# Seminar to prepare health care workers for adverse events. A brief facilitation guide

The purpose of the seminar is to prepare health care workers (HCW) for adverse events and build individual and organizational resilience by

- making them aware that incidents occur quite often, and what types of events may be encountered
- normalizing the personal reactions that arise, conveying that it is common and normal to react to unexpected and unfortunate events
- demonstrating what common needs in such a situation are and how colleagues can support each other
- creating a safe space for reflection and training
- giving an orientation on the importance of peer support and what it involves
- informing about procedures for event reporting and handling, including peer support

The seminar concept can be delivered in more broad-based training or onboarding settings, even in large groups, and/or at the departemental level. For the latter, it relevant to address in more detail the types of events that can be encountered and the local procedures for reporting and handling events, including the system for peer support available. The seminar can in general be tailored to different needs, for example by holding the two parts on different occasions.

The seminar builds on the principles in "Guide to caring for patients, users, families, and employees in connection with adverse events". Here is a Summary in English - Helsedirektoratet. Memory cards are available as a quick overview, as well. You will find these here Memory cards and Seminar for employees - Itryggehender together with the power point presentation "Preparing for mastery" which shows a line-up of slides for the seminar.

**A safe learning environment**

It is essential to create a psychologically safe learning environment for the seminar(s). Organizing a group into smaller discussion groups of two or three, or using digital tools such as Mentimeter for anonymous replies, reduces the degree of self-exposure and fosters openness and psychological safety. For simulation training, additional efforts are needed, as described in part two.

**A trusted facilitator**

Some parts of the seminar can be led by a manager, for example when it comes to local procedures for reporting and handling adverse events. Such topics are best left for a later stage in the seminar program, however, after a first stage of reflection. The key questions for reflection are best led by a facilitator, which can be a trained facilitator or a person from occupational health services, but can also be a trusted, experienced colleague or advisor.

## Part 1

**Introduction**

The introduction is intended to be quite brief as the reflection questions and peer support information are the main sections in part 1. The introduction touches on

- the frequency of occurrence of adverse events,
- the concept of infallibility culture and how perfection is an unrealistic expectation and can hamper necessary openness and learning
- what some of the short term reactions, and long term consequences, of being involved in adverse events can be.

**Key questions for reflection**

**1** We often start with a warm-up question, to tune the participants into the topic as well as set a reflection mode. At the same time the answers to the question demonstrate how common the experience of being involved in an adverse event is.

We ask ***Have you ever been involved in an adverse event?*** and give some exemplifications: "patient harm, potential harm, complication, medication error, misdiagnosis, missed care...". More than one answer is available, and the alternatives are 1) as a patient 2) as a family member 3) as an employee/HCW 4) indirectly, as a colleague 5) never.

Use of a digital tool such as Mentimeter, makes it very easy to share the answers (after all are collected, so that the participants are not influenced by others' answers). After collecting replies, we show them to the participants and comment on how common this experience is, as shown not only in national and international data, but also in the group's own data[1]. We tie this finding to the culture of infalliblity and its unrealistic expectations. Of course, the primary goal is to prevent errors and other adverse events, bur perfection is an unattainable goal, and being aware of this makes it easier to have an open, safe and learning-minded culture, which will in turn prevent adverse events.

**2** The next question is ***Think of an adverse event or a traumatic experience you have been involved in – which emotions or themes do you connect with this experience?*** [2] The answers demonstrate that many say the same thing, that there are common reactions, and this normalizes reactions, so that the individual HCW does not feel alone in having such experiences.

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[1] The distribution of answers is very similar from group to group in our experience, with very few who have never been involved. For the other alternatives, most answers are in the category of as an employee/HCW, followed by "indirectly, as a colleague", then as a family member, and lastly, as a patient.

[2] We would like to thank Dr Katja Schrøder, The University of Southern Denmark, for her work on employee seminars that has inspired our concept, including for the specific questions number 2 and 3, as well as her work on the "buddy system". Schrøder K, Bovil T, Jørgensen JS, Abrahamsen C. Evaluation of'the Buddy Study', a peer support program for second victims in healthcare: a survey in two Danish hospital departments. BMC Health Services Research. 2022;22(1)

3 The third question is **Think of the same situation again. How would you have liked to be met, what were your needs?** Again, the answers demonstrate that many say the same thing, that these are common needs, and that they often have not been met, although there are exceptions. The answers also demonstrate that the most common and basic needs are such that colleagues can support one another.

**Peer support**

The third question leads naturally to the topic of peer support. We do not recommend any one particular approach in our guidelines, since the needs and experiences of the various health and care institutions differ, but describe a variety of alternatives:

- informal peer support
- buddy system
- local team of dedicated, trained peer supports
- central resource group
- professional associations' peer support systems

We do, however, emphasize that peer support is what HCW find most important, and that formalizing peer support shows that the organization cares, and influences the culture positively as well. Moreover, peer support can be implemented with low-threshold, low-cost interventions, and we describe the buddy system to illustrate this.

**Additional topics**

As mentioned, local procedures are a relevant topic to include in such a seminar, including how the department or organization intends to or has organized peer support[3].

In addition, there is the importance of an open, safe and learning culture. This will in most cases demand more work than a seminar as described here, more than procedures and a peer support system, although these can be a positive force. Compassionate leadership and how to develop culture are described in more detail in our guide, and summarized in English in the memory card "Leadership and culture".

## Part 2

Part two is low-level, case-based simulation training for conversations with patients, users and families after adverse events.

[3] We would like to thank special advisor, Elisabeth Kehlet, Vestfold Hospital, for her assistance in designing and implementing case-based simulation training as related to the guide.

The intention also here is to prepare HCW and create a sense of self-efficacy, which in turn contributes to individual and organizational resilience. These are difficult conversations, and many are in addition hesitant when it comes to role play and simulation training, so it is especially important to take steps to create a safe learning environment. These include

- an introduction to the topics at hand, here, acknowledging that an event has occurred, the difference between an expression of regret and an apology, among others. This clarifies what is expected in the conversations
- framing the training as *practice*, like when practicing in a band og in sports, and *not a performance*. If possible timewise, giving an opportunity to try again in a new round underscores that this is practice
- a set-up where participants work in pairs, without an observer
- realistic cases, that participants can feel relate to their work situation
- in the debriefing phase, the person in the pair playing the HCW shares their reflections first
- feedback should be tuned in to the HCWs experience of the training, and focus on the positive, as well as carefully addressing what the recipient would have liked more of, less of, or done differently

Our experience is that participants find these sessions very engaging. Comments have been that they are surprised how much the case and training gave them new perspectives, in particular that of patients, users and families.

The set-up can be used not only in HCW groups, but also in leadership groups to both promote understanding and engagement in caring for those involved in adverse events, and to prepare for conversations and statements as leaders.

We have four ready-made cases, but tailor-made cases can be an even better option.