Helsepersonell som har vært involvert i uønskede hendelser

Notat fra Kunnskapssenteret
Systematisk litteratursøk
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kunnskapssenteret

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Nasjonalt kunnskapssenter for helsetjenesten fremskaffer og formidler kunnskap om effekt av metoder, virkemidler og tiltak og om kvalitet innen alle deler av helsetjenesten. Målet er å bidra til gode beslutninger slik at brukerne får best mulig helsetjenester. Kunnskapsenteret er formelt et forvaltningsorgan under Helsedirektoratet, men har ingen myndighetsfunksjoner og kan ikke instrueres i faglige spørsmål.

Nasjonalt kunnskapssenter for helsetjenesten
Oslo, juni, 2012

Hovedfunn

Helsepersonell som har vært involvert i en uønsket pasienthendelse kan få store følelsesmessige problemer og trenger støtte og oppfølging for å takle det som har skjedd. Vi har vi gjort et systematisk søk etter forskningslitteratur som har undersøkt hvordan det oppleves for helsepersonell å være involvert i en uønsket hendelse, hvilken støtte de har behov for i etterkant og hvilken effekt slike støttetiltak kan ha. Formålet med notatet er å gi en oversikt over forskningen.

- Vi inkluderte to systematiske oversikter fra 2008 og 2010. Oversiktene fant at vanlige reaksjoner hos helsepersonell som har vært involvert i en uønsket hendelse kan være skam- og skyldfølelse, angst, sjokk, ydmykelse og depresjon.Viktige faktorer for bearbeidelse av hendelsen kan være samtaler med kollegaer, en organisasjonskultur med fokus på læring, og åpen kommunikasjon med pasienten. Oversiktene fant lite dokumentasjon for effekten av støttetiltak som er ment å støtte helsepersonell i etterkant av uønskede hendelser.
- Vi inkluderte 20 enkeltstudier publisert f.o.m. 2009. Innholdet i studiene ble ikke oppsummert.
- Vi inkluderte 12 systematiske oversikter om effekten av debriefing av helsepersonell. Innholdet i oversiktene ble ikke oppsummert.

I dette notatet har vi avgrenset oss til publisert internasjonal forskningslitteratur og overføringsverdien fra utenlandske studier kan være begrenset. For å finne ut av hvilke støtte- og oppfølgingstiltak som har mest nytte i Norge, er det viktig å trekke på erfaringer fra norsk eller nordisk helsetjeneste.

Tittel:

Helsepersonell som har vært involvert i uønskede hendelser.

Publikasjonstype:

Systematisk litteraturliste

En systematisk litteraturliste er resultatet av å
- søke etter relevant litteratur ifølge en søkestrategi og
- eventuelt sortere denne litteraturen i grupper presentert med referanser og vanligvis sammendrag

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Svarer ikke på alt:

- Ingen kritisk vurdering av studienes kvalitet
- Ingen analyse av studiene
- Ingen anbefalinger

Hvem står bak denne publikasjonen?

Kunnskapssenteret har gjennomført oppdraget etter forespørsel fra Nasjonal enhet for pasientsikkerhet, Kunnskapssenteret

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Når ble litteratursøket utført?

Søk etter studier ble avsluttet mars, 2012.

Key messages (English)

Health personell involved in adverse events may suffer serious emotional problems and therefore need support and follow-up to be able to cope with the incident. We have performed a systematic literature search to identify research that has investigated the experiences and needs of health personnel who have been involved in adverse events, as well as the effects of interventions that are meant to help health personnel in these situations. The purpose of the search is to give an overview of the available research.

- We included two systematic reviews published in 2008 and 2010. The reviews found that common reactions with health personell involved in adverse events were shame, guilt, anxiety, shock, humiliation and depression. Discussions with colleagues, an organisational learning culture and open communiation with the patient were concidered important coping factors. There is limited evidence of the effects of interventions aimed at supporting health personell in these situastions.
- We included 20 primary studies published as of 2009. The findings in these studies were not summarized.
- We included 12 systematic reviews on the effects of debriefing of health personell. The findings in these studies were not summarized.

The literature search was limited to published international research and the transfer value from foreign studies may be limited. To determine what kind of interventions may be useful to support health personnel in Norway, it is important to investigate experiences from Norwegian or Nordic health care.

Innhold

Forord

I juli 2012 lanserer Nasjonalt kunnskapssenter for helsetjenesten Meldeordningen og nettsiden www.melde.no. I den forbindelse har vi søkt etter tilgjengelig forskning om temaer som kan være relevante for Meldeordningens målgruppe. I dette notatet presenteres resultatet fra et søk etter litteratur som handler om oppfølging av helsepersonell som har vært involvert i uønskede hendelser. Notater om forskning på andre temaer finnes på www.melde.no og på www.kunnskapssenteret.no/nasjonalenhetforpasientsikkerhet.

Prosjektgruppen har bestått av:

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- Marianne Tinnå, Kunnskapssenteret

Innledning

Uønskede hendelser i helsetjenesten kan få alvorlige konsekvenser for både pasienter og pårørende. Dette er et viktig tema i seg selv, og oppfølging av pasienter og pårørende etter uønskede hendelser er av avgjørende betydning. I dette notatet har vi imidlertid fokusert på at det ved uønskede hendelser også kan finnes et "second victim", det vil si helsepersonell som har vært involvert i en slik hendelse. Leger, sykepleiere og andre helsearbeidere kan få store emosjonelle problemer som følge av hendelsen. Konsekvensene av å være involvert i en uønsket pasienthendelse kan være depresjon, sykefravær, og til og med frafall fra yrket. De som er rammet har behov for god støtte og oppfølging (1).

I dette notatet har vi gjort et systematisk søk i forskningslitteraturen og undersøkt hva forskningen sier om tre problemstillinger:

- Hvordan oppleves det for helsepersonell å være involvert i en uønsket hendelse?
- Hvilken støtte og oppfølging har helsepersonell behov for og erfaring med i etterkant av en uønsket hendelse?
- Hva er effektene av tiltak som er ment å støtte helsepersonell i etterkant av en uønsket hendelse?

Spørsmålene besvares med referanser til systematiske oversikter og vi presenterer også en referanseliste over enkeltstudier som muligens kan besvare spørsmålene. Formålet er å gi en oversikt over forskningen på området.

Metode

Litteratursøk

For å identifisere relevant forskningslitteratur, utførte vi et systematisk søk i ulike bibliografiske databaser: PubMed, MEDLINE, Embase, PsycINFO, Cinahl, Cochrane Library og ISI Web of Science. Søket ble supplert med usystematiske søk i Google. Søket ble utført i mars 2012. Detaljert søkestrategi er gjengitt i vedlegg 1.

Inklusjonskriterier

To personer gjennomgikk søketreffet og valgte ut relevant litteratur ved hjelp av brede inklusjonskriter. Studiene måtte handle om helsepersonell som har vært involvert i uønskede hendelser og vi inkluderte alle studier som hadde undersøkt deres reaksjoner, deres erfaringer eller behov i etterkant av hendelsen. Vi var også interessert i alle typer studier som undersøkte effekten av ulike støttetiltak, som for eksempel kollegastøtteordning og debriefing.

Vi inkluderte systematiske oversikter og enkeltstudier. I en systematisk oversikt er det brukt systematiske og eksplisitte metoder for å identifisere, utvelge og kritisk vurdere relevant forskning, samt for å innsamle og analysere data fra studiene som er inkludert i oversikten. Enkeltstudiene vi inkluderte kunne være kvalitative studier, spørreundersøkelser, evalueringsrapporter og effektstudier med alle typer forskningsdesign. Vi hadde ingen begrensninger på type helsepersonell, institusjoner, type feil eller hendelser.

Utvelgelse og analyse

I første omgang gjennomgikk to personer alle referansene fra søket på tittel- og sammendragsnivå. Vi valgte ut alle referansene som så relevante ut og sorterte dem i henhold til hvilke spørsmål de besvarte og om de var enkeltstudier eller systematiske oversikter.

En person fortsatte med å velge ut systematiske oversikter og enkeltstudier for inklusjon i notatet. Systematiske oversikter ble inkludert først. Vi vurderte oversikte-

nes metodiske kvalitet ved hjelp av "Sjekkliste for vurdering av en oversiktsartikkel"[1] og skrev et kort sammendrag av resultatene. Deretter inkluderte vi enkeltstudier som var utgitt etter den nyeste systematiske oversiktens litteratursøk. Enkeltstudiene ble listet i vedlegg 2 og kort referert i teksten. De ble ikke kvalitetsvurdert eller gjennomgått i fulltekst.

[1] Tilgjengelig på http://www.kunnskapssenteret.no/Verkt%C3%B8y/Sjekklister+for+vurdering+av+forskningsartikler.2031.cms

Resultat

Litteratursøket genererte 2292 referanser. 152 av referansene var potensielt relevante for problemstillingene våre. Av disse fant vi to systematiske oversikter (se fulle sammendrag i vedlegg 2) og 20 enkeltstudier.

Systematiske oversikter

De systematiske oversiktene har oppsummert funn fra totalt 38 enkeltstudier. Nedenfor gis et sammendrag av funnene i de systematiske oversiktene.

Tabell 1 Beskrivelse av to systematiske oversikter

Førsteforfatter årstall **Tittel** **Metodisk kvalitet** **Populasjon**	**Resultater og konklusjon som oppsummert av forfatterne**
Schwappach 2008 (2) The emotional impact of medical error involvement on physicians: A call for leadership and organisational accountability. Lav metodisk kvalitet* Populasjon: Leger	"Involvement in medical errors often provokes intense emotional distress that seems to considerably increase the risk for burn-out and depression. The evidence suggests a reciprocal cycle of these symptoms and future suboptimal patient care and error. Communication and interaction with colleagues and supervisors are perceived as the most helpful resource by physicians. Physicians involved in errors usually feel not supported in coping with this experience by the institutions they work in. Many professionals respond to error with serious emotional distress, and these emotions can imprint a permanent emotional scar. Given the significant burden on physicians' health, well-being and performance associated with medical errors, health care institutions and clinical leaders have to take accountability and provide staff with formal and informal systems of support." (2, s. 9)
Sirriyeh 2010 (3) Coping with medical error: a systematic review of papers to	"Review findings suggest that there is consistent evidence for the widespread impact of medical error on health professionals. Psychological repercussions may include negative states such as shame, self-doubt,

assess the effects of involvement in medical errors on healthcare professionals' psychological well-being. Moderat metodisk kvalitet** Populasjon: Alle typer helsepersonell	anxiety and guilt. Despite much attention devoted to the assessment of negative outcomes, the potential for positive outcomes resulting from error also became apparent, with increased assertiveness, confidence and improved colleague relationships reported. Conclusion: It is evident that involvement in a medical error can elicit a significant psychological response from the health professional involved. However, a lack of literature around coping and support, coupled with inconsistencies and weaknesses in methodology, may need be addressed in future work. (3, s. 1)

* Metoden er mangelfullt beskrevet og det ser ikke ut til å ha vært noen kvalitetsvurdering eller vurdering av skjevheter i de inkluderte studiene. ** Søkestrategien er uklart beskrevet.

Begge oversiktene brukte begrepet ”medical error” og Sirriyeh 2010 definerte det slik: “the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim without the intervention of an unforeseen event” (3, s. 1). Sirriyeh 2010 var begrenset til engelskspråklig litteratur, mens Schwappach 2008 også inkluderte litteratur på tysk og fransk.

Funnene var for det meste basert på ulike typer kvalitative studier og spørreundersøkelser av leger eller sykepleiere. Begge oversiktene inkluderer en norsk studie fra 2005 (4). Vi henviser til originalpublikasjonene for flere detaljer om enkeltstudier og resultater (2;3).

Hvordan opplever leger og sykepleiere å være involvert i uønskede hendelser?

Vanlige reaksjoner hos helsepersonell som har vært involvert i en uønsket hendelse er skam- og skyldfølelse, angst, sjokk, ydmykelse og depresjon, spesielt hvis feilen har ført til alvorlig skade hos pasienten. Disse følelsene kan ha negativ innvirkning på hele tilværelsen til den som er rammet og kan få alvorlige konsekvenser for trivselen og utførelsen på jobb. Noen reagerer med usikkerhet og redusert selvtillit, søvnproblemer og utbrenthet. Noen opplever også at det å gjøre en feil fører til redusert tiltro hos kollegaer og pasienter. Men uønskede hendelser kan også føre til konstruktive endringer i praksis og til fruktbare diskusjoner mellom kollegaer.

Hvilken støtte og oppfølging har helsepersonell behov for og erfaring med i etterkant av hendelsen?

Både for pasienten og for de ansatte på sykehuset er håndteringen av hendelsen viktig. Forskningen på helsepersonells erfaringer med bearbeiding og støtteordninger er begrenset. Det som finnes indikerer at de som har opplevd at arbeidsgiver ikke har håndtert hendelsen godt i etterkant, også har får størst følelsesmessige problemer senere.

I de systematiske oversiktene var det tre temaer som ble fremholdt som ekstra nyttige for de ansatte:

- **Samtale med kollegaer**: Mange oppsøkte venner og familie for hjelp, men det å diskutere hendelsen med kollegaer ble ansett som spesielt verdifullt.

- **Læringskultur**: Det var viktig for bearbeidelsen av hendelsen at den ble brukt som en del av læringen i institusjonen. Helsepersonellet ønsket konstruktiv tilbakemelding på det som hadde skjedd og det ble ansett som viktig å være aktivt involvert i en læringsprosess i etterkant. Det fremgikk også at det var viktig at ledelsen ikke fokuserte på skyld, straff og negative reaksjoner for den enkelte, men var mer opptatt av systemperspektivet og hva som kunne læres av hendelsen.

- **Et godt forhold til pasienten og de pårørende:** Det var viktig å bevare et godt forhold til pasienten, blant annet gjennom åpen kommunikasjon om hva som hadde skjedd.

En av studiene som oversiktene refererer til fant at de ansatte hadde det best i de tilfellene hvor feilen var ”accepted, disclosed and resolved”, altså akseptert, åpent kommunisert til pasient, pårørende og kollegaer, og at en hadde funnet en god løsning for å hjelpe den aktuelle pasient og for å hindre at tilsvarende kunne skje igjen.

Det ser ut til at de som har vært involvert i uønskede hendelser ofte ikke har fått tilstrekkelig oppfølging fra institusjonen og at gode støtteordninger mangler. ”...support in the workplace was reported to be insufficient and, at times, even detrimental” (3, s. 3). Noen sykehusansatte rapporterte at de hadde blitt møtt med mistro, avhør og skyldfordeling hos ledelsen. En studie fant at til tross for at legene så verdien av å snakke sammen etter uønskede hendelser, sa mange at de kun ville ha tilbudt å hjelpe kollegaer som var deres venner. Noen mente også at det var vanskelig å søke hjelp på grunn av tidspress og av frykt for å utlevere seg selv. En studie fant at arbeidsmiljøet hindret dem i å snakke sammen om feilene og det så ut til at institusjonene manglet implementerte rammeverk som la til rette for slike samtaler.

Den ene oversikten, Schwappach 2008, påpeker likevel at flere og flere institusjoner fokuserer på hvordan de kan støtte sine ansatte og jobber med å implementere ulike

støtteordninger. Et eksempel er ”The support of staff”-programmet som inneholder gruppedebriefing, individuell rådgivning og kjerneårsaksanalyser (2).

Hva er effektene av tiltak som er ment å støtte helsepersonell i etterkant av en uønsket hendelse?

I følge oversiktene finnes det få studier som har undersøkt effekten av formelle og uformelle støttetiltak rettet mot helsepersonell. Det finnes også lite forskning på hvordan tiltakene kan brukes til å fremme læring og økt kvalitet i helsetjenesten. De to systematiske oversiktene nevner likevel noen tiltak som kan være aktuelle, som for eksempel mentorordninger, diskusjonsfora (som ”Morbidity and Mortality Conferences” MMC), innføring av temaet pasientsikkerhet som en del av pensum på medisin- og sykepleiestudiet, og formell og obligatorisk innmelding av uønskede hendelser i meldesystemer. Hvordan slike tiltak virker på helsepersonell etter å ha vært involvert i en uønsket hendelse kan imidlertid diskuteres og det er behov for mer forskning på temaet.

White og kollegaer utga i 2008 en usystematisk oversiktsartikkel om støttetiltak rettet mot helsepersonell som har vært involvert i uønskede hendelser (5). Her påpekes det at støtteordninger først og fremst bør forankres hos toppledelsen. ”The health care institution becomes the third victim after the patient and the provider when employees sense that they may be neglected, abandoned, or punished by the institution after a medical error” (5, s. 144). White bekrefter at det er lite forskning på effekten av relevante tiltak, men redegjør for fordeler og ulemper ved konkrete programmer. Redegjørelsen er basert på ekspertuttalelser eller enkeltstående upubliserte evalueringer. Tiltakene som drøftes er støtte fra “risk managers”, Critical Incident Stress Management, støttegrupper, program for juridisk assistanse og rutinemessig rådgivning etter alvorlige feil. Vi henviser til originalpublikasjonen for detaljer om dette.

Nyere enkeltstudier

Det siste litteratursøket i den nyeste systematiske oversikten ble utført i 2009 og vi har derfor hentet inn referanser til enkeltstudier som har blitt publisert etter dette. Referansene med sammendrag er listet opp i vedlegg 2.

Vi fant 20 relevante enkeltstudier som var publisert f.o.m. 2009. Studiene har sett på erfaringer med å gjøre feil og hvordan leger og sykepleier har taklet dette. Vi fant ingen studier på effekten av støttetiltak, men inkluderte artikler som omtaler prøveordninger, evalueringer og innføring av konkrete tiltak. Vi minner om at studiene ikke er kvalitetsvurdert og heller ikke gjennomgått i fulltekst.

I studienes sammendrag fremgår det at uformell støtte og kollegastøtte oppleves

som viktige og nyttige tiltak (6;7) men mange synes det er vanskelig å oppsøke hjelp (8). I en studie av allmennleger, ønsket mange å snakke mer med sine overordnede om omstendighetene rundt feilen, de ønsket bedre opplæring i å håndtere feilen samt en mer åpen diskusjon når hendelsen hadde oppstått (9). Feil kan føre til konstruktive endringer når institusjonen har en kultur som fokuserer på å støtte sine ansatte, på problemløsning og på å lære av sine feil (10;11).

I en studie har man undersøkt hvilke erfaringer ledere på hospice har med håndtering av feil (12) og en studie har sett på fastlegers erfaringer (13). To studier har undersøkt sykepleieres opplevelser av legemiddelfeil (14;15). En studie undersøkte hvordan alvorlighetsgraden på hendelsen påvirket sykepleiere (16).

Begreper som skam og skyld går ofte igjen når helsepersonell deler sine erfaringer. To studier har undersøkt hvordan helsepersonell oppfatter skyldspørsmål etter å ha gjort feil (17;18) og en har undersøkt medisinstudenters opplevelse av skam (19).

Fem artikler omtaler eller evaluerer erfaringer med konkrete støttetiltak som ”rapid response system”, "When things go wrong curriculum”, ”The Seven Pillars" og ”after action reviews” (20-23). Vi har også funnet en referanse til en prøveordning med kollegastøttetiltak ved Haukeland universitetssykehus i Bergen (24). En artikkel omtaler erfaringer med et konkret program for å utvikle støttetiltak for helsepersonell (25).

Stress- og krisehåndtering

I litteratursøket vårt har vi søkt etter litteratur som handler om uønskede hendelser eller feil. For å finne svar på spørsmålet om hvilke tiltak som kan hjelpe helsepersonell etter uønskede hendelser, kan det være relevant å trekke på kunnskap om stresshåndtering og håndtering av traumatiske hendelser eller kriser generelt. Relevante tiltak i den sammenhengen er ulike former for debriefing. Vi har gjort et enkelt søk etter systematiske oversikter publisert etter 2000 som handler om effekten av debriefing av helsepersonell i forbindelse med stress og ulike kriser. Søket resulterte i tolv oversikter med ulike perspektiver. Oversiktene er ikke kvalitetsvurdert eller oppsummert men referanser og sammendrag er tilgjengelige i vedlegg 3.

Det kan også være relevant å trekke på kunnskap fra psykososialt støttearbeid i luftfarten, politiet, militæret og andre bransjer som driver systematisk arbeid med krisehåndtering.

Diskusjon

Forbehold ved resultatene

I følge oversiktsforfatterne har enkeltstudiene som blir oppsummert en del metodiske svakheter. Det er for eksempel brukt ulike kriterier og spørreskjemaer for å måle de ansattes mentale helse slik at det kan være vanskelig å sammenligne resultatene fra studiene. I følge Schwappach 2008 kunne det også med fordel ha blitt brukt mer etablerte målinstrumenter, som General Health Questionnaire eller Beck Depression Inventory.

Mange av studiene er tverrsnittstudier som har sammenlignet ulike faktorer (som for eksempel ledelsens håndtering av hendelsen og helsepersonellets følelser) men som ikke kan brukes til å trekke sikre konklusjoner om direkte årsakssammenhenger. Flere av studiene var basert på selvrapportering og det kan være forskjell mellom det som virkelig har skjedd og det studiedeltagerne husker.

Schwappach 2008 avgrenset oversikten sin til studier på leger mens Sirriyeh 2010 inkluderte alle typer helsepersonell. Leger og sykepleiere, erfarne eller nyutdannede, kan ha ulike behov og erfaringer og det kan være problematisk å generalisere og overføre resultatene på tvers av yrkesgrupper.

I mange av studiene som er inkludert i oversiktene er det ikke tydelig definert hva som menes med ”uønskede hendelser” eller ”feil”. Resultatene er dermed ikke nødvendigvis overførbare til alle sammenhenger og det kan være problematisk å slå sammen resultatene.

Styrker og svakheter ved vår metode

Litteraturen er innhentet ved hjelp av et omfattende systematisk søk i flere relevante kilder. Vi kan likevel ha gått glipp av litteratur som ikke eksplisitt handler om temaet ”second victim”. For eksempel kan temaer som pasientsikkerhet og organisasjonskultur inneholde tilgrensende forskning som muligens kan bidra med kunnskap om

hva som kan hjelpe helsepersonell i å bedre takle uønskede hendelser. Dette kan vi ha gått glipp av i søket vårt. For å finne litteratur som ikke er publisert i vitenskapelige tidsskrift, har vi gjort ekstra søk i Google og sett gjennom referanselister i relevante artikler. Likevel kan vi ha gått glipp av studier som kun er publisert på institusjoners hjemmesider eller i tidskrift som ikke er indeksert i de kildene vi har brukt.

Formålet med notatet har vært å gi en oversikt over forskningen, presentere hovedfunn fra systematiske oversikter og oppfordre til videre lesning. Notatet oppfyller derfor ikke kravene til en fullstendig systematisk oversikt. En person har valgt ut relevante referanser og oppsummert innholdet i de systematiske oversiktene. Ideelt sett burde dette gjøres av to personer på bakgrunn av en forhåndsbestemt protokoll. Enkeltstudiene er ikke kvalitetsvurdert eller systematisk oppsummert.

Fordelen med å basere seg på systematiske oversikter slik vi har gjort her, er at noen allerede har gjort jobben med å søke, kvalitetsvurdere og oppsummere funnene fra enkeltstudiene. Ulempen kan være at vi er prisgitt oversiktenes søkestrategier, rapportering og konklusjoner. Oversiktene vi har funnet ser ut til å ha gjort brede søk og de har identifisert mange relevante studier, men på grunn av begrenset rapportering av søkestrategier kan vi ikke se bort fra at det finnes flere relevante studier. Schwappach 2008 oppgir ingen metode for kvalitetsvurdering av enkeltstudiene. Dette trekker ned kvaliteten på oversikten og vi vet ikke om studiene som er oppsummert i oversikten er så gode at vi kan stole på resultatene.

I dette notatet har vi avgrenset oss til publisert internasjonal forskningslitteratur og overføringsverdien fra utenlandske studier kan være begrenset. For å finne ut av hvilke støtte- og oppfølgingstiltak som har mest nytte i Norge, vil det være viktig å trekke på erfaringer og evalueringer fra norsk eller nordisk helsetjeneste.

Litteraturliste

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Vedlegg

Vedlegg 1 Søkestrategi

OVID (fellessøk i tre databaser)
Embase 1980 to 2012 Week 11
Ovid MEDLINE(R) In-Process & Other Non-Indexed Citations and Ovid MEDLINE(R) 1946 to Present,
PsycINFO 1806 to March Week 2 2012

Dato: 15.3.2012

1. Medical Errors/ use prmz or exp malpractice/ use prmz or exp Medication Errors/ use prmz
2. Errors/ use psyh
3. exp medical error/ or malpractice/
4. exp Health Personnel/ use prmz or exp administrative personnel/ use prmz or exp foreign professional personnel/ use prmz
5. professional personnel/ use psyh or clinicians/ use psyh or exp health personnel/ use psyh or exp therapists/ use psyh
6. *health care personnel/ or exp *hospital personnel/ or exp *medical personnel/ or exp *mental health care personnel/
7. (((harmful adj2 event*) or (adverse adj2 event*) or (unintended adj2 event*) or error* or incident* or malpractice* or mistake*) adj5 (personnel or staff or employee* or Doctor* or Nurse* or physician* or surgeon* or clinician* or trainee* or house officer* or health care professional* or resident*)).tw.
8. (1 or 2 or 3) and (4 or 5 or 6)
9. 7 or 8
10. ((systematic adj2 review*) or (evidence adj2 review*) or meta-analys*).mp,pt.
11. 9 and 10
12. remove duplicates from 11 [Søk 1: Systematiske oversikter om helsepersonell og uønsked hendelser generelt]

13. second victim*.tw. [Søk 2: Alt om “second victim”]

14. (study or studies or trial* or qualitative or focus group* or interview* or survey* or questionnaire* or cross-sectional or cohort or prospective anal* or retrospective anal* or follow-up anal* or pretest or posttest).mp,pt.
15. (9 and 14) not (12 or 13)
16. social support/ use emez or exp support group/ use emez or exp group therapy/ use emez
17. exp Social Environment/ use prmz or Social support/ use prmz
18. interpersonal interaction/ use psyh or exp "assistance (social behavior)"/ use psyh or exp employee interaction/ use psyh or group participation/ use psyh or exp interpersonal communication/ use psyh or exp peer relations/ use psyh
19. exp group processes/ use prmz or interpersonal relations/ use prmz or exp interprofessional relations/ use prmz
20. debriefing*.mp.

21. (support or handle* or handling or management or intervention* or recovery or coping or cope).ti.
22. (((harmful adj2 event*) or (adverse adj2 event*) or error* or incident* or malpractice* or mistake*) adj5 (personnel or staff or employee* or Doctor* or Nurse* or physician* or surgeon* or clinician* or trainee* or house officer* or health care professional* or resident*) adj2 support).tw.
23. Personnel Management/ use prmz or Leadership/ use prmz
24. health care personnel management/ use emez or personnel management/ use emez or hospital personnel management/ use emez
25. leadership/ use emez
26. exp leadership/ use psyh or management/ use psyh
27. leadership.tw.
28. working conditions/ use psyh or "quality of work life"/ use psyh or work load/ use psyh
29. work environment/ use emez
30. (organization* culture* or organisation* culture*).mp. or work* environment*.tw.
31. peer support*.mp.
32. or/16-31
33. 15 and 32
34. remove duplicates from 33 [Søk 3: Enkeltstudier om støttetiltak og mestring i etterkant av hendelsen]

37. *Medical Errors/ use prmz or exp *malpractice/ use prmz or exp *Medication Errors/ use prmz
38. *Errors/ use psyh
39. exp *medical error/ use emez or *malpractice/ use emez
40. exp *Health Personnel/ use prmz or exp *administrative personnel/ use prmz or exp *foreign professional personnel/ use prmz
41. *professional personnel/ use psyh or *clinicians/ use psyh or exp *health personnel/ use psyh or exp *therapists/ use psyh
42. *health care personnel/ use emez or exp *hospital personnel/ use emez or exp *medical personnel/ use emez or exp *mental health care personnel/ use emez
46. 14 and 43
49. (involv* or after or coping).tw.
50. 46 and 49
51. remove duplicates from 50 [Søk 4: Enkeltstudier på helsepersonell og uønskede hendelser generelt]

52. (((harmful adj2 event*) or (adverse adj2 event*) or (unintended adj2 event*) or error* or incident* or malpractice* or mistake*) adj5 (personnel or staff or employee* or Doctor* or Nurse* or physician* or surgeon* or clinician* or trainee* or house officer* or health care professional* or resident*)).ti.
53. 52 and 10
54. remove duplicates from 53 [Søk 5: Systematiske oversikter på helsepersonell og uønskede hendelser generelt. Supplerende tilttelsøk]

55. 52 and 14
56. (support or handle* or handling or management or intervention* or recovery or coping or cope or involv* or after).ti.
57. 55 and 56

58. remove duplicates from 57 [Søk 5: Enkeltstudier på støttetiltak, supplerende tittelsøk]

Cochrane Library (Cochrane database of Systematic Reviews, DARE, HTA, Central)

Dato: 15.3.2012

#1 MeSH descriptor Medical Errors explode all trees
#2 MeSH descriptor Malpractice explode all trees
#3 ((harmful next/2 event*) or (adverse next/2 event*) or error* or incident* or malpractice* or mistake*):ti,ab,kw
#4 (#1 OR #2 OR #3)
#5 MeSH descriptor Health Personnel explode all trees
#6 MeSH descriptor Foreign Professional Personnel explode all trees
#7 (personnel or staff or employee* or Doctor* or Nurse* or physician* or surgeon* or clinician* or trainee* or (house next officer*) or (health* next/2 professional*) or resident*):ti,ab,kw
#8 (#5 OR #6 OR #7)
#9 (#4 AND #8)
#10 "second victim"
#11 "second victims"
#12 MeSH descriptor Social Environment explode all trees
#13 MeSH descriptor Interpersonal Relations, this term only
#14 MeSH descriptor Group Processes explode all trees
#15 MeSH descriptor Interprofessional Relations explode all trees
#16 MeSH descriptor Crisis Intervention explode all trees
#17 (support* or handle* or handling):ti,ab,kw
#18 (support or handle* or handling or management or intervention* or recovery):ti
#19 MeSH descriptor Personnel Management, this term only
#20 MeSH descriptor Leadership explode all trees
#21 MeSH descriptor Organizational Culture explode all trees
#22 (leadership or (work* next environment*)):ti,ab,kw
#23 ((organization* next culture*) or (organisation* next culture*)):ti,ab,kw
#24 MeSH descriptor Social Support explode all trees
#25 (#12 OR #13 OR #14 OR #15 OR #16 OR #17 OR #18 OR #19 OR #20 OR #21 OR #22 OR #23 OR #24)
#26 (#9 AND #25)
#27 (#10 OR #11 OR #26)

ISI Web of Knowledge

Dato: 15.3.2012

#3 Topic=("harmful event*" or "adverse event*" or error*) AND Topic=(personnel or Doctors or Nurses or physicians or surgeons or clinicians or trainees or residents) AND Title=(support or handle* or handling or recovery or experience*) AND Topic=(study or

trial)
Databases=SCI-EXPANDED, SSCI, A&HCI Timespan=All Years
Lemmatization=On

#2 Topic=("harmful event*" or "adverse event*" or error*) AND Topic=(personnel or Doctors or Nurses or physicians or surgeons or clinicians or trainees residents) AND Topic=(support or handle* or handling) AND Topic=(systematic* review* or meta-analysis)
Databases=SCI-EXPANDED, SSCI, A&HCI Timespan=All Years
Lemmatization=On

PubMed

Dato: 15.3.2012

Søk 1: "second victim" OR "second victims"

Søk 2: (systematic[sb] AND ((harmful event* OR adverse event* OR error* OR incident* OR malpractice* OR mistake* OR unintended event*) AND (personnel OR staff OR employee* OR Doctor* OR Nurse* OR physician* OR surgeon* OR clinician* OR trainee* OR house officer* OR health care professional* OR resident*)) AND publisher [sb])

Søk 3: ((harmful event* OR adverse event* OR error* OR incident* OR malpractice* OR mistake* OR unintended event*) AND (personnel OR staff OR employee* OR Doctor* OR Nurse* OR physician* OR surgeon* OR clinician* OR trainee* OR house officer* OR health care professional* OR resident*) AND (study OR studies OR trial OR survey* OR qualitative OR questionnaire OR focus group*)) AND publisher [sb])

Søk etter systematiske oversikter om effekten av debriefing

Embase 1980 to 2012 Week 24
Ovid MEDLINE(R) In-Process & Other Non-Indexed Citations and Ovid MEDLINE(R) 1946 to Present
PsycINFO 1806 to June Week 2 2012

Dato: 20.6.2012

1 ((debriefing or critical incident stress management) and (personnel* or nurse* or physician* or doctor*) and (systematic review or database* search* or (review and (medline or embase or pubmed)) or meta-analysis or literature review)).mp,pt.
2. remove duplicates from 11

Cochrane Library

Dato: 20.6.2012

Title, abstract, keywords: debriefing

Vedlegg 2 Systematiske oversikter og enkeltstudier

Systematiske oversikter

1. Sirriyeh R, Lawton R, Gardner P, Armitage G. Coping with medical error: a systematic review of papers to assess the effects of involvement in medical errors on healthcare professionals' psychological well-being. Qual Saf Health Care 2010;19(6):e43. http://qualitysafety.bmj.com/content/19/6/1.45.long
   Sammendrag: Previous research has established health professionals as secondary victims of medical error, with the identification of a range of emotional and psychological repercussions that may occur as a result of involvement in error.2 3 Due to the vast range of emotional and psychological outcomes, research to date has been inconsistent in the variables measured and tools used. Therefore, differing conclusions have been drawn as to the nature of the impact of error on professionals and the subsequent repercussions for their team, patients and healthcare institution. A systematic review was conducted. Data sources were identified using database searches, with additional reference and hand searching. Eligibility criteria were applied to all studies identified, resulting in a total of 24 included studies. Quality assessment was conducted with the included studies using a tool that was developed as part of this research, but due to the limited number and diverse nature of studies, no exclusions were made on this basis. Review findings suggest that there is consistent evidence for the widespread impact of medical error on health professionals. Psychological repercussions may include negative states such as shame, self-doubt, anxiety and guilt. Despite much attention devoted to the assessment of negative outcomes, the potential for positive outcomes resulting from error also became apparent, with increased assertiveness, confidence and improved colleague relationships reported. It is evident that involvement in a medical error can elicit a significant psychological response from the health professional involved. However, a lack of literature around coping and support, coupled with inconsistencies and weaknesses in methodology, may need be addressed in future work.

2. Schwappach DLB, Boluarte TA. The emotional impact of medical error involvement on physicians: A call for leadership and organisational accountability. Swiss Med Wkly 2008;139(1-2):9. http://qualitysafety.bmj.com/content/19/6/1.45.full
   Sammendrag: Objective: Involvement in errors often results in serious health effects, emotional distress, as well as performance and work-related consequences in staff members, in particular physicians. The aim of this systematic review was to evaluate current evidence on a) the impact of involvement in medical errors on physicians, b) needs and experiences in coping with the experience of error, and c) interventions to support physicians involved in errors. Methods: A systematic review was conducted in a two-step procedure using predefined search protocols and inclusion criteria that cover the relevant literature published between 1980 and 2007. Results: Of 3,852 identified

candidate articles, 87 studies were selected for critical appraisal and 32 were included in the review. Involvement in medical errors often provokes intense emotional distress that seems to considerably increase the risk for burn-out and depression. The evidence suggests a reciprocal cycle of these symptoms and future suboptimal patient care and error. Communication and interaction with colleagues and supervisors are perceived as the most helpful resource by physicians. Physicians involved in errors usually feel not supported in coping with this experience by the institutions they work in. Conclusion: Many professionals respond to error with serious emotional distress, and these emotions can imprint a permanent emotional scar. Given the significant burden on physicians' health, well-being and performance associated with medical errors, health care institutions and clinical leaders have to take accountability and provide staff with formal and informal systems of support.

Enkeltstudier publisert f.o.m. 2009

Listen er sortert etter publikasjonsår med de nyeste referansene først. Sammendragene er kopiert fra kildene hvor referansene er funnet.

1. Gorini A, Miglioretti M, Pravettoni G. A new perspective on blame culture: an experimental study. J Eval Clin Pract 2012;18(3):671-5. http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2753.2012.01831.x/abstract
   Abstract: Objectives Recently, a range of different institutions worldwide has identified the culture of blame and the fear of being punished as the principal reasons for the lack of medical error reporting and, consequently, of their reiteration and of the poor quality of patient care. Despite much theoretical debate, there currently exist no experimental studies that directly investigate the presence and pervasiveness of the blame and punishment culture in health care contexts. In order to document empirical evidence for this culture in medicine and nursing, we conducted an experimental study asking physicians and nurses to express their fear of blame or punishment in the context of having made an error that would cause: (i) no; (ii) mild; (iii) severe consequences; or (iv) the death of the patient. Methods Two hundred and forty-nine health care providers (38 physicians, 11 medical students, 127 nurses and 73 nursing students) were included in the study. Two main data emerged: first, in general, the fear of being blamed is higher than the fear of being punished. Second, while the fear of being blamed is equally distributed among all participants, the fear of being punished varies according to the experience of subjects (it is higher in nursing students than in seniors nurses) and to their professional role (student and senior nurses are more susceptible to it than medical students and senior physicians). Conclusion Given the relevance of these factors in medical error reporting and the evidence that they are so deep-seated not only in senior professionals, but also in students, we argue that an educational approach, together with an organization-based intervention, is desirable to shape cultural attitudes of health care providers in the direction of a safety culture.

2. O'Beirne M, Sterling P, Palacios-Derflingher L, Hohman S, Zwicker K. Emotional impact of patient safety incidents on family physicians and their office staff. J Am Board Fam Med 2012;25(2):177-83.
http://www.jabfm.org/content/25/2/177.long
Abstract: OBJECTIVE: The objective of this study was to investigate the emotional responses and coping strategies that family physicians and their office staff reported in response to a patient safety incident. METHOD: Two questions contained in a patient safety incident report developed for a study of patient safety in family practice were analyzed. The questions asked reporters to indicate their emotional response to a patient safety incident and how they coped with it. A total of 264 confidential patient safety incident reports collected from September 2007 to August 2010 were analyzed. RESULTS: An emotional response was reported on 82.4% of reports. Of those reports on which an emotional response was reported, a coping strategy was reported on 62.8%. The top 4 reported emotional responses were frustration (48.3%), embarrassment (31.5%), anger (12.6%), and guilt (10.1%). Physicians reported an emotional response more often than clinic staff. An emotional response was reported more often when there was a possibility of harm. Coping strategies were reported as follows: 52% talked to someone about the incident, 37.2% did nothing in response to the incident, 17.9% told the patient about the incident, and 3.6% did something else. Female physicians reported using coping strategies less often than male physicians. A coping strategy was reported more often when there was a possibility of harm. CONCLUSIONS: All members of the health care team report experiencing emotions related to patient safety incidents in their practice. Incidents with minor or no harm still invoked emotional responses from the providers. It is important to understand the impact that patient safety incidents have on the medical clinic as a whole.

3. Ullström S, Sachs MA, Øvretveit J. Hur påverkas vårdpersonal av att vara inblandad i en händelse där patienten kommer til skada? Karolinska Institutet, Medical Management Centre; 2012. http://ki.se/content/1/c6/14/03/06/Second%20victim-rapporten%20120402.pdf
Sammendrag ikke tilgjengelig.

4. Venus E, Galam E, Aubert JP, Nougairede M. Medical errors reported by French general practitioners in training: results of a survey and individual interviews. BMJ Qual Saf 2012;21(4):279-86.
http://qualitysafety.bmj.com/content/early/2012/01/02/bmjqs-2011-000359.short?rss=1
Abstract: ContextFrench interns in general practice are, like all medical students, exposed to medical errors during their training.ObjectiveTo measure the professional and personal impact of medical errors on French general practitioner (GP) trainees.Design, setting and participantsQuantitative and qualitative study of medical errors and GP trainees enrolled at Paris Diderot University.MethodAn online anonymous questionnaire

was sent to all GP trainees at Paris Diderot University and recorded semi-structured interviews were conducted with 10 volunteers.Results70 of the 392 (18%) interns contacted replied to the questionnaire and 10 semi-structured interviews were then conducted. 97% of the participants had already made a medical error. Even with the extreme, conservative assumption that non-respondents would have reported no errors, the prevalence of self-reported medical errors in the whole sample would still have been 17%. 64% said they were at least strongly affected by their error and 74% made constructive changes to their work after the error. The interns revealed that the emotional impact of their errors were great with feelings such as guilt that could remain for more than 2 years after the event. 33% would have liked to talk more about the circumstances of their error with their superior. Most interns suggest more training on medical errors and more open-minded discussion when the error actually happens rather than formal training at the university.ConclusionMedical errors remain a sensitive subject that is not broached enough in our university but interns need to talk about their experiences with their peers to improve risk management and prevent the recurrence of new errors.

5. Courvoisier DS, Agoritsas T, Perneger TV, Schmidt RE, Cullati S. Regrets Associated with Providing Healthcare: Qualitative Study of Experiences of Hospital-Based Physicians and Nurses. Plos One 2011;6(8):e23138. www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0023138
Abstract: Background: Regret is an unavoidable corollary of clinical practice. Physicians and nurses perform countless clinical decisions and actions, in a context characterised by time pressure, information overload, complexity and uncertainty. Objective: To explore feelings associated with regretted clinical decisions or interventions of hospital-based physicians and nurses and to examine how these regrets are coped with. Method: Qualitative study of a volunteer sample of 12 physicians and 13 nurses from Swiss University Hospitals using semi-structured interviews and thematic analysis Results: All interviewees reported at least one intense regret, which sometimes led to sleep problems, or taking sickness leave. Respondents also reported an accumulation effect of small and large regrets, which sometimes led to quitting one's unit or choosing another specialty. Respondents used diverse ways of coping with regrets, including changing their practices and seeking support from peers and family but also suppression of thoughts related to the situation and ruminations on the situation. Another coping strategy was acceptance of one's limits and of medicine's limits. Physicians reported that they avoided sharing with close colleagues because they felt they could lose their credibility. Conclusions: Since regret seems related to both positive and negative consequences, it is important to learn more about regret coping among healthcare providers and to determine whether training in coping strategies could help reduce negative consequences such as sleep problems, absenteeism, or turnover.

6. Edrees HH, Paine LA, Feroli ER, Wu AW. Health care workers as second victims of medical errors. Pol Arch Med Wewn 2011;121(4):101-7. http://pamw.pl/sites/default/files/PAMW_2011_04_inv-Wu_0.pdf

Abstract: INTRODUCTION: "Second victims" are health care providers who are involved with patient adverse events and who subsequently have difficulty coping with their emotions. Growing attention is being paid to making system improvements to create safer health care and to the appropriate handling of patients and families harmed during the provision of medical care. In contrast, there has been little attention to helping health care workers cope with adverse events. OBJECTIVES: The aim of the study was to emphasize the importance of support structures for second victims in the handling of patient adverse events and in building a culture of safety within hospitals. METHODS: A survey was administered to health care workers who participated in a patient safety meeting. The total number of registered participants was 350 individuals from various professions and different institutions within Johns Hopkins Medicine. The first part of the survey was paper-based and the second was administered online. RESULTS: The survey results reflected a need in "second victim" support strategies within health care organizations. Overall, informal emotional support and peer support were among the most requested and most useful strategies. CONCLUSIONS: When there is a serious patient adverse event, there are always second victims who are health care workers. The Johns Hopkins Hospital has established a "Second Victims" Work Group that will develop support strategies, particularly a peer-support program, for health care professionals within the system. Copyright by Medycyna Praktyczna, 2011

7. Hu YY, Fix ML, Hevelone ND, Lipsitz SR, Greenberg CC, Weissman JS, et al. Physicians' needs in coping with emotional stressors. The case for peer support. Arch Surg 2012;147(3):212-7. http://archsurg.jamanetwork.com/article.aspx?doi=10.1001/archsurg.2011.312
Abstract: OBJECTIVE: To design an evidence-based intervention to address physician distress, based on the attitudes toward support among physicians at our hospital. Design, Setting, and PARTICIPANTS: A 56-item survey was administered to a convenience sample (n = 108) of resident and attending physicians at surgery, emergency medicine, and anesthesiology departmental conferences at a large tertiary care academic hospital. MAIN OUTCOME MEASURES: Likelihood of seeking support, perceived barriers, awareness of available services, sources of support, and experience with stress. RESULTS: Among the resident and attending physicians, 79% experienced either a serious adverse patient event and/or a traumatic personal event within the preceding year. Willingness to seek support was reported for legal situations (72%), involvement in medical errors (67%), adverse patient events (63%), substance abuse (67%), physical illness (62%), mental illness (50%), and interpersonal conflict at work (50%). Barriers included lack of time (89%), uncertainty or difficulty with access (69%), concerns about lack of confidentiality (68%), negative impact on career (68%), and stigma (62%). Physician colleagues were the most popular potential sources of support (88%), outnumbering traditional mechanisms such as the employee assistance program (29%) and mental health professionals (48%). Based on these results, a one-on-one peer physician support program was incorporated into support services at our hospital. CONCLUSIONS: Despite the prevalence of stressful experiences and the desire for support among physicians,

established services are underused. As colleagues are the most acceptable sources of support, we advocate peer support as the most effective way to address this sensitive but important issue.

8. Karga M, Kiekkas P, Aretha D, Lemonidou C. Changes in nursing practice: Associations with responses to and coping with errors. J Clin Nurs 2011;20(21-22):3246-55. http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2702.2011.03772.x/abstract;jsessionid=5CBD85FDBD10C376E98F9EE6F7CEBD3F.d03t04 http://dx.doi.org/10.1111/j.1365-2702.2011.03772.x
Abstract: Aims and objective. To investigate emotional responses of nurses and perceived senior staff responses to errors, error-coping strategies used by nurses and how these are associated with constructive or defensive changes in nursing practice. Background. Healthcare professionals have generally reported distressing emotional responses to errors and fear concerns about their consequences. However, errors can also be part of a developmental process, by offering opportunities for learning and leading to constructive changes in clinical practice. Design. Prospective, correlational, multicentre study. Methods. Five hundred and thirty-six structured questionnaires completed from nurses employed in various hospital departments were considered eligible for data extraction. The revised questionnaire used was evaluated for content validity. Results. Data analysis indicated that positive perceived senior staff responses (p=0030), accepting error responsibility (p=0031) and seeking social support (p=0019) predicted constructive changes in nursing practice, while negative perceived senior staff responses (p=0040) and error escape-avoidance (p=0041) predicted defensive changes. Conclusions. Errors promote constructive changes in clinical practice when nurses are encouraged to use adaptive error-coping strategies within a supportive, non-blaming culture. Relevance to clinical practice. These findings highlight the role of senior staff in the establishment of a supportive, trustful ward climate, so that nurses can learn from errors, prevent their recurrence and improve patient safety.

9. Lindstrom UH, Hamberg K, Johansson EE. Medical students' experiences of shame in professional enculturation. Med Educ 2011;45(10):1016-24. http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2923.2011.04022.x/abstract
Abstract: CONTEXT: Despite the intentions of caregivers not to harm, medical encounters may involve intimidation and induce emotions of shame. Reflection is a critical part of professional learning and training. However, the role of shame in medical education has scarcely been studied. The aim of this study was to explore medical students' reflections on shame-related experiences in clinical situations and to examine how they tackled these experiences. METHODS: A 24-credit course in Professional Development is held at the Medical School of Umea University, Sweden. A 1-day seminar on the theme of shame, which involves individual reflections and group discussions, is held in term 9. Medical students were invited to individually consider and write down their memories of situations in which they had experienced shame in clinical encounters. Of a total of 133 students, 75 were willing to share their written reflections anonymously.

Their essays were transcribed to computer text and analysed by means of qualitative content analysis. RESULTS: Three themes emerged. These included: Difficulties in disclosing shame; Shame-inducing circumstances, and Avoiding or addressing shame. Initially, students experienced problems in recalling shameful incidents, but successively described various situations which related to being taken by surprise, being exposed, and being associated with staff imprudence. Students disclosed shame avoidance behaviours, but also gave examples of how addressing shame provided them with new insights and restored their dignity. CONCLUSIONS: Students' reflections on shameful experiences elucidated the importance of attitudes, manners, standards and hierarchies in clinical situations. These are important issues to highlight in the professional enculturation of medical students; our emphasising of them may encourage medical teachers elsewhere to organise similar activities. Opportunities for mentoring medical students in tackling shame and adverse feelings, and in resolving conflict, are needed in medical curricula. Copyright Blackwell Publishing Ltd 2011

10. Bell SK, Moorman DW, Delbanco T. Improving the patient, family, and clinician experience after harmful events: The "When things go wrong" curriculum. Acad Med 2010;85(6):1010-7. http://journals.lww.com/academicmedicine/pages/articleviewer.aspx?year=2010&issue=06000&article=00027&type=abstract
Abstract: The emotional toll of medical error is high for both patients and clinicians, who are often unsure with whom 'and whether' they can discuss what happened. Although institutions are increasingly adopting full disclosure policies, trainees frequently do not disclose mistakes, and faculty physicians are underprepared to teach communication skills related to disclosure and apology. The authors developed an interactive educational program for trainees and faculty physicians that assesses experiences, attitudes, and perceptions about error, explores the human impact of error through filmed patient and family narratives, develops communication skills, and offers a strategy to facilitate bedside disclosures. Between spring 2007 and fall 2008, 154 trainees (medical students/residents) and 75 medical educators completed the program. Among learners surveyed, 62% of trainees and 88% of faculty physicians reported making medical mistakes. Of those, 62% and 78%, respectively, reported they did not apologize. While 65% of trainees said they would turn to senior doctors for assistance after an error, 26% were not sure where to get help. Just 20% of trainees and 21% of physicians reported adequate training to respond to error. Following the session, all of the faculty physicians surveyed indicated they felt better prepared to address and teach this topic. At a time of increased attention to disclosure, actual faculty and trainee practices suggest that role models, support systems, and education strategies are lacking. Trainees' widespread experience with error highlights the need for a disclosure curriculum early in medical education. Educational initiatives focusing on communication after harm should target teachers and students. 2010 Association of American Medical Colleges

11. Chard R. How perioperative nurses define, attribute causes of, and react to intraoperative nursing errors. AORN J 2010;91(1):132-45.
http://www.sciencedirect.com/science/article/pii/S0001209209005377
Abstract: Errors in nursing practice pose a continuing threat to patient safety. A descriptive, correlational study was conducted to examine the definitions, circumstances, and perceived causes of intraoperative nursing errors; reactions of perioperative nurses to intraoperative nursing errors; and the relationships among coping with intraoperative nursing errors, emotional distress, and changes in practice made as a result of error. The results indicate that strategies of accepting responsibility and using self-control are significant predictors of emotional distress. Seeking social support and planful problem solving emerged as significant predictors of constructive changes in practice. Most predictive of defensive changes was the strategy of escape/avoidance. Copyright 2010 AORN, Inc. Published by Elsevier Inc. All rights reserved

12. McDonald TB, Helmchen LA, Smith KM, Centomani N, Gunderson A, Mayer D, et al. Responding to patient safety incidents: the "seven pillars". Qual Saf Health Care 2010;19(6)
http://qualitysafety.bmj.com/content/19/6/1.31.full.pdf
Abstract: Background Although acknowledged to be an ethical imperative for providers, disclosure following patient safety incidents remains the exception. The appropriate response to a patient safety incident and the disclosure of medical errors are neither easy nor obvious. An inadequate response to patient harm or an inappropriate disclosure may frustrate practitioners, dent their professional reputation, and alienate patients. Methods The authors have presented a descriptive study on the comprehensive process for responding to patient safety incidents, including the disclosure of medical errors adopted at a large, urban tertiary care centre in the United States. Results In the first two years post-implementation, the "seven Reason J. Human error: models and management. BMJ 2000;320(7237):768-70.

13. Pelliciotti JdSS, Kimura M. Medications errors and health-related quality of life of nursing professionals in intensive care units. Rev Lat Am Enfermagem 2010;18(6):1062-9.
http://www.scielo.br/pdf/rlae/v18n6/04.pdf
Abstract: This study identifies the prevalence of medication errors in ICUs reported by nursing professionals, compares the health-related quality of life (HRQoL) and health status changes of those professionals both involved and not involved with medication errors in ICUs. A total of 94 nursing professionals in three ICUs of a private hospital were studied: 39 (41.5%) nurses and 55 (58.5%) nursing technicians. HRQoL was assessed through the Portuguese version of the SF-36 instrument. Eighteen professionals (19.1%) reported medication errors during the month prior to data collection. The errors were reported in 61.1% of the cases and the most frequent ones were those in the administration phase (67.8%). The professionals who reported medication errors

displayed worse health conditions than those who did not report errors. (PsycINFO Database Record (c) 2011 APA, all rights reserved) (journal abstract)

14. Scott SD, Hirschinger LE, Cox KR, McCoig M, Hahn-Cover K, Epperly KM, et al. Caring for our own: deploying a systemwide second victim rapid response team. Jt Comm J Qual Patient Saf 2010;36(5):233-40.
http://psnet.ahrq.gov/public/Scott-JCJQPS-2010-ID-18023.pdf
Abstract: A unique rapid response system was designed to provide social, psychological, emotional, and professional support for health care providers who are "second victims"--traumatized as a result of their involvement in an unanticipated adverse event, medical error, or patient-related injury.

15. Shanafelt TD, Balch CM, Bechamps G, Russell T, Dyrbye L, Satele D, et al. Burnout and medical errors among American surgeons. Ann Surg 2010;251(6):995-1000.
https://ps.mcic.com/appdocs/lps/Burnout%20and%20medical%20errors%20among%20American%20Surgeons.pdf
Abstract: Objective: To evaluate the relationship between burnout and perceived major medical errors among American surgeons. Background: Despite efforts to improve patient safety, medical errors by physicians remain a common cause of morbidity and mortality. Methods: Members of the American College of Surgeons were sent an anonymous, cross-sectional survey in June 2008. The survey included self-assessment of major medical errors, a validated depression screening tool, and standardized assessments of burnout and quality of life (QOL). Results: Of 7905 participating surgeons, 700 (8.9%) reported concern they had made a major medical error in the last 3 months. Over 70% of surgeons attributed the error to individual rather than system level factors. Reporting an error during the last 3 months had a large, statistically significant adverse relationship with mental QOL, all 3 domains of burnout (emotional exhaustion, depersonalization, and personal accomplishment) and symptoms of depression. Each one point increase in depersonalization (scale range, 0-33) was associated with an 11% increase in the likelihood of reporting an error while each one point increase in emotional exhaustion (scale range, 0-54) was associated with a 5% increase. Burnout and depression remained independent predictors of reporting a recent major medical error on multivariate analysis that controlled for other personal and professional factors. The frequency of overnight call, practice setting, method of compensation, and number of hours worked were not associated with errors on multivariate analysis. Conclusions: Major medical errors reported by surgeons are strongly related to a surgeon's degree of burnout and their mental QOL. Studies are needed to determine how to reduce surgeon distress and how to support surgeons when medical errors occur. 2010 Lippincott Williams & Wilkins

16. Sirriyeh R, Armitage G, Lawton R, Gardner P. Medical error in the hospice setting: exploring the perspectives of management staff. Int J Palliat Nurs 2010;16(8):377-86.

http://www.internurse.com/cgi-bin/go.pl/library/article.cgi?uid=77997;article=IJPN_16_8_377_386
Abstract: This study explores the experiences of health professionals in managerial roles at various levels in child and adult hospice care in northern England, studying perspectives around managing medical error, the issues that arise, and the challenges faced. A multicentred, descriptive, exploratory design was adopted. The sample comprised 10 hospice managers (five deputy and five senior managers) from four hospices (two adult and two children's) in the north of England. Participants took part in individual semi-structured interviews, which lasted between 45-60 minutes each. Interviews were transcribed and analysed by a team of three researchers, including two health psychologists and one nurse using a qualitative analytic framework. Emerging themes appeared to be inter-related and were ultimately linked to two meta-concepts; underpinning and fundamental to the data, these issues were intrinsically tied to all emerging themes. Primary themes were defined by their explanatory power and regularity. Primary themes highlighted the impact of managing error on management teams at a professional and personal level, the challenges for error management in hospice settings, the use of error management tools, and the conceptualization of blame in these settings. The strong influence of the health-care setting in which an error takes place on the outcomes of an error event for the health professional, managers, health-care organizations, and ultimately patients was evident.

17. Treiber LA, Jones JH. Devastatingly human: an analysis of registered nurses' medication error accounts. Qual Health Res 2010;20(10):1327-42.
http://qhr.sagepub.com/content/20/10/1327.abstract
Abstract: Despite many safeguards, nurses make the majority of medication administration errors. The purpose of our research was to investigate the perceived causes for such errors and to better understand how nurses deal with them. We performed an interpretive analysis of 158 accounts by nurses who made self-identified medication errors. We found common themes among these accounts. First, although nurses admitted responsibility for errors, they simultaneously identified a variety of external contributing factors. Second, nurses' accounts were often framed in terms of "being new," with the underlying background expectancy of inexperience. Third, emotionally devastating visceral responses to errors were common and often incongruent with error severity. Fourth, nurses had to deal with fear. Fifth, nurses voiced frustrations with technologies and regulations. Sixth, embedded within many of the accounts was a "lessons learned" theme, through which nurses developed "personal rules" as a result of an error. We conclude with suggestions for additional research.

18. Collins ME, Block SD, Arnold RM, Christakis NA. On the prospects for a blame-free medical culture. Soc Sci Med 2009;69(9):1287-90.
http://christakis.med.harvard.edu/pdf/publications/articles/102.pdf
Abstract: Official policy-making bodies and experts in medical error have called for a shift in perspective to a blame-free culture within medicine, predicated on the basis that errors

are largely attributable to systems rather than individuals. However, little is known about how the lived experience of blame in medical care relates to prospects for such a shift. In this essay we explore the benefits and costs of blame in medical culture. Our observations are informed by our clinical experience and supported by interview data from a study in which 163 American physicians were interviewed about caring for a total of 66 dying patients in two institutions. We observe three ways in which blame is invoked: (1) self-blame, (2) blame of impersonal forces or the "system," and (3) blame of others. Physicians articulate several important functions of blame: as a stimulus for learning and improvement; as a way to empathically allow physicians to forgive mistakes when others accept responsibility using self-blame; and as a way to achieve control over clinical outcomes. We argue that, since error is viewed as a personal failing and tends to evoke substantial self-blame, physicians do not tend to think of errors in a systems context. Given that physicians' ideology of self-blame is ingrained, accompanied by benefits, and limits a systems perspective on error, it may subvert attempts to establish a blame-free culture.

19. Cronin G, Andrews S. After action reviews: a new model for learning. Emerg Nurse 2009;17(3):32-5.
http://www.ncbi.nlm.nih.gov/pubmed/19552332
Abstract: University College London Hospitals NHS Foundation Trust is committed to developing a learning culture for its staff and, to achieve this, the organisation recently developed the after action review (AAR) model as a way for people involved in specific incidents to explore what happened and what they have learned. This article explains the concept of AAR and uses case studies to illustrate how it can improve patient care.

20. van Pelt F. Peer support: healthcare professionals supporting each other after adverse medical events. Qual Saf Health Care 2008;17(4):249-52.
http://qualitysafety.bmj.com/content/17/4/249.long
Abstract: The patient safety movement in healthcare is beginning to openly acknowledge the need to support the human side of adverse medical events in conjunction with evidence-based improvement initiatives. While medical literature has sporadically reported on the emotional impact of adverse events on healthcare professionals, little has been documented on the implementation of support services following these events. This article describes an adverse medical event where open communication and apology catalysed the development and implementation of a structured peer support service for care providers at the Brigham and Women's Hospital following adverse events. The Peer Support Service bypasses the stigmas that limit the utilisation of formal support services and offers care providers a safe environment to share the emotional impact of adverse events while serving as a foundation for open communication and a renewal of compassion in the workplace. As the breadth of stressors impacting healthcare professionals is revealed, the Peer Support Service is being recognised as a vital hospital-wide service. It also appears to offer an important leap forward in the critical areas of patient safety and quality of care.

Vedlegg 3 Systematiske oversikter om debriefing av helsepersonnel

1. Lim J, Bogossian F, Ahern K. Stress and coping in Singaporean nurses: a literature review. Nurs Health Sci 2010;12(2):251-8. http://onlinelibrary.wiley.com/doi/10.1111/j.1442-2018.2010.00514.x/abstract
   Abstract: Stress is ubiquitous in the nursing profession and is also prevalent in Asian countries, particularly the "four tigers of Asia": Singapore, Hong Kong, Taiwan, and South Korea. Based on the theoretical framework of Lazarus and Folkman (1984), the present review of the nursing literature aims to identify sources and effects of stress in Singaporean nurses and the coping strategies they use. Nurses reported major stressors including shortage of staff, high work demands and conflict at work. Common coping strategies included problem orientation, social support and relaxation techniques. Several studies reported nurses' intent to leave the profession. Recommendations to minimize the impact of stress include in-service programs to facilitate a problem-solving approach to resolving work-related issues such as conflict. Relaxation therapy and debriefing sessions may also help in reducing negative effects of work stressors. Finally, nurses' emotional coping can be enhanced by strengthening sources of social support, particularly from family.

2. Magyar J, Theophilos T. Review article: Debriefing critical incidents in the emergency department. Emerg Med Australas 2010;22(6):499-506. http://dx.doi.org/10.1111/j.1742-6723.2010.01345.x
   Abstract: The impact of work related stressors on emergency clinicians has long been recognized, yet there is little formal research into the benefits of debriefing hospital staff after critical incidents, such as failed resuscitation. This article examines current models of debriefing and their application to emergency staff through a review of the literature. The goal being, to outline best practice, with recommendations for guideline development and future research directives. An electronic database search was a conducted in Ovid and Psychinfo. All available abstracts were read and a hand search was completed of the references. Included articles were selected by a panel of two experts. Models and evidence relating to their efficacy were identified from the literature, and detailed evaluation included. The reviewed literature revealed a distinct paucity regarding the efficacy of debriefing of clinicians post CI and in particular randomized controlled trials. Despite this debriefing is perceived as important by emergency clinicians. However evidence presents both benefits and disadvantages to debriefing interventions. In the absence of evidence based practice guidelines, any development of models of debriefing in the emergency healthcare setting should be closely evaluated. And future research directives should aim towards large randomized control trials. 2010 The Authors. EMA 2010 Australasian College for Emergency Medicine and Australasian Society for Emergency Medicine

3. Roberts NP, Kitchiner NJ, Kenardy J, Bisson J, I. Early psychological interventions to treat acute traumatic stress symptoms. Cochrane Database Syst Rev 2010;(3):CD007944. http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD007944/frame.html
Abstract: BACKGROUND: The amelioration of psychological distress following traumatic events is a major concern. Systematic reviews suggest that interventions targeted at all of those exposed to such events are not effective at preventing post traumatic stress disorder (PTSD). Recently other forms of intervention have been developed with the aim of treating acute traumatic stress problems. OBJECTIVES: To perform a systematic review of randomised controlled trials of all psychological treatments and interventions commenced within three months of a traumatic event aimed at treating acute traumatic stress reactions. The review followed the guidelines of the Cochrane Collaboration. SEARCH METHODS: Systematic searches were performed of of CCDAN Registers up to August 2008. Editions of key journals were searched by hand over a period of two years; personal communication was undertaken with key experts in the field; online discussion fora were searched. SELECTION CRITERIA: Randomised controlled trials of any psychological intervention or treatment designed to reduce acute traumatic stress symptoms, with the exception of single session interventions. DATA COLLECTION AND ANALYSIS: Data were entered and analysed for summary effects using Review Manager 5.0 software. Standardised mean differences were calculated for continuous variable outcome data. Relative risks were calculated for dichotomous outcome data. When statistical heterogeneity was present a random effects model was applied. MAIN RESULTS: Fifteen studies (two with long term follow-up studies) were identified examining a range of interventions.In terms of main findings, twelve studies evaluated brief trauma focused cognitive behavioural interventions (TF-CBT). TF-CBT was more effective than a waiting list intervention (6 studies, 471 participants; SMD -0.64, 95% CI -1.06, -0.23) and supportive counselling (4 studies, 198 participants; SMD -0.67, 95% CI -1.12, -0.23). Effects against supportive counselling were still present at 6 month follow-up (4 studies, 170 participants; SMD -0.64, 95% CI -1.02, -0.25). There was no evidence of the effectiveness of a structured writing intervention when compared against minimal intervention (2 studies, 149 participants; SMD -0.15, 95% CI -0.48, 0.17). AUTHORS' CONCLUSIONS: There was evidence that individual TF-CBT was effective for individuals with acute traumatic stress symptoms compared to both waiting list and supportive counselling interventions. The quality of trials included was variable and sample sizes were often small. There was considerable clinical heterogeneity in the included studies and unexplained statistical heterogeneity observed in some comparisons. This suggests the need for caution in interpreting the results of this review. Additional high quality trials with longer follow up periods are required to further test TF-CBT and other forms of psychological intervention. EARLY PSYCHOLOGICAL INTERVENTIONS TO TREAT ACUTE TRAUMATIC STRESS SYMPTOMS: Traumatic events can have a significant impact on individuals', families' and communities' abilities to cope. In the past, single session interventions such as psychological debriefing were widely used with the aim of preventing continuing psychological difficulties. However, previous reviews have found

that single session individual interventions and interventions provided to all have not been effective at preventing PTSD. A range of other forms of intervention have been developed to try to reduce psychological distress for individuals exposed to trauma. This review evaluated the results of 15 studies that tested a diverse range of psychological interventions aimed at treating acute traumatic stress problems. There was evidence to support the use of trauma focused cognitive behavioural therapy with such individuals, although there were a number of potential biases in identified studies which means the results should be treated with some caution. Further research is required to evaluate longer terms effects of TF-CBT, to explore potential benefits of other forms of intervention and to identify the most effective ways of providing psychological help in the early stages after a traumatic event

4. Tran K, Nkansah E. Critical incident stress debriefing for first responders: a review of the clinical benefit and harm. Canadian Agency for Drugs and Technologies in Health (CADTH); 2010. http://www.mrw.interscience.wiley.com/cochrane/clhta/articles/HTA-32011001196/frame.html

5. Roberts NP, Kitchiner NJ, Kenardy J, Bisson J, I. Multiple session early psychological interventions for the prevention of post-traumatic stress disorder. Cochrane Database Syst Rev 2009;(3):CD006869. http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD006869/frame.html
   Abstract: BACKGROUND: The prevention of long-term psychological distress following traumatic events is a major concern. Systematic reviews have suggested that individual Psychological Debriefing is not an effective intervention at preventing post traumatic stress disorder (PTSD). Recently other forms of intervention have been developed with the aim of preventing PTSD. OBJECTIVES: To examine the efficacy of multiple session early psychological interventions commenced within three months of a traumatic event aimed at preventing PTSD. Single session individual/group psychological interventions were excluded. SEARCH METHODS: Computerised databases were searched systematically, the most recent search was conducted in August 2008. The Journal of Traumatic Stress and the Journal of Consulting and Clinical Psychology were handsearched for the last two years. Personal communication was undertaken with key experts in the field. SELECTION CRITERIA: Randomised controlled trials of any multiple session early psychological intervention or treatment (two or more sessions) designed to prevent symptoms of PTSD. DATA COLLECTION AND ANALYSIS: Data were entered using Review Manager software. The methodological quality of included studies was assessed individually by two review authors. Data were analysed for summary effects using Review Manager 4.2. Mean difference was used for meta-analysis of continuous outcomes and relative risk for dichotomous outcomes. MAIN RESULTS: Eleven studies with a total of 941 participants were found to have evaluated brief psychological interventions aimed at preventing PTSD in individuals exposed to a specific traumatic

event, examining a heterogeneous range of interventions. Eight studies were entered into meta-analysis. There was no observable difference between treatment and control conditions on primary outcome measures for these interventions at initial outcome (k=5, n=479; RR 0.84; 95% CI 0.60 to 1.17). There was a trend for increased self-report of PTSD symptoms at 3 to 6 month follow-up in those who received an intervention (k=4, n=292; SMD 0.23; 95% CI 0.00 to 0.46). Two studies compared a memory structuring intervention against supportive listening. There was no evidence supporting the efficacy of this intervention. AUTHORS' CONCLUSIONS: The results suggest that no psychological intervention can be recommended for routine use following traumatic events and that multiple session interventions, like single session interventions, may have an adverse effect on some individuals. The clear practice implication of this is that, at present, multiple session interventions aimed at all individuals exposed to traumatic events should not be used. Further, better designed studies that explore new approaches to early intervention are now required. MULTIPLE SESSION EARLY PSYCHOLOGICAL INTERVENTIONS FOR PREVENTION OF POST-TRAUMATIC STRESS DISORDER: Traumatic events can have a significant impact on individuals', families' and communities' abilities to cope. In the past, single session interventions such as psychological debriefing were widely used with the aim of preventing continuing psychological difficulties. However, previous reviews have found that single session individual interventions have not been effective at preventing post -traumatic stress disorder (PTSD). A range of other forms of intervention have been developed to try to prevent individuals exposed to trauma developing PTSD. This review evaluated the results of 11 studies that tested a diverse range of psychological interventions aimed at preventing PTSD. The results did not find any evidence to support the use of an intervention offered to everyone. There was some evidence that multiple session interventions may result in worse outcome than no intervention for some individuals. Further research is required to evaluate the most effective ways of providing psychological help in the early stages after a traumatic event.

6. McFarlane AC, Bryant RA. Post-traumatic stress disorder in occupational settings: Anticipating and managing the risk. Occup Med 2007;57(6):404-10. http://dx.doi.org/10.1093/occmed/kqm070
Abstract: Background: Post-traumatic stress disorder has had a substantial impact on employer liability for workplace psychological injury. The emergency services are an example of high-risk workforces that demand clear policies and procedures within an organization. The challenge is to minimize the injury to individuals and lessen the cost to organizations through the optimal application of preventative strategies. Methods: This field is not well represented in standard keyword searches and Medline was examined with linked fields of practice and research. Consensus guidelines that refer to this domain were also utilized. Few conclusions can be reached from the literature which directly examined occupational settings. Results: Organizations need to anticipate the possible traumatic exposures that may affect the workforce and have strategies to deal with the effects in the workplace, particularly the negative mental health outcomes in some

personnel. This domain is relevant to all employers as accidents and violence are possible in most workplaces. Screening should be considered for high-risk individuals, particularly following a major traumatic event or cumulative exposure, such as in the emergency services. While psychological debriefing has no demonstrated benefit, the benefits of early intervention necessitate ready access to evidence-based treatments that have minimum barriers to care. Employers should be aware that distress may present indirectly in a similar way as conflict with management, poor performance and poor general health. Conclusion: The knowledge about the impact of traumatic events obliges employers to have an active strategy to anticipate and manage the aftermath of such events as well as cumulative traumatic exposures. The Author 2007. Published by Oxford University Press on behalf of the Society of Occupational Medicine. All rights reserved

7. Aulagnier M, Verger P, Rouillon F. Efficacite du "debriefing psychologique" dans la prevention des troubles psychologiques post-traumatiques [Efficiency of psychological debriefing in preventing post-traumatic stress disorders]. Revue d'Epidemiologie et de Sante Publique 2004;52:67-79.
http://www.em-consulte.com/article/107117/alertePM
BACKGROUND: Traumatic events are frequently followed by an acute stress reaction that may develop into a post-traumatic stress disorder. An intervention called psychological debriefing has been proposed to prevent these disorders. Although this method is widely used at present, its preventive effect is controversial. This article consist in a review of the studies which evaluated psychological debriefing efficiency in the prevention of post-traumatic stress disorder and associated disorders in adults. METHOD: We carried out a bibliographical search on MEDLINE (1966-2001), PASCAL (1987-2001), EMBASE (1988-2001), FRANCIS (1984-2001) and SCIENCEDIRECT (1967-2001). The key words were posttraumatic stress disorder, debriefing, treatment, psychological follow up, and prevention. We selected the studies with the following criteria: adults, one psychological debriefing session in the Month following the event, inclusion of a control group, more than 20 persons per group and evaluation of psychological disorders with standardized instruments more than one Month after the trauma. RESULTS: Twenty nine studies were identified and 8 selected. Four studies did not show any intervention effect, 3 suggested a negative intervention effect, and 1 suggested a positive effect on anxiety, depressive symptoms and alcohol dependence. CONCLUSION: Psychological debriefing implies re-exposure through memory processes to the trauma, which can interfere with the natural course of adjustment and recovery. Several Authors have suggested that psychological debriefing may delay the diagnosis and thus the early treatment of post-traumatic stress disorder. Psychological debriefing may not be appropriate to all victims of every type of incident or trauma. We discuss the intervention and its design. This review did not show evidence for psychological debriefing efficiency, as a unique session, in the prevention of posttraumatic reactions. The design and the objectives may be re-examined. Further evaluations following rigorous methods are warranted.

8. Rose S, Bisson J, Wessely S. A systematic review of single-session psychological interventions. Psychother Psychosom 2003;72:176-84.
http://content.karger.com/produktedb/produkte.asp?DOI=10.1159/000070781
BACKGROUND: Single-session psychological interventions such as psychological debriefing have become widely used following traumatic events. The evidence for their effectiveness has been widely debated. This review aimed to consider the evidence for the effectiveness of one-off early interventions within 1 month of a traumatic event. METHODS: A systematic review using the standard Cochrane Collaboration methodology. Literature searches of various databases were performed to identify randomised controlled trials. The methodological quality of the studies identified was determined using standard measures, and the results were pooled to consider the overall evidence for effectiveness. RESULTS: Eleven randomised controlled trials were found, all of individual or couple interventions. Three studies associated the intervention with a positive outcome, 6 demonstrated no difference in outcome between intervention and non-intervention groups and 2 showed some negative outcomes in the intervention group (these studies had the longest follow-up periods). The methodological quality of the studies varied widely, but was generally poor. This review suggests that early optimism for brief early psychological interventions including debriefing was misplaced and that it should not be advocated for routine use. There remains an urgent need for randomised controlled trials of group debriefing and other early interventions.

9. Smith A, Roberts K. Interventions for post-traumatic stress disorder and psychological distress in emergency ambulance personnel: A review of the literature. Emerg Med J 2003;20(1):75-8.
http://emj.bmj.com/content/20/1/75.long
Abstract: A literature review was carried out to establish the extent of the literature on interventions for psychological distress and post-traumatic stress disorder in emergency ambulance personnel. A total of 292 articles were identified. Of these, 10 were relevant to this review. The primary intervention used with this population was critical incident stress debriefing, although there was some debate in the literature about the effectiveness of this intervention and the quality of the research conducted. More high quality research is needed on critical incident stress debriefing before being confident of its effectiveness.

10. Everly J, Flannery J, Eyler VA. Critical Incident Stress Management (CISM): a statistical review of the literature. Psychiatr Q 2002;73(3):171-82.
http://www.springerlink.com/content/xh0j7tcgxau76avl/?MUD=MP
Abstract: Crisis intervention has emerged over the last 50 years as a proven method for the provision of urgent psychological support in the wake of a critical incident or traumatic event. The history of crisis intervention is replete with singular, time-limited interventions. As crisis intervention has evolved, more sophisticated multicomponent crisis intervention systems have emerged. As they have appeared in the extant empirically-based literature, their results have proven promising. A previously published paper narratively reviewed the Critical Incident Stress Management (CISM) model of

multicomponent crisis intervention. The purpose of this paper was to offer a statistical review of CISM as an integrated multicomponent crisis intervention system. Using the methodology of meta-analysis, a review of eight CISM investigations revealed a Cohen's d of 3.11. A fail-safe number of 792 was similarly obtained.

11. Rose SC, Bisson J, Churchill R, Wessely S. Psychological debriefing for preventing post traumatic stress disorder (PTSD). Cochrane Database Syst Rev 2002;(2):CD000560. http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD000560/frame.html

    Abstract: BACKGROUND: Over approximately the last fifteen years, early psychological interventions, such as psychological 'debriefing', have been increasingly used following psychological trauma. Whilst this intervention has become popular and its use has spread to several settings, empirical evidence for its efficacy is noticeably lacking. This is the third update of a review of single session psychological "debriefing", first having been undertaken in 1997. OBJECTIVES: To assess the effectiveness of brief psychological debriefing for the management of psychological distress after trauma, and the prevention of post traumatic stress disorder. SEARCH METHODS: Electronic searching of MEDLINE, EMBASE, PsychLit, PILOTS, Biosis, Pascal, Occ.Safety and Health,SOCIOFILE, CINAHL, PSYCINFO, PSYNDEX, SIGLE, LILACS, CCTR, CINAHL, NRR, Hand search of Journal of Traumatic Stress. Contact with leading researchers. SELECTION CRITERIA: The focus of RCTs was on persons recently (one month or less) exposed to a traumatic event. The intervention consisted of a single session only, and involved some form of emotional processing/ventilation, by encouraging recollection/reworking of the traumatic event, accompanied by normalisation of emotional reaction to the event. DATA COLLECTION AND ANALYSIS: 15 trials fulfilled the inclusion criteria. Methodological quality was variable, but the majority of trials scored poorly. Data from 6 trials could not be included the meta-analyses. These trials are summarised in the text. MAIN RESULTS: Single session individual debriefing did not prevent the onset of post traumatic stress disorder (PTSD) nor reduce psychological distress, compared to control. At one year, one trial reported a significantly increased risk of PTSD in those receiving debriefing (OR 2.51 (95% CI 1.24 to 5.09). Those receiving the intervention reported no reduction in PTSD severity at 1-4 months (SMD 0.11 (95%CI 0.10 to 0.32)), 6-13 months (SMD 0.26 (95%CI 0.01 to 0.50)), or 3 years (SMD 0.17 (95%CI -0.34 to 0.67)). There was also no evidence that debriefing reduced general psychological morbidity, depression or anxiety, or that it was superior to an educational intervention. AUTHORS' CONCLUSIONS: There is no evidence that single session individual psychological debriefing is a useful treatment for the prevention of post traumatic stress disorder after traumatic incidents. Compulsory debriefing of victims of trauma should cease. A more appropriate response could involve a 'screen and treat' model (NICE 2005). PSYCHOLOGICAL DEBRIEFING FOR PREVENTING POST TRAUMATIC STRESS DISORDER (PTSD): This review concerns the efficacy of single session psychological "debriefing" in reducing psychological distress and preventing the development of post traumatic stress disorder (PTSD) after traumatic events.

Psychological debriefing is either equivalent to, or worse than, control or educational interventions in preventing or reducing the severity of PTSD, depression, anxiety and general psychological morbidity. There is some suggestion that it may increase the risk of PTSD and depression. The routine use of single session debriefing given to non selected trauma victims is not supported. No evidence has been found that this procedure is effective.

12. van Emmerik AA, Kamphuis JH, Hulsbosch AM, Emmelkamp PM. Single session debriefing after psychological trauma: a meta-analysis. Lancet 2002;360:766-71. http://www.sciencedirect.com/science/article/pii/S0140673602098975?via=ihub BACKGROUND: Despite conflicting research findings and uncertain efficacy, single session debriefing is standard clinical practice after traumatic events. We aimed to assess the efficacy of this intervention in prevention of chronic symptoms of post-traumatic stress disorder and other disorders after trauma. METHODS: In a meta-analysis, we selected appropriate studies from databases (Medline Advanced, PsychINFO, and PubMed), the Journal of Traumatic Stress, and reference lists of articles and book chapters. Inclusion criteria were that single session debriefing had been done within 1 month after trauma, symptoms were assessed with widely accepted clinical outcome measures, and data from psychological assessments that had been done before (pretest data) and after (post-test data) interventions and were essential for calculation of effect sizes had been reported. We included seven studies in final analyses, in which there were five critical incident stress debriefing (CISD) interventions, three non-CISD interventions, and six no-intervention controls. FINDINGS: Non-CISD interventions and no intervention improved symptoms of post-traumatic stress disorder, but CISD did not improve symptoms (weighted mean effect sizes 0.65 [95% CI 0.14-1.16], 0.47 [0.28-0.66], and 0.13 [-0.29 to 0.55], respectively). CISD did not improve natural recovery from other trauma-related disorders (0.12 [-0.22 to 0.47]). INTERPRETATION: CISD and non-CISD interventions do not improve natural recovery from psychological trauma.