

# Detach Yourself: The Positive Effect of Psychological Detachment on Patient Safety in Long-Term Care

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**Objectives:** Delivering health care is emotionally demanding. Emotional competencies that enable caregivers to identify and handle emotions may be important to deliver safe care, as it improves resilience and enables caregivers to make better decisions. A relevant emotional competence could be psychological detachment, which refers to the ability to psychologically detach from work and patients in off-duty hours. The objective of this study was to examine the relationship between psychological detachment and patient safety. In addition, the ability of teams to create a safe environment to discuss errors and take personal risks, i.e., psychological safety, was explored as an underlying condition for psychological detachment.

**Methods:** A total of 1219 caregivers (response rate = 44%) from 229 teams in two long-term care organizations completed a survey on psychological safety and psychological detachment at T0. Team managers rated patient safety of those teams at two points in time (T0 and T1).

**Results:** Two-level regression analysis showed that both psychological safety ( $\beta = 0.72, P < 0.01$ ) and psychological detachment ( $\beta = 0.54, P < 0.05$ ) relate directly to patient safety. Psychological safety relates positively to psychological detachment ( $\beta = 0.48, P < 0.01$ ) but was, however, not an underlying condition.

**Conclusions:** Perceived patient safety is enhanced by emotional competencies, at individual level by psychological detachment and at team level by psychological safety. Caregivers should be aware of the important influence emotional competencies have on patient safety and be trained to develop these competencies. Future research should focus on exploring underlying conditions for emotional competencies.

**Key Words:** nontechnical skills, psychological detachment, psychological safety, long-term care

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Research clearly demonstrates that patient safety not only depends on the technical skills of caregivers (“the adequacy of actions taken from a medical and technical perspective”) but also depends especially on their nontechnical skills.<sup>1,2</sup> Nontechnical skills refer to “the cognitive and interpersonal skills that complement an individual’s clinical knowledge and facilitate the effective delivery of safe care,” such as communication skills, situational awareness, critical thinking skills, and task management.<sup>2,3</sup> However, in studies of nontechnical skills, strikingly little attention is paid to emotional competencies, as if thinking and feeling are two separate worlds, whereas psychological research suggests that emotion plays an important role in decision-making.<sup>4</sup> Emotional competencies refer to “identifying, understanding, expressing,

regulating, and using one’s emotions and those of others.”<sup>5</sup> As delivering care can be emotionally demanding, the competencies to identify and handle emotion could be crucial to deliver safe care.<sup>4,6</sup> Such competencies may enable caregivers to make better decisions, be more resilient, and recover quickly from difficult or stressful situations.<sup>4,6–8</sup>

Research in diverse settings shows that mastering emotional competencies is associated with higher (job) performance. For example, Nelis et al<sup>7</sup> showed that emotional competencies among undergraduate students are related to better performance in terms of employability, psychological well-being, subjective health, and quality of social relationships. Kotsou et al<sup>8</sup> demonstrated this link in a broader setting as they show positive effects of emotional competencies among adults on personal and interpersonal functioning, such as life satisfaction, perceived stress, subjective health, and quality of social relationships. In health care, Mikolajczak et al<sup>9</sup> showed the association between high emotional competence among nurses and fewer burnout. Bourgeon et al<sup>10</sup> found a positive effect of emotional competence on medical performance among medical residents. Research in organizational psychology has identified recovery from work as an important emotional competence that influences performance. Empirical research has paid particular attention to psychological detachment from work in off-duty hours. Psychological detachment is defined as an “individual’s sense of being away from the work situation.”<sup>11</sup> It refers to “not being concerned with work-related feelings, thoughts, or activities such as reading/answering e-mails and making/answering phone calls at home.”<sup>12,13</sup> The recovering process of switching off and distancing oneself from the workplace physically and mentally during nonworking hours enables workers to restore resources that have been depleted at work. To date, research on psychological detachment shows a positive (direct) relationship between psychological detachment and both well-being (e.g., emotional exhaustion, life satisfaction) and job performance (i.e., task performance).<sup>14–17</sup> Psychological detachment may also be an important emotional competence for patient safety as it empowers caregivers to stay focused and engaged and may therefore prevent adverse events, even while facing high job demands.<sup>18,19</sup> Detachment from work in off-duty hours also creates the opportunity to engage in activities that provides new resources that can be invested in the job.<sup>19</sup> To our knowledge, however, no research has been conducted on the relationship between psychological detachment and patient safety.

Although psychological detachment has gained increasing attention and research has shown its positive effects, little is known about the underlying conditions that enable employees to detach themselves from work.<sup>19</sup> Sonnentag and Fritz<sup>19</sup> suggest that research on psychological detachment should focus more on social context and should investigate the assumption that “detachment is easier to achieve after having brought work matters to a cognitive closure.” Consequently, we examined whether “psychological safety” is a condition relevant to the psychological detachment of health caregivers. Psychological safety refers to “a shared belief that a team is safe for interpersonal risk taking.”<sup>20</sup>

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Psychological safety is seen as an important factor for patient safety.<sup>21–24</sup> The systematic literature review of Newman et al<sup>24</sup> shows strong evidence that psychological safety is an underlying condition for several nontechnical skills and team processes important to patient safety. Caregivers who experience greater psychological safety share a feeling that it is acceptable to take risks, experiment, voice ideas, concerns, doubts, and mistakes to team members.<sup>20–24</sup> They are therefore more likely to engage in communication, knowledge sharing, voice-behavior (e.g., speaking up), learning behavior, extra-role behavior, giving and seeking feedback, and emotional support. Consequently, more errors will be reported, which enables caregivers to learn from errors and prevent them from recurring. As a result, higher patient safety could be achieved.<sup>25–27</sup> Psychological safety might also be an underlying condition for psychological detachment because it allows caregivers to discuss their doubts and fears so they can receive help, support, and attain cognitive closure at work. This might reduce stress and help caregivers forget work-related concerns and obligations in off-duty hours so that they can rejuvenate their resources and strengthen their ability to provide safe care the next day. Psychological safety could enable and foster psychological detachment, which in turn could enhance patient safety.

The aim of this study is to analyze the relationship between psychological safety, psychological detachment, and patient safety, based on the following hypotheses:

*Hypothesis 1: Psychological safety positively affects psychological detachment.*

*Hypothesis 2: Psychological detachment positively affects patient safety.*

*Hypothesis 3: Psychological detachment partially mediates the relationship between psychological safety and patient safety.*

## METHODS

### Study Field

The study was conducted in two large long-term care organizations in the Netherlands. These organizations provide a variety of services for clients with physical or intellectual disorders, ranging from assisted living accommodation, consultations at home, to extended day activities. One organization has a client base of 1200 clients and is an important provider for the northern part of the Netherlands. The other organization is an important care provider in the southern part of the country with approximately 2400 clients. In both organizations, care is provided by highly autonomous care teams, which are geographically scattered over a dozen urban as well as rural areas. Only teams providing direct care to clients were included, meaning that teams that support care delivery with technical or general services were excluded. In this field, caregivers must not only cope with a greater workload, struggling to provide more complex care with fewer means, but also cope with increased mental demands caused by greater work pressure and job complexity.<sup>28</sup> All this could potentially lead to a drastic increase in patient safety incidents.<sup>29</sup> Examples of patient safety incidents in long-term care are accidental injuries involving patients and staff, falls, and (repeated) medication errors.<sup>28,30–32</sup> Psychological detachment may be especially relevant to long-term care as caregivers and patients often form close relationships, which may make it hard for caregivers to detach themselves in off-duty hours.

### Study Design

We conducted a longitudinal survey study among teams in two long-term care organizations. Each team has a team manager, but team managers supervise several teams (between 2 and 6 teams

each; 4 teams on average) and are therefore not part of the teams and not involved in actual care delivery. Team members received a paper-based survey at one point in time (i.e., T0), to measure psychological safety and psychological detachment. Team managers received a paper-based survey at two points in time with a 1-year interval (i.e., T0 and T1), to measure their perception of patient safety within their teams. Two letters accompanied the survey, one from the researchers and one from the employing organization. The letters covered the following topics: aim of this study, instruction to complete the survey, how results will be communicated, guaranteeing anonymity, deadline, and encouragement for participation. Teams with a minimum response rate of 80% would receive a pie as token of appreciation. The respondents were given a deadline of 1 month to return the survey. One week before the initial deadline, each team and their team manager received an e-mail with the current response rate. In addition, the initial deadline was postponed by 1 week. Insights into changes in policy or procedures between T0 and T1 that could affect patient safety were gathered through interviews. We interviewed two managers, two advisors, two staff members, and one member of a worker's council. We detected no modifications that could cloud our findings or act as confounders. We were not able to combine objective patient safety measures (e.g., fall incidents, medication errors) with subjective patient safety measures (i.e., perceived patient safety by team managers) because objective measures were not available at team level and were not up to date. If reported, objective measures are usually only available at department or organizational level. In addition, it seems to be difficult to directly relate objective measurements of adverse events to perceived patient safety. Research in hospitals showed, however, that improved teamwork and communication increased the frequency of errors reported.<sup>33</sup> The number of reported errors could reflect patient safety and the safety climate.<sup>20,22,23</sup>

### Sample

At T0, we posted the survey to 2731 members of 246 teams and 62 team managers with a prestamped return envelope. In total, 1197 members from 229 teams completed the survey (overall response, approximately 44%). After matching this sample with the managers' responses at T0 and T1, 607 members from 115 teams in total had ratings on psychological safety (T0), psychological detachment (T0), and patient safety (T0 and T1).

Our final sample is representative for the Dutch long-term care setting in terms of respondents' characteristics (Table 1). The sex ratio of our sample (86% female) is similar to the Dutch long-term care setting (85% female).<sup>34</sup> The average age of 40.55 is also comparable with the average age of 40 in the Dutch long-term care setting.<sup>34</sup> However, the average educational level of the final sample is significantly higher than in the overall long-term care setting. In our sample, 30.8% of team members hold a bachelor degree, far more than the 6% in the national setting. This could be explained by the severity or complexity of disorders of the client population that the teams in our sample deal with.

### Measures

The validated scale for psychological safety consisted of seven items developed by Edmondson (1999).<sup>20</sup> Sample item: "Members of our team are able to bring up problems and tough issues." We measured psychological detachment with three items from the validated (Dutch) Questionnaire Experience and Assessment of Labor survey.<sup>35</sup> Sample item: "In leisure time, I am still concerned about work issues." Patient safety was assessed with a self-developed scale that measured the perceived safety level in terms of preventing incidents and dangerous situations. The scale consisted of five items.

**TABLE 1.** Correlation Matrix

	Mean (SD)	$\alpha$	1	2	3	4	5	6	7	8
1 Psychological detachment (team T0)	3.52 (0.83)	0.77	1							
2 Psychological safety (team T0)	3.72 (0.59)	0.74	0.22*	1						
3 Patient safety (managers T0)	3.87 (0.52)	0.74	0.11*	0.07 <sup>†</sup>	1					
4 Patient safety (managers T1)	3.90 (0.55)	0.71	0.12*	0.21*	0.47*	1				
5 Sex, male	1.86 (0.35)		-0.06 <sup>†</sup>	0.06 <sup>†</sup>	0.09*	0.01	1			
6 Age	40.55 (11.66)		-0.02	-0.08*	0.09*	0.00	-0.07 <sup>†</sup>	1		
7 Educational level	4.83 (1.48)		-0.03	-0.04	-0.06	0.04	-0.05	-0.15 <sup>†</sup>	1	
8 Organizational tenure	11.67 (9.56)		0.02	-0.00	0.13*	0.02	-0.07 <sup>†</sup>	0.51*	-0.06	1
9 Team tenure	5.27 (5.08)		0.03	-0.00	0.13*	0.02	-0.02	0.34*	0.03	0.40*

\*Correlation is significant at the level of 0.01 (two-tailed).

<sup>†</sup>Correlation is significant at the level of 0.05 (two-tailed).

1 = male.

Sample item: “This team prevents incidents with clients through good teamwork.” All measures were rated on a five-point Likert scale ranging from 1 (totally disagree) to 5 (totally agree). The Cronbach  $\alpha$  varied between 0.71 and 0.77, as presented in Table 1. The results of factor analyses (principle component analysis, Oblimin rotation) confirmed the one-dimensional construct of psychological safety, psychological detachment, and patient safety.

We included age, sex, education, team tenure, and organizational tenure as control variables. We investigated the possibility that the two participating organizations varied in terms of psychological detachment.

### Analyses

Descriptive statistics and correlation analysis were calculated with SPSS 15.0 software. Two-level multilevel regression analyses were performed with Mplus software. The concepts psychological safety and psychological detachment are individual-level measures and therefore vary within and between teams. In contrast, patient safety is a team-level measure based on team managers' perceptions and therefore varies only between teams. Because hypotheses 2 and 3 refer to relationships in which the independent variable is measured on the individual level and the dependent variable on the team level, data does not vary within teams. Therefore, traditional multilevel analysis is not suitable. We followed the procedure recommended by Croon and Veldhoven,<sup>36</sup> which makes it possible to conduct a multilevel analysis that accounts for two levels (i.e., individual and team) but is based on an unbiased estimate of between-group variance only.

To test the mediating relationship suggested by hypothesis 3, we followed the procedure recommended by MacKinnon et al.<sup>37</sup> For this study, this means that psychological detachment mediates the relationship between psychological safety and patient safety in case (1) psychological safety has a significant effect on psychological detachment and (2) psychological detachment has a significant effect on patient safety in a regression analysis that also includes psychological safety. In case psychological safety has a significant but reduced effect on patient safety in step 2, partial mediation is shown. If psychological safety does not affect patient safety in step 2, we speak of full mediation.

### RESULTS

The aim of this study was to analyze the relationship between psychological safety, psychological detachment, and patient safety.

Our first hypothesis states that psychological safety will lead to greater psychological detachment. Our second hypothesis states that psychological detachment will lead to a higher degree of patient safety. Thirdly, we hypothesize that psychological detachment mediates the relationship between psychological safety and patient safety.

We began by determining whether these variables correlate and which control variables play a part. The correlation matrix (Table 1) presents the results of this first analysis. As expected (hypothesis 1), the correlation analysis showed that psychological safety relates positively to psychological detachment ( $r = 0.22, P < 0.01$ ). It also relates to patient safety at both T0 ( $r = 0.07, P < 0.05$ ) and T1 ( $r = 0.21, P < 0.01$ ). Also as expected (hypothesis 2), psychological detachment relates positively to patient safety at T0 ( $r = 0.11, P < 0.01$ ) and T1 ( $r = 0.12, P < 0.01$ ). To determine whether there is a causal relationship, as both hypothesis suggest, we needed to do further analyses.

The correlation analysis provides insight into the relevant control variables. It shows that being female relates positively to psychological safety ( $r = 0.06, P < 0.05$ ) and patient safety at T0 ( $r = 0.09, P < 0.05$ ) but relates negatively to detaching themselves from work ( $r = -0.06, P < 0.05$ ). Age relates positively to patient safety at T0 ( $r = 0.09, P < 0.01$ ) but negatively to psychological safety ( $r = -0.08, P < 0.01$ ). Organizational tenure relates positively to patient safety at T0 ( $r = 0.13, P < 0.01$ ).

To test the importance of the organization as a control variable (respondents work in two different organizations), we conducted a *t* test, which showed that psychological safety and patient safety at T1 did differ between the organizations.

Based on the correlation matrix and the *t* test, we decided to include sex, age, and organizational tenure as well as the dummy variable “organization” as control variables in our further analyses.

We performed multilevel regression analysis to see whether and how the variables are causally related and to determine the influence of the control variables. Multilevel regression analysis (Table 2) shows that psychological safety leads to more psychological detachment ( $\beta = 0.48, P < 0.01$ ). Hypothesis 1 is therefore confirmed. The results (Table 3, model 2) demonstrate that psychological detachment leads to a higher level of patient safety ( $\beta = 0.54, P < 0.05$ ). Hypothesis 2 is therefore confirmed.

To test our third hypothesis, we followed the procedure recommended by MacKinnon et al.<sup>37</sup> To establish a mediating relationship, two criteria must be met. The first is that psychological safety must have a significant effect on psychological detachment.<sup>37</sup> This criteria was met as hypothesis 1 was confirmed (Table 2). The

**TABLE 2.** Multilevel Regression Analysis on Psychological Detachment

	Psychological Detachment			
	Model 1		Model 2	
	Estimate	SE	Estimate	SE
Intercept	2.12	2.66	-0.16	2.93
Sex	-0.30	0.62	-0.59	0.55
Age	0.02	0.06	0.06	0.01
Organization tenure	0.02	0.02	0.01	0.02
Organization (dummy)	0.06	0.07	0.00	0.07
Patient safety (managers T0)	0.17*	0.07	0.14*	0.07
Psychological safety (team T0)			0.48†	0.15
Akaike (AIC)	16,331.98		17,858.31	
Bayesian (BIC)	16,369.89		17,909.48	
RMSEA	0.07		0.07	
CFI	0.85		0.83	
TLI	0.66		0.64	
χ <sup>2</sup>	281.74		358.92	
SRMR				
Within	0.01		0.01	
Between	0.25		0.23	

\*Significant at the level of 0.05.

†Significant at the level of 0.01.

AIC, Akaike information criterion; BIC, Bayesian information criterion; CFI, comparative fit index; RMSEA, root mean squared error of approximation; SRMR, standardized root mean square residual; TLI, Tucker-Lewis index.

second is that psychological detachment must have a significant effect on patient safety in a regression analysis that includes psychological safety. Table 3 (model 4) shows that the second criterion was not met; psychological detachment does not affect patient safety in a regression that includes psychological safety

(β = 0.31, ns). Therefore, hypothesis 3 is not confirmed. It seems that psychological safety does not lead to higher patient safety via psychological detachment, but it does affect patient safety directly (β = 0.72, P < 0.01).

**DISCUSSION**

From a systems perspective, one could argue that securing patient safety should involve changing the system, decreasing the workload, or changing the culture.<sup>38</sup> However, introducing these kinds of solutions would take much time and require massive organizational support. Our study suggests that emotional competence is relevant to delivering safe care. Improving the emotional competence of caregivers may be a parallel route to the same end, which is more related to a professional perspective on patient safety.

Our findings confirm the hypothesis that psychological detachment positively affects patient safety. It seems that not having work-related feelings, thoughts, or activities in off-duty hours has a positive effect on patient safety in long-term care as perceived by team managers. Detaching themselves from their job and focusing on other areas of life enables caregivers to restore their energy and may give them new ideas and perspectives to overcome challenging obstacles and enhance patient safety. These findings are in line with previous research showing that the ability to handle emotions is beneficial for performance, in terms of for example improved job satisfaction, less burnout, and higher levels of patient satisfaction.<sup>7-10,39</sup> In health care, performance is determined by processes that depend on intuitive decision-making (e.g., clinical reasoning and judgment) and which are easily influenced by emotions.<sup>4</sup>

Our findings also confirm the hypothesis that psychological safety positively affects psychological detachment. Contrary to the expectation, psychological detachment does not mediate the relationship between psychological safety and patient safety. There is, however, a positive relationship between psychological safety and patient safety as also found in other studies.<sup>23,24</sup> We expected psychological safety to be an underlying condition for

**TABLE 3.** Multilevel Regression Analysis on Patient Safety

	Patient Safety (Managers T1)							
	Model 1 Estimate	SE	Model 2 Estimate	SE	Model 3 Estimate	SE	Model 4 Estimate	SE
Intercept	3.97	2.73	2.25	2.74	1.46	2.62	0.54	2.71
Sex	-0.66	0.55	-0.64	0.53	-0.94	0.53	-0.91	0.53
Age	-0.02	0.07	-0.03	0.07	-0.00	0.07	-0.01	0.07
Organization tenure	-0.00	0.02	-0.00	0.02	-0.02	0.02	-0.02	0.02
Organization (dummy)	0.19*	0.09	0.17*	0.08	0.15	0.08	0.14	0.08
Patient safety (managers T0)	0.48†	0.07	0.45†	0.07	0.45†	0.06	0.44†	0.06
Psychological safety (team T0)					0.72†	0.17	0.71†	0.19
Psychological detachment (team T0)			0.54*	0.22			0.31	0.23
Akaike (AIC)	14,277.85		16,523.94		15,825.71		18,046.91	
Bayesian (BIC)	14,309.17		16,566.85		15,868.63		18,103.03	
RMSEA	0.07		0.06		0.07		0.06	
CFI	0.86		0.87		0.84		0.83	
TLI	0.74		0.75		0.70		0.69	
χ <sup>2</sup>	315.49†		340.80†		376.40†		431.72†	
SRMR								
Within	0.02		0.02		0.02		0.01	
Between	0.25		0.24		0.23		0.23	

\*Significant at the level of 0.05.

†Significant at the level of 0.01.

psychological detachment as it allows caregivers to discuss their doubts and worries, so they can receive help, support, and attain cognitive closure in working hours. It relates to Sonnentag and Fritz's assumption<sup>17</sup> that "detachment is easier to achieve after having brought work matters to a cognitive closure." Possibly, however, other social factors, such as leadership skills, are an underlying condition for both psychological safety and psychological detachment. A systematic literature review<sup>40</sup> shows a relationship between leadership style and employee stress; psychological detachment may be a factor in this relationship. Psychological detachment may also relate primarily to individual characteristics and capabilities and thus not be so influenced by context. Future research should therefore investigate a broad range of underlying factors and opt for three measurements over time to examine this mediating relationship.

Our findings strongly suggest that emotional competence is relevant to safe care delivery. Research on nontechnical skills related to patient safety has focused mostly on cognitive and interpersonal skills.<sup>41</sup> For example, there is an interest in "stress recognition" in safety literature but, from a cognitive perspective, knowing how performance is influenced by stressors.<sup>42</sup> It may be equally or more relevant to be able to recognize and regulate stress. Currently, training programs and interventions to improve patient safety are often based on Crew Resource Management (CRM) principles focused on enhancing communication, situational awareness, and teamwork among caregivers. Crew Resource Management lays emphasis on discussing potential critical factors in the care environment that might harm patients.<sup>43,44</sup> Through detecting and discussing errors, caregivers become more aware of potential factors for unsafe care in their environment and consequently also of their own flaws.<sup>45</sup> The aim is to stimulate team learning to prevent errors from repeating. However, increasing situational awareness may also have a negative impact on patient safety, if caregivers are intensely focused on potential safety risks and this in turn increases stress levels. We believe that caregivers need emotional competencies to deal with the increasing awareness of safety risks created by safety training programs for it to be effective. Emotional competencies are also relevant to deal with other feelings related to adverse events, such as remorse and fear, and can help caregivers become more resilient and recover faster from difficult situations. The importance of emotional competencies for patient safety is underlined by two systematic reviews in which is concluded that adverse events regularly have a strong emotional impact on caregivers, who often struggle with this in isolation without the needed support.<sup>46,47</sup> Of course, empathy and emotional involvement remain key to care delivery. However, safe care delivery is also about balancing emotional involvement with psychological detachment at work and being able to "bring working matters to a cognitive closure," detach from work, and enjoy daily activities and leisure time during off-duty hours.

### Limitations

One limitation of this study is its subjective measure for patient safety, based on team managers' perception. However, objective measures for patient safety, such as the number or type of incidents, are rarely measured at team level, and results are often unreliable or out of date. Moreover, the number of reported incidents often includes the culture and willingness to report incidents, not solely those dealing with patient safety. Therefore, objective patient safety measures may not be superior to self-reporting measures. Another limitation is that common source bias could play a role in the relationship between psychological safety and psychological detachment, as both were rated by team members at the same time. Ideally, a mediated relationship should be tested

by three different sources (team members, a leader, a manager) at three moments in time. In addition, the moderate overall response rate could potentially be a bias. This limitation may be less likely as our sample is representative for Dutch long-term care setting.

### Recommendations for Research and Practice

Future research should focus on the effect of emotional competence (as a nontechnical skill), on patient safety, and on ways to positively influence this competence. The importance of emotional competencies for performance and well-being has scientific ground, as discussed previously and in the introduction. Caregivers should be made aware of the important influence emotional competence, such as psychological detachment, has on patient safety. Caregivers need to be helped and trained to develop these competencies. Therefore, training of emotional competencies should be integrated into the initial curriculum of healthcare professionals.<sup>39</sup> In clinical practice when interventions to improve patient safety are implemented, such as CRM training, in addition to the cognitive technical skills, attention should be paid to the aftercare of caregivers who have been confronted with adverse events.<sup>48</sup> There are two victims in case of an adverse event: the patient (first victim) and the professionals involved (second victim).<sup>49,50</sup> The second victim could be faced with emotional trauma such as "guilt, perceptions of professional incompetence, and self-doubt as well as physical symptoms such as fatigue, insomnia, and nausea".<sup>51</sup> Although research is increasingly studying the impact of adverse events on the second victim, less attention is paid to supportive interventions, which help these victims deal with this emotional burden.<sup>46</sup> Safety interventions should therefore include the second victim in their curriculum. We recommend a "CRM plus program" that expands the curriculum with aftercare for caregivers and that focuses on training caregivers to cope with stressful situations.<sup>46,50</sup> On the one hand, caregivers should be trained at individual level to develop appropriate skills to detach themselves from their work and patients. On the other hand, teams should be trained how to support each other in coping with an error, as research has shown that peer support is important for coping with errors as second victim.<sup>47</sup>

### CONCLUSIONS

This study draws two major conclusions. First, it clearly shows that developing emotional competence at both individual and team level enhances patient safety in long-term care. On the individual level, the caregivers' ability to psychologically detach themselves from their work and clients enhances patient safety. On the team level, the ability to create a safe space for team members to speak up, discuss, and take personal risks enhances safe care delivery.

Second, the study shows that the relationship between psychological safety and patient safety is not mediated by psychological detachment. Therefore, we need to learn more about the factors that stimulate psychological detachment and how they relate to patient safety.

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