

HSIB QI Project: How supported do our staff feel throughout the HSIB investigation?



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Background

When a baby is born in poor condition and requires therapeutic cooling, an independent investigation is carried out by The Health Care Safety Investigation Branch (HSIB).

HSIB undertake investigations of the most serious maternity cases using independent, impartial and a standardised process that does not apportion blame or liability.

Common themes are identified to learn and improve practice. Maternity staff have been finding this process unpleasant, stressful and reported feeling unsupported by Homerton.

Aim

The overall trend in feedback showed staff were feeling alone, unsupported and with a lack of debriefing offered. Therefore we aim;

For 60% of Staff to feel 'well supported' throughout the HSIB process by May 2020.

Staff Feedback

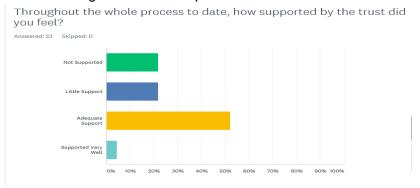
In September 2019 a survey was conducted to gather information from all staff who had been involved in an HSIB investigation. This included anesthetic and neonatal staff, midwives & obstetricians.

There were 23 respondents in total, and they said:

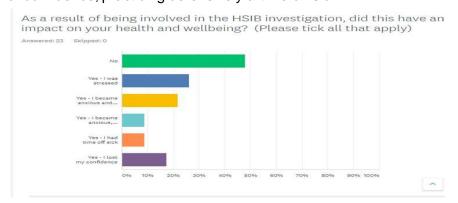


'I did not feel wholly supported or in the loop'

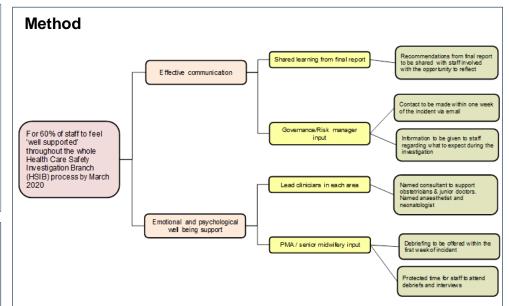
Only one respondent out of the 23 reported feeling well supported by Homerton throughout the whole process.



19 respondents reported the HSIB investigation having an impact on their health & well being, which included feeling stressed, anxious, loss of confidence, practicing defensively & time off sick.



The results clearly show that the HSIB process has had an impact on the health and wellbeing of the respondents.



Changes that have been made:

PDSA 1: The maternity governance team are sending all staff involved in a case referred to HSIB an email within one week of the incident aimed to:

- · Inform staff of admission to the NICU or neonatal death
- Alert staff to HSIB referral and provide information on what to expect, who to contact and how to get extra support

PDSA 2: Governance team educates midwives on HSIB during monthly mandatory training

PDSA 3: Information regarding HSIB visible around the maternity unit

PDSA 4: A lead professional appointed from each department (obstetrics/anaesthetics/Neonates/maternity teams) to offer support to staff in these specific areas.

Re-survey November 2020

17 members of staff responded to this survey.

6 respondents (35.29%) stated that they felt well supported throughout the whole HSIB process.

Conclusion & Reflections

Although we did not reach our target, this is a great improvement from last year. The governance team will continue to do its best to support our staff during the HSIB process.

Work is continuing on an effective way to distribute recommendations and ensure shared learning from the finalised reports. It is evident that staff's health & well being is affected by these investigations and they have expressed a need for more support and debriefing after an event.

The success of this project depends on the engagement of senior management team.

Planned Changes:

- A standardised platform to share/report learning and recommendations
- Reflection sessions once final report is published for those who wish to discuss the findings and recommendations
- A member of the governance team to be available after morning handover to give immediate support to staff who have been involved in difficult situations during their shift
- All staff following an HSIB investigation to be sent the survey to measure levels of support