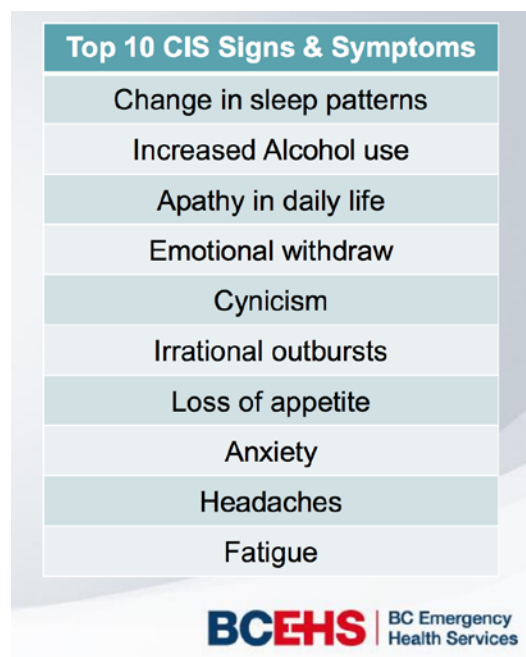
Managers and supervisors might encourage their staff member to call the PSP, provide details on how to do so and reassure them that it is a confidential service that is fully supported by the organization. They can also support their staff member by reassuring them that they continue to have complete trust in their professional abilities, and that they are important to the team[5]. The OCISM's "Tips for Supervisors and Managers of Employees Involved in a Traumatic Event" are a useful resource.

The following are examples of leaderships steps for managers and supervisors help support their staff:

- Connect with the individuals as soon as possible, in private, and express your concern. Let them know you care.

- Reaffirm confidence in them.

- Normalize their response to the situation, and self-disclose (briefly) if possible or appropriate.

- Explain what services are available to them, including the PSP, and how to access them.

- Reassure them of confidentiality the of your interaction and the available services.

- Notify staff of next steps, and keep them informed.

- Assess the individual's fitness for duty (physical and mental). Direct them to supports such as an Occupational Health Clinic, a family physician, a walk-in clinic or an ER (if after hours).

- If an individual needs to leave work, take steps to ensure their safety and ensure the individual is okay for travel or being at home.

- Consider calling in replacement staff.

- Monitor and check in with the individual regularly.

"We have a new group of peer supporters that started up in the summer. The group was so committed they've since been able to gain the trust of their team. That is success."

(Alberta Health Services)

Central Health proposes Denham's five human rights[4] for those involved in a critical incident, which all staff can easily remember with the acronym TRUST:

Figure 4.3: Five Human Rights

Five Human Rights
Treatment that is just
Respect
Understanding and compassion
Supportive care
Transparency

"Within 2 or 3 months of creating awareness about emotional distress after a critical incident, we had a critical incident. It paid off because rather than leadership swooping in, we helped leadership be accountable and step through the helping process. The client who was most affected said 'this is the first time in 25 years that a manager called to see how I was doing."

(Central Health)

There are a number of key phrases and key actions managers and supervisors can use to support their staff members[7].

Key phrases:

- "This had to have been difficult. Are you okay?"

- "I believe in you."

- "I cannot imagine what that must have been like for you. Can we talk about it?"

- "I can see this case hit you – it happens to us all sooner or later."

- "I need you to [suggest a very simple action] now. Can you do that?"

- "When we get through this situation, we will help you come to terms with what has happened…and get you support."

- "You are a good nurse/ doctor/ pharmacist/ volunteer/ student working in a very complex environment."

- "It's human to make errors."

- "It's common to think about it and lose sleep."

- "The fact that you are upset shows that you are a caring, committed health professional."

- "Over time, the feelings gradually lessen."

- "Remember all the good you have done."

Box 4.10: Do's and Don'ts for managers and supervisors

DO's:

- DO Be present;

- DO Practice active listening;

- DO Allow staff member to share the personal impact of their story; and

- DO Reaffirm confidence in their skills.

DON'Ts

- DO NOT condemn or second-guess their performance;

- DO NOT downplay their reactions or emotions; and

- DO NOT undermine their confidence or competency.

Confidentiality and Documentation

It is generally acknowledged that confidentiality is the cornerstone of the policy and of the PSP. Confidentiality is especially important to health professionals who fear being perceived as vulnerable or weak for seeking mental health support and, particularly with respect to patient safety incidents where they fear exposure to legal or disciplinary actions[1]. It is therefore important to be clear in the policy – and to the health professionals – that the organization will make every effort to maintain confidentiality within the PSP. It is also important that peer supporters make clear the limits of confidentiality to those they are supporting.

A detailed explanation of how best to maintain confidentiality and what is protected by legal privilege is provided in the section in the manual entitled "Addressing Confidentiality for Peer-to-Peer Support Programs for Health Professionals." [see Section 3]

One of the key recommendations about confidentiality coming out of this work is that PSPs should maintain minimal documentation about those seeking support. If any information about the clients is collected, then there are strict protocols for maintaining the confidentiality of the records such as keeping them in secured shared files on secured computers, accessible only to the coordinators of the program. The data collected should be kept for statistical and evaluation purposes only such as to help those responsible for the PSP review their processes, evaluate trends in the workplace, and determine whether there are proactive solutions to prevent critical incidents from adversely affecting their staff.

Regulated health professionals who are providing the support (such as physician-counsellors, social workers, or psychologists) should consult the appropriate legal resources concerning regulations about documentation. This not only protects confidentiality of the clients, but also protects peer supporters who are using their credentials to provide the support.

As noted in Section 3 [of the manual on Confidentiality], there are exceptions to confidentiality, such as when there is a risk for self-harm or harm to others.

> "Peer support means providing a safe and non-judgmental space for another to be heard, understood, and helped in a kind and compassionate way. It also means to be of service to another by being present moment by moment, empathetic, curious and trusting that the person I'm supporting is resourceful and whole internally despite their external circumstances."
>
> (Karen W., Pharmacist, Peer Supporter, SickKids)

Peer supporters

The peer supporters of a PSP are an integral component of the program, and the most important factor for its success. As such it is crucial that those implementing a PSP pay much attention to selecting, training and supporting them. The peer support role is typically voluntary and needs to be fully supported by management.

Role

It is the responsibility of peer supporters to understand their role and its boundaries and to be committed to the values and principles of the program.

Peer supporters also need to embrace their role as someone who helps their peers to leverage their own resilience, allowing them to heal themselves. It is also important that peer supporters avoid pathologizing what are normal reactions to stressful situations, and help normalize the emotions and feelings their peers are having.

Most importantly, peer supporters must recognize that they are not providing professional psychological support – they are not clinical therapists, nor are they providing psychological or psychiatric counselling.

The role of the peer supporter is to listen and coach. This means that they avoid diagnosing or providing psychological treatment to the clients, or determining solutions or directing their decisions. Peer supporters provide non-clinical emotional support to individuals in the form of empathetic support, active listening, encouragement and information about resources and other supports available to them. Although peer support can be offered on its own or as a complement to clinical care, a peer supporter does not take the place of a clinician and should not aim to "fix" a fellow employee.

It is also important to establish and maintain boundaries within peer support relationships between a professional and personal relationship. The BC First Responders' Mental Health PSP notes the following points that are worth considering when determining boundaries:

- Communicating boundaries early in the peer support relationship can be helpful in managing expectations. This might include setting limits on time or location — for instance, agreeing that peers may contact peer supporters only up to a specific time of day or that they cannot approach peer supporters while they are on a call.

- Those offering peer support should be friendly and compassionate but maintain a professional relationship. There can be a fine line between a helping relationship and a friendship. When the relationship becomes too personal, the peer support relationship should be ended.

- Establishing a back-up peer, or having oversight from a peer support coordinator or a psychologist, can assist when the boundaries appear to shift. If the relationship becomes close or inappropriate (if it becomes too intimate or sexual in nature, for instance), being able to hand off the file and extricate oneself from the relationship helps to keep peer support ethical and ensures that the peer who is need of support has someone else who can take over with an understanding of that person's needs.

- Peer support training should be provided on how to recognize when the peer supporter is becoming too involved or when the peer seeking help is becoming too dependent.

Another key distinction to establish is that the discussions between the peer supporter and the client should be primarily emotion-focused rather than problem-focused[8]. A problem-focused conversation is one that pays attention to facts (e.g. learning from mistakes, seeking information, determining what transpired, dealing with the problem itself) whereas an emotion-focused interaction addresses feelings and actions to help the individual move forward. The peer supporters are also there to provide referrals and/or identify resources as part of a constructive helping process.

For a fulsome description of the scope of the role of a peer supporter and their code of conduct, the SickKids "Scope of the Peer Role" and the Peer Support Program Code of Conduct, along with the BCEHS CISP peer support manual (Appendix C) are excellent resources.

Attributes

Certain characteristics contribute to the effectiveness and quality of a peer supporter. The following are some of the key attributes that have been inspired by both the MITSS, MHCC and BC First Responders Mental Health:

- empathetic, respectful, and non-judgmental;

- skilled at communicating and active listening to encourage openness and honesty;

- capable of critical thinking to assist the peer to discuss concerns, determine the peer's true needs, and detect when a peer is nearing or in crisis;

- emotional maturity;

- ability to gain trust of clients;

- culturally aware/sensitive;

- keen to learn and build peer support skills and accessible for team activities;

- committed to confidentiality (within legal limits); and,

- ability to work within established guidelines.

"There will always be that feeling of uncertainty....will I be able to help? Will I say the right things? How will I know what to do? What if I miss something? Being a peer is not about having the right answers and knowing exactly what to do or say because reality is you won't always be on point and no one expects you to be. Being a peer is about realizing you have been given an opportunity to step into someone's life. Recognizing the difficulty and courage it takes to seek out for help and express one's vulnerabilities. Realizing they are seeking for support/guidance, resources and a steer in a direction to help them through a challenging time. It's about being sincere, honest, offering practical suggestions, actively listening, checking in/following up, being genuine and being in the moment with them as best as you know how to be. For me being a peer is knowing small sincere efforts can go a long way. It is a challenging yet humbling experience. Every time I willingly step into a peer's life a part of their journey stays with me. Each experience is unique and motivates me to continue learning and growing both professionally and personally."

(Neelam W., RN, Peer Supporter, SickKids)

Box 4.11: Requirements for peer supporters

Alberta Health Services

Peer supporters are those who are:

- respected by co-workers and would go to for non-judgmental support;

- considered trustworthy by co-workers;

- have good communication skills, i.e. listening, eye contact, body language;

- shows concern and cares for co-workers' well-being;

- a mature individual, responsible, good work habits and a minimum two years with AHS;

- is working a position of at least .8 to full-time equivalent (negotiable) and days/nights, for easy accessibility as a peer supporter;

- is elected by his/her peers (with references from manager and peers on application);

- demonstrates good coping skills and a positive attitude;

- is committed to being available to assist with crisis intervention;

- is interested in the Peer Trauma Response Team and is interested in supporting his or her peers; and

- is able to leave their workplace to respond to an incident when necessary.

Another key attribute for a peer supporter is that they share lived experience similar to the clients who will be seeking help. In other words, they are health professionals who themselves have experienced emotional distress related to their work in healthcare, or who have had mental health challenges. This enables them to have empathy towards the clients and been seen as non-threatening by the clients. It is important to point out, however, that peer supporters should be recovered from this distress or have overcome their mental health challenges, to the point where they are able and ready to support a peer.

Peer supporters should also ideally be aligned with the values and principles of peer support. Box 4.12 provides a number of examples of values that define peer supporters.

Box 4.12: Core values expected of peer supporters

MHCC
[https://www.mentalhealthcommission.ca/English/document/18291/peer-support-guidelines]

- **Hope and recovery:** acknowledging the power of hope and the positive impact that comes from a recovery approach.

- **Self-determination:** having faith that each person intrinsically knows which path towards recovery is most suitable for them and their needs, noting that it is the peer's choice whether to become involved in a peer support relationship.

- **Empathetic and equal relationships:** noting that the peer support relationship and all involved can benefit from the reciprocity and better understanding that comes from a similar lived experience.

- **Dignity, respect and social inclusion:** acknowledging the intrinsic worth of all individuals, whatever their background, preferences or situation.

- **Integrity, authenticity and trust:** noting that confidentiality, reliability and ethical behaviour are honoured in each and every interaction.

- **Health and wellness:** acknowledging all aspects of a healthy and full life.

- **Lifelong learning and personal growth:** acknowledging the value of learning, changing and developing new perspectives for all individuals.

PAMQ/QPHP
(from the website http://www.pamq.org/en)

- **Confidentiality:** Maintain the highest standards of confidentiality and discretion to protect our clients' identity and privacy.

- **Respect:** Empathy and consideration. Being open and non-judgmental when faced with a situation, its consequences and the emotions it triggers. Impartiality.

- **Integrity:** Our actions are guided by the observance of our organizational values. Decency, honesty toward clients, colleagues and partners.

- **Knowledge sharing:** Sharing knowledge with a view to improving physicians' health. Sharing innovative intervention methods aimed at broadening the scope of action taken to foster physicians' well-being.

- **Teamwork:** Show respect for others' skills by working cooperatively and pooling knowledge (regarding resources, partners and colleagues).

> **Box 4.12 (continued): Core values expected of peer supporters**
>
> **Peer Support Canada**
>
> - hope and recovery;
> - empathetic and equal relationships;
> - self-determination;
> - dignity, respect and social inclusion;
> - integrity, authenticity and trust;
> - health and wellness; and
> - lifelong learning and personal growth.

As a final note, peer supporters are held to a high standard when it comes to conducting themselves in a professional manner, whether they are acting as a peer supporter or are in their regular role in the workplace. Any confidentiality breaches or ethics violations on their part reflects poorly on the team, and the organization needs to be clear that peer supporters should not behave in a manner that will discredit or erode trust in the PSP.

Recruitment

The recruitment and selection process for peer supporters is critical. Some organizations use an elaborate process that includes nominations, references, psychological screening and panel interviews to select peer supporters; for others, the process is less formal. Whatever the process, it is important to ensure the PSP has the right people on board or the right cohort of peer supporters; if not the PSP will not be successful. If an organization does not recruit the people with the right personalities and qualities, then this will impact the credibility, sustainability, optics and implementation of the program.

In some cases, potential peer supporters are recruited through management, who nominate staff they determine meet the criteria established by the organization (as per above attributes) although this may not be suitable in an organization with low trust in management. Alternatively, as the Centre for Professionalism and Peer Support notes, they ask departments to "nominate colleagues who they would want to go to for support."

Figure 4.4 outlines the process used by the former Trauma Prevention and Peer Support Training (TEMA) program used to recruit and select their peer supporters, which demonstrates a thorough selection process for selecting appropriate individuals for this important role.

Figure 4.4: First Responder Trauma Prevention and Peer Support Training Program (TEMA)

Some organizations also invite staff members to nominate themselves. The following is an example of a process organizations might use in this case [see the ForYOU Activation policy].

1. Invitation for expression of interest is posted.

2. Potential peer supporter sends expression of interest or fills out an application form (see Applicant Package and application form for AHS and sample application for the ForYOU program, including two peer references and one manager reference.

3. Psychologist interviews potential peer supporter for mental fitness.

4. Potential peer supporter is interviewed and assessed against criteria such as listening skills, empathic approach, and demonstration of understanding of confidentiality.

5. If accepted, the peer supporter signs a confidentiality and performance agreement.

For an example of the type of information to consider for the recruitment of peer supporters, see the Alberta Health Services' Applicant Package.

Some organizations find it easier at the outset to focus on leveraging internal experts, or staff members who are already trained in counselling or specialized therapeutic knowledge. It is important, however, to make sure that these internal experts are clear on the limits of this role as support and not counselling.

Supporting the supporters

Organizations need to safeguard the mental health of the peer supporters themselves. It is important to recognize that there is a possibility that peer supporters will also experience emotional distress from their work in the PSP, and that they may well need ongoing support. Because of the emotional nature of peer support, even the most resilient peer supporter could be prone to burnout or a mental health challenge.

Monitoring through supervision, mentoring of peer supporters, communities of practice for peer supporters, regular meetings for the cohort and ongoing training are all valuable methods to support peer supporters. As an example, after every encounter within the RISE program, "the peer responder activates a debriefing, in which he/she facilitates a session to receive support from the other members of the RISE team and to provide a learning opportunity for other members"[1].

In addition, it is important to be clear that a peer supporter's commitment is always voluntary, enabling them to step away when they feel they need to — if they find that the work triggers mental health concerns in themselves or if they are simply in need of a break.

The MITSS Clinician Support Tool Kit for Healthcare recommends that the organization provide a "tool box" for each peer supporter to ensure they have all the tools they need to succeed. This tool box could include:

- clear concise description for a peer supporter;

- list of recommended support for referral (if needed);

- list of active listening techniques;

- the do's and don'ts of listening;

- contact list for immediate escalation;

- training; and

- support services available to them.

> "Each year we have managed to get actively suicidal employees into hospital. We have helped employees with substance use disorder (SUD) move into treatment, but we still have a long way to go."
>
> (BCEHS)

Remuneration

It is usually the case that the role of peer supporters is a voluntary one. However, there are a number of details an organization must work out so that they might develop clear guidelines for when the peer supporter provides support during their working hours, or when they are called in to provide support. One clear recommendation from those who have developed a PSP is that organizations should consider the importance of allowing peer supporters time away from their regular work duties to provide the support or to attending PSP meetings. Peer supporters are also entitled to funded training and retraining, travel and other expenses, and appropriate recognition for the volunteer work they do.

Box 4.13: Example of a remuneration policy

Alberta Health Services

Following a critical event, peer supporters will be asked to go to the unit to offer support. The cost of replacing the peer, if they are called to a critical incident while on shift, is the responsibility of the unit the peer comes from and this time will NOT exceed four hours. If peer supporters on shift are unavailable to be deployed to the unit, peers may be called in from home. In the event that this happens these peers will be paid four hours callback pay. The Peer Supporter will submit to the PTRT Administrator a reimbursement form signed by the unit manager. Each peer will not be used as a peer supporter *more than twice a month* to prevent over-use and burnout. This will also help keep the replacement cost to all the units involved the same. Peer supporters will be responsible for attending team meetings and education sessions as covered under their roles and responsibilities. This may mean rescheduling shifts and will be the responsibility of the employee and their manager.

There are cases, however, when the role is an officially paid position, such as with the PAMQ/QPHP- an independent non-profit organization where physician advisors are hired to provide peer support in a structured manner. This is also the case with the OCISM program, where staff members are hired for this role or for a coordination role.

A number of organizations have salaried staff positions to coordinate and direct the program. A good example of a description of the role of a program manager for a PSP is the SickKids program.[see the Scope of Manager, Peer Support Program in the Tools and Resources section.

> "We get a lot of feedback about the difference that we make."
> (PAMQ/QPHP)

Training

Training is an integral component of the PSP. Not only should there be a comprehensive training program for the peer supporters, but it is also important that organizations provide specific training to leaders, managers & supervisors, as well as to all staff in the workplace.

Peer supporters training

Once peer supporters are selected and before they provide any services, they should be provided with training that will prepare them to support their peers who are experiencing psychological distress.

There are a number of external providers who provide training for peer support. Many of these are not focused directly on health services, but might be a valuable starting point for organizations that do not have the internal resources for such training. Some organizations used the following external providers:

- International Critical Incident Stress Foundation training;

- The Institute for Healthcare Improvement's "Building a Clinician Peer Support Program" which is conducted by the Medically Induced Trauma Support Services);

- The MHCC's The Working Mind program;

- Critical Incident Stress Management program; and

- Canadian Mental Health Association (CMHA).

The RISE program at Johns Hopkins Hospital offered psychological first aid (RAPID-PFA) training to their peer supporters; RAPID stands for Reflective listening, Assessment, Prioritization, Intervention and Disposition.

If an organization does have the internal resources and can draw on members of staff such as risk managers, counsellors, EAP provider, wellness team members, spiritual counsellors, or PSP staff, they might choose to develop their own custom-made training program that aligns with their vision and needs for a PSP.

Whether it is provided by an external company, through internal expertise or a combination of both, the training is usually for at least three full days.

Box 4.14: A note on adult learning

Ontario Tech University

PSP training should be a collaborative learning experience where adult learners and instructors learn with, from and about each other's perspectives and related work experience. This relationship requires respect and trust for each other's abilities and challenges.[1] Central to this approach is placing learners at the centre of the learning process[2].

This approach requires ongoing self-reflection on the part of the instructor to better adapt their teaching and evaluations to meet the changing and different learning styles of learners[3]. To that end, the instructor should strive to provide learners with the relevant tools, frameworks, concepts and materials that inform the subject area. They should also use a variety of teaching strategies in an interactive and respectful environment, such as traditional lecture-based learning, problem-based learning, experiential learning and appreciative inquiry learning. The methodologies used should combine both the cognitive (i.e., knowledge), psychomotor (i.e., skills), and affective (i.e., attitudes) domains of learning (i.e., Bloom's Taxonomy). The learning environment should be a safe, fun environment designed to exchange, share and explore new ideas between both learner(s) and instructor.

Continuing education such as PSP training can be conceptualized as an interactive activity involving three phases[4]:

1. **Exposure:** the introduction of the knowledge in the classroom (note the classroom can be online or in the traditional classroom).

2. **Immersion:** introduces learners to interaction with other professions in the classroom and during a simulated training experience to engage in the learning experience.

3. **Mastery:** the incorporation of the knowledge, skills and attitudes into daily professional practice.

To ensure learners have a good understanding of the application of knowledge and skills, evaluation is needed that includes a variety of activities (e.g., group work, presentations, interactive structured class discussion and written reports).

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1 Svinivke, M., & McKeachie, W. J. (2006). *McKeachie's Teaching Tips: Strategies, Research and Theory for College and University Teachers*. (13th ed.). Belmont California: Wadsworth, Cengage Learning.

2 Mulryan-Kyneav, C. (2010). Teaching large classes at college and university level: challenges and opportunities. *Teaching in Higher Education*, 15(2), 175–185.

3 Feiman-Nemser , S. (2008). From Preparation to Practice: Designing a Continuum to Strengthen and Sustain Teaching. *Teachers College Record*. 103:6, 1013–1055.

4 Charles G, Bainbridge L. The University of British Columbia model on interprofessional education. Journal of Interprofessional Care. 2010 January; 24(1):9-18.

Building on the MHCC's list of fundamental topics that should be required learning for peer supporters, we suggest the following basic curriculum.

- Fundamental principles, values, and ethics of peer support, including rules of confidentiality.

- Role and responsibilities of a peer supporter, including knowledge about limits and boundaries.

- Value of leveraging resilience and avoiding pathologizing normal reactions to stressful incidents.

- Cause and variety of common mental health issues for health professionals (compassion fatigue, vicarious trauma, stress, anxiety, burnout, depression, moral distress, post-traumatic stress disorder, serious safety events).

- Explanation of the Mental Health Continuum Model

- Recognizing and overcoming the stigma associated with mental health issues.

- Interpersonal communications and building supportive relationships.

- Crisis management training, to provide knowledge of how to identify and safely manage a crisis situation including:

  - the effect of crisis, trauma, and operational stress on well-being;

  - understanding human stress response;

  - stress management and resiliency;

  - process of recovery and change;

  - self-determination and how to foster it;

  - suicide awareness and intervention (BC peer manual Appendix G); and

  - difference between PTS and PTSD, along with signs of traumatic stress.

- Knowledge of available resources for referral.

- The importance of self-awareness and self-care to maintain one's own wellness and resilience.

- Preparing with the peer for the end of the peer support relationship.

- Review of internal organizational policies and legislation impacting peer interactions.

- Operational aspects of the PSP – mobilization, triage and any tools developed to arm peers with opportunity to assess for risk or to indicate peer engagement.

This training can be adapted to the needs of the PSP in each organization, and expanded as the scope of the program grows. For example, further peer supporter training could be about interpersonal conflicts at work, managing workload stress, grief counselling, or organizational topics such as HR procedures, policies and organizational alignment with other supports.

Peer supporters also need opportunities for continuous learning and development. As noted by BC First Responders' Mental Health, "in addition to ensuring that peer supporters have the skills and knowledge to do the work, training can be re-energizing and help build morale, camaraderie, and a sense of shared purpose and value among the peer support team."

The MITSS program recommends that there should be ongoing meetings with the supporters to review the cases and discuss what is working, what is not working and where they can improve.

Other training considerations

Although the training of peer supporters is the most significant training, others in the organization should also have the opportunity to learn about peer support.

To be successful, PSPs must be supported in principle by leadership and management, so it is important to provide them with a basic understanding of why peer support is important, and how best to support their workforce when there is a critical incident. The RISE program at Johns Hopkins Hospital made sure to train "several directors from units at increased risk for death and adverse events… an action that also corresponded to more calls originating from those units"[1].

Supervisors and managers need to be trained to ensure they identify individuals who might benefit from peer support, so they need to understand what the PSP does and how it can support their staff. The BCEHS developed a list of "What to look for – Any change in four areas of normal behaviour" including changes in physical, psychological, behavioural and cognitive behaviour, available in their Volunteer Peer Team Orientation Manual. The OCISM developed tips sheets including Tips on Coping Following a Traumatic Event and Tips for Supervisors and Managers of Employees Involved in a Traumatic Event to help managers know when there would be a need for a peer, along with a "do's and don't's" flyer.

It is also a good idea to provide basic training to everyone in the workplace including such topics as what mental health issues might arise as a result of work, what symptoms to look out for in themselves and their colleagues, how the PSP can help and how to access it. The MITSS program suggests that organizations consider writing a crisis communication plan that all staff have been educated about that can be accessed at any time. They provide examples of how some organizations have implemented this in their Clinician Support Tool Kit for Healthcare "Policies, Procedures and Practices" section.

Organizations need to break the stigma that exists regarding access and use of mental health services, as a way of breaking through the shame and blame culture. This goes a long way to reducing the stigma around mental health conditions and laying the foundation for the success of peer support.

How to ensure spread and sustainability of the program

Only once the PSP is in place, and peer supporters are trained and prepared to be on call to assist clients is it time to launch the program. By this time, the organization may have already announced plans for a PSP and built awareness and energy around the program, and also involved a number of workers in the needs assessment and planning. With the launch, however, when the PSP is ready to take on clients, then it is time for a promotional campaign.

What to promote

Key to the success of the program is promoting not only the services provided, but the values and principles behind the PSP. In particular, fully describing how the program will maintain confidentiality, including any limitations on this confidentiality, is key to reassuring staff that the PSP is a safe place for them to seek support.

It is also vital to promote the PSP as a non-judgmental inclusive space that is open to anyone regardless of their profession, sex, gender, culture, or levels. The MITSS program also recommends that the organization normalize the emotional impact to staff, for example by spreading the word that the PSP is about "normal people, having normal responses, to abnormal events"[9].

It is also important to emphasize to the potential clients that the organization's leadership and management are fully supportive of the program, and endorse its vision and values. The leadership and management should be fully on board to create a just culture where all those who work at their organization feel psychologically safe to seek help when they are emotionally distressed. This culture – where the organization is seen as supportive of mutual criticism and constructive feedback – plays a key role in the success of the program[5].

Edrees and Wu[10] list a number of barriers to developing a support program, among which are those can inform what might have to be countered in a promotional program (Table 4.1):

> "We have one quarter of the work force connected with peer supporters in four years."   (BCEHS)

Table 4.1: Potential barriers to developing a support program

Potential barriers (Edress and Wu)	How to counter
Stigma of mental health	Normalize emotional reactions to stress: It's about "normal people, having normal responses, to abnormal events" (http://mitss.org/download-the-toolkit/)
Trust and concerns about confidentiality or fear of hindering career advancement	Fully describe how the program will maintain confidentiality (see Box 19 for example)
Lack of interest on the part of staff	Identify reason for lack of interest, and train leaders, managers and supervisors to explain the importance and value of the PSP at every opportunity.
Novelty of concept	Be clear about what the PSP is and aims to accomplish. Begin with a pilot project on one or two units to familiarize staff with the idea of a PSP.

Publicizing and maintaining the values behind the PSP will inspire its growth and sustainability. As an example, the PAMQ/QPHP highlights the importance of their values with a rich and straightforward description of each one on their website (see Box 4.15).

"A peer support program is likely to be an evolving structure... a dynamic process that adjusts to identified needs and is not necessarily static."

(PAMQ/QPHP)

Box 4.15: Core values expected of peer supports

PAMQ/QPHP (from the [website](#))

- **Confidentiality:** Maintain the highest standards of confidentiality and discretion to protect our clients' identity and privacy.

- **Respect**: Empathy and consideration. Being open and non-judgmental when faced with a situation, its consequences and the emotions it triggers. Impartiality.

- **Integrity**: Our actions are guided by the observance of our organizational values. Decency, honesty toward clients, colleagues and partners.

- **Knowledge sharing**: Sharing knowledge with a view to improving physicians' health. Sharing innovative intervention methods aimed at broadening the scope of action taken to foster physicians' well-being.

- **Teamwork**: Show respect for others' skills by working cooperatively and pooling knowledge (regarding resources, partners and colleagues).

How to spread the word

The RISE program at Johns Hopkins Hospital recommends "a sustained, multipronged campaign" to increase awareness and trust among staff[1]. There are numerous methods to promote the PSP in an organization. The following are some suggestions:

Orientation of new staff: Many organizations include descriptions and information on how to access the PSP in their orientation to new staff, ensuring the messaging around just culture, psychological safety and leadership support is ingrained from the beginning.

Education sessions: Training sessions about the PSP and related topics (such as resilience training and, mental health awareness), which can be given as a stand-alone in-person workshop, as a web conference, or as part of regular inservice training or staff meetings.

Testimonials: Reassuring testimonials from those who have used the services of the PSP can be a powerful inspiration to encourage staff to seek support. The PAMQ/QPHP has [several short videos](#) of physicians who encourage others to reach out when they need help, thus humanizing the experience for everyone. There are also several [provider experience videos](#) available on CPSI's website that might also be a useful resource to organizations implementing a PSP, especially those that are focused on patient safety incidents.

"Elevator speech": The forYOU program created a short description of the PSP that leaders, managers, peer supporters and any staff can use to quickly tell someone about the program and give them a brief overview of why it is important and what support it includes ([Box 4.16](#)).

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Box 4.16: Elevator Speech

The forYOU team is a peer-support team developed to address the needs of staff when they have been involved in a difficult case which impacts them emotionally. The event does not have to be related to a medical error. This could be a case in which staff relate to the patient on a personal level and there is an unexpected patient outcome or it is just difficult to understand the outcome.

This is important because:

- ❖ Staff may feel guilty for the patient outcome, and are unable to share their feeing with others.
- ❖ Staff can begin to second-guess their clinical skills and knowledge base, if they are unable to confide in a trusted peer.
- ❖ In extreme cases staff may experience a professional crisis, leading to a potential change in career.

Available support includes:

- ❖ Over 300 clinicians (MDs, nurses, RT, and managers) have been specifically trained to assist staff in this type of situation.
- ❖ ForYOU brochures are available for staff and family members to help them better understand what the staff member may be experiencing.
- ❖ Additional resources include Risk management, Chaplains, EAP and additional professional counseling from a clinical psychologist when peer support is not sufficient.

The ultimate goal of the forYOU team is to help healthcare professionals at UMHC return to a 'pre-event baseline' level of performance following a traumatic patient event.

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Presentations: Any opportunity where groups are gathered at the workplace, such as conferences, staff meetings, workshops, grand rounds, M&M rounds, faculty orientations, OH&S meetings, committee meetings, joint OH&S committees, medical staff association meetings, in-service training, nursing week, or lunch & learn sessions, where a short presentation or toolkit can be made or a booth set up to remind staff about the PSP is also a useful way to spread the word.

Promotional materials: Organizations have developed a variety of promotional materials such as brochures, advertisements in internal newsletters, or such items as computer stickers, screen savers, business cards, magnets or pens that have the telephone number imprinted on them for easy access.

Social media: Information about the PSP on the organization's external or, if applicable, internal website, Facebook page, Twitter account or other means of marketing the PSP through social media can be useful to spread the word about the program more widely, especially if the PSP is a provincial or national program.

Evaluating the program

One of the most significant challenges of evaluating the PSP is that, because of confidentiality, not much data is recorded and even less is accessible to anyone other than those who are responsible for storing it securely.

However, with the data that is collected – such as number of peer supporters, leaders and staff trained, number of clients who contact the PSP and/or who are served, number of staff available for peer support, number of hours of staff volunteer time, cost of the program – the organization can at least determine such elements as utilization rates, return on investment and human resource costs. If other data is collected – such as type of incident or health issue, referrals made or follow up required, for example – then this data can also be used to evaluate the effectiveness of the PSP.

Although it might be difficult to ask clients who are seeking help to then evaluate the program, this might be offered as an opportunity, where appropriate, to seek feedback through a satisfaction survey about the support received. There is also a tool called the "Second Victim Experience and Support Tool" (SVEST) that evaluates the critical incident experiences of staff members and the quality of support services[11].The SVEST can be used to evaluate staff perceptions before and after the implementation of a peer support program.

Managers and supervisors might also be approached to evaluate the program, by providing feedback from their perspective about its usefulness for their staff.

It might also be useful to survey all staff to find out if they are aware of the PSP, if they have used it and if so, were they satisfied or do they have any suggestions for improving the program.

One of the most effective evaluations might be through the peer supporters, who can provide valuable feedback about their experiences, and exchange lessons learned with the other peer supporters and program directors.

It is also important that those responsible for the program connect with leadership and management to ensure they are meeting the goals they set for themselves, and still on course with their vision and mission.

Testimonial from a Staff Member Who Used Peer Support Program

"There are so many parts of nursing life that are incredibly challenging. There can be difficult moments where you find yourself in the middle of work chaos- the stress, the constant battle with time, the innate pressure to deliver the highest quality of care on your 11th hour. The journey we go through has many layers and all of those complex feelings we experience can take a toll. We are only but human. Having the awareness of when work life puts insurmountable pressure on your mental health and the foresight to actively seek the support you need are two things I think healthcare professionals constantly battle with….

This is where The Peer Support Program comes in. The day I met K., she provided that one-on-one support for me. It was at a time when I wasn't even aware of how much I needed it. I was emotionally and physically drained and I didn't know where to look for support. She called me. I think vulnerability can be a scary thing but the support I got that day and over the next month was probably was the sole largest contributor to rebuilding my strength and resilience. K. made herself available for face-to-face support as well as group debriefs. The encouragement I got from this program was confidential, non-judgmental and helped to remove some of the stigma that still exists around mental health. As nurses, we need to be honest and authentic with how trying our careers can be. By doing so, we all discover how important self-care is to having a healthy work life…

Peer support gave me concrete help and initiated the need to process a very difficult part of my career. This in turn made me feel strong enough to support other people as a CSN. When it comes to working with our team, confidence in a peer-based support system can be one of the most powerful ways to build each other up." (Clinical Charge Nurse, SickKids)

Conclusion

There are many hurdles to overcome, many decisions to make and many steps to take in the process of implementing a PSP, but those who have been through it attest to the fact that it is worth the time and effort required.

Key to the success of any program is that the leadership and management of the organization fully back the program and that this is visible to those who work, volunteer or are being trained at the workplace, which creates a psychologically safe environment for the PSP to gain momentum and succeed. The organization has to be seen to be "walking and talking the talk" where the PSP is part of a greater wellness portfolio, and where everyone feels comfortable seeking help.

Those who initiate the idea of a peer support program, or the champions of the PSP, need to understand that the process is long, but if they have clear goals and believe in the value of PSP, the program will take shape and eventually flourish.

Another important element to the growth and sustainability of the PSP is that all efforts are made to maintain confidentiality for those seeking support. As we have seen, it is difficult for health professionals to come forward for support if they think they will be perceived as vulnerable or weak for seeking mental health support.

If an organization makes the effort to work with their employees to find out what their needs are and what kind of peer support they are looking for, they will also have a much better chance of success.

Peer support is only one link in the chain of assistance for emotional distress, but it might be the most crucial link for individuals who would otherwise endure their psychological pain alone. CPSI urges all healthcare organizations to thoroughly investigate the value and benefits of a PSP for their workforce and, if they determine that such a program will help their workers through the many critical incidents and emotional distress they are likely to experience, then we also urge them to implement a PSP adapting the best practices outlined in this manual and using the many tools and resources we collected. [See the Creating a Safe Space Toolkit]

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Creating
a Safe Space

**Section 5: Healthcare
Worker Support Toolkit**

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Commission de la santé mentale du Canada

cpsi·icsp
Canadian Patient Safety Institute
Institut canadien pour la sécurité des patients

Acknowledgements

Section 5: Creating a Safe Space Healthcare Worker Support Toolkit

Section 5: Healthcare Worker Support Toolkit

Toolkit Purpose

The Toolkit was developed in partnership with the Mental Health Commission of Canada and supports healthcare leaders and policy makers to develop, implement or improve healthcare worker support programs. The Toolkit includes tools, resources and templates from organizations across the globe who have successfully implemented their own healthcare worker support programs.

Toolkit Development

The 2018 environmental scan focused on peer support programs for healthcare providers and their resources. The researchers performed a scoping study using the Arskey and O'Malley framework[1] to characterize the range and context of interventions used to psychologically support health professionals.

In the 2020 environmental scan, the Canadian Patient Safety Institute and the Mental Health Commission of Canada broadened the scope of the scan to include psychological safety models for healthcare providers, which included psychological self-care supports and supports that address moral distress. The toolkit was updated to reflect the broadened scope of the 2020 scan. Two strategies were used to update the toolkit:

1. Healthcare worker support program developers and experts in the field were contacted to provide any additional resources.

2. A systematic grey literature search was conducted.

Toolkit Summary

Following the above search strategies, tools, resources, and templates from 24 organizations were included in the 2018 scan, and 37 organizations/programs were added following the 2020 scan.

Types of tools, resources, and templates that are available in the toolkit include healthcare worker support program specific information, such as program descriptions, program development documents, promotional and recruitment materials, policy documents, evaluation tools, training resources, and testimonials. In addition, tools, resources, and templates related to the psychological well-being of healthcare workers, including psychological self-care and moral distress, were also included such as background information (e.g., fact sheets, worksheets, PowerPoint presentations) on the psychological well-being of healthcare workers and webinars. These types of resources are reflected in the "Category" column in the tables below. For additional information and context for these resources, the originating organization, title of the resource, brief description, and access to the resource are also provided in the toolkit tables below.

The toolkit is divided into three tables:

> **Table 5.1** includes resources from peer support programs identified in the 2018 and 2020 environment scans, tools on developing and improving peer support programs, and general psychological well-being resources from experts and organizations (including COVID-19 resources).

Table 5.2 includes resources that address psychological self-care in healthcare workers, such as fact sheets about psychological self-care, worksheets for developing a psychological self-care plan, and webinars.

Table 5.3 includes resources that address moral distress in the healthcare sector, such as links to moral distress projects currently being developed, fact sheets, toolkits, ethical decision-making frameworks, and PowerPoint presentations.

Programs and Materials

Table 5.1: Peer Support Resources

Organization	Title	Category	Description	Access
Alberta Health Services	Peer Trauma Response Team Logic Model	Program Description	Logic model for expanding AHS's peer trauma response team	PDF
	Peer Trauma Response Team Network Committee - Terms of Reference	Program development tool	Terms of Reference for the Peer Trauma Response Team Network Committee	PDF
	Peer Trauma Response Team - Applicant Package	Recruitment	AHS's peer supporter applicant package including background information and application templates	PDF
	Peer Trauma Response Team Incident Report Form	Documentation template	Incident report form to log peer support interactions	PDF
ARISE	ARISE: A randomized controlled trial of a multi-component intervention for nurses in critical care and trauma	PowerPoint Presentation	A presentation on the background, development, description, and evaluation of the ARISE program.	PDF
Attention-Based Training from the Royal College of Surgeons in Ireland (RCSI)	ABT Manuals for weeks 1-8.	Program Material	Program materials for the Attention-Based Training Program by RCSI. This program was modified from a similar program that demonstrated success to address COVID-19 related stress and anxiety. Program manuals include brief descriptions of each session with links to YouTube videos that go over each session.	Week 1: PDF Week 2: PDF Week 3: PDF Week 4: PDF Week 5: PDF Week 6: PDF Week 7: PDF

Organization	Title	Category	Description	Access
				Week 8: PDF
Battle Buddies	Battle Buddy Pocket Card	Program Material	Every Battle Buddy is provided a "Battle Buddy Pocket Card" that outlines the rationale and processes of the system. Posters with similar information are also posted in work areas.	PDF
BC Emergency Health Services	BC EHS CIS Program Logic Model	Program description	Logic model for BC EHS's Critical Incident Stress program	PDF
	FAQ - Psychological Supports for Employees	Program description	FAQ document on BC EHS's psychological supports available to employees	PDF
	Slide deck - Tackling occupational stress injuries - The BC EHS Experience	Program description	Slide deck providing a background on occupational stress injuries and an overview of BC EHS's response program	PDF
	Critical Incident Stress Program Policy	Policy document	BC EHS's policy document on their Critical Incident Stress Program	PDF
	Critical Incident Stress Program - Volunteer Peer Team Orientation Manual	Recruitment	Orientation manual for new peer team members	PDF
BC First Responders	BC First Responders Mental Health Website	Program development tool	Homepage of BC First Responder's mental health resource library which includes many tools, documents, and templates to promote first responder mental health	Webpage
	Overview of Peer Support Programs	Program development tool	Overview of what a peer support program is, components and recommended training	PDF
	Developing a peer support policy	Policy document	Document on how to create a peer support policy and an associated policy template	PDF

Organization	Title	Category	Description	Access
BC Ministry of Health	Supporting the Psychosocial Well-being of Health Care Providers During the Novel Coronavirus (COVID-19) Pandemic	Background	This document outlines guidance for psychosocial planning for health care providers who provide care and services during the COVID-19 pandemic.	PDF
Brigham and Women's Hospital - Centre for professionalism and peer support	Peer Support	Program description	Homepage of Brigham and Women's Hospital's peer support program	Webpage
	Peer Support FAQ	Program description	Overview of Brigham and Women's Hospital's peer support program including FAQ's	PDF
	Coping and Recovery after a Medical Error	Promotional material	One-pager on reactions and coping strategies for clinicians following a medical error	PDF
	Coping and Recovery after an Adverse Event	Promotional material	One-pager on reactions and coping strategies for clinicians following an adverse event	PDF
Burlison et al.	Second Victim Experience and Support Tool (SVEST)	Evaluation Tool	Journal article that introduces and evaluates the "SVEST" assessment tool - a staff survey on experience and supports available for the second victim; the article includes a download link to the SVEST tool	PDF
Burnout Intervention Program - Al Amal Mental Health Complex	Program Agenda	Program description	Program schedule and agenda, along with content handouts that review burnout, visual imagery, progressive muscle relaxation, and social skills training.	Word Document
Canadian Medical Association	The Wellness Connection	Webpage	The Wellness Connection is a virtual peer support program for physicians and medical learners to gather and discuss shared experiences, get support, seek advice, and help each other. The webpage provides background on the program, links to the different platforms of the program (e.g., virtual peer support, a "gratitude space", and	Webpage

Organization	Title	Category	Description	Access
			educational content/training resources).	
		Background	Document reviews the background, objectives, implementation process, and expected outcomes of the virtual support program.	PDF
Canadian Mental Health Association	Here4Healthcare	Webpage	Provides resources for the mental health and well-being of healthcare workers and achieving work-life balance.	Webpage
Canadian Patient Safety Institute	Healthcare Provider Video - Patient and provider	Testimonial	Patient and provider come together in wake of patient safety incident	Video
	Healthcare Provider Video - Peer support	Testimonial	Dr. Julia Trahey calls for peer support networks to assist providers following patient safety incidents	Video
	Healthcare Provider Video - Physician story	Testimonial	Dr. Francois deWet turns "physician's worst nightmare" into opportunity for improvement	Video
	The Impact of Disclosure: Second Victim of Harm	Testimonial	Nurse Nadine Glenn, shares her story of the impact of a patient safety incident on her life and career	Video
Chatham-Kent Health Alliance	Critical Incident Stress Management	Policy Document	Policy document on the provision of Critical Incident Stress Management services to support the recovery of health care workers experiencing normal distress following exposure to abnormal events	PDF
	Critical Incident Stress Management: Peer Support Guide	Policy Document	Policy document on the provision of Critical Incident Stress Management for staff, physicians, volunteers, and students	PDF
	Critical Incident Stress Management: Peer Support Group	Program Description	Brochure describing the Critical Incident Stress Management program	PDF

Organization	Title	Category	Description	Access
Emergency Medicine Cases	Failing up after Medical Error	Testimonial	Short podcast on a physician's experience following a medical error	Podcast
forYOU - University of Missouri Health Care	forYOU elevator speech	Program description	Elevator speech providing an overview of the forYOU program	PDF
	forYOU Team Homepage	Program description	Homepage of the University of Missouri Health Care's forYou Program. Provides overview of the second victim phenomenon and program resources	Webpage
	The Scott Three-Tiered Interventional Model of Second Victim Support	Program description	One-pager on the 3 tiers of support available in the forYOU program	PDF
	Building a Second Victim Support Program Checklist	Program development tool	forYOU's concise checklist on key actions to develop and implement your own second victim peer support program	PDF
	Designing a Second Victim Support Program: Assessment Worksheet/Planner	Program development tool	forYOU's planning template to help organizations to develop and implement their own second victim peer support program	PDF
	forYOU Interaction tracking	Evaluation tool	Tracking template for interactions between the peer supporter and the program participant	PDF
	Leadership - forYOU team activation policy	Policy document	forYOU policy document	PDF
	forYOU Brochure for Employees	Promotional material	Promotional brochure that describes the forYOU program and signs and symptoms of the second victim phenomenon. Includes a survey for program users to provide feedback on the support they received	PDF

Organization	Title	Category	Description	Access
	forYOU Brochure for Family Members	Promotional material	Promotional brochure directed at family members, describing the support the forYOU program provides	PDF
	Second Victim Trajectory	Promotional material	One-pager on the 6 stages of recovery after adverse event and associated supports	PDF
	forYOU team membership application form	Recruitment	Application form to join the forYOU peer support team	PDF
Health Canada - Occupational & Critical Incident Stress Management (OCISM)	OCISM Tips for coping for individuals directly involved in a traumatic event	Promotional material	Coping tips for an individual involved in a traumatic event	PDF
	OCISM Tips for coping for individuals involved in sustained, high intensity work	Promotional material	Coping tips for individuals exposed to ongoing trauma as a part of their work	PDF
	OCISM Tips for Family, Friends and Co-workers of individuals involved in a traumatic event.	Promotional material	Tips for family members on how to support their loved one who has experienced a trauma at work	PDF
	OCISM Tips for supervisors and managers of employees involved in a traumatic event	Promotional material	Tips for managers to support an employee who has been through a traumatic event	PDF

Creating a Safe Space Healthcare Worker Support Toolkit

Strategies to Address the Psychological Safety of Healthcare Workers

Organization	Title	Category	Description	Access
	OCISM Tips on Coping following a traumatic Event	Promotional material	Lists signs and symptoms following a traumatic event.	PDF
	OCISM Brochure	Promotional material	Brochure on the background, purpose and actions of the OCISM Program	PDF
IHI - Institute for Healthcare improvement	Leadership Response to a Sentinel Event: Respectful, Effective Crisis Management	Background	IHI's website of resources to support individuals and organizations after an adverse event	Webpage
	Why Is Psychological Safety So Important in Health Care?	Background	Short video on the importance of psychological health and safety in healthcare	Video
	Online Training - Responding to Adverse Events	Training resources	Online training on responding to an adverse event. One module focuses specifically on the second victim Note: The training is free, however you must create an account to access it	Webpage
	Conversation and Action Guide to Support Staff Well-Being and Joy in Work During and After the COVID-19 Pandemic	Program development tool	A guide that provides actionable items for leaders to engage in conversations with colleagues. The aim is to improve communication and problem-solving for staff well-being, develop creative solutions, and promote joy and long-term success. An IHI account is needed to log-in and access the guide at the link provided.	Webpage
	"Psychological PPE": Promote Health Care Workforce Mental Health and Well-Being	Program development tool	A guide that provides evidence-based recommendations for healthcare workers and leaders to support mental health in a healthcare setting. A visual graphic is also provided to be posted for staff as a reference. An IHI account is needed to log-in and access the guide and visual graphic.	Webpage
	PS 101: Introduction to Patient Safety from the IHI Open School	Program description	A free course that includes 3 lessons on adverse events and patient safety, the role of healthcare workers in a	Webpage

Organization	Title	Category	Description	Access
			culture of safety and building safer systems. To access, navigate to website and log in with IHI username and password. Click Browse Catalog, search "PS 101" and click "Enroll" (you will be able to do so at no charge). You'll return to your Learning Center and see PS 101 listed. Click "Launch" to start the course	
	IHI Virtual Learning Hour: Workforce Safety in the Age of COVID-19	Webinar	A free, open-access webinar presented by IHI that provides information for leaders on key safety principles for healthcare workers during COVID-19, how to implement support programs, and apply lessons learned from COVID-19 to accelerate worker safety.	Video
	Industry Voices—3 actions to support healthcare workers' well-being during COVID-19	Background	An article reviewing themes identified by IHI from key publications and interviews to provide information and support healthcare organizations during the pandemic.	Webpage
International Critical Incident Stress Foundation Inc.	ICISF Academy of Crisis Intervention	Training resources	ICISF offers a variety of online and in-person training courses on crisis intervention	Webpage
Living Works	Applied Suicide Intervention Skills Training (ASIST)	Training resources	Applied Suicide Intervention Skills Training (ASIST) is a two-day interactive session on how to intervene and help prevent the immediate risk of suicide	Webpage
	SafeTALK	Training resources	SafeTALK is a half-day alertness training course that helps people recognize signs of a potential suicide and how to intervene	Webpage

Organization	Title	Category	Description	Access
Medically Induced Trauma Support Services (MITSS)	MITSS Homepage	Program description	Homepage of Medically Induced Trauma Support Services Program. Program is currently being moved to The Betsy Lehman Center – information available at the link.	Webpage
	Clinician Support Tool Kit for Healthcare	Program development tool	Toolkit of resources and templates collated by the MITSS team to support other organizations to develop their own support programs. A new toolkit will be available in 2020, the original toolkit is available at the link.	PDF
	Disclosure and Apology: What's Missing? Advancing Programs that Support Clinicians	Program development tool	Report from a full day forum entitled "Disclosure and Apology - What's Missing", which discussed best practices in developing support programs for healthcare professionals	PDF
	MITSS Organizational Assessment Tool for Clinician Support	Program development tool	Organizational self-assessment on key actions required to develop a peer support program	PDF
	MITSS Staff Support Assessment Tool	Evaluation tool	Staff survey on organizational supports available to them following a serious adverse patient event	PDF
Mental Health Commission of Canada	Advancing Psychological Health and Safety within Healthcare Settings	Background	Homepage highlighting the MHCC's work in psychological health and safety in the healthcare sector	Webpage
	Guidelines for the Practice and Training of Peer Support	Background	National guidelines on the practice and training of peer supporters	PDF

Organization	Title	Category	Description	Access
	Implementing the National Standard in the Canadian Health Sector: A Cross Case Analysis	Background	This report shows the findings from 19 healthcare organizations who implemented the National Standard for Psychological Health and Safety in the Workplace over three years - their facilitators and barriers to creating a mentally healthy workplace	PDF
	Issue Brief - Workplace Mental Health	Background	Background brief on the issue and importance of psychological health and safety in the healthcare sector	PDF
	Join the Movement Video	Background	Short video on the importance of psychological health and safety in healthcare	Video
	Making the Case for Peer Support	Background	Comprehensive report evaluating the state of peer support in Canada	PDF
	Webinar - Taking care of those providing care: Psychological health and safety in Canadian healthcare settings	Background	Webinar on the importance of psychological health and safety in the healthcare sector	Video
	Webinar - Proactive Peer Support: Protecting and promoting the wellbeing of first responders	Program description	Webinar on the York Region Paramedic Services peer support program	Video
	MHCC - Philippe Larivière, Paramedic Instructor | Stories of Recovery- First Responders	Testimonial	Philippe (Paramedic Instructor, Manitoba) shares his experience of living in recovery with mental illness incited by a particularly difficult call	Video

Organization	Title	Category	Description	Access
	Mental Health First Aid	Training resources	Mental Health First Aid is a training course designed to give members of the public the skills to help someone who is developing a mental health problem or experiencing a mental health crisis	Webpage
	The Working Mind - First Responders	Training resources	The Working Mind First Responders (TWMFR), formerly known as Road to Mental Readiness, is an education-based program designed to address and promote mental health and reduce the stigma of mental illness in a first-responder setting	Webpage
	The Working Mind (TWM) Healthcare	Training resources	The Working Mind (TWM) Healthcare is an education-based program designed to address and promote mental health and reduce the stigma of mental illness in healthcare workers. Two courses are available: Caring for Self (for employees) and Caring for your Team (for managers).	Webpage
	Free online crisis training for essential workers during COVID-19: Caring for Yourself, Caring for your Team, Caring for Others	Training resources	MHCC developed 3 crisis response training programs for essential workers. Throughout COVID-19, essential workers may experience depression and heightened anxiety. These programs are specifically designed to help provide tools and knowledge to better understand their own mental health and the mental health of others.	PDF
	Webinar: Building Mental Health into Emergency Management and Business Continuity Programs: Pandemic Response	Webinar	Webinar addresses the need to incorporate mental health when developing emergency management and business continuity plans considering the pandemic response. Webinar addresses impact of emergencies and disasters on mental health, mental health needs of workers during an emergency and disaster, and how to build mental health into emergency management and business continuity plans using the National Standard of Canada on Psychological Health and Safety in the Workplace.	Webinar Slide deck

Organization	Title	Category	Description	Access
	Opening Minds Workplace Mental Health program	Program description	This service helps organizations navigate the development and execution of an effective and sustainable workplace mental health strategy. By engaging with employers, executive leadership teams and staff of all levels, this process is designed to build or improve on any strategies that may already be in place.	Webpage
	General and COVID-19 specific Resources for Healthcare Sector	Background	Two webpages contain a variety of useful resources for mental health in the healthcare sector, one webpage for general resources and another for COVID-19 specific resources. Resources include reports, posters, videos, webpages, guides, brochures, etc.	General: Webpage COVID-19: Webpage
Michael Garron Hospital	Providing Care and Support for our Staff - Brochure	Promotional material	This brochure describes Michael Garron Hospital's Emergency Department care and support team program that is available for staff	PDF
	Emotional Support Handout	Promotional material	Handout to educate staff how to recognize common reactions to stressful events, strategies to cope, where to get support, and how to help others as a co-worker or family/friend.	PDF
	Emotional Support Response Team: Guiding Principles for Leadership	Training resources	A training PowerPoint presentation for leadership that provides information on why supporting their team is important, signs/symptoms of trauma, when and how to activate the emotional support response team, the role of spiritual care and OHS, and debriefing and resolution strategies.	PDF
	Emotional Support Response Pilot: Director/Manager Update	Training resources	A presentation for directors on the scope and background of the emotional support response pilot project, as well as the protocol and evaluation metrics of the project.	PDF

Organization	Title	Category	Description	Access
	Second Victim Peer Support: Caring for Our Own	Training resources	Training for peer support workers that provides information on understanding "second victims", signs/symptoms of trauma, levels of support for HCW in the hospital, and the role of peer supporters.	PDF
	COVID-19 Tiered Approach to Physician Support	Program description	Recommendations from working groups across the hospital to increase access and continuity of support for physicians during COVID-19.	PDF
	Providing Care and Support for our Staff - Brochure	Promotional material	This brochure describes Michael Garron Hospital's Emergency Department care and support team program that is available for staff	PDF
	Emotional Support Handout	Promotional material	Handout to educate staff how to recognize common reactions to stressful events, strategies to cope, where to get support, and how to help others as a co-worker or family/friend.	PDF
Mindfulness in Motion (MIM)	MIM: An Onsite Mindfulness Based Intervention (MBI) for Chronically High Stress Work Environments to Increase Resiliency and Work Engagement	Program description	The document includes a literature review, an informational video, as well as a program protocol, agenda, and evaluation.	Webpage
Phoenix Australia Centre for Post-Traumatic Mental Health	Development of guidelines on peer support using the Delphi methodology	Program development tool	A study designed to inform the practice of peer support internationally based on the best available advice from experts and practitioners in the field.	PDF
Quebec Physician's	Analysis of the Effectiveness of Employee Assistance	Program description	Report on the effectiveness of the Quebec EAP program in supporting physicians	PDF

Organization	Title	Category	Description	Access
Health Program	Programs: The Case of the QPHP			
	Program Homepage	Program description	Homepage of the Quebec Physician's Health Program	Webpage
	Rapport Annuel 2017-2018	Program description	Annual report of the PAMQ program.	PDF (French Only)
	During a workplace crisis - is it possible not to react	Promotional material	Two-pager on responding to difficult situations at work.	PDF
RISE: Resilience in Stressful Events - Johns Hopkins	Caring for the Caregiver - Introduction	Program description	Video on overview of the Caring for the Caregiver program	Video
	Caring for the Caregiver: Peer Support for Caregivers in Distress	Program description	One-pager overview of the Caring for the Caregiver program	PDF
	Hospital peer-to-peer support	Program description	Homepage of the Caring for the Caregiver: Implementing RISE (Resilience in Stressful Events) Program. Provides an overview of the issue and their program	Webpage
	The Aftermath of Medical Errors: Supporting Our Second Victim Colleagues	PowerPoint	Background on "second victims", review on implementation of a Second Victim Peer Support Structure at The Johns Hopkins Hospital.	PDF
SickKids	Trauma Response and Peer Support policy	Policy document	SickKids policy statement on trauma response and peer support	PDF

Organization	Title	Category	Description	Access
	Scope of Manager, Peer Support Program Role	Recruitment	Document explaining the scope, roles and responsibilities of the Manager, peer supporter program role	PDF
TedTalks	Ted Talk - Dr. Brian Goldman - Doctors make mistakes. Can we talk about that?	Testimonial	Canadian physician, Dr. Brian Goldman, shares his experience following a medical error	Video
The Royal College of Emergency Medicine	The Safety Toolkit – Supporting the Second Victim	Program Development tool	Toolkit of document and resources collated by the Royal College of Emergency Medicine to support the second victim	PDF
	Supporting the Second Victim - Recommendations	Promotional material	One-pager of recommended actions for individuals and leadership teams to support the second victim	PDF
University of Kentucky - hCATS (health Colleges Advancing Team Skills) to CPR (Cultivating Practices of Resilience) Camp	CPR Camp Schedule	Program material	Detailed schedule of program activities.	PDF
	Habits of Resilient People Handout	Program material	A handout that covers habits that enhance resiliency.	PDF
	hCATS Cultivating Practices in Resilience Project Plan	Program material	Group project activity handout.	PDF
	Slice of Life: Pre- and Post- Opening Burnout Activity	Program material	A handout given to clients before and after participating in the program. The pre-program burnout activity allows participants to indicate what they do during their week. The post-program burnout activity allows participants to schedule their week in a way that will allow them to be resilient and their best self.	Pre-Program: PDF Post-Program: PDF
	Wrap up and work-life balance	Program material	Detailed agenda for wrap-up group discussion and a work-life balance planning activity.	PDF

Organization	Title	Category	Description	Access
Washington Patient Safety Coalition	PODCAST: The New Wave of Healthcare - Episode 2: How can large hospital systems offer care to its caregivers after an adverse event?	Testimonial	Podcast of healthcare professionals discussing their experiences following an adverse event	Podcast
Well-Being at Work	Well-Being at Work: Equipping young doctors with skills to thrive in medicine.	Background	One-page document on the background, format, and delivery mode of the program as well as links to media coverage.	PDF
Workplace Strategies for mental health	Peer support Programs	Program development tool	Overview of setting up a workplace peer support program	Webpage

Table 5.2: Psychological Self-Care Resources

Organization	Title	Category	Description	Access
American Holistic Nurses Association	Holistic Self-Care for Nurses	Background	A webpage by AHNA that provides self-assessment, background information, and tools for self-care.	Webpage
American Psychiatric Nurses Association	Managing stress and self-Care during COVID-19: Information for nurses	Background	A webpage by APNA that provides tips for managing stress, signs, and symptoms of excessive stress, and coping with moral distress.	Webpage

Organization	Title	Category	Description	Access
Australasian College of Paramedicine	Self-Care for Healthcare Workers during disasters	Background	A document that reviews the importance of self-care for healthcare workers and provides a worksheet for developing a self-care plan.	PDF
Black Dog Institute	Self-care planning for healthcare workers: COVID-19 mental health and wellbeing resources	Background	A document that explains what self-care is and provides worksheets to create a self-care plan and templates for personal planning. Designed specifically for Healthcare Providers during Covid-19.	PDF
Canada's Department of National Defense	Sustaining the Wellbeing of Healthcare Personnel during COVID-19 Pandemic	Background	A fact sheet provided by DND that reviews sources of stress during the pandemic for healthcare workers and positive coping strategies and self-care techniques to mitigate stress.	PDF
College of Nurses of Ontario	Self-care Sheet	Background	Provides information on self-care, guiding questions, and strategies for self-care.	PDF
Health Outreach Partners	Self-Care: Taking Care of Ourselves So We Can Take Care of Others	Background	Information on what individual and organizational self-care is and strategies for developing self-care techniques on an individual and organizational level.	PDF
Homewood Health	Building a Self-Care Plan	Background	A toolkit that provides information on the relevance of self-care for healthcare workers, self-care techniques, and how to build a self-care plan.	PDF

Organization	Title	Category	Description	Access
Marshfield Clinic	Self-Care: What and Why	Background	Information on defining self-care, evidence base for self-care plans, and practice base for self-care.	Webpage
	Self-Care Planning	Background	A 3-step plan to developing a self-care plan.	Webpage
McLean Hospital	Clinician Self-Care Webinar	Webinar (available in English and Spanish)	A webinar by Dr. Blaise Aguirre that offers strategies from dialectical behavior therapy to help mental health professionals and health care workers from all disciplines cope with the challenges they are facing during COVID-19. The webpage provides a recording of the webinar, a downloadable version of the slides, and answers to viewers' questions.	Webpage
Mental Health Commission of Canada	The Working Mind: COVID-19 Self-care & Resilience Guide	Background	A document that provides a mental health self-assessment, background on self-care and resilience, and guide on developing a self-care and resilience plan.	PDF
Ohio State University	Staying Calm and Well in the Midst of the COVID-19 Storm	Webinar	An 8-week webinar series that was recorded and is available for free online that offers practical evidence-based tactics and resources for managing mental health during the pandemic.	Webpage
Saskatchewan Health Authority	Building a Self-Care Plan	Background	Information and worksheet to develop a self-care plan.	PDF
TED Talks	The Importance of Self-Care Playlist	Webinar	A playlist of TED Talks that focus on the topic of self-care.	Webpage
University of North Carolina, Department of	Webinars and Video-based Mental Health and Self-care	Webinar	This webpage provides links to webinars about the well-being of healthcare workers, self-care fitness videos, as	Webpage

Organization	Title	Category	Description	Access
Psychiatry	Resources		well as other apps and web-based resources.	
University of Buffalo, School of Social Work	Emergency Self-Care Worksheet	Background	Provides step-by-step instruction to prepare a self-care plan for when things go quickly and/or unexpectedly wrong.	PDF
University of Saskatchewan	Self-Care for Northern Practitioners	Background	A resource for practitioners located in northern Canadian communities, reviewing sources of job stress, burnout, and ways to develop self-care strategies.	Webpage

Table 5.3: Moral Distress Resources

Organization	Title	Category	Description	Access
American Association for Critical Care Nurses	The 4A's to Rise Above Moral Distress	Background	Description of the 4A's to address moral distress.	PDF
American Journal of Nursing, Continuing Education	Moral Distress: A Catalyst in Building Moral Resilience	Training resources	This article outlines the concept and prevalence of moral distress, describes its impact and precipitating factors, and discusses promising practices and interventions.	PDF
Assistant Secretary for Preparedness and Response's Technical Resources, Assistance Center, and Information Exchange (TRACIE)	Preventing and Addressing Moral Injury Affecting Healthcare Workers During the COVID-19 Pandemic	Background	An introduction to moral distress and a review of ways to prevent and address moral distress in healthcare workers. Also includes self-care strategies and additional resources.	PDF
British Columbia Ministry of Health – Fraser Health	COVID-19 Ethical Decision-Making Framework	Background	The ethical decision-making framework, and underlying principles and values provides an interim process to support healthcare organizations and teams to make challenging decisions in a COVID-19 outbreak.	PDF

Organization	Title	Category	Description	Access
Canadian Medical Association	COVID-19 and Moral Distress	Background	A review of moral distress in healthcare, the importance of addressing moral distress, causes and symptoms, and strategies for clinicians, leaders, and organizations to address moral distress.	PDF
Center for Health Evaluation and Outcome Services (CHEOS)	Moving from moral distress to moral action: A self-care intervention for ICU professionals	Evaluation tool	MCA is accessed through a confidential website and consists of eight steps that break down a moral distress problem and help generate solutions. It aims to improve resiliency by increasing effort into looking after oneself, analysing and thinking through the situation causing them distress, and taking meaningful action to address it. Blurbs and videos explain each component and visual representations including tables, graphs, and word clouds are produced as participants make their way through each step.	Webpage
Center to Advance Palliative Care	Fast Five: Strategies for Addressing Moral Distress in Frontline Health Care Workers	Background	Brief 5-minute video featuring Dr. Ira Byock, Chief Medical Officer for the Providence Health System Institute for Human Caring. Dr. Byock shares three practical initiatives that can foster human connection among patients, families, and clinical care teams.	YouTube Video
College Nurses of Ontario	Ethics Practice Standard	Background	This document describes the ethical values and provides scenarios of ethical situations in which there is a conflict of values to encourage reflection and discussion. No solutions are offered, but behavioural directives are provided to help nurses work through ethical situations and provide information about the College of Nurses of Ontario's (CNO's) expectations for ethical conduct.	PDF
Moral Injury of Healthcare	Moral Injury Solutions for Individuals	Program development	Solutions for individuals to take care of themselves and of each other to address moral distress.	PDF

Organization	Title	Category	Description	Access
	Moral Injury Solutions for Leadership	Program development	Solutions for leadership to care for their staff and community to address moral distress.	PDF
	Kaiser Health News: Beyond Burnout: Docs Decry 'Moral Injury' From Financial Pressures of Health Care	Background	News article about moral injury and moral distress, and an interview with the creators of the organization, Moral Injury of Healthcare.	Webpage
Nova Scotia Health Ethics Network (NHEN)	Understanding and Responding to Moral Distress in Health Care – 2019 Conference	Background	A list of resources compiled at the NSHEN 2019 Conference on understanding and addressing moral distress.	PDF
Phoenix Australia Centre for Post-Traumatic Mental Health & The Royal Ottawa's Centre of Excellence - PTSD	A new guide to managing moral injury in healthcare workers during COVID-19	Background	This guide to moral injury during COVID-19 has been developed as a practical resource for healthcare workers and organisations to better understand the range of moral emotions arising from the COVID-19 pandemic and to develop organisational and individual strategies to mitigate risks of lasting harm.	PDF
University of Kentucky	The Moral Distress Education Project	Program description	The project is a self-guided web documentary that aims to educate, inform, and de-stigmatize moral distress to help viewers process morally distressing experiences. The documentary includes interviews with a team of multi-disciplinary experts ranging in topics including defining moral distress, end-of-life cases, origins, signs and consequences of moral distress, and solutions.	Webpage

Organization	Title	Category	Description	Access
	Moral Distress Resources	Background	A collection of resources on moral distress, including links to measures of moral distress, articles on better understanding and addressing moral distress, and case studies of moral distress.	Webpage
University of Virginia School of Medicine	The Cost of Caring: Recognizing & Reducing Moral Distress	Background	A review of moral distress, recognizing moral distress, and strategies for reducing moral distress.	PowerPoint

Creating
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Conclusion

Conclusion

The Canadian Patient Safety Institute (CPSI) is grateful to the many healthcare workers, experts in peer support programs, healthcare lawyers, patients, researchers and policy makers who have made this work possible. All have helped us along our journey to provide healthcare organizations with resources to help their workers when they experience emotional distress in the workplace. We are particularly appreciative of the Mental Health Commission of Canada for their inspiring advice and assistance, and for providing much fundamental information about mental health for our collaborative project.

Whether you are a leader of a healthcare organization contemplating how best to improve the mental health of your workers, a healthcare worker who is in the midst of implementing a peer support program, or simply someone with a germ of an idea to help support your peers, we hope this manual has been useful to you. We invite you to share your peer support program story with us, so that others might also learn from your experiences. If you have ideas about what else CPSI might do to help organizations across Canada implement successful peer support programs, please contact us at [info@cpsi-icsp.ca].

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Appendices

Appendix 1: Second Victim Experience and Support Tool (SVEST) Survey

The second victim describes a healthcare professional who is involved in a patient safety incident and is emotionally traumatized by the event. There is a common understanding that health professionals feel emotionally distressed after a patient safety incident (PSI), resulting in a negative impact on both the health professional's health and on patient safety. There has therefore been an impetus within the patient safety movement and healthcare organizations to find ways to support health professionals who are emotionally traumatized after a PSI.

The Canadian Patient Safety Institute (CPSI), a not-for-profit organization that exists to raise awareness and facilitate transformation in patient safety, is therefore reaching out to healthcare providers to seek for input on the second victim experience and support.

The following survey, conducted in partnership between the Canadian Patient Safety Institute and the University of Ontario Institute of Technology (UOIT), seeks to evaluate your experiences as a healthcare provider with adverse patient safety events and the support you may have received.

This study is intended **for Front Line Healthcare workers**, specifically targeting **clinicians, allied health workers and technologists** providing services in all settings, including hospitals, outpatient care, behavioral health, long-term care, and home healthcare. For the purpose of this study we are targeting clinicians, allied health professionals and technologists who provide direct care to patients. Those healthcare workers who have dual roles that includes management, teaching or research, must have **at least 20% of their work dedicated to direct patient care.**

The survey will take between 30-45 minutes to complete. If you have any questions regarding this survey, please contact …. at …. and …. Ext. ….Thank you for taking the time to complete the survey.

DEMOGRAPHICS

1. Please identify your role in healthcare:
   - ☐ Clinician
   - ☐ Manager
   - ☐ Executive
   - ☐ Other (Please specify) _____

2. Professional discipline:
   - ☐ Dietician
   - ☐ Medical / Laboratory Technologist
   - ☐ Nurse
   - ☐ Occupational Therapist
   - ☐ Pharmacist
   - ☐ Physical Therapist
   - ☐ Physician
   - ☐ Respiratory Therapist

☐ Other (Please Specify) _____

3.   Please identify the area of practice relevant to your current work:
    ☐ Acute Care
    ☐ Primary Care
    ☐ Long Term Care
    ☐ Community Care
    ☐ Other (Please specify) _____

4.   Please name the province or territory in which you reside_____ (*Dropdown menu*)

5.   Please indicate your years of experience in healthcare:
    ☐ 2 years or less
    ☐ 3-5 years
    ☐ 6-8 years
    ☐ 9-12 years
    ☐ 12 years or more

6.   Have you ever been involved in a serious patient safety event impacting one of your patients?
    ☐ Yes
    ☐ No

7.   In the last 12 months, did a patient safety event cause you to experience anxiety, depression or wondering if you were able to continue to do your job?
    ☐ Yes
    ☐ No

*Jonathan D. Burlison, Susan D. Scott, Emily K. Browne, Sierra G. Thompson, and James M. Hoffman, "The Second Victim Experience and Support Tool: Validation of an Organizational Resource for Assessing Second Victim Effects and the Quality of Support Resources", J Patient Saf, Volume 00, Number 00, Month 2014.

Second victim responses and support characteristics:

Please indicate how much you agree with the following statements as they pertain to yourself and your own experiences at your organization for those who have been negatively affected by their involvement with an adverse patient safety event. These incidents may or may not have been due to error. They also may or may not include circumstances that resulted in patient harm or even reached the patient (i.e., near-miss patient safety events).

Scoring: The responses to Question 1 – 9 are rated on a 1 to 5 Likert scale, where higher scores represent greater amounts of second victim responses, the degree to which support resources are perceived as inadequate, and the extent of the 2 second victim – related negative work outcomes (i.e., turnover intentions and absenteeism). Rate 1 – 5 [1-Strongly Disagree; 2-Disagree; 3-Neither Agree or Disagree; 4-Agree; 5-Strongly Agree]

8. Psychological Distress

	1 Strongly Disagree	2 Disagree	3 Neither Agree or Disagree	4 Agree	5 Strongly Agree	6 Not Applicable
I have experienced embarrassment from these instances.						
My involvement in these types of instances has made me fearful of future occurrences.						
My experiences have made me feel miserable.						
I feel deep remorse for my past involvements in these types of events.						

9. Physical Distress

	1 Strongly Disagree	2 Disagree	3 Neither Agree or Disagree	4 Agree	5 Strongly Agree	6 Not Applicable
The mental weight of my experience is exhausting.						
My experience with these occurrences can make it hard to sleep regularly.						
The stress from these situations has made me feel queasy or nauseous.						
Thinking about these situations can make it difficult to have an appetite.						

Second Victim Support Option Desirability:

Please indicate your **level of desirability** for the following types of support that could be offered by your organization for those who have been negatively affected by their involvement with an adverse patient safety event. These patient safety incidents may or may not have been due to error. They also may or may not include circumstances that resulted in patient harm or even reached the patient (i.e., near-miss patient safety events).

Scoring: The responses for Question 10 are rated on a 1 to 5 Likert scale, where a response of 4 or 5 represents the support option being desired and 1 or 2 represents the support option being not desired. The responses for these items are rated on a 1 to 5 Likert scale, where a response of 4 or 5 represents the support option being desired and 1 or 2 represents the support option being not desired.

10. Desired Forms of Support

	1 Strongly Disagree	2 Disagree	3 Neither Agree or Disagree	4 Agree	5 Strongly Agree	6 Not Applicable
The ability to immediately take time away from my unit for a little while.						
A specified peaceful location that is available to recover and recompose after one of these types of events.						
A respected peer to discuss the details of what happened.						
An employee assistance program that can provide free counseling to employees outside of work.						
A discussion with my manager or supervisor about the incident.						
The opportunity to schedule a time with a counselor at my hospital to discuss the event.						
A confidential way to get in touch with someone 24 hours a day to discuss how my experience may be affecting me.						

Questions 11-14 are open-ended questions. Please complete the following 4 open-ended questions:

11. Have you in the past 12 months or currently receiving any type of second victim support at your institution?
    a. If yes, please describe the support received. [Open-ended question]
    b. Are you satisfied with the amount and type of support received? [Open-ended question]

12. What type of second victim support would you like to receive? [Open-ended question]

13. Based on your experience, what would you do differently if you were supporting a peer or colleague going through the same thing you went through? [Open-ended question]

14. What is your advice to us as we design for a "perfect world" where the best support/guidance possible is provided when a team member(s) is emotionally impacted following a patient safety incident? [Open-ended question]

Appendix 2: 2020 Environmental Scan

Survey Questions

1. Are you aware of any services, programs or supports aimed at preventing and/or addressing moral distress for healthcare workers?
   No (go to question 2)
   Yes
   a. Please describe:
   _____

2. Are you aware of any services, programs or supports aimed at fostering healthcare workers' moral resilience?
   No (go to question 3)
   Yes
   a. Please describe:
   _____

3. Are you aware of any tools and resources (e.g. manuals, training resources, policy documents) in place to support psychological self-care for healthcare workers?
   No (go to question 4)
   Yes
   a. Please describe: _____

4. Which organizations and/or people should we be collaborating with in this effort?

5. Do you have any advice as we begin research in this field (e.g., terms to search, websites or journals to visit, etc.)?
   Yes
   a. Please describe:
   _____

6. Are you aware of any tools and resources (e.g. manuals, training resources, policy documents) in place to support psychological self-care for healthcare workers?
   No (go to question 7)
   Yes
   a. Please describe: _____

7. Which organizations and/or people should we be collaborating with in this effort?

8. Do you have any advice as we begin research in this field (e.g., terms to search, websites or journals to visit, etc.)?

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