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Perspectives of healthcare professionals regarding support following adverse events in three public hospitals in Gauteng: two sides of the coin

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Abstract

Purpose The purpose of this study was to explore and describe the perceptions of support among healthcare professionals (HCPs) following adverse event involvement in three public hospitals in Gauteng, South Africa.

Background The impact of adverse events on HCPs remains an underestimated health concern that warrants further attention to enable continued care for patients and successful careers after events. Experiences are magnified by unsupportive work environments, and are evident in increased hostility, blaming, fear of punishment, and reputational harm. While these HCPs require support to enable them to recover and learn from their involvement, the resources provided by healthcare organizations are varied and often inadequate. There is limited comprehension of the support needed by the HCP following involvement in adverse events.

Methods A qualitative, exploratory, descriptive, and contextual research design was used. A total of 16 nurses and 12 managers from the public hospitals were purposively selected. Data was collected by means of semi-structured interviews which were digitally recorded and transcribed verbatim. Data was analysed using thematic analysis [1].

Results The results revealed that there are variations regarding what was perceived as support from the healthcare professionals involved and the managers. The participants revealed that hospitals have no structures in place, others affirmed unstructured and unsystematic support. However, the managers confirmed otherwise stating the availability of required support, and citing the services were custom made for the patients involved and their relatives.

Conclusion This study provides better understanding of the perspectives of HCP regarding following adverse events in three public hospitals in Gauteng.

Keywords Perspectives, Support, Healthcare professionals, Adverse events, Public hospital

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Introduction and background

Healthcare professionals frequently experience major emotional distress following involvement in adverse events, with serious outcomes for their well-being, patient safety, and the organization. This distress has been well described and reported in published literature [2]. Previous studies mentioned reports of guilt, anger, loss of confidence, and decreased job satisfaction as affirmed [3, 4]. To address these concerns, experts and national guidelines have appealed to healthcare facilities to create systems to support the staff following the events. In addition, the Joint Commission recommended prompt measures to support healthcare professionals involved in adverse events globally [5].

However, attempts to provide formal professional support often fell short with the majority failing to meet the needs of their staff. Subsequently, studies have disclosed that several healthcare professionals suffered in silence as they struggled to acquire support after involvement in adverse events, leading to intense emotional distress [6, 7]. While support programs have shown effectiveness and are getting attention, little is known about their structure and operations and how the needs of healthcare professionals following adverse events are met. A survey conducted in the United States and Canada affirmed that approximately 90% of the staff were not adequately supported following these adverse events [8]. While other authors highlight even although programs were in place to support healthcare professionals, more comprehensive programs are needed [9, 10].

Globally, following adverse events, investigations are conducted including the root cause analysis to prevent the occurrence of events in the future and to learn from the event [11]. However, the formal investigations seldom provided adequate and timely feedback to those involved. This practice and lack of feedback made it more difficult for the involved healthcare professionals to emotionally process the event and reach closure [12–14]. A previous review article [15], which explored the interplay between the health system, patient safety culture, and second victimhood confirmed that the standard response to adverse events by management is firstly, to attend to patients and relatives or family members followed by addressing organizational issues, like notifying the legal team. Additionally, the article explicitly demonstrated that the HCPs are the least attended stakeholders and are not prioritized during such events. Of concern, is a study citing that 68% of the HCPs involved in AEs did not receive any institutional support. Literature further stated that the involved HCPs were neglected, left in isolation, felt frustrated and confused prior being notified of the scheduled review at short notice. It became evident that blaming the second victims and threatening them with lawsuits were common in healthcare settings [13–15].

Previous studies affirmed that involvement in an adverse event does require support, especially from the healthcare management. Healthcare professionals who have been involved in such events reported visible signs of depression with resultant helplessness, hopelessness, and sadness while some contemplated suicide [4, 7, 14]. Other studies concurred with these finding, alluding that following the involvement in adverse events, the healthcare professionals presented with symptoms like post-traumatic stress syndrome such as guilt feelings, anxiety, and loss of professional reputation [4, 14, 15]. From the other studies, some participants reported that they felt stressed and anxious with a possibility of insomnia and difficulty in concentrating on their work. A few of these professionals stated that they were unable to eat because of loss of appetite leading to reduced energy levels and exhaustion. Ultimately these distressing effects and negative feelings uttered resulted in professional isolation and some considered leaving the profession. Nine out of the 13 professional nurses preferred speaking to a colleague or someone in their working space/ward about the adverse event who will not judge them or their actions on the day [3, 5, 6].

In another study, the HCP preferred time off work to deliberate on the impact of their involvement [16]. There was an indication of a need for a receptive, empathic leadership that is communicative, can listen without blame and not judgemental, which required that a manager should provide support based on the immediate emotional needs of the involved. According to the findings, a person who is in a similar job situation was likely to understand the possibility of the adverse event taking place [16–18]. The participants expressed that they would appreciate being provided with emotional and informational support [15, 19]. It was affirmed that there was a need to be informed on the progress of the investigation into the adverse event and to be provided with professional psychological support. A need for referral to a counsellor to assist them in dealing with the anxiety and stress related to the event emerged in other studies, with others affirming that they desired to be given time away from work to enable them to think over the events [11, 13–15].

The public hospitals being studied were in Gauteng Province, South Africa, where Incident reviews involving healthcare professionals were conducted following adverse events to identify the root cause and to prevent future events from happening. Despite this exercise, the reviews have not provided closure for the involved healthcare professionals [20]. According to previous reports [21], there was insufficient research on the perspectives of healthcare professionals regarding support from their organisations following adverse events, and

the extent to which the organizations addressed them, as evidenced in the literature [6, 7, 16, 19].

Problem statement

The researcher observed that although the availability of support was mentioned in the public hospitals in Gauteng, South Africa, the managerial interventions failed to meet the needs of the involved healthcare professionals [20]. This was evidenced by recurring emotional distress, decline in quality patient care, high rate of absenteeism, and low staff morale among staff who were directly involved in these adverse events. The researcher could not find any previous studies that explored the perspectives of healthcare professionals regarding support following adverse events in public hospitals in Gauteng, South Africa. Hence, the need to explore and describe this research gap to identify those perspectives.

Table 1 Semi structured interview guide

Participants	Sample questions asked
Involved healthcare professionals	Theme 1: Tell me a story about when you were involved in an adverse event. How did you feel, what was your immediate reaction? Who was the first person you notified about this adverse event? What was the reaction of the person you informed? What did you expect from this person? Did you have prior knowledge of the procedures and persons to consult and report to following the adverse event. In your opinion, what was your experience of the incident review process? Theme 2 In your opinion, what can management action for employees after involvement in adverse events? What would you recommend that management implement to effectively address the support of those involved?
Managers	Can you tell me about the procedure for adverse events review at your institution? How are the healthcare professionals involved in adverse events supported? In your opinion, is this sufficient? In your opinion, what will be the most effective intervention to initiate support for these professionals? Will this intervention provide the support of those involved? Is the incident review process beneficial to the institution, and if so, how? What would you recommend to effectively address the support of involved healthcare professionals?

Methods

Study design

A qualitative, exploratory, descriptive, and contextual research design was followed. The design was appropriate as it enabled the researcher to understand the perspectives of healthcare professionals. This approach provided an opportunity for the researcher to gather information from the healthcare professionals' perspectives regarding support following adverse events.

Research setting, participants, and sampling

The study setting was made up of three public hospitals in the Gauteng Province. The population for this study consisted of professional nurses and managers. Purposive sampling method was used to select the participants. The participants were approached and recruited by the researcher. The criteria for inclusion for PNs were permanent employment in three public hospitals in Gauteng for a period not less than two-years and an adverse event involvement. Regarding managers, only those who had previously managed the PNs involved in an adverse event in a public hospital in Gauteng were considered for inclusion in the study. The researcher introduced the aims of the study and obtained written consent for conducting the interviews and for digitally recording them.

Data collection

Permission was sought and obtained from the managers to utilize the managers' offices and hospital boardrooms as data collection areas at a day and time which was suitable to them. However, most of the involved HCP preferred to be interviewed away from their workplace after working hours citing fear of being recognised by their immediate supervisors. Data were collected by the researcher through semi-structured interviews supported by documented field notes from September 2019 and to November 2020 involving 28 participants. The interview guide with open-ended questions was used throughout the interviews, and each interview lasted for approximately 45–90 min. Communication skills such as reflecting, clarifying, and summarising were utilized to clarify the responses of the participants. A central question was asked followed by probing statements. Below is Table 1 of the semi structured interview guide.

Data analysis

Data were analysed [1], and the coding was performed by an independent coder with expertise in phenomenological data analysis. Following this process, the researcher and the independent coder, held a consensus meeting to peruse the recognized themes and subthemes. Follow-up discussions were conducted by the researcher and participants to confirm that the data which were analyzed was a true reflection of their perspectives.

Ethical considerations

Ethical clearance was acquired from the Wits University Human Research Ethics Committee (Protocol number: M180809). Permission to conduct research was granted by the research committees of the three public hospitals. All the participants read and signed the free and informed consent prior to the interviews. The study adhered to the Helsinki Declaration in the Ethics approval and consent to participate. The participants were assured of the confidentiality and anonymity of the recordings and transcripts, as well as the freedom to withdraw from the study at any time without giving a reason. A unique code was generated for each participant to maintain their confidentiality.

Trustworthiness

In this study, trustworthiness was enhanced by using the four criteria [22], namely credibility, dependability, confirmability, and transferability. Credibility was maintained through prolonged engagement in the hospitals, by the researcher immersing self in the data, and through member checking. Peer debriefing where depth in-depth discussions were held by the researcher and two supervisors, who are experts in qualitative research was also implemented. The audiotapes were used during transcription to enhance rigor and confirming that the participant's voices were reflected. Data triangulation was augmented through the field notes, digitally recorded data, and observations. Dependability was confirmed through utilizing the digitally recorded and transcribed data and audit trail of the collected and analysed data. The verbatim quotes from the participants were used to conclude. A dense description of the research methodology and descriptive data was provided so that other researchers could evaluate the applicability to other contexts to ensure transferability.

Table 2 Demographic profile of participants

Demographic variable	Value (n28)
Age range	
> 30	2
30–40	8
41–50	11
51–60	5
60+	2
Gender	
Male	6
Female	22
Profession	
Professional nurses	13
Managers	15
AE Involvement	
Direct involvement	13
Indirect involvement/Managed	15

Table 3 Themes and subthemes:

Theme 1: Some form of support or no support received by PNs following AEs	Theme 1: Some form of support or no support offered to the PNs following their involvement in AEs.
1.1 Administrative support	1.2 Administrative support
1.3 Management intervention	1.4 Management intervention
1.5 Comprehensive investigation/incident review session	1.6 Comprehensive investigation/incident review session
1.7 No support received	1.8 No support offered
Theme 2: Recommendations for support to be received by professional nurses following AEs	Theme 2: Recommendations for support to be offered by managers following the involvement of PNs in AEs
Managerial support	Structured support programs
• Empathetic support	• Provision of resources
• Someone to talk to and be understood	• Additional training
• Review of the incident review process	• Review of the incident review process

Results

Twenty-eight (28) semi-structured interviews were conducted with the participants and data saturation was achieved at participant number 28. Two more interviews were conducted thereafter but did not yield new information. Majority of the participants were female ($n = 22$) with six males ($n = 6$), and their ages ranged from 30 to 62 years. The characteristics include their ages, gender, profession, and adverse event involvement. Table 2 depicts the demographic profile for healthcare professionals involved in adverse events in public hospitals in Gauteng, South Africa.

The findings of this study yielded two themes and four subthemes which emerged from the analysed data. The themes unveiled the perspectives of healthcare professionals regarding support following adverse events in the three public hospitals in Gauteng as outlined below in Table 3.

Themes and subthemes are provided below.

Theme 1: support received

Theme 1 relates to some form of support, or no support received by professional nurses or offered by managers following AEs. This support was in terms of the following that emerged as the subthemes emerged of Theme 1:

(a) administrative support; (b) management intervention; (c) comprehensive investigation/incident review sessions; and (d) no support received. These are deliberated briefly below:

Subtheme 1: administrative support

The HCP provided their perspective regarding administrative support from managers as affirmed by the quotations from N1 and N2 below:

Participant N1, a healthcare professional mentioned that: *"A few minutes after the incident happened, I just saw the Zonal Matron storm into the ward like a lion charging into a battlefield. We were directed to meet in the duty room, told to make sure that before we leave the ward the reports were completely written and sent to the Matron…I was traumatised by the event, yet all that management is concerned with was a report, how insensitive? None of them asked how we were feeling.* (N1: Looking sad).

In addition, participant N2 stated how she felt when asked to compile the incident report, saying: *"This was my first incident, and no one was there to assist me with writing this report. I started to write frustrated, sobbing and confused, only to discovered that the patients' file was removed, and we were not even made aware. How was I supposed to compile a report when the patient's file was missing; what can we do in so little time? I could not start writing and just stared at the window lost and wandering why I came to this hospital".* (N2: Looking angry).

*Participant N3 supported saying: "Well, there are no guidelines. There are many different forms that when you must start writing, you cannot make head or tail of anything. From my perspective, there is no structure; this is how we do it. The policies and procedures for reporting and recording adverse events lacked clarity. (*N3: shaking head*).*

On the other side of the coin, the managers stated that they provided the PNs with administrative support to guide towards completion of the adverse events documents, hence the request to write down while the sequence of events was fresh in their minds and submit them to prevent them from mixing the facts. This is affirmed by the quotes from the managers: *"When we receive notification of an adverse event[A/E] that occurred in a specific ward, we immediately [management] assemble there and encourage the involved staff to write what happened and not hearsay or what others suggest, and we encourage them that they must avoid incriminating themselves".* (Manager 1: speaking with confidence)

"All the involved staff members that are on duty are advised to complete an incident report based on what has happened, and I as a manager, I reread all the incident reports that they've written and try to identify where the problem was". (M2: Pointing to clarify).

Sub-theme 2: management intervention

The professional nurses agreed that management does intervene but, in their opinion, this was meant to ridicule them instead of being caring and compassionate to someone who is feeling anxious, emotional and frustrated. It was revealed that the existing interventions such as Emergency department Medical Review area, counselling and Employee Awareness Programmes [EAP], were reserved for the affected patients and their families as indicated by N6 and N7 below saying:

"We never knew there were new incident forms to record the incidents and instead, the Zone Matron made fun of us at the incident review seating asking us questions in full view of the other colleagues; Is this the form to use? Why didn't she correct us before the day?" Management doesn't care about us" (N6…. Looking surprised).

participant N7 acclaimed: *"What EAP, where? Those consultations and their offices are reserved for the patients, we are just the working class here, period. How we feel afterwards does not matter in the eyes of management".* (N7…. Sounding annoyed)

However, two managers who were previously assigned to manage the healthcare professionals involved in adverse events provided a different perspective/version of the sequence of events on how management intervenes following the documentation of the incident report. This is what M3 and M4 expressed: *"Under normal circumstances the staff member concerned will go to the emergency department for medical review, but we also refer them to employee assistance or an employee wellness programme for support, because we understand that being involved is very traumatic".* (M3: Speaking softly but with confidence).

A participant M4 said: *"Once the staff has finished writing the incident report, we usually validate that what they wrote is a true reflection of the chain of events, then we calm them down because they cannot leave the ward in a sad state…imagine the visitors and patients. Then we advise them to go for consultation, but they can choose whether internal or external according to their preferences".* (M4: lifting eyebrows).

Sub-theme 3: comprehensive investigation and incident review session

The PNs provided their perspectives regarding the internal investigations and the incident reviews. Some of them declared that the investigation left them feeling ridiculed, intimidated, as they were blamed for the AEs while others mentioned that they were not offered the opportunity to prepare the necessary documentation towards the seating nor the ability to learn from the adverse events.

Participant N5 and N6 stated: *"So, we were taken immediately to the hearing the morning after that the evening of the adverse incident, the morning we went for the review. We could not prepare anything and some of our colleagues didn't come. It does not matter because till today we got no feedback from the review, and we know for a fact that*

we did nothing wrong, but we will always be blacklisted". (N5: sounding frustrated).

"The review was supposed to be a learning opportunity for all of us, but the way it is conducted leaves much to be desired. It was worse than a battlefield. There was no respect for our feelings just blaming and crushing every answer we gave them. After the investigation and review we don't get feedback pr report, so you are left hanging after being crushed in front of everyone in attendance". (N6: looking down with a sad face).

All the managers acknowledged that the investigation process provided details towards verifying the root causes and assisted in finding the solution to the AEs. The information gathered was used to facilitate the scheduling of the incident review process and was vital to ensuring closure following the AEs. The explanation from M5 and M6 were as follows:

"You will then have an incident review in the ward, an internal session where you look at what transpired, what we could have done differently, did the staff have enough knowledge on how to deal with what happened with the patient, in terms of the patient's diagnosis, in terms of the level of training, in terms of adverse events? Were the staff members capable of dealing with such things?" (M5: Staring at the table).

"At times when the wards are busy there isn't time for a ward review, so we commence with preparations for the main review. This helps to ensure that all staff, not just those involved in the event are afforded a fair chance to explain what happened, how it happened and the way forward. This is a learning opportunity for the entire hospital hence we invite a representative from each ward to attend. (M6: making facial gestures)

Subtheme 4: no support received/offered

The PNs concurred that the support received from the management was haphazard, inadequate and left much to be desired; according to them there was no support… as indicated by N7 and N8, saying:*"If it is an employee assistance program, it should assist employees, us that were involved in the incident, instead of saying here are the details of a counsellor. How come the patients are referred better and not us? We are suffering in silence and yet management are turning a blind eye"* (N8: sounding angry).

The managers also asserted that there was no support provided to the involved PNs following their involvement in AEs. The participant, M9 alluded below: *"We provide little pamphlets that are issued to the [involved] staff members; they can either be referred to by their immediate manager or they can do a self-referral. We cannot do more than this …sadly, the patients are referred for emergency intervention to prevent complications" (*M9: Sounding sad*).*

Another manager confirmed this: *"You know with the resources available I don't think there's more that we could have done",* meaning that no other form of support existed for the involved PN.

Theme 2: recommendations for support

Theme 2 relates to recommendations for support to be received by professional nurses or to be offered by managers following the involvement of PNs in AEs. The recommendations were in terms of the following that emerged as the subthemes of Theme 2:

a) empathetic support vs. provision of resources; b) someone to talk to and be understood vs. additional training and c) review of the incident review process.

Sub-theme 2.1. Empathetic support vs. provision of resources

The PN recommended that management should provide them with empathetic support following their involvement in adverse events. A referral was made to the existing EAP by a PN, stating that: *"The management takes care of the patients and their families (hence the services of EAP), but there is no support for us as nurses after involvement in these incidents; I believe that this needs to change.*(N5, teary eyes*).*

The managers suggested that structured support programs inclusive of the provision of resources for the PNs following involvement in AEs, giving examples such " witnessing how the investigations are conducted outside their hospitals and observing to make comparison and bring fresh ideas to their respective areas will benefit the PNs: Managers M5 and M3 agreed on these ideas saying *"And I think we need to make sure that they really get support, because sometimes they even go attend the external investigation processes at other hospitals to witness how things are conducted".* (M5, Sounding confident).

While M3 mentioned *"But I think that really, we should have much more general support. Yes, we have the Employee Assistant Programme which is [available for the involved staff for referral], but its efficiency is questionable". Surely, they can revive this to provide a better service to our staff (M3,* spoke ***softly, sounded***uncertain and shy**).**

The Managers on the other hand sustained that resources should be provided by the senior management at each hospital to ensure that specialty units are provided with adequate skilled staff which will reduce the number of AEs. A participant M said: *"I think we as management should allocate more qualified staff in specialty wards. accordingly, and more registrars in high-risk wards. pregnant women and those in labour; this way they can see who a high-risk patient is and treat accordingly"* (M4…).

Another manager communicated *"This is a specialty hospital, so we need advanced midwives to assess the accurate progress of labour accurately and implement the expected nursing care plan, so the pregnant mothers can receive the attention they deserve on arrival and prevent complications earlier.* (M2.)

Sub-Theme 2.2 someone to talk to and be understood vs. additional training

The PN proposed that managers should provide services of or access to someone that they (PN) could talk to and who will understand them without judging them. They confirmed that talking will ensure they share the emotional burden of AEs involvement and were longing to gather personal and professional reassurance.

The quotes from N6 and N7 confirmed as follows:

The managers agreed that referral of the PN to someone with expertise in human behaviour and mental processes, will afford them (PN), a safe space to talk and for their illustrations to be understood: A manager M2 said *"We [managers] should be able to psychologically attend to [the involved staff]. I think it would be wise to have an EAP programme that's driven by a psychologist, a social worker, or somebody who is more informed about how to manage the psychological being of someone who was involved in incident"*.

The managers recommended that additional training should be provided to the PNs following involvement AEs. Participant M3 and M4 mentioned that: *"I believe that we as managers should also conduct additional and regular in-service education sessions, where we will be aiming to prepare the staff for avoiding the incidents in future"* (M3….); with M4 supporting the statement; "*We should always provide in-service training on SAEs and how to deal with them. In addition, keep on reminding them that, in their workplace there will be those incidents. We must have a way of avoiding them, so we train them so that we avoid the recurrence".* (M4….)

Sub-theme 2.3 review of the incident review process

The PN recommended that the managers have a relook of the incident review process to eliminate the associated culture of blaming, naming, and shaming the involved PNs. They substantiated that the relook should incorporate the feedback to be provided following an investigation process and enable them to learn at both personal and hospital level. The participant N7 mentioned: *"The review panel should note that we do not leave our homes to hurt patients intentionally, yet we are treated like criminals. They should structure the questions differently unlike they are interrogating us. The questions are asked such that you can hear that the panel has already concluded that you are guilty…what happened to the saying that one is …innocent till proven guilty? Not here maybe elsewhere. We are even blamed by management AEs caused by system errors, something beyond our control seriously"* (N7).

The managers similarly recommended a relook of the incident review process. A participant M1 substantiated that "*I believe that our incident reviews are not conducted in such a way that they provide comfort or learning to the involved staff], so we should be considerate on how the incident reviews are conducted".* (M1….). While M shared similar sentiments saying: *"a different approach when conducting these reviews will bring more ease to our staff and then there will be more, how can I put it, they will find closure and be able to learn from their mistakes".* (M1, Looking sad).

Discussion

Main findings

The study focused of the perspectives of HCP regarding support following AEs in three public hospitals in Gauteng. Although the interviews unveiled similarities in theme one and accompanying subthemes, the perspectives from the healthcare professionals were different. For instance, the PNs affirmed the administrative support provided by the managers, was conducted abruptly, in an insensitive and cold manner, preventing them an opportunity to comprehend what had just happened, and added to their emotional distress which was consistent with previous studies [2, 4, 7, 9]. Most of the PNs affirmed that they were left traumatised by the alleged support more than the involvement in the AEs itself. Surprising, the managers perceived that the administrative support they provided to the PN was adequate, conducted professionally and comprehensively to gather the events leading to the AEs and simultaneously reassuring the involved PNs [3, 7, 23]. What was outstanding in our study was the variety of responses.

For noting, the findings revealed that Employee Assistance Programs (EAP) and Emergency area services were available at the three public hospitals. It was sad to note that although the managers mentioned that there were programs to support the PNs involved in AEs, few PNs were aware of their existence, but chose not to utilize them due to a lack of trust while the majority were unable to access them. It was stated that the PNs perceived that the types of interventions mentioned by managers were specifically reserved for the affected patients and their families, and not for the involved PNs; thus, according to them, there was no beneficial intervention provided by the managers. The managers mentioned that other services were available as part of management intervention which was different in comparison to the affirmation from the PNs. The findings are congruent with those published [10, 15].

The comprehensive investigation preceding the incident review session was conducted following AEs to confirm the root cause analysis and facilitate the review seating. The PN's affirmed lack of clear investigation process and evident disorganisation that added to their emotional distress. However, the managers perceived that without a comprehensive investigation process, they would not be able to compile the information vital to schedule the incident review (IR). Lack of management follow-up and poor sequence in the investigation process added to the PN's emotional distress, creating it challenging to get closure, consistent with previous research [2, 23, 24]. The incident review process was conducted following the AEs for the involved PNs to learn from them. However, the PNs perceived the sessions as interrogative, with concluded connotations. It was revealed that during the incident review sessions, the managers posed the questions to the PNs as if they (managers) were personally attacking those PNs involved in AEs, without giving them the chance to respond to the questions or ask for clarity.

In relation to recommendations for support, the PN mentioned they would have needed empathetic support from the managers following involvement in AEs (24, 26). They were expecting the management to be appreciative and visible in the wards asking are you ok…. not the way they apparently charged into the specified areas to blame and shame the PNs. Based on this, the authors can assume that the managers should be present in the absence of AEs and appreciate the PNs rather than fail to recognise them. The visibility of considerate and caring management was previously found in literature (25, 27). The managers on the other hand stated they would have supported the PN by the provision of resources. It emerged that some areas were not adequately staffed, hence the exposure/possibility of AEs occurring. Our study prove that AE involvement was related to inadequate and insufficient staffing especially in specialty units like maternity where majority of adverse events were reported, consistent with previous research.

PNs stated the need to speak to someone and be understood. Our finding revealed that expert intervention was imperative in times of AEs involvement where the PNs were showing signs of emotional distress, anxiety and fear of litigation; and to be understood, as this person routinely deals with everyone going through burdensome circumstances – this would enable the involved PNs to voice out their frustration, anxiety and otherwise without being judged.

However, the managers specified otherwise that they would have opted to provide additional training to support the PNs following AEs involvement. It became clear that the PNs involvement resulted from lack of knowledge regarding identification of situations that predisposed to AEs. Our findings thus affirm that continuous learning on the identification and prevention of AEs would benefit both the PNs and the hospital as the latter would be better prepared and in readiness for future AEs, consistent with previous studies.

The PN and managers unanimously agreed that they would have needed the incident review process to be reviewed. The PNs spelled out that they would have needed to be identified earlier prior the process to ensure mental readiness and allowed to prepare the required documents. The managers affirmed similar views. It was worth noting that although the findings from the perspectives of the PNs and the managers revealed similar themes and subthemes, the interpretation was different, as confirmed by previous research [3, 7, 23].

Conclusion

The findings of this study revealed better understanding of the perspectives of HCP regarding support following AEs in three public hospitals in Gauteng. The appreciation of PNs was deemed vital to ensure the support is positively perceived, and this will be made possible by visible managers who visit not amid AEs. Following AEs, empathetic support is imperative to ease the fear, anxiety and frustration associated with the AEs, thus managers should provide empathetic support. Sufficient time should be allocated to affirm that PNs are familiar with new and revised AEs related documentation. Managers should prioritise affording the PNs access to experts who will understand them to hopefully ease the emotional burden of AEs involvement, including revision of policies regarding the Employee assistance program so it is accessible to the PNs and not just the patients and families. Finally reviewing the incident review process to ensure learning from the AEs.

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Authors' contributions

Elizabeth Nkosi compiled the original draft, final analysis, and final writing up and submission of the article.Sue Armstrong conducted the review, formal analysis, visualisation, editing and final review. Nokuthula Nkosi conducted the review, formal analysis, visualisation, editing and final review.

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Data availability

No datasets were generated or analysed during the current study.

Declarations

Ethics approval and consent to participate

Ethical clearance was acquired from the Wits University Human Research Ethics Committee (Protocol number: M180809). Permission to conduct research was granted by the research committees of the three public

hospitals. All the participants read and signed the free and informed consent prior to the interviews. The study adhered to the Helsinki Declaration in the Ethics approval and consent to participate.

Consent for publication
Not applicable.

Competing interests
The authors declare no competing interests.

Implications for practice
This is the first study conducted in the public hospitals in Gauteng exploring the perspectives of healthcare professionals support following adverse events involvement. There are implications for practice and management. This is a new area of study with few reported outcomes. There is a need for healthcare leaders to scrutinize the structures and performance of their existing support systems.

Study limitations
The study was conducted during the COVID-19 pandemic hence the responses could have been hurried to get over the interviews. Some of the participants were deployed to other hospitals where it was impossible for the researcher to follow them up due to the restrictions related to the pandemic.

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