

## MITSS STAFF SUPPORT ASSESSMENT TOOL

**In order to assess the support mechanisms currently in place at your institution for clinicians involved in or affected by serious adverse patient events, staff can fill out the survey below. For purposes of this survey, we have defined serious adverse patient event as any unexpected, unanticipated incident that is not related to the patient's underlying condition or reason for treatment that results in harm to the patient. The event may or may not be due to medical error.**

In the past 5 years, have you ever been directly involved in a serious adverse patient event? Y  N   
(E.g.: member of team caring for patient who expires during care unexpectedly, etc.)

If you have answered yes, please go on to the following sections regarding services or interventions relating to staff support. If you have been involved in more than one adverse patient event, please base your answers on your most recent experience.

| <b>For the services or interventions listed below,<br/>please indicate their <u>availability</u> to you following the event:</b>  | Not Available         |   |   |   |
|---|-----------------------|---|---|---|
|   | Found on my own       |   |   |   |
|   | Offered After I Asked |   |   |   |
|   | Actively Offered      |   |   |   |
| <i>For each line, please mark the <u>one</u> response that best reflects your experience</i>  |                       |   |   |   |
| Formal emotional support  | ○                     | ○ | ○ | ○ |
| Informal emotional support  | ○                     | ○ | ○ | ○ |
| Prompt debriefing, crisis intervention stress management (either for individual or for group/team)  | ○                     | ○ | ○ | ○ |
| Access to counseling, psychological or psychiatric services   | ○                     | ○ | ○ | ○ |
| An opportunity to discuss any ethical concerns you had relating to the event or the processes that were followed subsequently   | ○                     | ○ | ○ | ○ |
| An opportunity to take time out from your clinical duties   | ○                     | ○ | ○ | ○ |
| Supportive guidance/mentoring as you continued with your clinical duties  | ○                     | ○ | ○ | ○ |
| Help to communicate with the patient and/or family  | ○                     | ○ | ○ | ○ |
| Clear and timely information about the processes that are followed after serious adverse events (e.g. peer review committees, root cause analyses, preparation of incident reports) | ○                     | ○ | ○ | ○ |
| Guidance about the roles you were expected to play in the processes that are followed after serious adverse events  | ○                     | ○ | ○ | ○ |
| Help to prepare to participate in the processes that were followed after the serious adverse event  | ○                     | ○ | ○ | ○ |
| A safe opportunity to contribute any insights you had into how similar events could be prevented in the future  | ○                     | ○ | ○ | ○ |
| Personal legal advice and support   | ○                     | ○ | ○ | ○ |

*For other forms of support please see question 4 below*

| <b>For the services or interventions that were <u>available to you</u> following the event,<br/>please indicate whether you used any of them:</b> | Yes | No | N/A |
|---|-----|----|-----|
| <i>For each line, please mark <u>one</u> response that best reflects your experience</i>  |     |    |     |
| Formal emotional support  | ○   | ○  | ○   |
| Informal emotional support  | ○   | ○  | ○   |
| Prompt debriefing, crisis intervention stress management (either for individual or for group/team)  | ○   | ○  | ○   |
| Access to counseling, psychological or psychiatric services   | ○   | ○  | ○   |
| An opportunity to discuss any ethical concerns you had relating to the event or the processes that were followed subsequently                     | ○   | ○  | ○   |
| An opportunity to take time out from your clinical duties   | ○   | ○  | ○   |
| Supportive guidance/mentoring as you continued with your clinical duties  | ○   | ○  | ○   |
| Help to communicate with the patient and/or family  | ○   | ○  | ○   |

|  |                       |                       |                       |
|--|-----------------------|-----------------------|-----------------------|
| Clear and timely information about the processes that are followed after serious adverse events<br>(e.g. peer review committees, root cause analyses, preparation of incident reports) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Guidance about the roles you were expected to play in the processes that are followed after serious adverse events   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Help to prepare to participate in the processes that were followed after the serious adverse event   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| A safe opportunity to contribute any insights you had into how similar events could be prevented in the future   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Personal legal advice and support  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

*For other forms of support please see question 4 below*

| <b>For the services or interventions that you used please indicate how useful you found each of them:</b>  | <b>Not Useful</b>     | <b>Somewhat Useful</b> | <b>Useful</b>         | <b>Very Useful</b>    | <b>N/A</b>            |
|--|-----------------------|------------------------|-----------------------|-----------------------|-----------------------|
| <i>For each line, please mark the <u>one</u> response that best reflects your experience</i>   |                       |                        |                       |                       |                       |
| Formal emotional support   | <input type="radio"/> | <input type="radio"/>  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Informal emotional support   | <input type="radio"/> | <input type="radio"/>  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Prompt debriefing, crisis intervention stress management (either for individual or for group/team)   | <input type="radio"/> | <input type="radio"/>  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Access to counseling, psychological or psychiatric services  | <input type="radio"/> | <input type="radio"/>  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| An opportunity to discuss any ethical concerns you had relating to the event or the processes that were followed subsequently  | <input type="radio"/> | <input type="radio"/>  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| An opportunity to take time out from your clinical duties  | <input type="radio"/> | <input type="radio"/>  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Supportive guidance/mentoring as you continued with your clinical duties   | <input type="radio"/> | <input type="radio"/>  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Help to communicate with the patient and/or family   | <input type="radio"/> | <input type="radio"/>  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Clear and timely information about the processes that are followed after serious adverse events<br>(e.g. peer review committees, root cause analyses, preparation of incident reports) | <input type="radio"/> | <input type="radio"/>  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Guidance about the roles you were expected to play in the processes that are followed after serious adverse events   | <input type="radio"/> | <input type="radio"/>  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Help to prepare to participate in the processes that were followed after the serious adverse event   | <input type="radio"/> | <input type="radio"/>  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| A safe opportunity to contribute any insights you had into how similar events could be prevented in the future   | <input type="radio"/> | <input type="radio"/>  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Personal legal advice and support  | <input type="radio"/> | <input type="radio"/>  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

*For other forms of support please see question 4 below*

### **Other forms of support:**

Were there were other forms of support that are not covered in the lists above that were offered to you, that you used, found useful or would have found useful?

| <b>Are there any other types of support, not listed above, that you were offered, used, found useful, or think you would have found useful?</b> | <b>offered</b>        | <b>used</b>           | <b>found useful</b>   | <b>would have found useful</b> |
|---|-----------------------|-----------------------|-----------------------|--------------------------------|
| <i>Please describe briefly below and tick as many options as apply to the right:</i>  |                       |                       |                       |                                |
|   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/>          |
|   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/>          |
|   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/>          |
|   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/>          |
|   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/>          |
|   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/>          |
|   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/>          |
|   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/>          |
|   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/>          |
|   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/>          |
|   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/>          |
|   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/>          |
|   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/>          |

**Experiences following the event:**

| Please indicate your level of agreement or disagreement with the following statements about your experiences following the adverse event                  | I do not know  |       |          |                   |  |
|---|----------------|-------|----------|-------------------|--|
|   | Strongly agree | Agree | Disagree | Strongly Disagree |  |
| <i>Please complete all questions by marking the <u>one</u> response that best reflects your experience</i>  |                |       |          |                   |  |
| 1. I was always clearly briefed about the 'next steps' in the hospital's processes for following up after serious adverse events                          |                |       |          |                   |  |
| 2. Memories of what happened to the patient kept troubling me for a long time after the event   |                |       |          |                   |  |
| 3. I worried a lot about what my clinical peers would think about me after the event  |                |       |          |                   |  |
| 4. I knew how to access confidential emotional support within the institution if I needed it  |                |       |          |                   |  |
| 5. The hospital had a clear process through which I could report any concerns I had about patient safety without fear of retribution or punitive action   |                |       |          |                   |  |
| 6. I found it difficult to continue to practice effectively after the event   |                |       |          |                   |  |
| 7. I worried a lot about a lawsuit (or the possibility of one)  |                |       |          |                   |  |
| 8. I felt (or would have felt) embarrassed about seeking psychological support after the event  |                |       |          |                   |  |
| 9. My clinical colleagues provided meaningful and sustained support after the event   |                |       |          |                   |  |
| 10. There were times when I felt less able to work safely and effectively because of what happened  |                |       |          |                   |  |
| 11. My clinical line manager provided meaningful and sustained support after the event  |                |       |          |                   |  |
| 12. For a while after the event I felt shunned by some of my clinical colleagues  |                |       |          |                   |  |
| 13. My family and friends were the mainstay of my support after the event   |                |       |          |                   |  |
| 14. I moved or seriously considered moving to another institution because of the event or what happened afterwards  |                |       |          |                   |  |
| 15. I left or seriously considered leaving my profession because of the event or what happened afterwards   |                |       |          |                   |  |
| 16. I was enabled to communicate appropriately with the patient and/or family after the event   |                |       |          |                   |  |
| 17. There was a designated member of the organization who did a good job guiding me through the processes that are followed after a serious adverse event |                |       |          |                   |  |
| 18. I felt adequately supported by the organization and associated structures   |                |       |          |                   |  |
| 19. I think that the organization learned from the event and took appropriate steps to reduce the chance of it happening again                            |                |       |          |                   |  |
| 20. I feared having to speak to the patient and/ or family  |                |       |          |                   |  |
| 21. I had the opportunity to speak with the patient and/or family   |                |       |          |                   |  |
| 22. I wanted to speak to the patient and/or family but was told not to do so  |                |       |          |                   |  |
| 23. I was supported/trained in how to disclose to the patient and/or family   |                |       |          |                   |  |
| 24. I had extreme anxiety about disclosing to the patient and/or family   |                |       |          |                   |  |
| 25. The organization ensured that the needs of the patient and/or family after the event were appropriately met   |                |       |          |                   |  |

**Background**

Please provide some background details about yourself, and when and where the adverse event occurred.

|                             |                           |                       |
|-----------------------------|---------------------------|-----------------------|
| The adverse event occurred: |                           |                       |
| Less than 1 years ago       | Between 1 and 3 years ago | More than 3 years ago |

|  |                        |            |
|--|------------------------|------------|
| Since then, do you think support for clinicians involved in serious adverse events in the organization in which it occurred has: |                        |            |
| Improved:  | stayed about the same: | got worse: |

|  |            |           |       |
|--|------------|-----------|-------|
| Which of the following best describes your profession: |            |           |       |
| Nurse  | Pharmacist | Physician | Other |

**We hope that the information you have provided will lead to important and sustainable staff support.**