## **Clinician & Staff Support Survey**

This anonymous, confidential survey will help us assess support mechanisms currently in place for staff involved in or affected by serious adverse patient events. For purposes of this survey, a serious adverse patient event is defined as an **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.

1. In the past 5 years, have you ever been directly involved in a serious adverse patient	event?											
(E.g.: member of team caring for patient who expires during care unexpectedly, etc.)  YES NO		For the services listed, please indicate their availability to you following the event:				For the services that were available to you, indicate whether you used them:			For the services <b>that you used</b> please indicate how useful you found each of them:			
<b>2.</b> If you have answered yes, please complete the following survey 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.	ACTIVELY OFFICELY	CERTED VANDER	THE AFTER OWN	MOTAL.	YES MUNDER	Q	, juk	NOT LOW	SOMEWHAY USEE USEE	The Market	, KEAN LIGHT	TO SEE STATE OF THE SEC
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 process after serious adverse events (e.g. peer review committees, root cause analyses, 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												

<b>3. Other forms of support:</b> 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?		Q		USAFUL.	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
Please describe briefly below and tick as many options as apply to the right.	A A A A A A A A A A A A A A A A A A A	4. 4.	Q. S.	WOULD HA	5
4. Experiences following the event:					
Please indicate your level of agreement or disagreement with the following statements about your experiences following the adverse event.	SHOWER Y	Olsa GAEE	AGREE	STHONORY AGHEFERTY	100 NOT FAIL.
I was always clearly briefed about the 'next steps' in the hospital's processes for following up after serious adverse events					
Memories of what happened to the patient kept troubling me for a long time after the event					
I worried a lot about what my clinical peers would think about me after the event					
I knew how to access confidential emotional support within the institution if I needed it					
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					
I found it difficult to continue to practice effectively after the event					
I worried a lot about a lawsuit (or the possibility of one)					
I felt (or would have felt) embarrassed about seeking psychological support after the event					
My clinical colleagues provided meaningful and sustained support after the event					
There were times when I felt less able to work safely and effectively because of what happened					
My clinical line manager provided meaningful and sustained support after the event					
For a while after the event I felt shunned by some of my clinical colleagues					

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My family and friends were the mainstay of my support after the event					
I moved or seriously considered moving to another institution because of the event or what happened afterwards					
I left or seriously considered leaving my profession because of the event or what happened afterwards					
I was enabled to communicate appropriately with the patient and/or family after the event					
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					
I felt adequately supported by the organization and associated structures					
I think that the organization learned from the event and took appropriate steps to reduce the chance of it happening again					
I feared having to speak to the patient and/ or family					
I had the opportunity to speak with the patient and/or family					
I wanted to speak to the patient and/or family but was told not to do so					
I was supported/trained in how to disclose to the patient and/or family					
I had extreme anxiety about disclosing to the patient and/or family					
The organization ensured that the needs of the patient and/or family after the event were appropriately met					

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

The adverse event occurred:

LESS THAN 1 YEAR 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 has:

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Thank you very much for your assistance in filling out this anonymous, confidential survey. We hope that the information you have provided will lead to important and sustainable staff support.



Which of the following best describes your profession: