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Colleague Care – Implementing a staff peer support program

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Abstract

Objectives: In line with the widespread acknowledgement of the harms which can be caused to healthcare staff through their role in adverse events and unexpected patient outcomes, so is there now acceptance of the role of staff peer support programs to support these 'second victims' in a non-clinical way. Here, we share reproduceable steps that any service might take in creating their own staff peer support program.
Methods: We outline the establishment of a program in a NSW health-service encompassing several hospitals and services, from initiation of the program, customising it to our local needs, engaging the broader health service, launching the program, and the ongoing maintenance required.
Results: Dedicated resourcing and strong executive support have been essential to launch and maintain the program. Reaching all staff in a large organisation and building trust in the program's confidentiality have been the main challenges.
Conclusions: Staff peer support programs, whilst early in their evidence, offer a way to provide practical, non-clinical support to staff harmed through adverse events in healthcare. Here, we offer methodology and learnings for all services to consider when implementing a localised program.

Keywords: second victim, peer support, clinician wellbeing, adverse events, staff health

Since Alfred Wu first coined the term 'second victim' in 2000,[1] there is now widespread acknowledgement in healthcare literature of the distress which can be experienced by healthcare workers involved in adverse events or unexpected patient outcomes.[2–7]

Staff peer-support programs have been developed internationally over the past 15 years to address this,[8–13] after early research identified that impacted staff wished for options beyond Employee Assistance Programs (EAPs) or mental health services.[14–16] Such programs have been considered as part of the Zero Suicides Framework rolled out in many Australian states to support staff impacted by such events[17] and are also featured in Restorative and Just Culture Frameworks.[18]

Staff peer-support is not about 'treating' the second victim, but rather supporting them, reassuring them that such events do occasionally occur, and linking them in with additional resources. This support is provided through 'peer responders', experienced and trusted colleagues who have experienced similar events. In the Scott Three-Tiered Interventional Model of second victim support,[10] three escalating levels of support for second victims are envisaged. Support begins in 'Tier 1', at the base of the

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pyramid, with local unit support available from a manager or colleague in one's department, primarily as reassurance and case review. Staff peer support programs sit in 'Tier 2', where trained peer supporters can provide one-on-one crisis intervention, mentoring, and support through any investigation process. 'Tier 3', at the peak of the pyramid, consists of professional support and guidance through established networks such as EAP, social workers, psychologists, and chaplains. In this way, peer support does not replace but rather augments existing supports.

Sydney Local Health District (SLHD) is a large healthcare organisation with 13000 staff, including five hospitals, a virtual hospital, and several community health services. It has a dedicated physician wellbeing team, MDOK, which has operated since 2017. The desire for a peer support service was born from the distress witnessed by clinical governance and senior staff when supporting staff involved in adverse event processes. In 2019, a collaboration was formed between the clinical governance unit, MDOK, and EAP to pilot a staff peer support program. The small pilot demonstrated feasibility and acceptability, and continued on an infrequent and informal scale over the COVID-19 pandemic.

This article describes the re-implementation of the program and upscaling across the entire District from late 2022. We are grateful to Queensland Health staff for sharing their implementation guide to establish a peer support program,[19] where these steps were first described, which we utilised extensively when developing our own program, as outlined below. We also discuss challenges and learnings along the way.

Initiate

Our first step in initiating a staff peer support program was building a willing coalition. A member of the physician wellbeing team, a psychiatrist with dedicated non-clinical time (SM), was assigned as the program lead. Chief Executive support was pre-existing, and executive sponsorship was provided by the Executive Director Medical Services, Clinical Governance and Risk. This supported the implementation process significantly, including easier collaboration with other relevant streams such as Legal and Workforce.

Our working party consisted of representation from across our District, from all disciplines, with skillsets primarily in clinical governance, mental health (including EAP, mental health staff, and MDOK), education, medicolegal, and leadership.

Once the working group was convened, a brief scoping document was drafted and agreed upon, outlining the purpose of the program and literature behind such initiatives, the scope of the program (namely, supporting staff after a range of adverse events), key stakeholders, and a timeline for implementation and scaling up across the District.

Customise

After forming our working group, significant time was spent customising the program to local needs and creating a guideline which outlined how our program would work. We familiarised ourselves with similar programs from elsewhere, both through publications[8–13,20] and also reaching out to leaders in the field.

Our guideline was planned as an iterative document, with an agreement that it need not be finalised before the program launched – providing an outline for the program and covering core safety requirements, but with capacity to evolve. Our guideline covers the following core areas, which we think are vital for services to consider when establishing their own staff peer support program:

- Definitions and terms (we use the term 'impacted worker' to refer to staff experiencing harm from adverse events, noting some controversy in the literature about the term 'second victim'[21]; and the term 'peer responder' for the trained peer).
- Scope (which types of adverse or other events will be covered).
- Description of the model.
- How peer responders are identified, trained, and provided with ongoing supervision.
- How impacted workers can access the service.
- The content of a peer response, and the skills and competencies required to deliver this.
- Escalation pathways (regarding concerns about impairment or acute mental health risk).
- Legal and confidentiality matters (including maintaining confidentiality and no record keeping, except where there are potential reportable concerns about health, conduct, or performance indicating risks to patient safety).
- Ongoing governance for the program.
- Plans for evaluation and data collection.

Clearly defining and differentiating the model as being separate from, but complementing existing clinical services such as EAP, was important. Our description of the model emphasises non-clinical support as one of a range of options after adverse events. We are very clear in our description that peer support is not a substitute for critical response management or EAP, that it is not therapy or counselling, not an advocacy service, and is not part of any investigation, governance, or workforce process.[22]

Our scope was to include all adverse or unanticipated events, and whilst this started as a narrow list, it has slowly grown to ensure completeness. Our current scope is listed in Table 1. In terms of customising it to our local area, we were requested to include staff

Table 1. Current scope of the Colleague Care Program

An adverse event
An unexpected death at work
A patient complaint (either at hospital/district level or through regulatory body)
A professional complaint (including through Workforce or a matter through professional council, excluding inappropriate conduct complaints such as bullying or harassment)
A coronial investigation, inquest, or other legal matter
A civil claim against the SLHD that involves the staff member
Any Code Black or aggressive/threatening behaviour from a patient or family member
Any Clinical Emergency Response System call (the deteriorating patient safety net system)
Certain staff injuries (aggression, needlesticks/exposure to bodily fluids, and other physical injuries)
Any patient care involving Voluntary-Assisted Dying (VAD)

involved in Voluntary-Assisted Dying who might need support, even though this is not an adverse event, but acknowledging that staff can be impacted through its provision.[23–25] The group was also asked to exclude bullying and harassment, and personal matters, as it was felt these sit within the remit of EAP and Workforce staff. We decided to make the program open to all staff, acknowledging that non-clinical staff members are also impacted by adverse events.

Many other features of the program were customised to local needs. Given this was established in the aftermath of the COVID pandemic, it was felt to be too burdensome to ask peer responders to provide an immediate response as some other programs have done,[9,12] so we settled for a 2–3 business days turnaround. We agreed on a goal to train 1% ($n = 130$) of all staff to be peer responders, acknowledging that there was a variety in numbers trained by other programs from 1–5% of all staff[8,10,11]; and setting a number both achievable, and with good coverage across the various physical locations of the District.

It was entirely voluntary for impacted workers to access the program, and they can either refer themselves or be referred by clinical governance staff or line managers. We have shifted how referrals can be made to the program – initially opting to allow only certain staff to view the list of peer responders, so that peer responders were not overwhelmed with referrals. As our confidence in the program has grown, and feedback has indicated that all staff would like to see who the peer responders are, we have recently made this information public-facing within the District, so impacted workers can choose and approach peer responders themselves.

A cautious and thorough approach was taken to selection of peer responders to ensure trust and safety in the program, which may not be required in smaller programs where applicants are better known. Potential peer responders complete a formal Expression of Interest (EOI) and two references (from a peer and supervisor), which ask whether referees feel the core competencies are met (Table 2). A Workforce check has more recently been added to the selection process. Whilst there is a wide variety of training for peer responders documented in the literature, from as little as 2 h[8] up to full 1–2 days courses of Psychological/Mental Health First Aid,[19] our team felt it would be difficult for busy clinicians to attend multi-day training, and it was agreed that 3 h were suitable, so as not to be a barrier. Our training focuses on logistics of the program (including escalation pathways), psychological safety, providing a non-clinical supportive response, and important features around confidentiality and legal matters within the program, including both didactic content and role-plays.

Engage

As we refined details for the program, we began considering District-wide promotion. Other programs[9,11] commented on the importance of promotional work in launching, so we created the name Colleague Care, and a logo, fliers, brochures, virtual backgrounds, and email signatures. We spoke in multiple staff forums and meetings on the concept of the second victim, introducing the program and encouraging interested staff to sign up as peer responders.

Launch

Based on experience elsewhere,[11] we decided to run the program on the Microsoft 365 platform, to have an online presence for staff through SharePoint and automate our EOI and reference-check process. Setting this up required no additional IT resources.

After final review of our program's draft guidelines, we continued widespread communications and included a 'go live' date which was formalised with an all-staff CEO email announcing the launch of the program, and directing people to the SharePoint site and online education sessions. Note that we continued to iterate and improve the program beyond this date.

Table 2. Core competencies expected in applicants to be a peer responder

Able to provide active listening without judgement or reactivity
Able to normalise the experience of having an adverse event, without divulging excessive detail of own experiences
Able to self-monitor and have self-awareness about own behaviour, emotions, and thoughts
Able to provide acknowledgement and reassurance when a colleague is distressed, including being able to 'sit' with someone experiencing distress
Able to be discrete and maintain confidentiality when needed
Able to manage own boundaries and other ethical concerns as they arise
Able to encourage meaningful action for a colleague experiencing distress
Reliable and organised
Able to communicate appropriately through different channels, including text, call, email, and face-to-face
Has desire and ability to learn and develop skills in above domains

Table 3. Current data being collected on program usage and exposure

Theme	Data being collected
Communications to all staff about the program	Total number of short, targeted education sessions delivered on the program Total number of people reached through these education programs
SharePoint site usage (data available from SharePoint)	SharePoint site – total views SharePoint site – unique viewers Average time spent on page (seconds)
Peer Responder numbers	Total EOIs for peer responders Total referee checks completed Current number of peer responders on master list (i.e. All reference checks and training completed) Number of peer responders who have left the program
Peer Responder training	Total peer responder training sessions since launch Total attendance at training sessions
Usage	Total number of peer responses, with the following data collected about each response: • Date of referral • Estimated time between incident and time that a peer response was provided • Estimated time between notification of an investigation process and time that a peer response was provided • Source of referral • Type of incident • Discipline of impacted workers • Specialty/department of impacted worker • Site of impacted worker • Number of times peer responder saw the impacted worker • Mode of contact (i.e. face-to-face, phone, or online) • Total time spent supporting peer responder • Whether impacted worker accessed other supports on peer responder's recommendation

Maintenance

Once the program had launched, we progressed plans for ongoing governance. Peer responders were assigned monthly supervision groups which were capped in numbers. All peers were invited to attend any session but only had to attend if they had formally seen an impacted worker.

An ongoing quarterly governance group was established to support the program. This group consists of

both leaders and frontline staff, making sure all disciplines and locations are represented. Quarterly data reports (see Table 3 for what is collected) are prepared, and any issues addressed. A yearly evaluation of the program[26] is done by the program lead and actioned as needed. There are plans to commence a Community of Practice for our peer responders to have an opportunity to network, receive education, and contribute to aspects of the program.

Lessons Learnt

Being the first of its kind that we know of in a NSW Health Hospital, there are many things we have learnt since launching.

To run a program over a large health service, which minimises significant risks by ensuring thorough screening and training of peer responders, requires dedicated resources. We are only able to do this because of the existence of our physician wellbeing team, MDOK, and the work they have done over several years to focus on clinician wellbeing. Our program lead has dedicated approximately 0.3–0.4 FTE to the program from implementation and must be the link between all stakeholders, including the peer responders, the educators, the supervisors, the Executive, and the broader workforce and impacted workers. We have a small amount of dedicated medical educator time and administrative assistance.

The ongoing time commitment has surpassed expectations, consistent with other comments in the literature.[8] We have achieved half our target of 1% of all staff as peer responders, so recruitment remains a rolling process – EOIs can come in at any time, and as new peer responders are trained up, there is attrition of existing ones, primarily through change of employment. Our approach to recruitment was more cautious than other descriptions and has likely slowed intake. We have also not reached all staff in our promotions, which will continue for some time. We encourage other services to consider sustainability of the program from the initiation phase, including how processes can be automated and streamlined and whether dedicated staff time, even fractional, is available on an ongoing basis. The scale and reach of the program will likely depend on resourcing. An alternative may be to start with a single unit or discipline, and scale up as able, as others have done.[11]

Frontline feedback since launch has really emphasised the importance of building trust in the confidentiality of the program, and the wish for frontline staff to know who the peer responders are, prompting us to make peer responder profiles public-facing. This has anecdotally been well-received, with an increase in program utilisation. Bringing in more frontline staff during the implementation phase might have encouraged us to do this earlier, although we note our implementation team composition was not dissimilar to others described in the literature.[8,11]

We feel that a committed Executive sponsor and implementation and governance teams really helped develop the program, allowing rapid launch. Input from Legal and Workforce has been invaluable and we would recommend this early on, as others have done.[8,11] Spending considerable time on the guidelines for the program was helpful to quell any anxiety over how the program fits within existing structures such as EAP and ultimately aided collaboration and strengthened the program.

Finally, we have found collection of data to be challenging and under constant review. Whilst we started with a formal and centralised data capture process, the evolution of the program to allow impacted workers to reach out independently to peer responders, and the feedback of peer responders that they are often using their skills with colleagues without a formal referral, has made us re-evaluate our approach to how we best capture the benefit of the program. We believe the data approach outlined in Table 3 is a good compromise, with some of the data collected centrally by the program lead, and others reliant on peer responders capturing after they respond to impacted workers. We hope to present this data at a later date.

Conclusion

We cannot escape the fact that everyday healthcare workers are harmed by adverse events, and whilst patients will mostly be the 'primary victims', supporting staff is crucial to avoid them leaving the workforce or suffering ongoing symptoms. Staff peer support programs, whilst early in their evidence, offer a way to provide practical, non-clinical support from people who have been through something similar to the impacted worker. Here, we outline the steps of implementing our program, from initiating with a willing coalition; customising the concept to meet local needs; engaging future peer responders, impacted workers, and referrers; launching with lots of communication; and eventually moving into maintenance phase of the program. We hope this description is helpful to others looking to implement something similar.

Author's Note

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