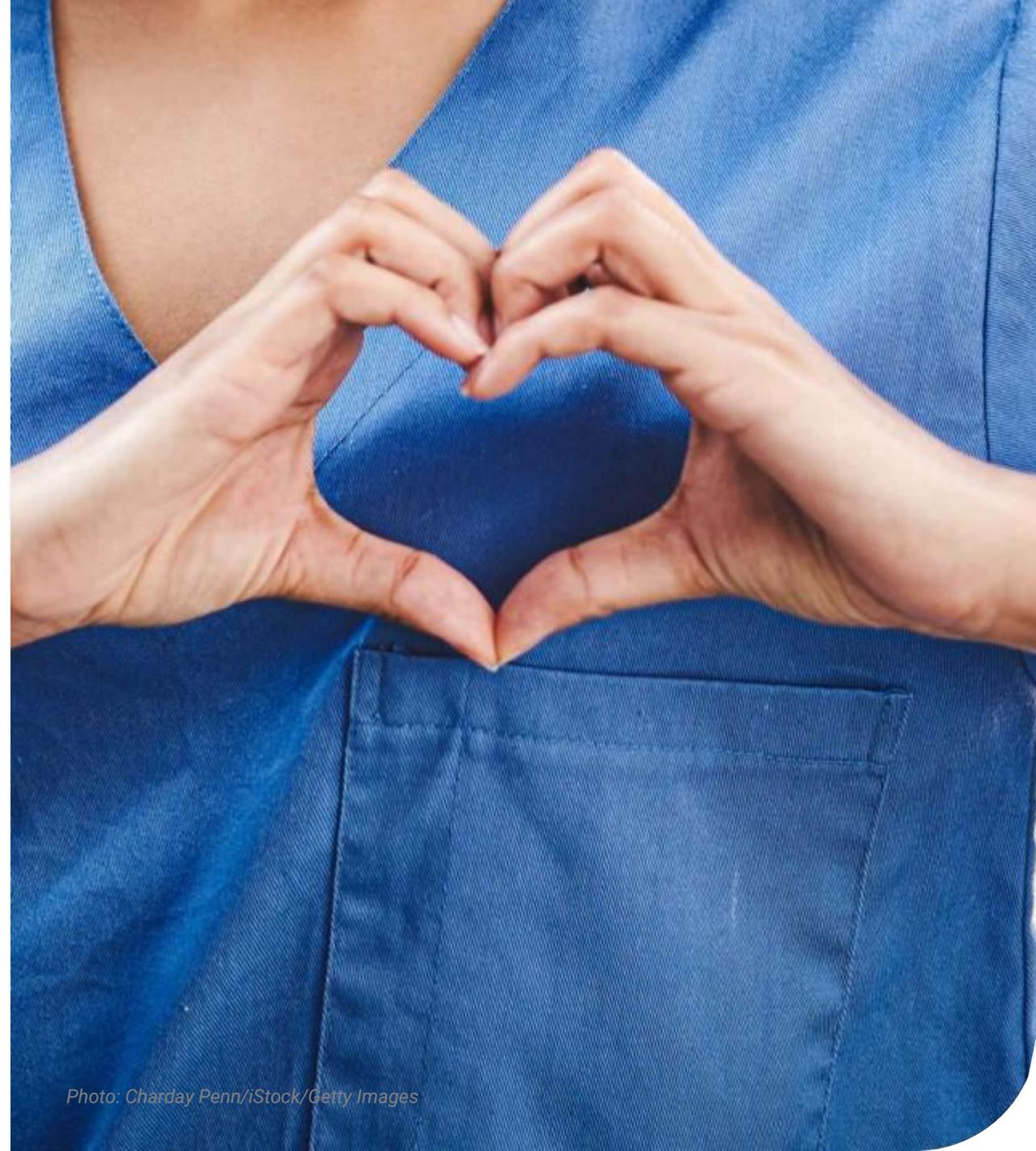


Adverse Events

Caring for health care workers - Building resilience and safety culture

BMJ International Forum 2026 Oslo



Presenters



Joy Buikema Fjærtøft
Project Leader
Organizational Psychologist
Norwegian Directorate of Health



Katja Schrøder
Midwife, Associate Professor
Department of Public Health
University of Southern Denmark



Elisabeth Kehlet
Specialist Psychologist
Special Advisor
Vestfold Hospital, Norway

Health and Care Services, Norway

Population 5,6 million • Large distances • 340,000 employees • 357 municipalities
60 hospitals • Oslo University Hospital is Europe's largest with 24,000 employees



Norway ranks first in patient safety
Imperial College London, 2025

Still, patient harm in 12% of hospital stays
Global Trigger Tool, 2025



Helsedirektoratet

Norwegian Directorate of Health

Guide to caring for patients, users, families and employees involved in adverse events

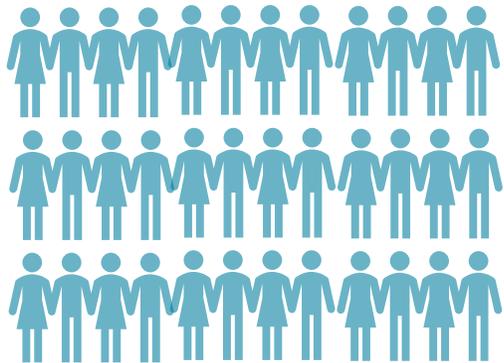


Materials in English

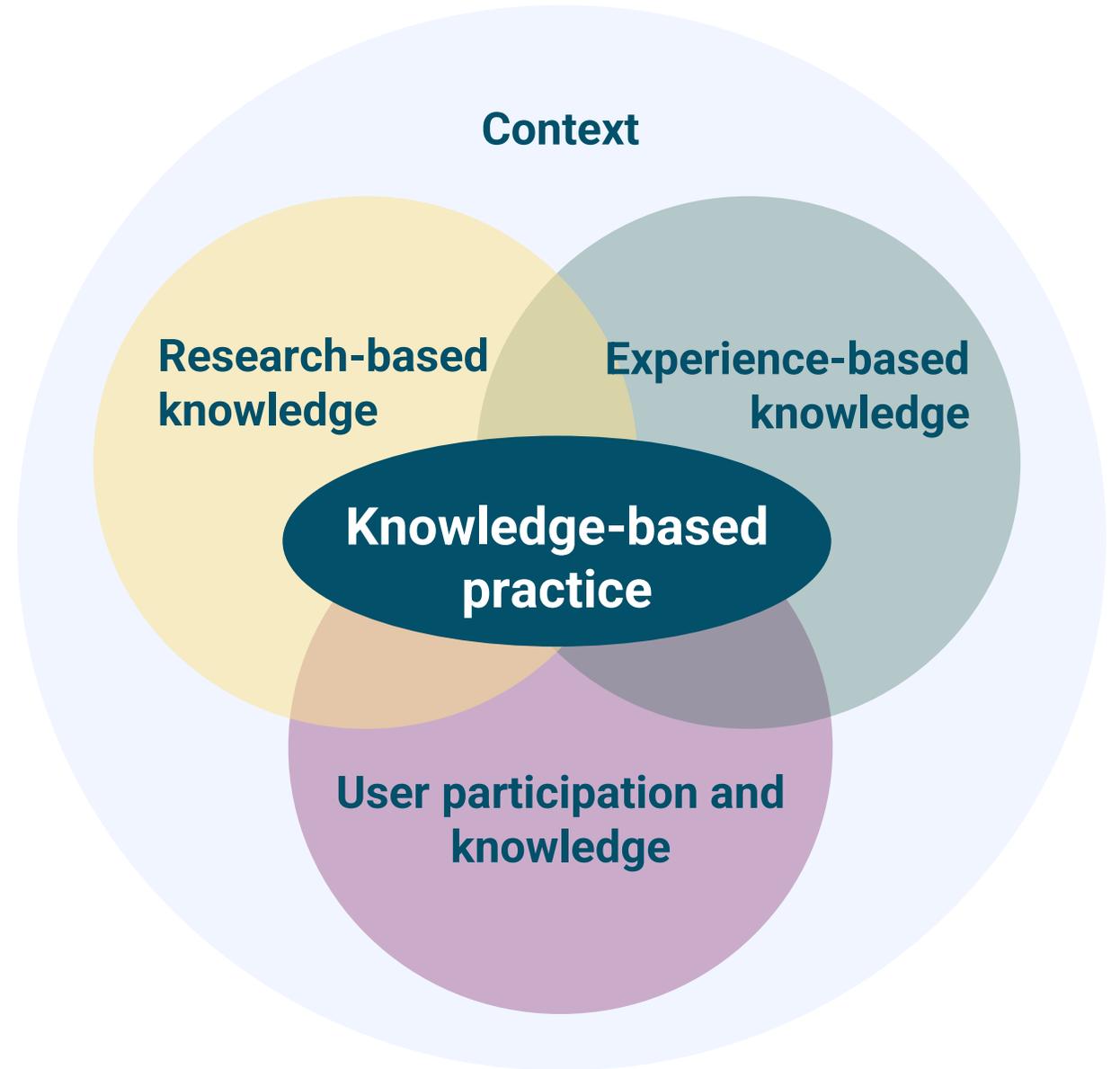
Co-creative process



Project group



Reference group



Integrated perspective



Patients, users, family



Employees

Talking about what goes wrong requires a high level of psychological safety



Photo: Yuri Arcurs/Mostphotos

Expanded concept of care

more than emotional support

- systematic process with several steps
- includes participating in incident reviews, learning and improvement
- starts before an event even occurs



Caring for health care workers. 10 steps

Acute Phase

Follow-up Phase



Empathy and support



Foto: Stockbilder

Seminars

Preparation for mastery

- adverse events: prevalence, type
 - normal reactions
 - how would you like to be treated?
 - peer support
-
- training for conversations with patients and relatives

→ Build resilience
→ Avoid stigmatization



Photo: Yuri Arcurs Mostphotos

Culture of infallibility

Swedish and Danish research show that 71-92% of midwives and obstetricians have experienced serious adverse events

yet have **low acceptance for fallibility.**

Schrøder, et al. 2021

→ Hindrance for psychological safety



Reactions after events can be

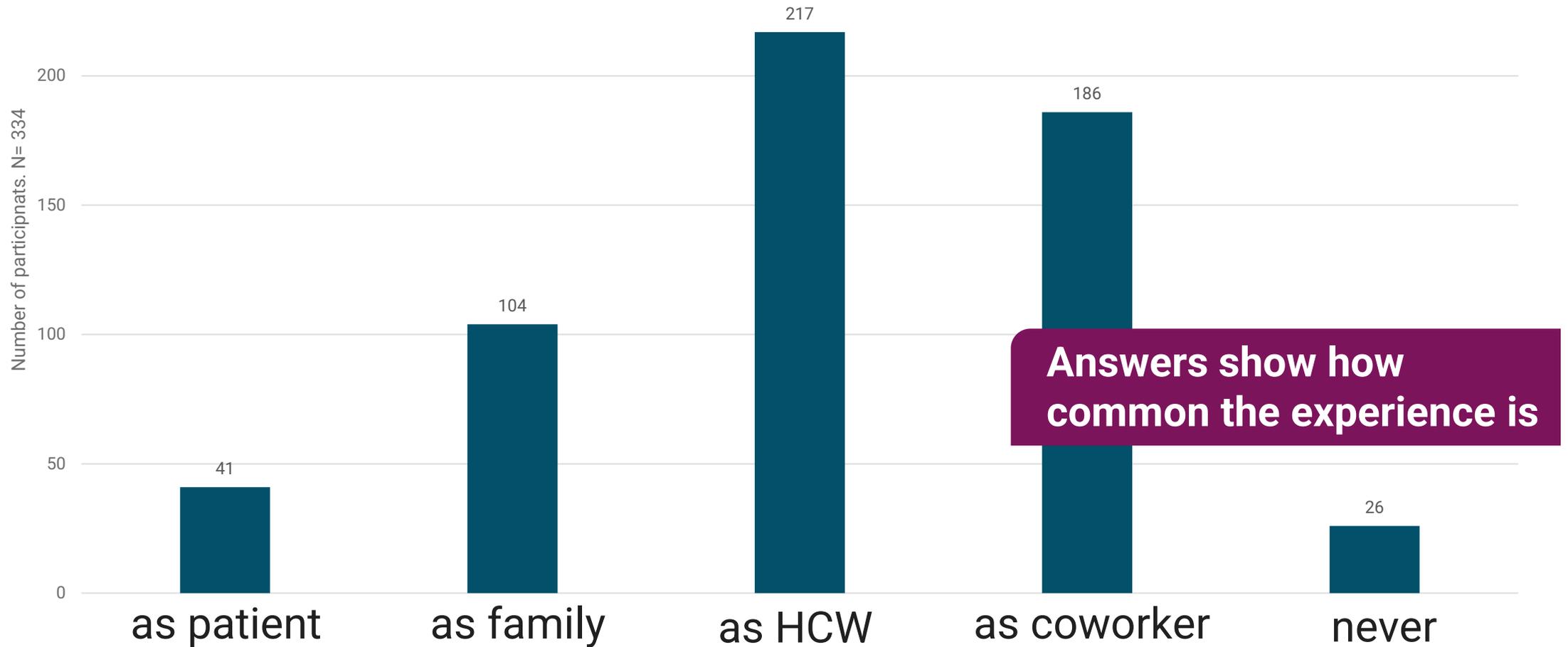
- change in sense of identity
 - shame
 - isolation
-
- anxiety, depression, burnout
 - defensive practice
 - leaving the profession

Schrøder et al. 2021, Van Gerven et al 2016, Øyri et al. 2023, Busch et al. 2020 and others

1

Have you ever been involved in an adverse event?

patient harm, potential harm, complication, medication error, misdiagnosis, missed care...



2

What emotions or themes do you associate with this experience?

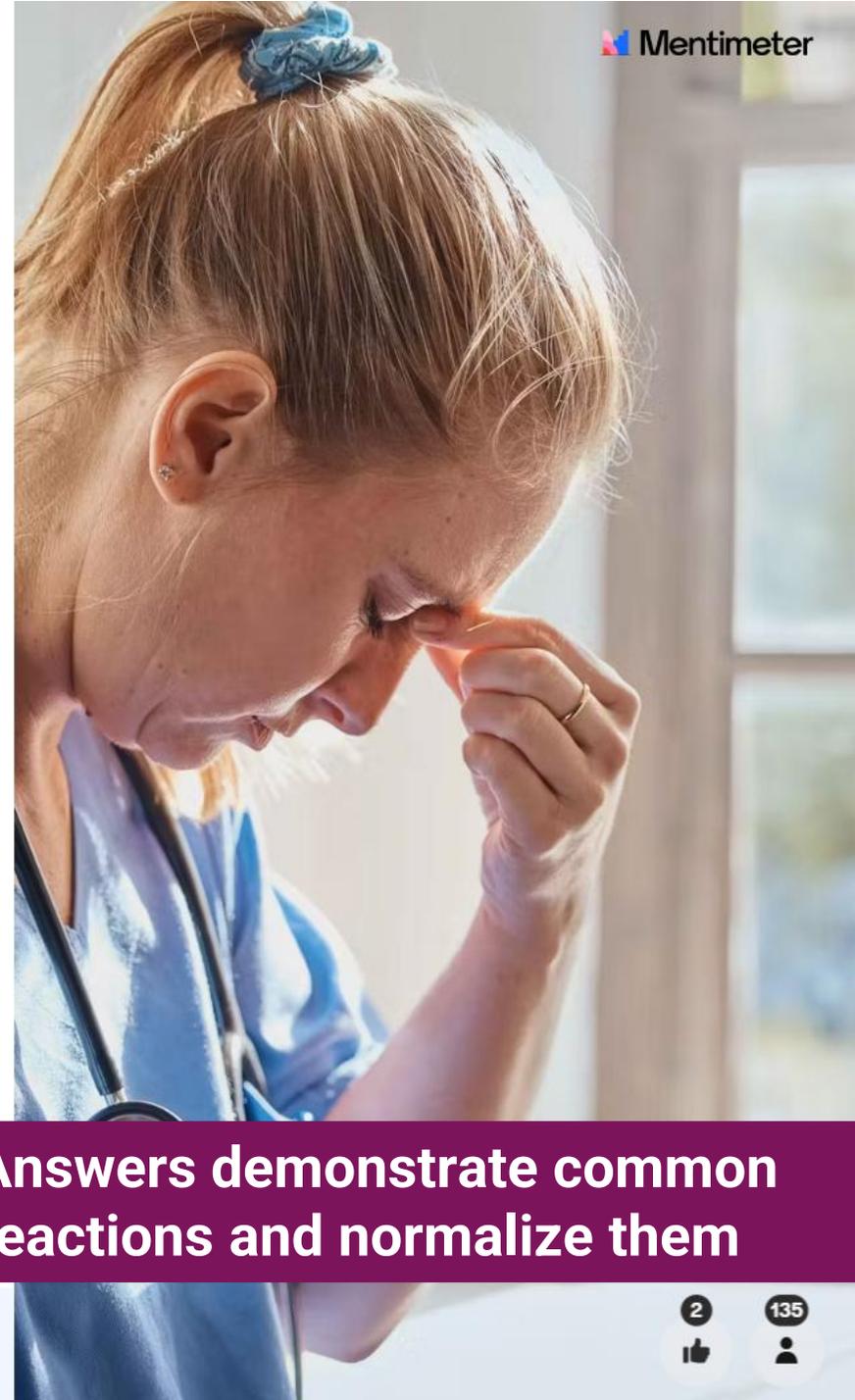
- Fear, anxiety
- Shame
- Positive follow-up - various examples
- Inadequacy, incompetency
- Sorrow, sadness
- Guilt
- Powerlessness, helplessness
- Despair
- Uncertainty
- Questions what happened?, what could have been done differently?



Number of replies

Top ten

N = 252 persons



Answers demonstrate common reactions and normalize them

3

How would you have liked to be met, what were your needs?



- Support
- Understanding
- Talks, be listened to
- Care, empathy, kindness
- Review of the event
- Follow-up
- Learning
- Confirmation
- Accept for fallibility
- Openness and honesty

Number of replies

Top ten

N = 252 persons

Answers demonstrate that needs are such that colleagues can support one another



Types of peer support

Informal peer support

Buddy system

Local team

Central resource group

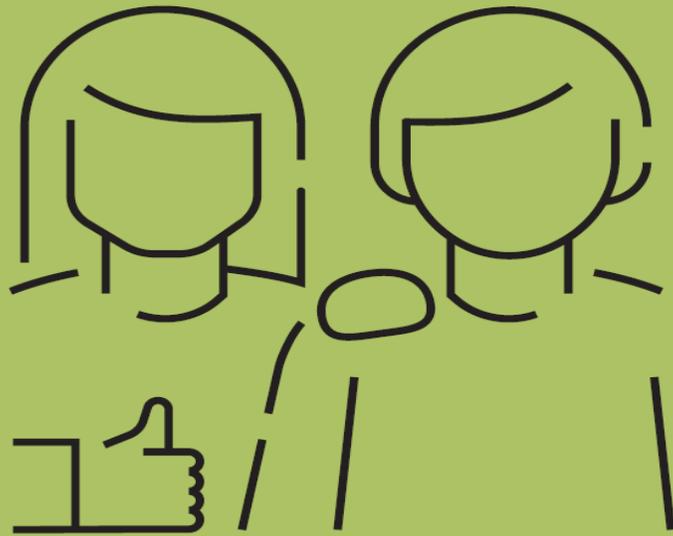
Professional associations'
peer support systems

Formalizing peer support

- shows that the organization cares
- influences the culture positively
- can be implemented with low-threshold, low-cost interventions

The buddy study

– et kollegialt støtteprogram
for medarbejdere



Buddy system

- All HCPs must attend a seminar about second victim, listening skills and ‘buddy talk’ (2 hours).
- After this, all must choose two buddies from their group of peers (interprofessional).
- The buddy is notified if there has been an adverse event.
- Buddy-talks are confidential.
- Two hours are allocated for the buddy-talks – distributed as you see fit. Must not extend beyond four weeks.

The buddy role

- Contact the colleague involved within 24 (or 48) hours. If this is not possible, the alternate buddy is activated.
- Provide psychological first aid: Be present and able to contain and support the other person.
- “Walk with the person” – be a companion on the journey.



Photo: Priscilla du Preez/Unsplash

Results

Seminar

- I have gained knowledge about the second victim phenomenon 98%
- I feel prepared to become a buddy for my colleagues 87%
- I am satisfied with the overall content of the seminar 92%

Buddy-talks

- After 18 months, 26 HCPs had activated their buddy (out of 29 registered buddy calls)
- Other support programs report that smaller numbers use the programs than anticipated

Self-selected relations were considered to add a greater sense of safety and to encourage a general sense of responsibility toward each other.

Talking to a peer with the same background and training was considered to provide more qualified professional assessment of clinical decision-making.

Simulation training

Conversations with patients, users and families



Practicing conversations in pairs



In a real situation there are often more participants. Here it is you and your partner who have the conversation – one in the role as patient/user/family member, and the other as a health care worker (HCW).

Photo: Andrew de Martin/Moonta/istock

"Imagine the event involved your wife, children, mother, father, or yourself.... Imagine the conversation you would like to have with the doctor and the team, and if necessary, management."

Jannicke Mellin-Olsen (1957-2025)
anesthesiologist and board member
Patient Safety Movement

Learning objectives – practice conversations

1. Acknowledge that an unfortunate event has occurred.
2. Determine whether the case calls for an expression of regret and/or apology
3. Show empathy and acknowledge (validate) reactions.
4. Express regret and/or apologize in a way that feels genuine and sincere.
5. Give the patient/family time to process what is said.
6. Invite them to give feedback (then and there, or later), so that services can be improved.

Check the memory card "Caring for patients, users, and families" for the distinction between expressing regret and conveying a sincere apology.

Procedure – steps in the simulation training

1. Choose a case and determine roles. Use your imagination and fill in the case so it is meaningful for you.
2. The patient/family member/HCW specified says the opening line.
3. HCW leads a conversation in line with the learning objectives.
4. The HCW shares their reflections on the conversation.
5. The patient reports back with the learning objectives in mind
 - what worked well
 - what they would like more of.
6. If time permits, have another round of the conversation.
7. Switch roles and go through the case again, or choose a new one.

Four cases



1

Medication error. Wrong dose

Edel was an active 78-year-old widow who lived at home without assistance from the health services. She had the misfortune to fall and break her hip, and is staying in the orthopedic ward for a few extra days due to severe pain. The doctor prescribed 5 mg morphine at a strength of 10 mg/ml intravenously every 3-6 hours as needed.

During the night Edel asked for morphine for the pain. There was a lot to do that shift, and the nurse on duty did not get any help to double-check the medication. She was stressed by all the patients who needed help and supervision. The nurse administered the morphine dose, but miscalculated it. Instead of 0.5 ml of morphine, Edel received 5 ml of morphine intravenously.

When the nurse checked on Edel half an hour later to see if the morphine had effect, Edel was unresponsive, her skin pale and clammy, and her breathing rate low. The nurse called the doctor and said she suspected that Edel has been given too much morphine. The doctor prescribed Naloxone repeatedly throughout the night until Edel is stable.

The next day, Edel received information about what had happened and called her daughter. Her daughter asked to meet with the nurse and doctor.

Opening remark from daughter:

"How could something like this happen? It was just luck that this turned out well. Don't you have procedures for double-checking?"

2

Suicide. Man with cognitive impairment

Kjell was 60 years old and had a senior management position. He had been in mental health care for the past three weeks, examined and diagnosed with frontal lobe dementia. This was a great loss and sorrow for Kjell. According to his spouse, he had recently been restless, irritable, slept little and eaten little.

He was discharged at his own request. He wanted to go home, explaining he had things to do in order to finish his job properly. He also wanted nothing more to do with mental health care.

Kjell took his own life two days after being discharged.

You invite the family members to follow-up conversations, in order to express regret/apologize for the patient being discharged without further action.

You and head of the mental health center meet with the son (27) from a previous marriage. He is angry and wants an explanation as to why there was no follow-up after discharge.

Opening remark from son:

"How could you discharge Dad without offering any follow-up? The guidelines state that families should be involved in the discharge process, but I heard nothing."



Materials in English

Example Implementation

- Case and simulation training is **integrated in a new competence program** for suicide prevention and follow-up, 13 000 users
- To better care for families og promote more openness to their ideas for improvement
- To better prepare health care workers and build resilience



Simulation training for hospital leaders

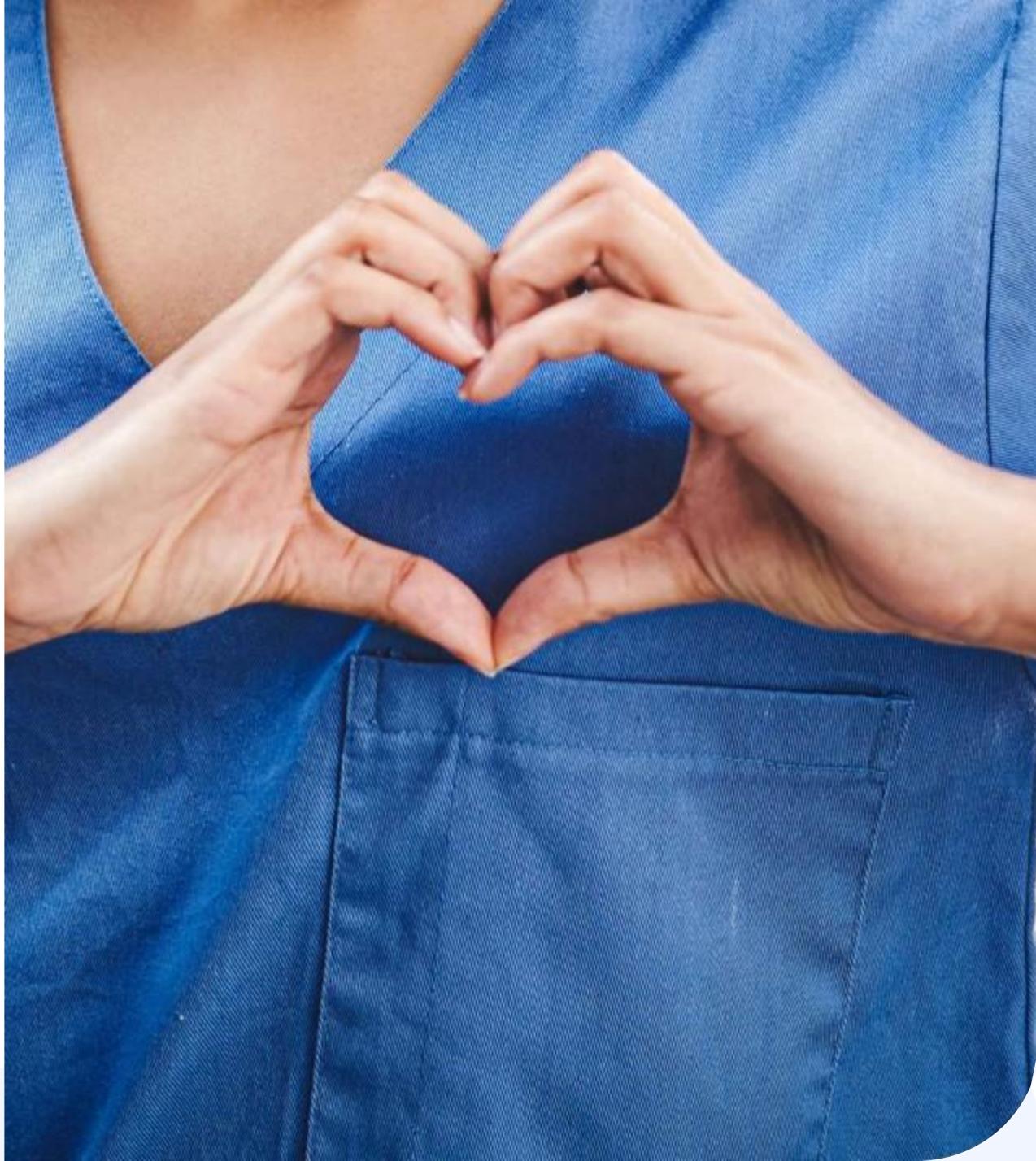
- A tilbakemelding hva den var fornøyd med og hva den ville gjort annerledes.
 - Hvilke vurderinger som lå bak valgene.
 - B tilbakemelding hva som fungerte bra og hvorfor.
 - Gjenta om tid?
- 2 minutter:
- Debriefline – lærte dere noe? Hva?



Summing up

Build resilience and safety culture by caring for employees:

- systematic follow-up after adverse events
 - emotional support as well as learning from events
 - compassionate leadership
-
- **preparation through short seminars with simulation training**
 - **peer support**



Visit our poster!

- caring for patients, users and families
- conversations and apologies
- restoring trust

Collaboration?

- joy.buikema.fjaertoft@helsedir.no

Caring for patients, users and families in connection with adverse events



Better care of all involved in adverse events has the potential to not only mitigate their suffering in the short and long term, but to also restore relationships and trust, promote psychologically safe, open and learning cultures, and thus prevent future adverse events.



The Norwegian Directorate of Health published in 2024 a guide to caring for patients, users, families and employees in connection with adverse events. It was developed using an evidence-based and co-creative process with broad participation of stakeholders, including those with lived experience, as illustrated in the knowledge model here.

The guide describes what is important to consider, why this is so, based on the knowledge model, and in addition includes practical tools that show how the guidelines can be operationalized and put to use.

Seminar models have been developed, as well as other initiatives and supporting materials, for example short version laminated cards, to promote distribution and implementation.



Caring

Caring involves not only empathy and support, but also restorative actions, and inviting those involved to take part in safe learning arenas after an event

Context and background

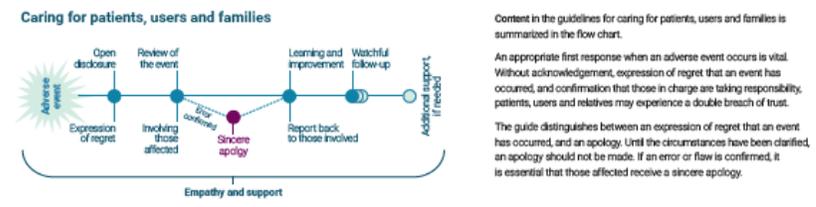
Norway ranks first internationally in patient safety (Imperial College London, 2025), nevertheless there are challenges regarding

1. level of patient harm
2. economic and human costs of adverse events
3. reporting and discussing errors in healthcare

Objectives

The objectives of the project are threefold

1. improved care of those affected by adverse events
2. more psychologically safe, open and learning-minded cultures
3. broad and flexible implementation



Elements in a sincere apology

- 1 Acknowledgement of error(s)
- 2 Description of what happened
- 3 Clear stance on taking responsibility
- 4 Expression of remorse
- 5 Change in behavior/practice

Pseudo-apologies

- 1 Regretting the patient's or family's reaction to the event, not the event itself
- 2 Giving only an explanation of what happened, without expressing feeling sorry
- 3 Appearing forced, or apologizing without really meaning it, because one has been told to do it
- 4 Conducting an apology as a formality, without emotion or empathy

Restorative approach

Restoration of

- relations
- mental health
- trust

• showing empathy

- asking, not assuming
- listening
- involving in learning and improvement

Response

- The guide has been positively received as addressing an unmet need.
- Implementation activities are underway in health and care facilities throughout the country.
- Various meetings and conferences, simulation-training in conversations after adverse events, revised procedures and practice, e-learning and other materials.
- The authors continue to be active in promoting and presenting the guide.

Authors: Joy Buikema Fjaertoft, Norwegian Directorate of Health / Olav Raste, University of Oslo, Oslo University Hospital / Frank Andersen, Patient Injury Association / Jannicke Bruvik, Patient and Service User Ombudsman / Line Hsaund, Norwegian Nurses Organization / Tone Bovim, Regional Centre – Violence, Trauma and Suicide Prevention, Oslo University Hospital / Sina Fumes Øyl, SHARE - Centre for Resilience in Healthcare at University of Stavanger, Stavanger University Hospital / Kim Edgar Karlsen, Norwegian Psychological Association / Karin Isaksson Rø, Institute for Studies of the Medical Profession / Elisbeth Kehlet, Vestfold Hospital / Jannicke Mellin-Olsen (deceased) Basrum Hospital, Patient Safety Movement Board.

All affiliations, except Patient Safety Movement Board, are located in Norway. Contact: joybuikema.fjaertoft@helsedir.no





Helsedirektoratet

Norwegian Directorate of Health

