EVALUATING THE EFFECTIVENESS OF TRAINING USED FOR THE IMPLEMENTATION OF A PEER SUPPORT PROGRAM TO SUPPORT SECOND VICTIMS

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DNP Project Team Proposal Approval Form

The members of the DNP Project Team of Karen Adamouski-Marion
Student's Name

met on (date): 6/2/2020 and agree that the proposal titled,

Phase I Implementation Peer Support Program

has sufficient merit for the DNP Project to be conducted.

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Date 6/8/2020

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Date 6/2/2020

Note: This form is to be completed and given to the DNP Project Advisor within 10 days of the Team Approval Meeting. Attach one (1) copy of the full proposal with this form.

Date Received by the DNP Project Advisor: 6/8/2020

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Abstract

In many health care organizations, the needed support for second victims, or care of the caregiver, is lacking or unavailable. This was true of the Inova health system organization at the conception of this project. This paper describes the process of establishing the need for a peer support program and evaluating the effectiveness of the selected peer support training program to meet the needs of the peer supporters, the team members they serve, and the organization. Unfortunately, unanticipated and tragic events will happen to excellent health care team members; the results are often anxiety, depression, guilt, and fear. The effects of being a second victim can result in post-traumatic stress and compassion fatigue, with some team members ultimately leaving the profession or even worse, committing suicide. After obtaining Institutional Review Board approval, the project team initiated a quality improvement project to evaluate the effectiveness of the peer support training during the implementation of a peer support program in all five of the Inova hospitals in Northern Virginia. Of the 45 team members who signed up for the initial peer support training, 17 agreed to participate in the project in the preintervention phase, and 15 participated in the postintervention phase. Although the training materials utilized were found to be effective, opportunities for improvement that included limitations such as available resources at night and on weekends, logistics, and information support tools were revealed.

Keywords: second victim, peer support, clinician support programs for second victims, evaluating peer support programs

Table of Contents

Section 1: Background and Significance of Proposed Project

A clinician's response to the occurrence of an adverse medical event seems to correlate with the culture of the health care organization (Wu et al., 2020). In 1999, the Institute of Medicine released a report, *To Err Is Human: Building a Safer Health System*, laying out a comprehensive strategy for government, industry, health care providers, and consumers to reduce the incidence of preventable medical errors. The report concluded that health care has the knowledge to prevent many of the mistakes that occur (Institute of Medicine, 1999). Despite the many initiatives that have been developed to enhance safety in the health care environment, patients continue to experience unanticipated safety events while in the care of clinicians. Although these initiatives continue to reduce the incidence of health care errors, the complexities of health care and significant limitations imposed by human fallibility will not address all potential safety issues (Wu et al., 2020).

Multiple studies have shown that involvement in medical errors and adverse events can take a significant toll on clinicians. A *second victim* is defined as a health care provider who is involved in an unanticipated adverse patient event, a medical error, and/or a patient-related injury, and thus becomes victimized in the sense of being traumatized by the event (Wu et al., 2020). It is estimated that one in seven patients is affected by adverse events, and that as many as half of all clinicians will be involved in a serious adverse event at least once during their career (Quillivan et al., 2016). Hospital environments that promote open discussion and support about events and offer meaningful patient safety event feedback enhance providers' ability to learn and improve from mistakes (Mira et al., 2017). This nonpunitive response to errors may help health care providers cope effectively with involvement in a patient safety event. Organizations that hope to retain talent must understand and address the second victim phenomenon. By

implementing a peer support program to limit the negative effects of second victim experiences, organizations can improve their safety culture and reduce the incidence of adverse patient events.

Practice Issue

Some degree of emotional distress is likely when a clinician is involved in an error or adverse event, regardless of severity. Nurses are at high risk of involvement in a patient safety event because they are the main care providers, spending much of their time at the point of care and performing most medication administration (Quillivan et al., 2016). An adverse event can destroy the nurse's personal and professional identity and can have a similar impact on physician providers, who may suffer mental and emotional distress from being involved in a medical mistake (Robertson & Long, 2018). Following such an event, many clinicians are left second-guessing their ability to continue to care for others.

Health care systems must acknowledge that these events can happen to anyone and work to keep clinicians in the profession by providing resources that lend support to second victims. Across studies, clinicians involved in these events report feelings of responsibility for the patient outcome and loss of confidence; some report symptoms of posttraumatic stress disorder (Mira et al., 2017). Some clinicians are affected profoundly and with potentially lasting consequences, including changing jobs, leaving the profession altogether, and in rare instances, committing suicide (Scott, 2015). Organizations must address this serious issue if they hope to keep a viable workforce. Supportive interventions for second victims serve as protective factors that can enhance coping skills and optimize recovery of clinicians experiencing the impact of an unanticipated clinical event (Burlison et al., 2017). A peer support program is a cost-effective way to reduce clinician harm and have an impact on adverse events. Ensuring that the right training program is selected is critical when implementing and sustaining a program.

PICO Question

Designing and implementing a quality improvement project includes asking a specific clinical question. The PICO question specifically defines the (P) population to be studied, the (I) intervention to be used, a (C) comparison, and the desired (O) outcome. The PICO question for this project is, Does the training used during implementation of a peer support program effectively prepare attendees to support peers during an adverse medical event?

Situation Leading to Proposed Project

Several recent events that occurred within the Inova health system led to the proposal of this project. One involved a nurse who expressed being haunted in her dreams by a patient who died suddenly, after the nurse had assured her that she was recovering well. The team member was having difficulty sleeping and functioning at work. The only recourse the manager could offer was the Employee Assistance Program (EAP), which the nurse declined. Her subsequent interview with Risk Management and Patient Safety indicated that she required help. Rather than conduct a formal interview, the patient safety consultant took time to listen to the nurse, and after 45 minutes, the nurse shared that she simply needed to tell someone what had happened. She experienced a sense of relief and felt that she was now able to speak about the event.

Another event involved a clinician who froze when a patient violently attacked another clinician. The clinician was upset with herself for not intervening and felt a sense of remorse that she was responsible for what had happened. Again, the organization offered EAP, but the clinician chose not to participate. However, the clinician worked in behavioral health and had colleagues who she felt she could reach out to. Her desire to reach out to a colleague rather than to EAP supports that turning to peers is the preferred choice.

With the onset of the recent COVID-19 pandemic, employees are voicing the need for peer support because of the difficult situations they are confronting. Seeing patients deteriorate rapidly and watching some die without family present has caused many clinicians to question whether their current field of choice remains a good fit. These situations have provided the impetus to create a peer support program.

Evidence-Based Practice Model

Plan-Do-Study-Act Model

The PDSA cycle (Plan-Do-Study-Act) is a systematic process developed by Deming for increasing knowledge in relation to continual improvement of a new idea, process, or service (Melnyk & Fineout-Overholt, 2015). This approach is based on repeated small trials, consideration of what has been learned, and improvement implementation. This model was chosen because it provided guidance for this quality improvement project during the implementation of a new program and training. The cycle begins with the Plan step, which involves identifying a goal or purpose, formulating a theory, and putting a plan into action. In the Do step, the components of the plan are implemented, such as implementing a training. During the Study step, data is analyzed to determine what was learned. The Act step closes the cycle, and the change can be refined based on what was learned so that the test can be repeated (see Appendix A). These steps can be repeated as part of a continuing cycle of learning and improvement (Melnyk & Fineout-Overholt, 2015).

The project will capture the Phase I training but will be arranged so that it can be repeated in future trainings. The PDSA cycle for this project is:

- Plan: The preparation is completed prior to executing the project. The goal of the project, evaluating the training to ensure that it meets the needs of the peer supporters

and the organization, is reviewed with all inter- and intraprofessional team members. A PowerPoint presentation is developed to give an overview of the project. The questionnaire is developed as well as the intervention, peer supporter training. The peer supporters who will attend the training are identified by their unit leaders and contacted in advance to be given the opportunity to participate in the DNP project. Those who agree to participate are then scheduled for a 30-minute call to discuss the questions on the questionnaire.

- Do: The training is implemented. Peer supporters attend a 4-hour in-person training. Following the training, the peer supporters are contacted, and a posttraining meeting is scheduled to discuss the training and assess how much information has been retained. Peer supporters are also asked to reach out after an encounter so that they can validate preparation for the encounter and make recommendations.
- Study: Results are measured by comparing questionnaire responses and reviewing the recommendations. Recommendations are reviewed to determine if they are supported by the literature. Results are discussed with the project team.
- Act: Any modifications to the training will be made at this time, based on the findings from the project. The project can then be repeated during future trainings to ensure that the modifications correct any concerns.

Section 2: Development and Implementation

The aim of this quality improvement project is to identify and ensure effective training of peer support team members to provide compassionate support to their peers during stressful events. Turnover rates and data from the Human Resources Department and data from the Inova's 2019 safety culture survey will be reviewed, and spreadsheets will be created to identify the units with the greatest need. Department directors and leaders will engage in peer support leader training regarding the peer support program and assist in identifying peer supporters from their respective units. The peer supporters who elect to participate will be interviewed using pre- and postquestionnaires to ensure that they clearly understand their role and to assess program effectiveness. Implementation will include training peer supporters, encounters with team members on the unit, and monthly follow-up with patient safety consultants. The program will be considered implemented once the training has been validated and the feedback has been presented.

Literature Review

A literature review is conducted to evaluate what is known and not known about a topic of interest and should summarize current evidence on the topic to identify gaps between the current and the desired states (Moran et al., 2020). Essentially, the review provides a foundation of knowledge on a topic that prevents duplication and identifies the need for further evidence. To ensure a successful outcome, a literature search should be based on "a systematic, thorough, and rigorous approach that is unbiased, up to date, and reproducible" (Moran et al., 2020, p. 123). This literature review was conducted to examine the second victim phenomenon, the implementation of peer support programs, and the different approaches to peer support.

Search Methods

The following online databases were used in the initial search for the literature: CINAHL, MEDLINE, Ovid MEDLINE, PubMed, and Google Scholar. Keywords used were *second victim, second victims, clinicians as second victims in health care adverse events, clinician support programs for second victims, peer support programs for second victims, clinician support programs,* and *health care adverse event second victims*. Over 61,000 articles were found, and criteria were further limited to English language and within 15 years. Some early articles were retained because they are considered benchmark publications or primary research. The time frame was then further limited from 2015 to current.

General and Specific Results

Systematic reviews or systematic reviews as a topic were further eliminated for the purpose of this review, although some were retained for use elsewhere in the project paper. Thirty-nine articles were reviewed for quality, strength of evidence, applicability, and currency. Twenty were selected for this literature review and matrix (see Appendix B). The remaining articles were not used because they either duplicated studies already included, lacked strength of evidence, or lacked applicability. Studies older than 10 years were excluded to ensure that only the most current studies on the subject were used. As noted in the keyword list, the term *health care* was added in some searches because the concept of the second victim applies beyond health care (e.g., second victimization in law enforcement).

Exclusion criteria were limited to gather all potential sources to see what research had been done and to understand gaps in the literature. If the search resulted in an unrelated topic, such as the second victimization of law enforcement, the article was eliminated. Articles focusing more on legal aspects of a medical adverse event as opposed to clinician impact and

those that did not include information about provider support, the second victim phenomenon, or significant expert opinion were excluded. Qualitative and quantitative research articles, expert opinion articles, and case studies published in English from inside and outside the United States were searched and included in the literature review. The 20 articles deemed appropriate to support the project are described in an evidence table in Appendix B.

Literature Review Findings

The articles for the literature review include quantitative studies, expert opinions, qualitative studies, and controlled trials. The themes of the articles were discussed according to a) the effects that adverse events have on clinicians, b) the need for organizational peer support programs, and c) the approaches used to support peers. Some studies include information on multiple themes. As a result, they are discussed in one area as opposed to another based on whether their discussion and findings focused more on the effects of being a second victim, how to support clinicians, or how to implement a program.

Effects of Adverse Events on Clinicians

Four of the 20 studies focused on reviewing the effects of adverse events on the clinician. The studies shared stories of personal problems, psychological issues, and lack of organizational support (Mira et al., 2017; Quillivan et al., 2016; Robertson & Long, 2018; Scott, 2011). A University of Missouri study (Scott, 2011) found that one in seven staff members involved in a patient safety error within the prior year experienced “personal problems” related to the event, including anxiety and depression. In addition, 68% of the respondents reported not receiving any form of support (Scott, 2011). The common theme was that adverse events have a negative impact on clinician well-being.

Some degree of emotional distress is likely when a clinician is involved in any error or adverse event, regardless of severity. Responses to errors and adverse events are individualized, meaning that the severity of any error(s), degree of perceived responsibility, and the outcome for the patient seem to be predictive of the degree of distress clinicians experience after an adverse event (Quillivan et al., 2016). Across studies, clinicians involved in these events report feelings of responsibility for the patient outcome and loss of confidence; some report symptoms of posttraumatic stress disorder (Mira et al., 2017, Quillivan et al., 2016; Scott, 2011). Some clinicians are affected profoundly and with potentially lasting consequences, including changing jobs, leaving the profession altogether, and in rare instances, committing suicide. Organizations must recognize that this issue is serious and must be addressed to retain a viable workforce.

Scott's 2011 benchmark study was conducted using interviews with 31 second victims. The study found that the postevent trajectory of how a second victim will react after an event is largely predictable and typically progresses through six stages: chaos, reflections, integrity restoration, enduring inquisitions, obtaining emotional support, and moving on. In addition, institutional support systems could be developed to screen at-risk providers and support them through the stages. Limitations included the small sample size (n = 31), and the study was noted to be less generalizable and less reliable than larger studies; however, it did support the findings of other research on the same issue and lay the foundation for additional research. A complete understanding of the second victim phenomenon is essential to design and test supportive interventions that achieve a healthy recovery (Scott, 2011).

From the literature, it is evident that clinician feelings of shame, anxiety, depression, and other negative emotions are genuine and of real concern. The pervasive culture of perfectionism and individual blame in medicine plays a considerable role toward these negative effects

(Robertson & Long, 2018). Expecting clinicians to be emotionally unattached is unrealistic, unhealthy for them as individuals, and unhealthy for the organization. The second victim phenomenon can be devastating not only for affected health care professionals, but also for patients and the health care system. Neglecting it will neither cultivate empathy with harmed patients nor increase attention to patient safety issues (Robertson & Long 2018).

Parallel to how health care organizations care for patients is how they must care for clinicians who become second victims, especially those people who strive to do well but find themselves in an emotionally complex situation. Nurses are at high risk of involvement in a patient safety event because they are the main care providers, spending much of their time at the point of care and performing most of the medication administration (Quillivan et al., 2016). An adverse event can destroy the nurse's personal and professional identity and have a similar impact on physician providers who may suffer mental and emotional distress from being involved in a medical mistake (Robertson & Long, 2018). As a result, many clinicians are left second-guessing their ability to continue to care for others.

The Need to Implement Organizational Peer Support Programs

Eight of the 20 studies focused on the need for organizational peer support programs (Burlison et al., 2017; Edrees et al., 2011; Edrees et al., 2017; Hall & Scott, 2012; Krzan et al., 2015; Lane et al., 2018; Mira et al., 2017; Ullström et al., 2014). They generally concurred that it was irresponsible on the part of the organization to allow second victim clinicians to continue providing patient care without acknowledging the necessity of processing what had occurred or offering peer and/or professional support (Edrees et al., 2017; Lane et al., 2018; Ulström et al., 2014). Offering support is considered best practice for the care not only of second victim clinicians, but also their future patients (Krzan et al., 2015). Despite the many initiatives that

have been developed to enhance safety within the health care environment, patients continue to experience unanticipated safety events while in the care of clinicians. The literature supports the need to implement peer support programs.

A survey of 898 health care workers at the University of Missouri revealed that 30% of staff had experienced a patient event within the past year that caused such personal problems as anxiety, depression, and grief (Hall & Scott, 2012). The distress caused by adverse events can occur with clinicians from any type of health profession. This study supported the predictable path of six stages reported in Scott's 2011 study. Hall and Scott also reported that clinicians who typically progress through the six stages follow one of three trajectories: regaining perspective, coping but maintaining a level of sadness, or dropping out of their role completely. The study was based on a larger sample size (n = 898) than Scott's previous study; therefore, the findings are more generalizable, and the evidence can apply to other groups. Hall and Scott recommend the need for a 3-tiered approach to support clinicians: unit responders as the first level of support, institutional experts as the second level, and professional counseling services as the third (Hall & Scott, 2012). This approach also provides guidance for implementing a peer support program.

Edrees et al. (2011) administered a survey to 350 people across health professions at the Johns Hopkins Medical Center. The researchers revealed that support and attention were provided to patients of medical errors but not to the clinicians who were involved. The study drew from a large sample size (n = 350), making the results generalizable and reliable. The researchers' conclusions support the findings of other studies that recommend providing support programs (Burlison et al., 2017; Edrees et al., 2011; Krzan et al., 2015). A follow-up qualitative study based on semistructured interviews and additional structured questions found again that

participants identified a need for peer support, both for the second victim and potentially for individuals who provide that support (Edrees et al., 2017).

The Emergency Care Research Institute disseminates a newsletter for the Healthcare Risk Control System. In their February 2018 report, they reviewed several expert opinions regarding organizational support. The report supports the concept that an organization might need to transform its culture and change policies to support second victims (2018). Burlison et al. (2017) demonstrated a pressing need for health care organizations to invest in support resources and programs to reduce or prevent the consequences of second victim experiences. Responding to a questionnaire, clinicians rated second victim support options. The most desired was "A respected peer to discuss the details of what happened" (Burlison et al., 2017). Mira et al. (2017) determined that a second victim support program, along with other recommendations about what to do following an adverse event, can contribute to a safer working environment for clinicians.

Ullström et al. (2014), in a qualitative study that included interviews (n = 21) of health care professionals at a Swedish university hospital, addressed the gap between the second victim's need for organizational support and the actual support available. The findings confirmed earlier studies showing that emotional distress follows medical adverse events. The impact on the health care professional correlated to the organization's response to the event. Most informants lacked organizational support or received support that was unstructured and disorganized (Ullström et al., 2014). However, Krzan et al. (2015) found that after implementation of a peer support program, 85% of the staff members (95 of 112 individuals who responded to the applicable survey item) agreed that the department had benefited from the program. Implementing a peer support program benefits not only the clinicians, but also the organization.

Approaches to Peer Support Programs

Eight of the 20 studies addressed approaches to peer support programs (Albott et al., 2020; Connors et al., 2020; Dukhanin et al., 2018; Edrees et al., 2016; Kinman et al., 2020; Merandi et al., 2018; Scott, 2015; Tumelty, 2018). Once an institution embraces the concept of creating an organizational support program in response to adverse medical events, determining how to accomplish it is the next step. According to the evidence, some organizations thought having peer supporters available was important, but others preferred offering professional psychological support (Connors et al., 2020; Edrees et al., 2016; Merandi et al., 2018). A group of experts addressed nurses as second victims specifically (Scott, 2015). Findings suggest that peer support programs are likely to be viewed favorably by second victims (Connors et al., 2020; Edrees et al., 2016). However, the term *second victim* might create a barrier to using peer support, and sustainability is a factor during crisis times such as the 2020 COVID-19 pandemic.

Several studies found that health care clinicians who accessed peer support programs thought it was a valuable resource and that it helped them return to work effectively after an error or adverse event (Connors et al., 2020; Edrees et al., 2016; Merandi et al., 2018). Edrees et al. (2016) conducted a comprehensive study at Johns Hopkins Hospital using the Resilience in Stressful Events (RISE) peer support program, which was developed to provide support to employees following adverse events. The team confirmed the importance of support systems within health care organizations to help health care professionals cope with traumatic medical and nursing events. Methods included using descriptive statistics to summarize demographic characteristics and proportions of responses to categorical, Likert, and ordinal scales. Qualitative analysis and coding were used to analyze open-ended responses from questionnaires and focus groups (Edrees et al., 2016). A follow-up study found that nurses indicated favorable perceptions

of using RISE, and although its utilization was associated with greater resilience, frontline nurses still reported higher burnout despite having a support program (Connors et al., 2020).

Scott (2015) investigated the impact of the second victim experience on patient safety attitudes and perceptions using the Agency for Healthcare Research and Quality Hospital Survey on Patient Safety instrument during four survey periods over approximately 6 years. This study focused on the impact of the peer support program and its utilization. The study included 4,228 clinicians who participated in the four surveys in three hospital settings following approval by the University of Missouri-Columbia Health Sciences Institutional Review Board. Findings revealed that the impact of the second victim experience and the provision of support to individual clinicians might extend beyond the clinicians themselves, penetrating the working environment at both the unit and overall facility levels (Scott, 2015).

Another approach discussed extensively in the literature examined barriers to utilizing second victim support programs. In a qualitative study, participants shared their views about the term *second victim*, and the findings suggest that some physicians and legal professionals were uncomfortable with the term despite its widespread use in other fields (Tumelty, 2018). Merandi et al. (2018) suggested that better communication is needed during early implementation of any peer support program to increase awareness and use of resources among health care clinicians. In addition, Dukhanin et al. (2018) identified barriers such as blame culture, the need to promote the initiative, and more staff to handle adverse events, which are potential gaps that should be addressed when planning the best approach to implementing a peer support program.

Albott et al. (2020) used Battle Buddies, a program adopted from the U.S. Army describing a deployable psychological resilience intervention founded on a peer support model, as an intervention during the COVID-19 outbreak to support health care workers. Kinman et al.

(2020) also addressed supporting the well-being of health workers during the COVID-19 crisis. This study found that staff who were already mentally and physically depleted were at particularly high risk for work-related stress and burnout in response to the increasing demands and diminishing staffing levels and other resources engendered by the pandemic. The risk of trauma and suicide is particularly high among some groups of health care staff. Existing risks to the well-being of health care professionals will be compounded under the current highly pressurized conditions (Kinman et al., 2020). Both studies found that promoting healthy environments through infrastructure with clinician peer support improved clinician satisfaction and resulted in positive patient outcomes (Albott et al., 2020; Kinman et al., 2018).

The literature confirms that the second victim phenomenon is real and must be acknowledged and addressed. Although many peer support programs have proven effective, finding the one that will work within an organization takes careful review and planning. During implementation of a program, time should be invested in promoting the initiative and in evaluating the training to ensure that the program has both sustainability and reproducibility. The literature supports the proposed quality improvement project to evaluate the effectiveness of a peer support training program during the initial implementation.

Congruence

Inova's mission is "to provide world-class healthcare—every time, every touch—to each person in every community we have the privilege to serve" (Inova, 2019, "Inova Mission, Vision and Values" section). The vision is "To be among the leading health systems in the nation," and the values are "Patient Always, Our People, One Team, Integrity, and Excellence" (Inova, 2019, "Inova Mission, Vision and Values" section). The strategic direction for Inova is driven by decisions, actions, and resources of the mission, vision, and values. During the strategy

development process, careful attention and consideration of the initial culture work that had been completed in previous years resulted in promoting three of the Cultural Beliefs into Inova's values: Value People, Patient Always, and Stronger Together (Inova, 2019).

A second victim peer support program aligns well with these values. In addition, Inova's 2019 safety culture survey of all five hospitals identified several areas of focus for improving the safety culture: Feedback and Communication about Error, Non-punitive Response to Error, Hospital Management Support for Patient Safety, Teamwork across Hospital Units, Teamwork within Hospital Units, and Staffing. Building a culturally safe and respectful organization that genuinely addresses safety concerns is a substantial and complex undertaking (Jarousse, 2015). Creating an environment in which clinicians feel safe disclosing their involvement in errors and adverse events is important for patients, families, clinicians, and organizations. There is a pressing need for health care organizations to invest in support resources and programs to reduce or prevent the consequences of second victim experiences (Burlison et al., 2017).

Health care entities should focus on providing necessary support to clinicians (Wu et al., 2020). A second victim peer support program, along with other recommendations about what to do following an adverse event, can contribute to a safer working environment for clinicians (Mira et al., 2017). The purpose of this project is to lay the foundation for implementing an institutional support plan that will provide emotional first aid and professional guidance and evaluate the impact on provider/team member retention and satisfaction in a hospital/health system setting. The first steps of this process include increasing institutional awareness and identifying team members who can be peer supporters via this Phase I project.

Objectives

The following objectives for the project are aligned with the DNP Essentials developed by the American Association of Colleges of Nursing (2006):

1. Develop support from key stakeholders that will be needed for approval, support, and execution of Phase I peer support project implementation in August 2020 by reaching out to unit leaders across the health system to identify units for Phase I implementation (Essential III: Clinical Scholarship and Analytical Methods for Evidence-Based Practice; Essential VI: Interprofessional Collaboration for Improving Patient and Population Health Outcomes).
2. Participate in peer support training in August 2020 and create a way to check in with peer supporters on a routine basis to ensure sustainability of the program by October 2020 (Essential VI: Interprofessional Collaboration for Improving Patient and Population Health Outcomes; Essential VIII: Advanced Nursing Practice).
3. Identify resources needed to support a second victim program at the organizational, hospital, and unit level by reviewing/analyzing and critically appraising the evidence to implement the best evidence-based practice from the literature as well as completing a needs assessment/cost benefit analysis (Essential I: Scientific Underpinnings for Practice; Essential II: Organizational and Systems Leadership for Quality Improvement and Systems Thinking).
4. Develop a questionnaire to assess peer supporter knowledge of peer support prior to training and the effectiveness of peer supporter training after interaction with team member and analyze data, link data to peer support training, and modify training

based on feedback (Essential IV: Information Systems/Technology and Patient Care Technology for the Improvement and Transformation of Health Care).

5. Identify units for Phase I implementation of peer support program by evaluating safety culture survey data from 2019 and unit turnover data from 2019 and first quarter of 2020 during summer 2020 (Essential VIII: Advanced Nursing Practice). Although units were identified, peer support leader training sessions determined who the Phase I peer supporters would be. This effort is currently more focused on sustainability of the program following training.
6. Complete the Inova Institutional Review Board (IRB) and the Peoria, Illinois, community IRB protocols to study the Phase I implementation of the peer support program pilot by summer 2020 (Essential II: Organizational and Systems Leadership for Quality Improvement and Systems Thinking).
7. After attending the peer support training, learners will verbalize how to apply active listening, how to identify if a peer requires additional support, how to refer a peer for higher level support, and how to follow up with a peer, in fall 2020 (Essential II: Organizational and Systems Leadership for Quality Improvement and Systems Thinking; Essential III: Clinical Scholarship and Analytical Methods for Evidence-Based Practice).

The foundational DNP Essentials have guided the direction of this project and its objectives, which includes obtaining stakeholder support for the execution of the project by networking with key leaders to understand the work that had been done in advance of the project. This step proved to be critical and helped identify the need to get approval from both the Holistic Council and the Research and Evidence Based Practice Council to move the project forward.

Once the councils approved, approval was sought via a form submitted to both the Inova and the Peoria community IRBs. Following this approval, a questionnaire was developed to assess peer supporter knowledge and gauge the effectiveness of the training based on feedback. The DNP Essentials were also used to evaluate survey data to determine which units would benefit most from training.

Section 3: Plan and Implementation Strategy

A carefully considered plan is an important aspect of successful project implementation (Moran et al., 2020). First, a needs assessment was completed, which included careful consideration of how the change would impact team members and the organization. In addition, a project schedule was created to outline the implementation process, assign team member roles, and ensure that project deadlines would be met. Conducting a needs assessment allows the DNP student to drill down to the microlevel to determine the most important or immediate needs of the organization, and to create a plan to articulate what must be known, who the participants should be, and how the data will be gathered. A needs assessment can also determine how findings are shared with the organization (Moran et al., 2020).

Assessments

Needs Assessment: Peer Support Program Implementation

Psychological distress after an adverse event has a lasting impact on the clinician's quality of life and might affect job performance and the ability to provide safe patient care (Ozeke et al., 2019). Second victim experiences can affect the well-being of health care providers and compromise patient safety. A supportive patient safety culture may reduce second victim–related trauma (Quillivan et al., 2016). Health care systems must acknowledge that these events can happen to anyone and work to keep nurses and other providers in the profession by offering resources that lend support to second victims. Supportive interventions for second victims can enhance coping skills and optimize recovery of clinicians experiencing the impact of a difficult clinical event (Burlison et al., 2017).

Trigger for Practice Change

Many clinicians who have worked in the health care industry for any length of time have either witnessed or been involved in an adverse event or medical error. The experience can leave clinicians questioning if they are meant to remain in the profession. Some describe the experience as life altering; they speak about patients appearing to them in their dreams as well as the feeling of being haunted by the victim. Although the mistakes that occurred are likely to be a result of human error, system process failure, or perhaps even at-risk behavior, organizations typically fail to recognize that the error itself was not intentional and instead focus on the outcome. Unfortunately, the consequence of being involved in an adverse event can result in the clinician's being an unintended second victim.

The trigger for a practice change within the Inova health system was not an isolated event; rather it has been an organizational journey to improve safety culture. It began in 2014 when the Department of Medicine at Inova Fairfax Hospital implemented a Just Culture journey in response to input from providers on the safety culture survey. A "Just Culture" is one in which clinicians are cognizant of, and look for, the risks around them, report errors and hazards, make the right choices, and help design safe systems to prevent mistakes; it is a middle ground between a blame-free culture with no personal accountability and a culture in which individuals are blamed for all mistakes (Marzilli, 2014). After adopting the Just Culture algorithm model in peer review with practice concerns and in behavior-related concerns, the survey was repeated, and improvement was noted. After sharing the results with the system leaders in 2017, the decision was made to move forward with mandatory leadership training in Just Culture principles at all five Inova hospitals in 2018.

In 2019, Inova's safety culture survey revealed that, although some units showed improvement, others continued to show decline. Following that survey, the Patient Safety Department embarked on the next step of the Just Culture journey: developing a peer support program. This detailed process involved interprofessional collaboration from many committees and leaders across the system. These teams considered the social, economic, ethical, and legal factors from the literature in determining the best course of action for both the health care organization and the team members.

Social Factors

Nurses are at a high risk of involvement in a patient safety event because, as the main care providers, they spend much of their time at the point of care and perform most of the medication administration (Quillivan et al., 2016). The literature states that an adverse event can both destroy the clinician's personal and professional identity and cause emotional distress (Robertson & Long, 2018). As a result, many clinicians are left second-guessing their ability to continue to care for others. Dr. Susan Scott, a well-published researcher on the second-victim phenomenon, confirmed this point at a peer support conference at Inova early in 2020 by sharing the story of a nurse who committed suicide after a medical mistake that she recognized and voluntarily admitted to making (S. Scott, personal communication, January 23, 2020).

Economic Factors

To address economic factors, the team that created the Resilience in Stressful Events (RISE) second victim program at Johns Hopkins suggested examining the financial impact of peer support in human resources terms. Johns Hopkins team members tallied the cost of running the program to include hours that volunteer peer responders were unable to do billable work, and the cost per year for each nurse who received peer support was about $656.00 (Edrees et al., 2016. In addition, Johns Hopkins estimated the cost of replacing a nurse at $100,000.00 or more.

They found a net cost savings of nearly $22,600.00 per nurse who received help from RISE and that the RISE program total benefit was about $1.8 million (Edrees et al., 2016. Physician replacement costs were found to be greater. In 2015, the average cost of losing a physician was estimated to be $ 268,000 - $957,000 per physician based on specialty, experience, and expertise (Hamidi et al., 2018). In 2019, the system-wide turnover rate for physicians was 12.8% within the Inova health system.

Ethical Factors

Ethics involves the knowledge of using practical approaches to thinking through ethical challenges and ultimately deciding how best to respond to the challenge (Mason et al., 2016). When an error occurs and is noticed, providing an explanation of the error to patients, families, and hospital colleagues is a difficult and threatening process for most physicians and nurses. In particular, the expression of moral feelings such as guilt, regret, and remorse plays an important role in explaining the errors to patients and families (Ozeke et al., 2019).

When a nurse knows the right course of action for a patient, family, or community and is prevented from taking that action by internal or external variables, moral distress results (Mason et al., 2016). Most clinicians fear that acceptance of guilt or expressions of remorse could be used by litigants in malpractice lawsuits, so apologies and full disclosure are rare in the medical world (Ozeke et al., 2019). Nevertheless, disclosing adverse events and apologizing to harmed patients is the ethical choice, regardless of whether it decreases or increases rates of litigation (Ozeke et al., 2019). In 2019, Inova began including the Patient Family Advisory Committee in the root cause analysis process following safety events. In addition, they began disclosing information to patients and family regarding these events.

Legal and Political Factors

In some states, the courts have attempted to encourage clinicians to reveal medical errors by enacting "apology laws." Under these laws, a clinician's apology to a patient or family cannot be used against that physician in future litigation (Ozeke et al., 2019). Promoting and protecting open communication appears to be the main goal. Although apologizing is no guarantee of preventing lawsuits, the studies show that full disclosure to patients is associated with greater trust, higher satisfaction, more positive emotional response, and less support for sanctions against the clinician. However, insurance companies might avoid payouts if a patient accepts the apology in lieu of full compensation. It is unknown whether these laws will reach their aims of encouraging apologies and open communication and decreasing litigation (Ozeke et al., 2019).

Impact on the Team

The literature states that if not treated, a second victim experience can harm the emotional and physical health of the health care provider and subsequently compromise patient safety (Quillivan et al., 2016). Some degree of emotional distress is likely when a clinician is involved in any error or adverse event, regardless of severity. Responses to error and adverse events are individualized, meaning that the severity of any error(s), degree of perceived responsibility, and patient outcome seem to be predictive of the degree of distress clinicians experience after an adverse event (Quillivan et al., 2016).

Across studies, clinicians involved in these events report feelings of responsibility for the patient outcome and loss of confidence; some report symptoms of post-traumatic stress disorder (Mira et al., 2017). Some clinicians are affected profoundly and with potentially lasting consequences, including changing jobs, leaving the profession altogether, and in rare instances, committing suicide (Scott, 2015). Organizations must recognize that this serious issue must be addressed if they hope to retain a viable workforce.

Nurses leaving their jobs and the profession is an issue of international concern, with the gap between supply and demand reported to be widening (Halter et al., 2017). The most strongly supported determinants of turnover in the literature reviewed were at the individual level: stress and burnout, job dissatisfaction, and commitment (Wu et al., 2020). Patient safety culture has been linked to second victim–related distress and nursing turnover. Studies have reported costs of turnover ranging from $10,098.00 to $88,000.00 per nurse, with an estimated total turnover cost ranging from $0.55 million to $8.5 million (Halter et al., 2017).

In many cases, the clinician will face litigation following a medical error. It is well documented that a lawsuit can be one of the most emotionally damaging experiences for a clinician (Ozeke et al., 2019). In addition, the literature points to the negative impact a punitive culture can have on patient safety. Ultimately, health care systems cannot continue doing business as usual if they hope to reduce the occurrence of patient safety events, retain clinicians, and reduce turnover costs.

Impact on Patient Population

The second victim phenomenon can also be devastating for patients and the health care system (Scott, 2015). Neglecting it will neither cultivate empathy with harmed patients nor increase attention to patient safety issues. Harmed patients, their families, and health care professionals must work collaboratively to improve the way health care responds to medical errors to better address patient safety issues and prevent future victims (Gómez-Durán et al., 2019). The stakeholders include patients, families, clinicians, health care organizations, and the entire community, so the potential impact of improvement is enormous.

The right of patients to safe, reliable, and patient-centered care is critical and, most important, the primary goal of medicine (Ozeke et al., 2019). In the same respect, clinicians who

become second victims must be cared for, especially when they strive to do well and then find themselves in an emotionally complex situation. The health care industry must articulate to the public, politicians, and media that system failure can lead to medical error even in the hands of well-educated and competent clinicians (Ozeke et al., 2019). Furthermore, awareness of this phenomenon and appropriate institutional responses to harmed patients, their families, and the clinicians involved is essential for safe patient care.

Typically, there is more than one solution to an issue, and each option differs in cost, predictability, and duration (Mason et al., 2016). Considering the significant impact that the issue of second victim has on patient safety, clinician turnover, and the overall well-being of the clinician, there is a critical need to support second victim programs. By identifying the goal and developing and analyzing possible solutions, nurses will acquire a better understanding of what steps an organization can undertake (Mason et al., 2016).

Benefit to the Organization

A nonpunitive patient safety culture might act as a catalyst to increase support for those involved in patient safety events, which in turn could reduce or even prevent second victim–related trauma (Mira et al., 2017). Hospitals interested in limiting the negative effects of second victim experiences would benefit from reducing punitive responses and encouraging supportive responses as health care providers cope with their involvement in patient safety events (Quillivan et al., 2016). Many hospital organizations likely already have useful insights on the second victim experiences of their clinical staff from their existing patient safety culture data.

The Joint Commission urges health care organizations to support second victims as soon as possible after an adverse event occurs. By addressing traumatized health care workers, organizations can help ensure that other patients are protected from the domino effect that

adverse events can have on clinician performance (The Joint Commission, 2018). Organizations committed to transforming their culture into a Just Culture are most likely to be successful in improving patient safety and reducing errors.

Creating an environment where clinicians feel safe disclosing their involvement in errors and adverse events is important for patients, families, clinicians, and organizations. There is a pressing need for health care organizations to invest in resources and programs to reduce or prevent the consequences of second victim experiences (Burlison et al., 2017). The primary focus for health care entities should be on providing necessary support to clinicians (Edrees et al., 2016). A second victim program, along with other recommendations about what to do after an adverse event occurs, can contribute to a safer working environment (Mira et al., 2017).

Hospital environments that promote open discussion and support about patient safety events and offer meaningful feedback enhance clinicians' ability to learn and improve from mistakes; responding to errors in nonpunitive ways might help clinicians cope effectively with involvement in a patient safety event (Quillivan et al., 2016). Organizations that provide a second victim program recognize the benefits for both the organization and its patients. Those for the organization will be improved productivity, employee job satisfaction, reduced staff turnover, and better clinical outcomes for patients.

Practice Change

The culture of a health care organization influences how a clinician responds after an adverse event occurs. Creating a supportive environment is instrumental in reducing the significant toll an adverse event can have on clinicians (Scott, 2015). Many social, economic, ethical, and legal factors play into clinician second victimization. Organizations that hope to retain talent need to understand and address the second victim phenomenon. By limiting the

negative effects of second victim experiences, organizations can improve their safety culture and reduce the incidence of adverse patient events.

The literature clearly identifies the effects of not doing anything, and there is sufficient evidence to sustain a practice change to support second victims. The financial benefits in workforce retention and reduced adverse events are well worth the investment of implementing a peer support program in any health care organization. As discussed previously, the organizational culture within a hospital can be a limiting or facilitating factor when addressing distress to the clinician and ensuring patient safety. Inova, which is in the business of caring for others, should also be in the business of caring for their own team members.

Action Plan

An action plan was created to delineate the steps to achieve the stated project objectives, how to conduct project implementation, and how to involve stakeholders in the project (see Appendix C). The action plan was modified as needed and reports were given to stakeholders monthly or as requested. Much of the pre-implementation work, which consisted of acquiring project approval as well as IRB approval, occurred in June and July. Because this was a quality improvement project, the project was approved to proceed, and work began in late July and early August by identifying team members who would participate in the Phase I training and agree to participate in the DNP evaluation project. The education plan and training were solidified in late July and early August prior to the first training session.

Discussion

Implementation of the CARE (compassion, action, resilience, empathy) peer support workshops was scheduled to begin in August 2020, a date predetermined by the Inova organization. To identify units and team members who would benefit most from a peer support

program, the responses from the safety survey and unit turnover data were reviewed. Analysis and discussion with the team revealed that, due to unit-specific challenges related to COVID-19 restrictions, the identified teams might not be able to participate. To meet the organization's need to evaluate the training, work began in July to educate leaders about the program so that they could identify team members to be trained. Members of the project team provided Zoom informational sessions defining *second victim*, describing the CARE support program, and explaining how to identify team members to complete CARE peer support workshops.

Email messages were sent to leadership at all five Inova hospitals, providing dates and times for leader informational sessions via Zoom and for in-person team member workshops and instructions on how to sign up for sessions and workshops. The three workshops to assess Phase I training were limited to 15 participants each. Updates about the training and progress were presented at both provider and leader meetings throughout the system to provide information about the program, the number of attendees, and progress toward the goals.

Educational Content

The educational content for the project consisted of an instructor delivering live presentations on the peer support training program. Leader education was provided via Zoom sessions that introduced the second victim phenomenon and information regarding the program via a 15-minute slide presentation (see Appendix D). A longer PowerPoint was created for the peer support training, and an open-ended questionnaire was developed to assess training effectiveness (see Appendices E & F). Peer supporters were provided with encounter forms to use when providing support to fellow team members (see Appendix G). These forms were designed to track basic information about who is utilizing peer support rather than detailed information about the encounter.

Educational Process and Methodology

Those who will benefit most from a peer support program will be those team members who receive support from a trained peer supporter. However, those most impacted by this project will be those team members who elect to participate in the peer support training to become peer supporters. In addition, those with the most influence over the educational training program will be those who agree to participate in the pre- and posttraining discussions. Because this quality improvement project focuses on the effectiveness of the training tool being used to educate peer supporters, it is important to understand the knowledge retained from the training and used in peer support encounters. To provide safe and effective care to their peers, peer supporters must be able to integrate knowledge, skills, and attitudes to make sound judgement and decisions.

The education tool selected is an evidence-based training tool developed by Dr. Susan Scott. The University of Missouri Health Care (MUHC) forYOU program provided the framework from which the Inova CARE peer support was developed (Merandi et al., 2018). Strategic elements of the program's structure were reviewed and adapted for system-wide deployment. To become a peer supporter, a team member is referred by their leader and enrolled in a 4-hour workshop. Using the sign-up roster, the team members are contacted prior to the training to be given an opportunity to hear about the project and make an informed decision about electing to participate. The DNP student developed the pre- and postintervention questionnaires to determine team members' knowledge of peer support before and after the training and how much information the team member retained. By focusing on how well peer supporters receive the training and what they retain in supporting implementation of the program, the DNP student can influence the health care quality at the microlevel (Moran et al., 2020).

The FADE (focus, analyze, develop, execute) model was used to help guide the project and better understand what needs to be improved (see Appendix H). By asking detailed questions, the team is better equipped to set aims, establish measures, and select changes (Moran et al., 2020). During the focus phase, it was important to define what needed to be accomplished. Inova selected the MUHC training tool because it has been proven successful in implementing a peer support program at other hospitals in the United States; however, our team wanted to ensure that it was the right tool for training peer supporters at our organization. In addition, because the training program was modified to suit our organization, our team needed to ensure that all the vital components remained.

Next, during the analyze phase, we assessed various methods such as surveys and questionnaires to determine how best to capture the information we were seeking. From this discussion, we determined that the best way to evaluate the training program would be to have one-on-one conversations with the participants, using the questionnaire as a guide. The information collected would provide optimal understanding of the training program's strengths and limitations as well as insight into how well the training prepared the peer supporters to provide safe and effective care to their peers. Hence, we developed our questionnaire with open-ended questions to facilitate discussion and execute the project.

To know that a change is an improvement, the project must be repeated through several PDSA cycles (Moran et al., 2020). Although all team members who sign up for this training will be educated using this tool, only those who elect to participate in the project will be interviewed and thus be able to influence future training. Findings will be captured via discussions to identify gaps. As gaps are identified, recommendations about how to improve the training will be made,

presented, and approved by the team prior to editing the training slides. After the education materials are updated, the project will be repeated using the same methods.

Educational Materials

The CARE peer support training tool is a PowerPoint presentation (see Appendix E) developed from the YOU matter program, which uses the Scott Three-Tiered Interventional Model of Support for Second Victims (Merandi et al, 2017):

- Tier1 provides one-on-one reassurance and support to second victims by the local unit/department.
- Tier 2 consists of trained peer supporters, the patient safety team, and risk management activation if the second victim requires further assistance.
- Tier 3 results in expedited referral to ensure availability of professional support/guidance as needed (e.g., employee assistance program, chaplain, social work, clinical psychologist) (cite this).

This training has been well documented using the six-stage Second Victim Trajectory. Ultimately, the degree of supportive presence impacts the outcome for thriving, surviving, or dropping out. Stages 1 to 3 are phases of increased realization of the situation and what it means. Stages 4 to 6 occur with outcomes depending on the impact for the team members and the level of support they receive that enables them to thrive, survive, or drop out completely (Merandi et al, 2017).

The team reviewed the slides in the presentation for readability, clarity, and adequate cultural content. The CARE peer support workshop was modified from the 8-hour forYOU program to 4 hours to eliminate repetitive content, second victim personal stories, and time spent on role play and breaks. It also kept the workshop budget friendly by eliminating the need to

provide lunch. Because the training occurred during the COVID-19 pandemic, organization restrictions required that in-person class size be limited to 15 per class to maintain physical distance, participants were required to remain masked during the entire session, and hand hygiene was used prior to any group activity. Classes were taught on-site at the Inova Fairfax Medical Center main campus. The presentation format introduces and explains a concept and then gives trainees the opportunity to discuss and have dialogue with the presenter. In addition, participants are encouraged to partner and discuss how they would use these concepts in practice by using case studies.

The CARE peer support network requires involvement at all levels of the organization. Leaders were required to participate in workshops to learn about the program and understand its requirements and expectations, so our team developed an abbreviated presentation of the CARE peer support program (see Appendix D). It focuses on clinician well-being, how the CARE program supports the organizational values, the definition of *second victim*, types of support models, the CARE program, and how we are building our network. Members of the team were invited to present to several medical executive committees, shared governance committees, and research committees throughout the organization.

I developed a survey tool consisting of five open-ended questions to assess pre- and postintervention knowledge of peer support (see Appendix F). A sixth question will be asked after an actual encounter to determine if the peer supporter was well supported by the training or if there is opportunity for improvement. Checklists, tip sheets, and supportive tools will be created based on feedback from the peer supporters. Peer supporters will be required to complete an encounter form after an actual encounter with a team member. The form includes a

description of the adverse event and referrals made to the team member for additional support if required (see Appendix G).

Resources

When developing a budget for evaluating a peer support training program, program expenses as well as start-up, capital, and operational costs were considered. It was important to define how many training classes would be included in the evaluation. Training was divided into phases, with Phase I consisting of three classes limited to no more than 15 team members due to COVID-19 restrictions. Of 45 eligible team members, 17 elected to participate in the evaluation. Costs associated with the training for the presenter and the team members who attended these three classes were included. Program revenue was reviewed based on information presented in the literature. Inova required that these costs be determined when assessing the project needs.

Budget

Program Expenses

Program expenses comprised salary and wages of team members who would attend the training, participate in evaluation, and support program implementation. The team members are already employed in salaried roles, so this expense was estimated as the exact dollar amount the organization would spend on a unit of production (Leger & Dunham-Taylor, 2018). With the assistance of Human Resources and using the peer supporter sign-up roster, yearly salaries for each team member were calculated into estimated costs to attend the 4-hour training. All 43 team members were eligible, so all costs were factored in because the organization had to train all team members; however, only 17 participated in the evaluation (see Appendix I).

Start-Up Costs

Minimal resources will be needed for the peer support project. Start-up costs are all expenses incurred to plan, register, organize, and launch a new program (Leger & Dunham-Taylor, 2018). The resources include flyers and brochures to educate team members about the program and provide information on how to utilize this benefit. Reference tools will be needed for training peer supporters and supporting encounters with team members.

For the purpose of the project, PowerPoint presentations will be used to educate leaders and team members about this program. Marketing and training tools will mainly be paper and printer ink. Encounter forms for the peer reviewer to use during the visit could be either electronic or paper. The postsurvey tool used to complete the evaluation is electronic, and the time it takes for the evaluator to type in the feedback from the peer supporter is included in the cost estimates in Appendix I.

Capital and Operational Costs

Capital costs, the fees associated with the initial setup of a project, usually occur only at the beginning of a project; operational costs cover recurring business expenses (Leger & Dunham-Taylor, 2018). A designated phone and computer will be used to identify potential team members. There are no additional operational costs other than brochures because training will take place within the health system, and the organization already pays these expenses.

Program Revenue

Program revenue can likely be measured in staff retention (Edrees et al., 2016). Employee turnover is extremely expensive for an organization. If a peer support program can be linked to preventing turnover, its value does equate monetarily, which may be demonstrative as a business case. The Johns Hopkins Hospital found a net cost savings of nearly $22,600.00 per nurse who received help from a second victim program (Edrees et al., 2016). Preventing just one

nurse from resigning can potentially save an institution a minimum of $22,600.00 and more for specialists and advanced practice providers. Implementing a program can be a cost-effective way to promote retention and reduce costly turnover. The return on investment is evident. Considering the total program benefit/loss, it is evident that the benefit of implementing and evaluating the effectiveness of this peer support training program far outweighs the costs (see Appendix I).

Data Analysis

Data analysis plans vary based on the DNP project approach and can be diverse, including a broad array of outcome measures (Moran et al., 2020). The most important need for Inova when implementing a peer support program was to ensure that the training program for the workshop met the needs of the peer supporters and ultimately the team members who received support. As a project group, it was determined that this could be accomplished by taking a qualitative approach to ensure that team members participating in the training workshop understood the material being presented and could effectively support their peers.

The project group decided to conduct pre- and postintervention interviews using open-ended questions that would help determine the peer support trainees' level of knowledge and whether information from the training was retained. In addition, if a trained team member had a second victim experience and peer support encounter, it was important to know if the process for completing encounter forms and scheduling a follow-up with the team member was achieved. The data collected during interviews was typed and verified during the conversation with the peer supporter. Upon completion of the interviews, data will be reviewed to identify themes. Qualitative data analysis involves thoughtful review to identify themes of pattens in the data

(Moran et al., 2020). These themes will be presented in an open-ended follow-up postimplementation.

Section 4: Evaluation and Sustainability

The evaluation plan identifies the criteria that will be used to evaluate what worked and did not work and helps to determine the needed next steps to sustain the project over time (Moran et al., 2020). This plan helps to identify the tools that will be used to guide how best to proceed and what will be needed to ensure success. The project team met to discuss and agree on what tools would be used to evaluate the goals of the project.

Evaluation

The project evaluation plan may include individuals who will be involved in the process, the overall project objectives, and the outcome performance measures (Moran et al., 2020). This project is focused on evaluating the content of the training to ensure that the core principles are used to support peers during peer support encounters following an adverse event. Program evaluation can identify other opportunities for quality improvement, evidence-based practice, and research projects (Moran et al., 2020). The primary tool being used to collect information is the questionnaire developed by the DNP student (see Appendix F). An issues log used to record problems that arose during the project helped keep track of and effectively manage issues prior to and during project implementation (see Appendix J).

The final way this project will be evaluated is by determining how well the peer supporters and leaders can operationalize the program on their units and complete encounter forms (see Appendix G). Those who agreed to participate in the project to evaluate the effectiveness of the training will be contacted to provide feedback that will be used to determine how well the training prepared each team member to provide peer support. Encounter forms are being used to help track how often peer support is used and how well it is disseminated throughout the Inova organization. The patient safety consultant (PSC) located at each of the five

hospitals will oversee the collection of these forms. Forms will be stored on a quality patient safety share drive, and access will be limited to these consultants.

Sustainability

The sustainability plan should define what is needed and what will be done to ensure that the project endures over time (Moran et al., 2020). All PSCs will be master trained to teach the CARE peer support workshops at each of the five Inova hospital locations to alleviate having team members travel to the Fairfax campus where the initial workshops took place, which will also enable campuses to expand the program and target specific departments. Each hospital's PSC will hold monthly peer support meetings to help operationalize the program and identify any concerns to be addressed. Each hospital has one PSC, except for the largest hospital in the system, which has two.

In addition to the local support, monthly Zoom meetings will be facilitated by the Inova patient safety office to give all peer supporters from all five hospitals the opportunity to share stories, discuss concerns, and increase their learning. This will help to build a network of team members who can not only support peers, but also reach out to one another for assistance and support. Information regarding the progress of this program will be presented at provider and leadership meetings throughout the system by the Inova patient safety office.

The strengths and areas of opportunity related to ethical, legal, cultural, and economic issues that were identified during the assessment phase were considered when creating a sustainability plan. "Ethics are declarations of what is right or wrong and are usually presented as systems of valued behaviors and beliefs" (Aiken, 2004, p.100). Implementing and sustaining this peer support program is well aligned with Inova values. The program also supports the code of ethics for nurses, in that the nurse owes the same duties to self as to others, including the

responsibility to preserve integrity and safety while improving health care environments and conditions of employment (Aiken, 2004). Ethically, confidentiality must be maintained regarding peer support encounters so that the well-being of the team member is preserved. Although peer supporters are encouraged to share learnings from encounters during Zoom support meetings, specific detailed accounts are discouraged. The program must ensure that team members do not suffer any additional distress because of a peer support encounter.

Legally, the peer support encounter forms are administrative records in that they do not identify specific information related to the adverse encounter; rather, they identify only that the encounter with the team member took place and mention any follow-up that the team member might require. The form is helpful in keeping track of how well the program is being used and providing follow-up in the event a peer supporter leaves the organization. Investigation of the adverse event to identify potential problems or negligence is separate from peer support encounters. However, as with incident reports, the information collected is protected and confidential (Aiken, 2004). The peer supporter meetings are focused on how to best support the peer supporters with educational learning and supportive materials. Under the Patient Safety and Quality Improvement Act of 2005, no information can be obtained or used in a court of law against the team member who was supported (Kinnaman, 2007).

Culturally, the peer supporters are as diverse as the team members who work for the organization. They are varied in age, race, gender, and expertise. Upon completion of the peer support workshop, a badge buddy will be presented to peer supporters to help identify them as team members who can provide peer support (see Appendix K). The bright green badge provides a visual way that peer supporters can identify and approach other peer supporters on their campus. In addition, the Zoom meetings provide a way to build a supportive network. Having

local support and a PSC to reach out to for guidance helps if there is not a good match between the peer supporter and the second victim. This stakeholder engagement is used not only to evaluate the effectiveness of the training but also to sustain the program.

Economically, the sustainability plan does not require any additional team members to support the program. Patient safety consultants will oversee the training and implementation at their local sites and will facilitate monthly meetings. These salaried team members oversee the patient safety program at each of the hospitals and are directly involved in managing adverse events. They are uniquely qualified to oversee this type of program because they maintain confidentiality and work with team members during investigations. The badge buddies, training, and supportive materials are a minimal cost compared to the benefit this program provides. The benefit for all team members far outweighs any costs associated with sustaining the CARE peer support program.

Section 5: Results and Outcomes

Ideally, evaluation begins when an assessment is initiated and continues across the life of a program to ensure proper implementation (Melnyk & Fineout-Overholt, 2015). For this project, evaluation incorporated several evidence-based measures to assess how well each DNP project objective was achieved. Evaluating the effectiveness of the training program was the primary focus. It was important to select evidence-based measures to help guide the process and keep the team on track.

Evaluation and Outcomes

Evidence-Based Measures Used for Evaluation

Donabedian's concepts are described as "the lens through which we view the theoretical underpinnings of quality improvement work" (Hall & Roussel, 2014, p. 187). During the evaluation, the team hoped to answer questions about program needs, implementation, and outcomes. Examining the three aspects of quality—structure, process, and outcome—provides comprehensive insight into the contribution that each makes to the quality concern being examined (Hall & Roussel, 2014). Assessing the structure of a quality improvement project reveals its constraints and opportunities (Hall & Roussel, 2014), and by assessing the structure of this project, the team identified specific program needs and evidence-based models to support proper implementation. Process and outcomes, which are more causally related (Hall & Roussel, 2014), guided the evaluation and were integral to each of the models selected: the PDSA, PBED, and FADE models.

PDSA Model for Evaluation

Evaluation involves an assessment of learners, educators, curricula, and the program (Melnyk & Fineout-Overholt, 2015). The study phase of the PDSA model was used to evaluate

the effectiveness of the peer support training. Results were measured using performance indicators: preintervention and postintervention questionnaires with open-ended questions and interviewing the learners (peer supporters). The evaluation was conducted before program initiation to determine whether elements of the intervention, such as materials or messages (curricula), were feasible, appropriate, and meaningful for the target population.

Descriptive Statistics and Performance Indicators. Leaders and team members who attended the peer support workshops were the targeted audience. Descriptive statistics were used as one form of analysis to describe, summarize, or show the data in a meaningful way; however, a limitation of using descriptive statistics is that they do not allow conclusions beyond the set of data that is analyzed and can describe only what is directly shown (Gertsman, 2015).

Performance indicators were used to draw conclusions from the project. Those used to evaluate educational programs typically measure the skills, knowledge, behaviors, outcome expectations, and attitudes of the learners (Melnyk & Fineout-Overholt, 2015). Themes that emerged from the interview discussions included knowledge, requirements (outcome expectations), intervention strategies (skills), and logistics (behaviors). The results are described using descriptive statistics and performance indicators.

Preintervention. Following the preintervention qualitative survey, 40% of the team members who signed up for the initial peer support training, including nurses, residents, therapists, nutritionists, and senior leaders, agreed to participate in the DNP project. Prior knowledge varied widely among the team members, and only 17% had participated as peer supporters at other organizations. All team members had an interest in this topic and hoped to learn more at the workshop and learn intervention strategies and skills.

Table 1 shows the number and rate of team members who could or could not respond correctly to each question about peer support before receiving training. Only two (12%) had no prior knowledge before the interview and their inability to answer four of the five questions. Only three (18%) understood how to be a peer supporter. Logistics was difficult in the preintervention phase, as no one knew about using an encounter form; however, 11 (65%) of team members already knew how to refer a team member for higher level support or to go to their leader. All team members were able to describe active listening.

Table 1

Results of Preintervention Evaluation Questions

Preintervention Evaluation Questions	Number/rate of participants who responded correctly	Number/rate of participants who could not respond correctly
1. **Are you aware of any intervention strategies used to support colleagues who require peer support?**	13 (76%)	4 (24%)
2. **How do you apply active listening?**	17 (100%)	0
3. **How do you schedule time to meet with a team member for peer support?**	15 (88%)	2 (12%)
4. **How do you refer a team member for higher level support?**	11 (65%)	6 (35%)
5. **Do you understand the requirements of a peer supporter?**	3 (18%)	14 (82%)
The next question would be asked after an actual encounter with a team member: 6. **Did you feel prepared by the training for your role as a peer supporter during this encounter with a team member? If not, please tell me how we can improve this training.**		

Postintervention. Fifteen (88%) of the team members who participated in the preintervention responded to the postintervention. Only seven (47%) participated in the final

question following an encounter. Findings (see Table 2) reveal that all peer supporters were able to describe the CARE peer support program and intervention strategies; however, several asked for a tip sheet or something else to guide them prior to having an actual encounter. As with the preintervention interview, all peer supporters could describe active listening and how to apply it.

Although team members learned how to schedule time to meet with peer supporters, doing so will be challenging for the two who work on night shift and do not have anyone to take over their assignment while they support a fellow team member. They also discussed the challenge of needing a designated space to meet with a peer. Limitations with resources at night and on the weekend had not been considered prior to the training, so this feedback was valuable.

All the team members were able to discuss working with their manager or the PSC when referring a team member for higher level support. The senior leader stated that she felt comfortable referring a team member to EAP herself. Requirements of a peer supporter were acknowledged and understood but were identified as challenging for team members who need to leave after a shift to care for children. Team members also shared that managers do not typically allow overtime and did not realize that "voluntary" means unpaid time.

Table 2

Results of Postintervention Evaluation Questions

	Postintervention Evaluation Questions	Number/rate of participants who responded correctly	Number/rate of participants who could not respond correctly
1.	**Are you aware of any intervention strategies used to support colleagues who require peer support?**	15 (100%)	0
2.	**How do you apply active listening?**	15 (100%)	0
3.	**How do you schedule time to meet with a team member for peer support?**	15 (100%)	0

4. **How do you refer a team member for higher level support?**	15 (100%)	0
5. **Do you understand the requirements of a peer supporter?**	15 (100%)	0
The next question would be asked after an actual encounter with a team member:		
6. **Did you feel prepared by the training for your role as a peer supporter during this encounter with a team member? If not, please tell me how we can improve this training.**	6 (40%)	1 (7%)

PBED Model for Evaluation

Improving the culture of safety is one of Inova's key strategic goals, and implementing a successful peer support program supports this strategic goal by supporting the caregiver, which in turn reduces medical error and provides safe, high-quality patient care. The PBED (plan, brief, execute, debrief) model incorporates briefings and debriefings to promote teamwork, communication, and collaboration (Hall & Roussel, 2014). Using this model kept the project on task with the aid of a journal and an issues log (see Appendix J), and guided evaluation of each objective during debriefing with the project experts, which was completed when each objective was met to their satisfaction and issues from the log had been addressed. This model was used in conjunction with the PDSA model. The AACN's DNP Essentials (2006) incorporated into each objective served as a guide for what needed to be accomplished.

Objective 1: Develop support from key stakeholders that will be needed for approval, support, and execution of Phase I peer support project implementation in August 2020 by reaching out to unit leaders across the health system to identify units for Phase I implementation (Essential III: Clinical Scholarship and Analytical Methods for Evidence-Based Practice; Essential VI: Interprofessional Collaboration for Improving Patient and Population Health Outcomes). I achieved this objective by first developing a plan for the project and then reaching out to Inova's senior director of Patient Safety regarding implementation of a peer support

program. After discussion and being informed that the organization was interested in such a program, it was determined that the DNP project could best serve the organization by implementing a quality improvement project to evaluate the training of the peer supporters.

Prior to starting the project, I met with the Holistic Council and system Nursing Research committees to discuss (brief) the project with them and get support and approval, which I achieved by preparing a PowerPoint presentation that discussed the purpose, objectives, and overview of the topic (plan). In addition, I reached out to leaders regarding informational sessions about the program and workshops and directed them how to enroll. To identify units that could benefit from peer support, I analyzed prior safety survey and turnover data; however, due to the COVID-19 constraints, nurse leaders had to assist in identifying team members who could participate in the Phase I training workshops (execute). Updates regarding the project were provided during huddles and at many system meetings, including those of the Medical Executive Committee, the Nursing Research Council, Nursing Shared Governance, and the Holistic Council (debrief). This objective was achieved successfully with the enrollment and attendance of the peer supporters in the Phase I training workshops. Concerns identified while working to achieve this goal were captured in the issues log.

Objective 2: Participate in peer support training in August 2020 and create a way to check in with peer supporters on a routine basis to ensure sustainability of the program by October 2020 (Essential VI: Interprofessional Collaboration for Improving Patient and Population Health Outcomes; Essential VIII: Advanced Nursing Practice). Training dates were identified by the project team, and training facilities were reserved for in-person training (plan). Because of COVID-19 physical distancing requirements, class sizes were limited to 15 team members. Information regarding the classes was provided via email and in huddles (brief).

The project expert on our team was the master trainer, and I received peer support training during the Phase I August workshop (execute) and received a certificate (see Appendix L). In addition, to create a mode for checking in with peer supporters, I met with the PSCs at each of the five Inova hospitals to develop a monthly peer support check-in process. After several meetings, we agreed that one of the PSCs would facilitate a monthly Zoom meeting. I communicated the information and our discussions to our project expert for approval (debrief). Upon approval, I was asked to cofacilitate the first check-in. I drafted an email to be sent to the peer supporters to inform them about the check-in. I also drafted an agenda for the first check-in that included establishing a purpose for the check-ins with input from the peer supporters that was used to guide the discussion of the first check-in meeting. Information provided by the peer supporters during the feedback session was captured and discussed with the project team. The objective was met once the training and the first peer support check-in were completed.

Objective 3: Identify resources needed to support a second victim program at the organizational, hospital, and unit level by reviewing/analyzing and critically appraising the evidence to implement the best evidence-based practice from the literature as well as completing a needs assessment/cost benefit analysis (Essential I: Scientific Underpinnings for Practice; Essential II: Organizational and Systems Leadership for Quality Improvement and Systems Thinking). I met this objective by conducting a literature review and making recommendations after completing a cost/benefit analysis and needs assessment. Information was obtained, reviewed, communicated, and executed (see Sections 2 and 3). The need for this program was supported by the safety survey and turnover data, which aligned with the literature results (plan). The costs were found to be minimal and the potential benefit to the safety culture of the organization and team member retention, great (brief). The project was implemented at minimal

cost to the organization, and I completed the evaluation of the effectiveness of the training program at no additional cost (execute). Information regarding this process was communicated to the project team and to committees that requested feedback (debrief).

Objective 4: Develop a questionnaire to assess peer supporter knowledge of peer support prior to training and the effectiveness of peer supporter training after interaction with team member and analyze data, link data to peer support training, and modify training based on feedback (Essential IV: Information Systems/Technology and Patient Care Technology for the Improvement and Transformation of Health Care). Meeting this objective incorporated all three models. The FADE model was used to determine that a questionnaire would facilitate open discussion to produce feedback we sought to understand the effectiveness of the training program in providing the peer supporters with strategies and skills they needed to be successful. The objective to create the questionnaire was completed; however, based on recommendations and enhancements, the project will likely need to be repeated to ensure continued success.

Objective 5: Identify units for Phase I implementation of peer support program by evaluating safety culture survey data from 2019 and unit turnover data from 2019 and first quarter of 2020 during summer 2020 (Essential VIII: Advanced Nursing Practice). As a DNP student, I was able to achieve this objective by first identifying the people I needed to reach out to obtain the data I needed to analyze (plan). After reaching out, I shared the project objective and what I was trying to achieve (brief). After obtaining the turnover data from our Human Resources Department and obtaining the safety survey data from the Patient Safety office, I began analyzing the data (execute).

Units that immediately stood out were emergency departments, intermediate care units, respiratory departments, and surgical services, because the data demonstrated that low safety

survey scores correlated with high turnover rates. I then shared these findings with my project team (debrief). Unfortunately, although units were identified for participation, we determined that due to COVID-19 constraints, unit leaders would help identify whether their units were ready to participate and who they would send for training. I then assisted with the peer support leader training workshops and logged information in my journal and my issues log. Team members were identified by their leaders for the Phase I peer supporter workshop. Although the objective was not met as originally planned, results showed that it could be achieved in that manner. In the end, participation from the emergency departments in the Phase I workshops was high, and many of the units I had identified participated in the workshops.

Objective 6: Complete the Inova Institutional Review Board (IRB) and the Peoria, Illinois, community IRB protocols to study the Phase I implementation of the peer support program pilot by summer 2020 (Essential II: Organizational and Systems Leadership for Quality Improvement and Systems Thinking). This objective was completed prior to the start of the project in the summer of 2020. Information was initially obtained during a discussion with the DNP project advisor and the project experts at Inova to ensure agreement on the objectives (plan). I then completed the documentation and submitted the paperwork for IRB submission (execute). The project team was briefed and received a copy of these documents. The project was deemed a quality improvement project, and after approval was received (debrief), implemented.

Objective 7: After attending the peer support training, learners will verbalize how to apply active listening, how to identify if a peer requires additional support, how to refer a peer for higher level support, and how to follow up with a peer, in fall 2020. (Essential II: Organizational and Systems Leadership for Quality Improvement and Systems Thinking; Essential III: Clinical Scholarship and Analytical Methods for Evidence-Based Practice). To

achieve this objective, which focused on assessing the knowledge obtained during the training, the DNP student scheduled follow-up meetings and completed phone interviews with the peer supporters who had previously agreed to participate. Not all peer supporters who participated in the preintervention interviews participated in the postintervention interviews. However, all of those who participated verbalized their peer support knowledge, so this objective was achieved.

To summarize, all project objectives were achieved as described, although some were not achieved as originally intended. The fifth objective is a good example. Planning was done during the early onset of the COVID-19 pandemic, but we realized that this objective could not be achieved as written. Being flexible and open to suggestions and ideas offered by the project expert was critical to keeping the project on schedule. An unintended consequence was that, by using an alternative method, we were able to educate leaders while achieving the same outcome of identifying team members for the peer support training from units that could most benefit from peer support. In the end, the alternative method proved to be just as effective as reviewing survey and turnover data, and perhaps even more effective.

FADE Model for Evaluation

FADE (focus, analyze, develop, execute) is a common quality improvement method used to determine how well a program is operationalized (Moran et al., 2020; see Appendix H). The focus phase helped to guide the team to understand what we needed to accomplish. The analyze phase assisted the team in creating the survey tool, helping to identify how best to capture and analyze data by using a questionnaire that facilitated discussion. It also helped to identify the logistics and evaluate how effectively the peer supporters used the encounter forms and whether the peer support check-ins were meeting the peer supporters' needs.

Initially, encounter forms were sent to the peer supporters as advised during the training; however, two peer supporters mentioned during a follow-up interview that they had forgotten to complete the form, which provided opportunity to improve the training for this process. This model also will be used to monitor the attendance of peer supporters at the peer support check-in. However, the effectiveness of these check-ins is still being evaluated. This model will continue to be used to make recommendations for improvement as this project is sustained over time.

As the literature suggests, finding a peer support program that works well in an organization takes careful planning and review. When developing a training program, many factors must be considered, including not only economics as shared by the Johns Hopkins RISE program (Edrees et al., 2016), but also social and ethical factors that impact the team. Although the You matter program provided a proven education tool (Merandi et al., 2018), modifying it to impact training effectiveness for Inova was crucial.

The focus of this project was to evaluate the effectiveness of the peer support training program but identifying the need for an organizational peer support program and addressing each of the DNP objectives were imperative to the successful implementation of the CARE peer support program. As the literature indicates, although offering support is considered best practice (Burlison et al., 2017; Edrees et al., 2011; Krzan et al., 2015), the real testament will be the long-term impact of the peer support program and its utilization over the next several years (Scott, 2015). The literature strongly suggests that team members who access peer support programs find that they work more effectively (Connors et al., 2020; Edrees et al., 2016; Merandi et al., 2018). The hope is that this program will also support team members through the COVID-19 crisis (Kinman et al., 2020).

Section 6: Recommendations and Conclusions

Project success is dependent on the perception of the key stakeholders, including the DNP student, the organization where the project is implemented, and the academic institution (Moran et al., 2020). The other keys to the success of this project were communication and keeping the project team engaged. Although many recommendations were considered and incorporated, not all were adopted.

Recommendations

The nature of this project and how it was implemented require that it be maintained by the Patient Safety Department. The workshop training, badge buddy distribution, peer support network check-in, and management of the encounter forms created during this project implementation are currently maintained by the PSCs at each of the Inova hospitals. The portion of the DNP project focused on evaluating the training used for the implementation of the peer support program is completed. Because the DNP evaluations using the developed questionnaire tool are no longer being completed, there is nothing further to be reduced or phased out.

However, the DNP project should be repeated to ensure that identified opportunities and barriers have been addressed and that no others are identified going forward. The project could be presented annually for the first 3 years of the program or longer if deemed appropriate. As the peer support program matures, the project can be expanded to include team members who have utilized a CARE peer supporter to ensure that their needs are being met and that they feel well supported. Future projects might also compare peer support workshop surveys to the DNP questionnaire to determine if all information needed could be captured in one survey. The peer support workshop training is ongoing and is currently offered monthly. It continues to be led by the senior director of Patient Safety.

In addition, information can also be collected during the system's safety culture survey by including questions causally related to this topic. Ongoing evaluations outside the scope of the DNP project would include evaluations completed by participants at the conclusion of each workshop. Those evaluations are completed using a SurveyMonkey tool and are completely different from the questions asked in the DNP questionnaire tool. My review of those surveys indicates that most peer supporters are happy with the training at the completion of the workshop. However, by using the discussion questionnaire tool, I learned that peer supporters really do not know how well the information from the workshop will support them until they have either time to reflect on the training or have an encounter with a team member. One peer supporter shared that, because her training had occurred so far in advance of having an actual encounter, she needed access to reference material to feel prepared.

Part of Inova's strategic plan is to improve the organization's culture of safety. A peer support program acknowledges that Inova is committed to their team members' well-being by providing the resources they need to do their job both physically and mentally. As a result of the leader workshops, many leaders were enthusiastic about the program and were instrumental in identifying team members to participate in the peer support workshops. This program directly supports Inova's values of Patient Always, Our People, One Team, Integrity, and Excellence. The CARE peer support program supports Our People: All team members, not just clinicians, are eligible to use a peer supporter if necessary. The decision to support all team members was made to support our One Team approach to improving the safety culture. In recognition that many support team members are impacted by various events, including the COVID-19 pandemic, we want to ensure that everyone is supported to maintain Integrity and Excellence. Each of these decisions supports Patient Always.

This program not only aligns with Inova's values, but also supports the strategic plan to embrace a Just Culture and accountability while improving the safety culture. This was accomplished by implementing the program: Team members have already reached out to peer supporters, or better yet, have had peer supporters reach out to them. Information and feedback shared during encounters are kept confidential, and completed encounter forms are housed on a Patient Safety share drive with strictly limited access. However, information about experiences is discussed and shared during the peer supporter network check-ins, which not only support our peer supporters, but also ensure that everyone knows how to make appropriate referrals.

Recommendations were made based on feedback provided during the postintervention discussions. Although the peer supporters were not made aware of the information presented to the leaders at the workshop training, several reported that they were not given time to meet with team members and had no resources to relieve them of their duties. Apparently, leaders had not fully understood the expectations of their role in this program. In addition, the leader workshop slides did not clearly explain that leaders were being asked not only to identify team members for peer support training, but also to ensure that resources to support peer support encounters would be available on all shifts. Therefore, it is recommended that at minimum, one slide be added to the peer support workshop presentation explaining how to operationalize and ensure leader support for the peer supporters, particularly by providing time on the unit to give peer support.

Findings from feedback also included not knowing next steps or what to do after they had completed the workshop. Some of these questions were being addressed at the peer supporter check-ins, but those not able to attend were missing the information. I reviewed the slides used in the peer support workshop training and saw that information provided on final thoughts and next steps appeared on the second to the last slide after a 4-hour training, so I recommend adding a

"To do" section before the next steps information. A print copy of this slide could be included in the training packet so peer supporters would have a list of expectations and information about how to operationalize the program on their respective units for future reference. Peer supporters also asked for information or a brochure to give team members because they believed that most were not aware of the program, did not understand what it was, or did not know how to access it. Creating a web page to share general information about the CARE peer support program and house resources for peer supporters is another recommendation for addressing these concerns. A brief tip sheet was created for peer supporters to refer to before meeting with a team member. I also recommend creating an electronic form that could be linked to a database for ease of use by peer supporters to capture and track how well the peer support program is being used.

Peer supporters also recommended creating a brochure; however, when investigating this idea, the team learned from the Media Relations Department that Inova is moving away from using print brochures and focusing instead on electronic technology to communicate information. The project expert suggested creating a business card template that peer supporters could use to provide contact information and direct team members who need additional help or information. The specifics are currently under development. Additional projects and opportunities to improve will be identified as the program continues to mature.

Conclusions

The implementation of the CARE peer support program could not have come at a more critical time, considering the onset of the global COVID-19 pandemic and the stress it put on our team members. The program is designed to support all team members, both clinical and nonclinical. Although the initial primary focus was on caring for the caregiver, Inova recognized that all team members would benefit from a peer support program and made the training

workshops available to all departments. This DNP project of implementing and evaluating the effectiveness of the peer support training program contributed to my growth as a DNP by ensuring that team members had what they needed to be effective, successful peer supporters. Leaders must learn how to help themselves and others to live effectively with continual change and to succeed amid uncertainty and complexity (Sorensen Marshall & Broome, 2017). This project supports all team members, clinicians, and leaders in the organization and is strategic in continuing to build a solid safety culture.

To lead change is to generate and mobilize resources toward innovation and improvement (Sorensen Marshall & Broome, 2017). The DNP project mobilized volunteer resources from all over the Inova health system to improve the well-being of all team members. The peer support workshops have empowered team members to engage as peer supporters and be change agents. DNP prepared leaders must create training that produces favorable results to ensure success of a new program (Sorensen Marshall & Broome, 2017). While speaking directly with team members before and after the peer support training workshops, I identified small changes that could make a significant impact on the success of this program. By completing this project, I met my personal leadership goal of leading change within my health care organization, and I have developed valuable skills that will serve me well into the future when partnering with colleagues and motivating others.

The goal of the DNP prepared leader is to improve outcomes by introducing evidence and innovation into practice (Moran et al., 2020). With this DNP project, I achieved my personal practice goal of improving both patient and team member safety. The literature review produced many articles demonstrating that peer support is an effective method to improve safety culture and team member well-being, which in turn produces favorable outcomes for patients. Working

with the project team to gather information, create a plan, put the plan into action, and disseminate the results built and enhanced my skills. By having discussions before and after the training workshops, I gained insight into how to best support the peer supporters in making this program successful.

As I reflect on my personal educational goals and learning, I recognize that this project enabled me to put what I learned in the classroom into practice. Incorporating the skills and knowledge outlined in the DNP Essentials was critical in developing a program that can be sustained within the Inova health system. Attainment of the Essentials of Doctoral Education for Advanced Nursing Practice by DNP students is one of the first steps in evaluating the effectiveness of the degree to prepare nurses for advanced nursing practice roles (Moran et al., 2020). Adherence to the Essentials ensured that I was able to meet my personal educational goals while completing the DNP project and program, creating future opportunities for roles to assist in the transformation of health care.

The AACN's DNP Essentials (2006) drove the evolution of this project: I used nursing theory to guide the project and provide a solid foundation. Established quality improvement models were used to determine how best to capture and analyze data. Nursing science and practice helped me develop key skills for evaluating the effectiveness of the peer support training workshop. Interactions with project experts, team members, leaders, and clinicians fostered the skills needed to facilitate meaningful organization-wide changes during the implementation of the CARE peer support program. Ultimately, the DNP Essentials guided the development of this scholarly project from its conception to implementation and practice through evaluating and interpreting data to ensure the success of those peer supporters who participated in the training workshops.

The PICO question for this project is, “Does the training used during implementation of a peer support program effectively prepare attendees to support peers during an adverse medical event?” Based on the project findings, the answer is yes. Most peer supporters retained the knowledge gained from the training and felt prepared to have an encounter with a team member who experienced an adverse medical event. It is, however, important to recognize that everyone who attends these training workshops has their own needs. Those who elected to participate in this DNP project helped to guide the resources and training available to future peer supporters. I believe that Inova as an organization is well on its way to improving the safety culture for their team members and the overall care of the patients they serve within their community.

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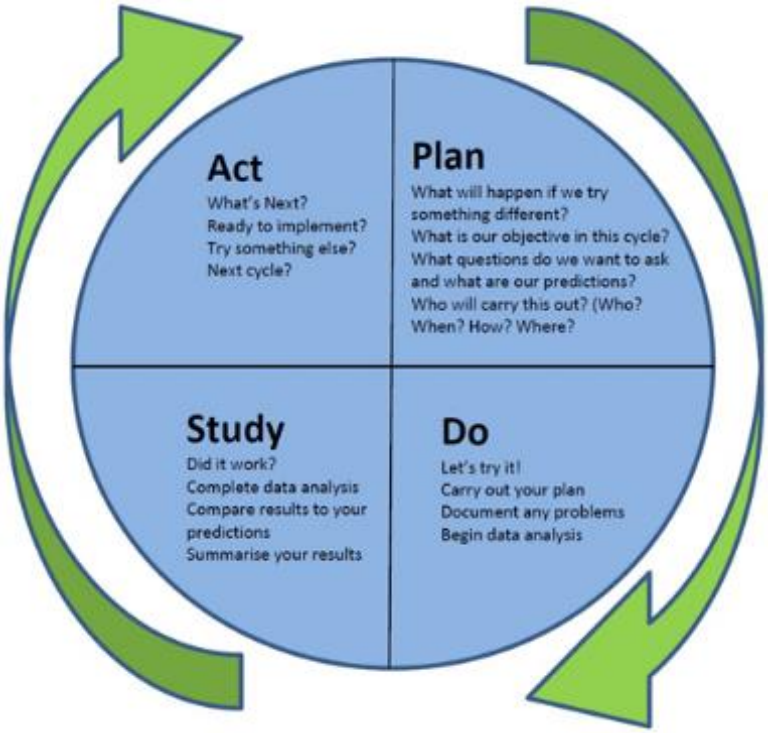
Appendix A: PDSA Cycle



Note: From *PDSA Cycle* by the W. Edwards Deming Institute, 2021 (https://deming.org/explore/pdsa/).

Appendix B: Literature Review Critique

Author/Number	Research Questions/Hypothesis	Methods	Study Variables
1. The Second Victim Experience and Support Tool: Validation of an organizational resource for assessing second victim effects and the quality of support resources Year published: 2017 **Authors:** Burlison, J. D., Scott, S. D., Browne, E. K., Thompson, S. G., & Hoffman, J. M.	This study presents the development and psychometric evaluation of the Second Victim Experience and Support Tool (SVEST), a survey instrument that can assist health care organizations to implement and track the performance of second victim support resources.	**Setting:** This study was conducted in 2013 at a specialized pediatric hospital treating children with catastrophic illnesses. The SVEST (29 items representing 7 dimensions and 2 outcome variables) was completed by 303 health care providers involved in direct patient care. The survey collected responses on second victim-related psychological and physical symptoms and the quality of support resources. Desirability of possible support resources was also measured. The SVEST was assessed for content validity, internal consistency, and construct validity with confirmatory factor analysis. **Design:** Qualitative	The 7 dimensions were psychological distress, physical distress, colleague support, supervisor support, institutional support, non-work-related support, and professional self-efficacy. The 2 outcome variables were turnover intentions and absenteeism.
Measures/Reliability Validity	**Results**	**Limitations**	**Summary: Decision/Reservations**
Instruments: Second Victim Experience and Support Tool (SVEST) The study used Hinkin's guide for developing questionnaires35, which is well cited and recognized as a cornerstone piece in survey design.	Confirmatory factor analysis results suggested good model fit for the survey. Cronbach α reliability scores for the survey dimensions ranged from 0.61 to 0.89. The most desired second victim support option was "A respected peer to discuss the details of what happened."	Although the developed questionnaire can provide useful information on the extent of distress faced by second victims at a health care organization and the quality of available resources, it is merely one tool to be used in the assessment and treatment of second victims. We recommend that those who use this survey to follow-up with participants through methods such as interviews and focus groups to further understand the second victim experiences of their staff.	**Level of Evidence: VI** **Quality of evidence:** Evidence from a single descriptive or qualitative study. This study provides preliminary support for the SVEST as a reliable and valid instrument to obtain this information. The SVEST can be used by health care leaders to guide the implementation of new second victim resources, assess the quality of support resources, and track the performance of second victim programs over time.

Author/Number	Research Questions/Hypothesis	Methods	Study Variables
2. Peer support for nurses as second victims: Resilience, burnout, and job satisfaction Year published: 2020 **Authors:** Connors, C. A., Dukhanin, V., March, A. L., Parks, J. A., Norvell, M., & Wu, A. W.	This study evaluated awareness and utilization of Resilience in Stressful Events (RISE) among nurses at one teaching hospital; perceptions of program benefits; and resilience, burnout, and job satisfaction among RISE users versus nonusers	Cross-sectional surveys of staff nurses and nurse leaders. Pearson chi-square tests and logistic regressions were used to establish significant differences.	Second victim, peer support, resilience, burnout, job satisfaction, nurses
Measures/Reliability Validity	**Results**	**Limitations**	**Summary: Decision/Reservations**
Instruments: Survey Five-point Likert-type scales were used to elicit responses in the domains of interest: professional burnout, job satisfaction, and personal resilience.	There were 337 responses (response rate 8.3%) from staff nurses. Awareness of Resilience in Stressful Events (RISE) was 87%, but there was limited RISE activation for oneself (23%) or others (6%). Among recent users (n = 30), 47% reported that RISE improved their ability to work with confidence, 65% felt better after using RISE, and 70% found the program helpful. Among nonusers, 39% wished they had used RISE, and 34% wished they had activated RISE on behalf of a colleague. Nurses who used RISE reported more burnout and greater resilience than those who had not, but similar job satisfaction.	The survey was distributed to all hospital nurses to maintain anonymity of those who had used RISE. However, this type of mass email survey distribution generally results in lower response rates. The survey was designed to elicit responses regardless of familiarity with RISE. The response rate among the nurse leaders was higher and nonrespondents were those who left the forum session early and thus were unable to complete the survey. Finally, because data collection was observational and cross-sectional, it was not possible to establish causal relationships between the use of RISE and individual characteristics such as personal resilience and burnout.	**Level of Evidence: III** **Quality of evidence:** Evidence obtained from well-designed controlled trials without randomization (i.e., quasi-experimental).

Author/Number	Research Questions/Hypothesis	Methods	Study Variables
3. Suffering in silence: Medical error and its impact on health care providers Year published: 2018 **Authors:** Robertson, J. J., & Long, B.	The objectives of this article are to 1) discuss the impact medical error has on involved provider(s), 2) provide potential reasons why medical error can have a negative impact on provider mental health, and 3) suggest solutions for providers and health care organizations to recognize and mitigate the adverse effects medical error has on providers.	Physicians and other providers may feel a variety of adverse emotions after medical error, including guilt, shame, anxiety, fear, and depression. It is thought that the pervasive culture of perfectionism and individual blame in medicine plays a considerable role toward these negative effects. In addition, studies have found that despite physicians' desire for support after medical error, many physicians feel a lack of personal and administrative support. This may further contribute to poor emotional well-being.	Medical error; resiliency; second victim; wellness. Qualitative
Measures/Reliability Validity	**Results**	**Limitations**	**Summary: Decision/Reservations**
Instruments: Interview based	Potential solutions in the literature are proposed, including provider counseling, learning from mistakes without fear of punishment, discussing mistakes with others, focusing on the system versus the individual, and emphasizing provider wellness	Much of the reviewed literature is limited in terms of an emergency medicine focus or even regarding physicians in general. In addition, most studies are survey- or interview-based, which limits objectivity. While additional, more objective research is needed in terms of mitigating the effects of error on physicians, this review may help provide insight and support for those who feel alone in their attempt to heal after being involved in an adverse medical event.	**Level of Evidence: VII** **Quality of evidence:** Evidence from the opinion of authorities and/or reports of expert committees. Unintentional medical error will likely always be a part of the medical system. However, by focusing on provider as well as patient health, we may be able to foster resilience in providers and improve care for patients in healthy, safe, and constructive environments.

Author/Number	Research Questions/Hypothesis	Methods	Study Variables
4. Patient safety culture and the second victim phenomenon: Connecting culture to staff distress in nurses Year published: 2016 **Authors:** Quillivan, R. R., Burlison, J. D., Browne, E. K., Scott, S. D., & Hoffman, J. M.	A cross-sectional survey study was conducted to assess the influence of patient safety culture on second victim-related distress. The purpose of this study was to 1) investigate the effect of patient safety culture on health care provider second victim-related distress and to 2) explore whether patient safety culture affects the degree to which second victims are supported in the aftermath of event involvement.	This study, which was conducted at a specialized pediatric hospital that treats children with cancer and other catastrophic illnesses, was approved by the hospital's Institutional Review Board. The Agency for Healthcare Research and Quality (AHRQ) Hospital Survey on Patient Safety Culture (HSOPSC) and the Second Victim Experience and Support Tool (SVEST), which was developed to assess organizational support and personal and professional distress after involvement in a patient safety event, were administered to nurses involved in direct patient care.	Demographic variables (specialty tenure, unit tenure, hospital tenure, and week hours) were entered into the first step of each hierarchical regression model. 1) The predictor variable must be significantly related to the outcome variable; 2) the predictor variable must be significantly related to the mediator; 3) when the outcome is regressed simultaneously on the predictor and mediator, the mediator must be significantly related to the outcome; and 4) the relation between the predictor and the outcome with the mediator in the regression equation must be significantly more attenuated than when the outcome was regressed only on the predictor.
Measures/Reliability Validity	**Results**	**Limitations**	**Summary: Decision/Reservations**
Instruments: Patient safety culture was measured from AHRQ HSOPSC items, and second victim distress and organizational support were measured from SVEST items.	Of 358 nurses at a specialized pediatric hospital, 169 (47.2%) completed both surveys. Hierarchical linear regression demonstrated that the patient safety culture survey dimension nonpunitive response to error was significantly associated with reductions in the second victim survey dimensions psychological, physical, and professional distress ($p < 0.001$). As a mediator, organizational support fully explained the nonpunitive response to error-physical distress and nonpunitive response to error-professional distress relationships and partially explained the nonpunitive response to error-psychological distress relationship.	Not specifically identified; however, as mentioned in the Methods section, at the time of data collection, the hospital did not have a formalized program to address the prevention or reduction of the effects of second victim experiences. Such a program might have introduced unwanted biases in the survey responses. If this study is replicated at hospitals with such a program, the results could vary. For example, the presence of a peer support program may affect clinician perceptions of patient safety culture independent of their experiences with patient safety events.	**Level of Evidence: II** **Quality of evidence:** Evidence obtained from at least one well-designed RCT (e.g. large multisite RCT). The results suggest that punitive safety cultures may contribute to self-reported perceptions of second victim-related psychological, physical, and professional distress, which could reflect a lack of organizational support. Reducing punitive response to error and encouraging supportive coworker, supervisor, and institutional interactions may be useful strategies to manage the severity of second victim experiences.

Author/Number	Research Questions/Hypothesis	Methods	Study Variables
5. Implementation of a second victim program in the neonatal intensive care unit: An interim analysis of employee satisfaction Year published: 2018 **Authors:** Merandi, J., Winning, A. M., Liao, N., Rogers, E., Lewe, D., & Gerhardt, C. A.	Examined satisfaction with a peer support program to provide lessons learned from early implementation.	Data are from a longitudinal survey administered as part of an ongoing, quality improvement initiative to evaluate the impact of a peer support program for second victims. As a quality improvement initiative, which involved anonymous surveys and posed minimal risk to participants, the Institutional Review Board determined this project was exempt from review.	Anxiety Depression Burnout Turnover Peer Support
Measures/Reliability Validity	**Results**	**Limitations**	**Summary: Decision/Reservations**
Instruments: Two open-ended questions assessed participant satisfaction with the program. Participants voluntarily provided written responses, with no maximum word count. The questions were: (Q1) "How did the program support you in returning to work after a traumatic event or experience?" (Q2) "Please provide any other feedback or recommendations for improving the program."	Ninety-three (37%) participants observed or were directly involved in an error or adverse event during the preceding six months. Thirty-six (14%) received support from someone within the neonatal intensive care unit, and 16 (16%) had spoken with a peer supporter after the event. All users reported benefit from the interaction. However, most participants were unaware of the program or had not utilized it.	Future studies should delineate the characteristics of adverse events to determine subtypes that might contribute to variability in outcomes or use of services. Standardized measures (e.g., anxiety, depression, burnout) to identify specific benefits of second victim peer support programs and objective data regarding turnover and absenteeism are also recommended. Given the brevity of many participants' responses to open-ended survey questions, qualitative interviews may elicit more detailed information. Response bias should also be considered due to survey response rates.	**Level of Evidence: IV** **Quality of evidence:** Evidence from well-designed case-control and cohort studies

Author/Number	Research Questions/Hypothesis	Methods	Study Variables
6. The second victim phenomenon after a clinical error: The design and evaluation of a website to reduce caregivers' emotional responses after a clinical error Year published: 2017 **Authors:** Mira, J. J., Carrillo, I, Guilabert, M., Lorenzo, S., Pérez-Pérez, P., Silvestre, C., Ferrús, L., & the members of the Spanish Second Victim Research Team	The aim of this study was to design and evaluate an online program directed at frontline hospital and primary care health professionals that raises awareness and provides information about the second victim phenomenon.	The design of the Mitigating Impact in Second Victims (MISE) online program was based on a literature review, and its contents were selected by a group of 15 experts on patient safety with experience in both clinical and academic settings. The MISE structure and content were evaluated by 26 patient safety managers at hospitals and within primary care in addition to 266 frontline health care professionals who followed the program, taking into account its comprehension, usefulness of the information, and general adequacy. Finally, the amount of knowledge gained from the program was assessed with three objective measures (pre- and posttest design).	Level of knowledge
Measures/Reliability Validity	**Results**	**Limitations**	**Summary: Decision/Reservations**
Instruments: MISE was structured in two packages, one informative and the other demonstrative. The informative package offered information on basic patient safety concepts (incidents for patient safety, incidents without harm, near errors, adverse events), along with the frequency, causality, consequences, avoid ability, and other characteristics of adverse events at hospitals and within primary care. It introduced the concepts of second and third victims and the results from research on the impact of adverse events.	The comprehension and practical value of the MISE content were positively assessed by 88% (23/26) and 92% (24/26) of patient safety managers, respectively. MISE was positively evaluated by health care professionals, who awarded it 8.8 points out of a maximum 10. Users who finished MISE improved their knowledge on patient safety terminology, prevalence and impact of adverse events and clinical errors, second victim support models, and recommended actions following a severe adverse event ($P <. 001$).	Did not possess information about the type of professionals who declined invitations to follow MISE. A minimum sampling size was defined considering a worst case of 80% correct answers to the questions. The correct answers related to system failure did not match this assumption. This study was not designed to assess its effect on secondary prevention of posttraumatic stress; that is something that future research should evaluate.	**Level of Evidence: VI** **Quality of evidence:** Evidence from a single descriptive or qualitative study. The MISE program is designed to assist intervention programs to mitigate the impact of adverse events in professionals. It is not an emotional recovery program for second victims; instead, it responds to the need for the group of professionals to understand what is felt subsequent to an adverse event. MISE also contributes to frontline professionals gaining greater awareness about the emotional needs that are experienced when an error occurs and the importance of speaking about the incident with their colleagues.

Author/Number	Research Questions/Hypothesis	Methods	Study Variables
7. Implementation of a "second victim" program in a pediatric hospital Year published: 2015 **Authors:** Krzan, K. D., Merandi, J., Morvay, S., & Mirtallo, J.	A formal support program for pharmacy employees involved in adverse drug events, patient-related injuries, and other traumatic work experiences is described.	The department of pharmacy was designated as the pilot testing area for the second victim program. The department comprises 181 employees, including pharmacists, pharmacy technicians, pharmacy transporters, administrators, and support staff.	**Independent:** **Dependent:**
Measures/Reliability Validity	**Results**	**Limitations**	**Summary: Decision/Reservations**
Instruments: The survey was reviewed by a statistician prior to distribution and was considered to be validated, as it closely mirrored the MUHC survey.1 The anonymous survey (Appendix A) was made available to the department (n = 181), and employees were given three weeks to respond. Of the 121 individuals who responded (a 66.8% response rate), 113 (93.3%) felt that the pharmacy department would benefit from a program to support second victims.	After implementation of the program, 85% of pharmacy staff members (95 of 112 individuals who responded to the applicable survey item) felt that the department had benefited from the YOU Matter program (Table 2). In a free-text response area, several individuals noted that they felt that it was too early to truly realize the benefit of the program. There were 3 individuals who reported speaking with a peer supporter after an event and 11 individuals who had referred a coworker to a peer supporter.	In the future, it will be important to continue to collect data and determine if implementing a second victim support program helps employees feel supported during difficult times and able to have the help they need to perform their difficult jobs effectively. It will be necessary to ensure that all new employees receive tier 1 training when they begin employment.	**Level of Evidence: VI** **Quality of evidence:** Evidence from a single descriptive or qualitative study

Author/Number	Research Questions/Hypothesis	Methods	Study Variables
8. Implementing the RISE second victim support programme at the Johns Hopkins Hospital: A case study Year published: 2016 **Authors:** Edrees, H., Connors, C., Paine, L., Norvell, M., Taylor, H., & Wu, A. W.	1) Developing the RISE program, 2) recruiting and training peer responders, 3) pilot launch in the Department of Pediatrics and 4) hospital-wide implementation.	Mixed-methods study, including frequency counts of encounters, staff surveys and evaluations by RISE peer responders. Descriptive statistics were used to summarize demographic characteristics and proportions of responses to categorical, Likert and ordinal scales. Qualitative analysis and coding were used to analyze open-ended responses from questionnaires and focus groups.	Perspective of the peer responders after their encounters with callers. Encounter Form Assessment Form Focus Group
Measures/Reliability Validity	**Results**	**Limitations**	**Summary: Decision/Reservations**
Instruments: Hour-long peer responder meetings were conducted monthly and included discussions of the published literature, practice delivering PFA and sharing of second victim encounters. Material was presented in the form of lectures, storytelling sessions, role-play exercises and group discussions. Debriefings occurred after each RISE encounter and provided collective learning opportunities for peer responders to reflect, mentor, support one another and gain vicarious experience about calls. These meetings took place for an hour.	A baseline staff survey found that most staff had experienced an unanticipated adverse event, and most would prefer peer support. A total of 119 calls, involving ~500 individuals, were received in the first 52 months. The majority of calls were from nurses, and very few were related to medical errors (4%). Peer responders reported that the encounters were successful in 88% of cases and 83.3% reported meeting the caller's needs.	Low awareness of the program was a barrier to hospital-wide expansion. However, over the 4 years, the rate of calls increased from ~1-4 calls per month. The program evolved to accommodate requests for group support.	**Level of Evidence: VI** **Quality of evidence:** Evidence from a single descriptive or qualitative study

Author/Number	Research Questions/Hypothesis	Methods	Study Variables
9. The second victim: A contested term? Year published: 2018 **Author:** Tumelty, M.-E.	Exploration of perceptionson the terminology used to describe physicians who experience distress after an adverse event or medical error.	The study used a qualitative approach, using semistructured interviews as the data gathering instrument. The sample involved representatives of medical training bodies (2 individual interviews and 1 focus group of 4 individuals) and legal professionals (barristers) (12 individual interviews). Those interviewed from medical training bodies were physicians who have an active role in the college providing training and support to their members.	Second victim, adverse event, medical error, impact, negligence, malpractice, physician
Measures/Reliability Validity	**Results**	**Limitations**	**Summary: Decision/Reservations**
Instruments: Semistructured interviews	A number of participants shared their views on the term second victim, and the findings of this study suggest that some physicians and legal professionals are uncomfortable with the term second victim despite its widespread use in other jurisdictions. This is due to the traditional connotations that surround the term victim, and the perception that being labeled a victim may undermine the harm experienced by the patient.	The small number of participants in the study and the absence of the patients' perspective on this topic.	**Level of Evidence: VI** **Quality of evidence:** Evidence from a single descriptive or qualitative study

Author/Number	Research Questions/Hypothesis	Methods	Study Variables
10. Trying to be “perfect in an imperfect world”: Strategies for healing healthcare’s second victims Year published: 2018 **Author:** Emergency Care Research Institute	Strategies for supporting “second victims," providers most directly involved in an adverse event, were highlighted.	Expert opinion of the Healthcare Risk Control System	Opinion Perspectives Clinician suffering Qualitative
Measures/Reliability Validity	**Results**	**Limitations**	**Summary: Decision/Reservations**
Instruments:	Health care organizations should develop programs to support health care personnel who have been involved in an event that leads to patient harm. Personnel may need care and support from the time they learn of the event until months, or even years, later. The organization may have to transform its culture and change its policies to support second victims	Limited evidence-based methodologies	**Level of Evidence: V** **Quality of evidence:** Evidence from systematic reviews of descriptive and qualitative studies (metasynthesis)

Author/Number	Research Questions/Hypothesis	Methods	Study Variables
11. Health care workers as second victims of medical errors Year published: 2011 **Authors:** Edrees, H. H., Paine, L. A., Feroli, E. R., & Wu, A. W.	Health System/350 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.	Qualitative Study Cross-Sectional Survey of health professionals This study explores the second victim phenomenon, describes current approaches for addressing the emotional impact, and shares survey findings from participants who attended a session on the topic.	Emotional support Peer support Coping strategies
Measures/Reliability Validity	**Results**	**Limitations**	**Summary: Decision/Reservations**
Instruments: Survey	The survey results reflected a need in second victim support strategies within health care organizations.	When there are adverse events, there are providers who feel effects and support programs are needed.	**Level of Evidence: III** **Quality of evidence:** Evidence obtained from well-designed controlled trials without randomization (i.e., quasi-experimental)

Author/Number	Research Questions/Hypothesis	Methods	Study Variables
12. The second victim of adverse health care events Year published: 2012 **Authors:** Hall, L. W., & Scott. S. D.	This article discusses how health care professionals are often considered "second victims" of adverse medical events, due to the psychological and emotional trauma they experience. To support second victims, it is important for health institutions to implement early warning systems that address harm risks associated with adverse incidents. In this article, researchers specifically focus on nurses and how respond to adverse medical events.	Follow-up survey of 898 2nd victims	Perception Distress Emotional trauma Recovery
Measures/Reliability Validity	**Results**	**Limitations**	**Summary: Decision/Reservations**
Instruments: University Hospital/898	Agree with post event trajectory and suggest a 3-tiered approach to support systems Level 3/Quality A Lewis (2012) Medical Center/477 Qualitative study& literature review. Health systems should develop early warning systems to alert unit or team leaders when health workers are at risk of harm from such events.	Although many health care organizations anticipate second victims' needs and are planning interventions to help them make a healthy recovery, few have formalized action plans to address these victims' many unique needs at the organizational level. Ideally, readily accessible support infrastructure should be accessible to all clinicians 24/7 so staff members experiencing an unanticipated clinical event can get immediate help.	**Level of Evidence: III** **Quality of evidence:** Evidence obtained from well-designed controlled trials without randomization (i.e., quasi-experimental)

Author/Number	Research Questions/Hypothesis	Methods	Study Variables
13. The second victim phenomenon: A harsh reality of health care professions Year published: 2011 **Author:** Scott, S. D.	31 qualitative interviews with individuals identified as potentially suffering from the second victim experience within a period of 4 years. Research participants included 10 physicians, 10 health professionals, and 11 registered nurses. Professional experience ranged between 6 months and 36 years (mean = 13.5 years). Time lapse since the unanticipated clinical event ranged from 3 weeks to 44 months (mean = 14 months).	Culture of Safety Survey (included specific questions) Qualitative interviews	Chaos and accident response Intrusive reflections Restoring personal integrity Enduring the inquisition Obtaining emotional first aid Moving on
Measures/Reliability Validity	**Results**	**Limitations**	**Summary: Decision/Reservations**
Instruments: Interviews To validate these findings, we conducted focus groups with original research participants. Participants reviewed the proposed recovery trajectory and validated that they had indeed experienced the identified stages. The participants then offered their recommendations regarding desired or ideal institutional support for each stage.	1 in 7 reported a patient safety event that caused personal problems, 68% received no support.	Each clinician's experience is unique, their evoked response story is somewhat predictable, which might lead one to believe that a stereotypical program of support would be effective.	**Level of Evidence: III** **Quality of evidence:** Evidence obtained from well-designed controlled trials without randomization (i.e., quasi-experimental)

Author/Number	Research Questions/Hypothesis	Methods	Study Variables
14. Suffering in silence: A qualitative study of second victims of adverse events Year published: 2014 **Authors:** Ullström, S., Sachs, M. A., Hansson, J., Ovretveit, J., & Brommels, M.	The aim of this study was to investigate how health care professionals at a Swedish university hospital were affected by their involvement in adverse events, with emphasis on the organizational support they needed and the organizational support they received.	Qualitative/professionals who experienced events were interviewed 21 health care professionals at a Swedish university hospital who each had experienced an adverse event were interviewed. Data from semi-structured interviews were analyzed by qualitative content analysis using QSR NVivo software for coding and categorization.	The patient outcomes were classified as follows: death (six events), permanent injury (two events), short-term harm but no permanent injury (nine events), no harm to the patient (two events), no medical injury but the patient was offended (one event) and no information on the outcome for the patient (one event). Even when the patient was not harmed, the hospital had classified the event as a risk situation for the patient and consequently the event was reported.
Measures/Reliability Validity	**Results**	**Limitations**	**Summary: Decision/Reservations**
Instruments: Each interview lasted between 60 and 90 min. We asked the informants for permission to digitally record the interviews; all except two agreed. One other interview was not recorded, making a total of three interviews in which the researcher took only handwritten notes. The 18 recorded interviews were transcribed verbatim and we verified their reliability by rechecking half of them against the recordings.	Most informants lacked organizational support, or they received support that was unstructured.	The relatively small number of informants makes our findings mostly relevant to this setting. As shown, a case study like ours can still provide in-depth understanding of a particular system or phenomenon, and pinpoint specific contextual factors that need to be considered when applying the insights elsewhere. Another limitation relates to the fact that because the informants were volunteers, there is an issue of self-selection bias. However, despite the relatively small sample size, our informants varied in profession, gender, years in practice and also regarding the nature and outcome of the adverse event.	**Level of Evidence: VI** **Quality of evidence:** Evidence from a single descriptive or qualitative study

Author/Number	Research Questions/Hypothesis	Methods	Study Variables
15. Battle Buddies: Rapid deployment of a psychological resilience intervention for health care workers during the COVID-19 pandemic Year published: 2020 **Authors:** Albott, C. S., Wozniak, J. R., McGlinch, B. P., Wall, M. H., Gold, B. S., & Vinogradov, S.	Development of a Psychological Stress Program that follows the US Army Battle Buddy Program. The Question: To identify and support at-risk individuals who may be predisposed to stress reactions because of lower initial resilience, inadequate coping, or exposure to high levels of risk/danger/trauma during the crisis.	Level 1 Battle Buddy with peer support from unit. Level 2 Provides units with a faculty member from Dept. of Psychiatry and facilitates group sessions. Level 3 Provides individual support with mental health consultants. Observational Study	Burnout Stress Resilience
Measures/Reliability Validity	**Results**	**Limitations**	**Summary: Decision/Reservations**
Instruments: Questionnaire	Easy to implement and beneficial to identifying clinicians who may require additional support. Promotes resilience and is easy to replicate.	Additional studies needed to learn about potential long-term benefits of overcoming stressors posed by the pandemic.	**Level of Evidence: VI** **Quality of evidence:** Evidence from a single descriptive or qualitative study Similar to Scott's 3-tiered approach

Author/Number	Research Questions/Hypothesis	Methods	Study Variables
16. Second victim support: Implications for patient safety attitudes and perceptions Year published: 2015 **Author:** Scott, S. D.	The purpose of this study was to investigate the impact of the second victim experience on patient safety attitudes and perceptions using the AHRQ-HSOPS survey instrument during four survey periods over approximately six years. Upon approval from the University of Missouri-Columbia Health Sciences Institutional Review Board, a cross-sectional analysis of existing MUHC Patient Safety Culture Survey findings was conducted. This study was designed to monitor for group differences among three clinician types (non-victims, second victims with support, and second victims without support).	A total of 4,228 clinicians participated in the four surveys within the three hospital settings. Clinicians participating in the study were divided into two professional types: nursing personnel (registered nurses and licensed practical nurses) and allied health professionals (respiratory therapists, pharmacists, paramedics, etc.)	13 variables (12 survey dimensions and the overall safety grade), a large number of statistical tests was required.
Measures/Reliability Validity	**Results**	**Limitations**	**Summary: Decision/Reservations**
Instruments: Analysis of the 12 patient safety dimensions and overall safety grade across time for the three clinician groups was conducted (Table 3). For individual dimensions, the supported second victim (SV+) mean scores are quite similar to non-victims; however, a striking difference is observed between supported second victim (SV+) and non-supported second victim (SV-) mean scores. In all 13 dimensions, the unsupported second victim (SV-) scores were lower than the supported victim (SV+) scores.	This study reveals that the impact of the second victim experience and the provision of support (or lack thereof) to individual clinicians may extend beyond the clinicians themselves, penetrating the working environment at both the unit and overall facility levels.	An area that needs further investigation is the influence that second victim support might have on the overall patient safety culture in the context of the clinical work environment. This gap in knowledge provides an opportunity to discover the impact of clinician support on long-term patient safety perceptions and attitudes.	**Level of Evidence: III** **Quality of evidence:** Evidence obtained from well-designed controlled trials without randomization, quasi-experimental

Author/Number	Research Questions/Hypothesis	Methods	Study Variables
17. Supporting the well-being of healthcare workers during and after COVID-19 Year published: 2020 **Authors:** Kinman, G., Teoh, K., & Harriss, A.	Large-scale study conducted in China found more than half the sample (54%) rated the psychological impact of the outbreak as moderate or severe, with 29% and 16% reporting moderate to severe symptoms of depression and anxiety, respectively discussed in relation to UK findings. Preliminary findings on the effects of COVID-19 on the UK population found that levels of depression and anxiety in the UK population increased markedly after the lockdown was announced. Effects are likely to be pronounced in those with existing mental health problems. As the pandemic progresses, financial worries and employment uncertainty are likely to compound feelings of anxiety, hopelessness and frustration.	Reviews of the mental health and well-being of the health care workforce in the UK conducted prior to the outbreak showed that staff were already demoralized and mentally and physically depleted they were found to be at particularly high risk of work-related stress and burnout in response to increasing demands and diminishing staffing levels and other resources. The risk of trauma and suicide were particularly high among some groups of health care staff. Clearly, the existing risks to the well-being of health care professionals will be compounded under the current highly pressurized conditions.	Worries Uncertainty Stress Trauma
Measures/Reliability Validity	**Results**	**Limitations**	**Summary: Decision/Reservations**
Instruments: Surveys	Three strategic principles for good leadership during the COVID-19 pandemic: effective crisis management, planning and action; communication that provides up-to-date information and encourages individual empowerment; and the provision of a ‘continuum of staff support’ that offers a range of initiatives, normalizes feelings of distress, and encourages their expression. Leaders and managers need to be empathic, compassionate, understanding, aware of employees’ personal circumstances and that they may change rapidly.	It should be recognized, however, that the uptake of support among health care professionals is frequently stigmatized and this can be a barrier to seeking support.	**Level of Evidence: III** **Quality of evidence:** Evidence obtained from well-designed controlled trials without randomization (i.e. quasi-experimental)

Author/Number	Research Questions/Hypothesis	Methods	Study Variables
18. Do hospitals support second victims? Collective insights from patient safety leaders in Maryland Year published: 2017 **Authors:** Edrees, H. H., Morlock, L., & Wu, A. W.	The purpose of this study was to describe the extent to which organizational second victim support is perceived as desirable by patient safety representatives in acute care hospitals in Maryland and to identify and describe existing second victim support programs.	Qualitative study based on semistructured interviews and additional structured questions. IRB approval was obtained from the Johns Hopkins Bloomberg School of Public Health. Population was the universe of acute care hospitals in Maryland (n = 46), which are regulated by the Department of Health and Mental Hygiene Office of Health Care Quality. Purposive sampling was used to identify participants whose role is to oversee patient safety programs and event reporting processes in their institutions. These individuals were then invited via phone or e-mail to participate in the study.	The main variables of interest were the presence of an EAP, organizational support services for employees involved in adverse events, and organizational support for others less directly involved in incidents; perceptions about beneficial features and services of an ideal health care worker support program; and description of existing second victim programs.
Measures/Reliability Validity	**Results**	**Limitations**	**Summary: Decision/Reservations**
Instruments: Semistructured, in-depth interviews were conducted to collect information on participant characteristics, and attitudes and perceptions about ideal and existing support programs. Field notes were recorded during and after the interviews to capture thoughts, recurring themes, and additional comments. The interviews averaged 33 minutes. Verbal consent was obtained to audio record the interviews, which were then transcribed verbatim. Anonymity of participants and hospitals was assured.	Participants identified a need for peer support, both for the second victim and potentially for individuals who provide that support. Six (16%) of the 38 hospitals had second victim support programs, which varied in structure, accessibility, and outcomes, while an additional 5 hospitals (13%) were developing such a program.	Future research is needed to evaluate the effectiveness of these programs. The first was that the questions used in interview have not been validated. A second is that a single individual generated and coded the interview transcripts, which may have introduced bias. Finally, we did not analyze the participants' responses with hospital characteristics and the type of programs being offered. Future studies should include more analysis on the association of hospital characteristics and participant responses in additional populations.	**Level of Evidence: VI** **Quality of evidence:** Evidence from a single descriptive or qualitative study

Author/Number	Research Questions/Hypothesis	Methods	Study Variables
19. A second victim support program in pediatrics: Successes and challenges to implementation Year published: 2018 **Authors:** Dukhanin, V., Edrees, H. H., Connors, C. A., Kang, E., Norvell, M., & Wu, A. W.	Evaluating the effectiveness and identifying barriers to addressing the needs of second victims	The study used a mixed method approach that included a quantitative analysis of surveys and content of open-ended commentaries about respondents experience with seeking second victim support.	
Measures/Reliability Validity	**Results**	**Limitations**	**Summary: Decision/Reservations**
Instruments: Surveys from Survey Monkey to over 900 recipients with over 4 weeks to respond.	Survey response rates were 22.4% and 23.3% respectively. Quantitative analysis showed that respondents at the later time point were more likely to contact an organization's support structure and had great awareness of availability or support. Also identified barriers including blame culture, the need to promote the initiative, and more staff to handle adverse events.	Response rates for both surveys were low.	**Level of Evidence: IV** **Quality of evidence:** Evidence from well-designed case-control and cohort studies

Author/Number	Research Questions/Hypothesis	Methods	Study Variables
20. Supporting clinicians after adverse events: Development of a clinician peer support program Year published: 2018 **Authors:** Lane, M. A., Newman, B. M., Taylor, M. Z., O'Neill, M., Ghetti, C., Woltman, R. M., & Waterman, A. D.	The development of a clinician peer support program (PSP) at a large academic medical center that includes both adult and pediatric hospitals. We describe the process used to select and train PSP providers and to identify those needing support and barriers to program development. Barnes-Jewish Hospital is a 1251-bed tertiary care facility that provides care to adult patients in St. Louis, Missouri.	A curriculum was developed to train clinicians to provide support to their peers based on research of clinician response to adverse events, utilization of various support resources, and clinician resiliency and ways to enhance natural resilience. An average of 4.8 individuals were referred per month (range = 0–12). Of the 165 clinicians referred, 17 (10.3%) declined follow-up from the program. Individuals receiving support had a median of two interactions (range = 1–10). Among those receiving support from the clinician PSP, 16 (10.8%) required referral to a higher level of support.	Second victim, peer support, clinician well-being
Measures/Reliability Validity	**Results**	**Limitations**	**Summary: Decision/Reservations**
Instruments: Peer support trainees participated in simulations in pairs. During these simulations, peer supporters were trained to use active, empathetic listening skills and inquiry to help the individual reflect on their experience. The peer support clinician was trained to help elicit subtle ways that the stressor event may be affecting the clinician including impacting their sleep, hobbies, or relationships outside of the hospital. Each participant was given the opportunity to act in the supported clinician role and the peer supporter role. Participants were given the opportunity to reflect and share approaches to interactions with each other.	A total of 88 clinicians were nominated by department chairs or through self-nomination. After completion of training, 36 were included in the clinician peer supporter pool.	Although our model was successful during initial program development, it is not sustainable long term. Over time, they experienced decreased participation in monthly meetings and calls designed to share program updates due to competing demands on the peer support clinicians who did not have any protected time for these efforts. Organizations seeking to replicate should seek to secure a financial commitment from their organizational leadership to ensure long-term program sustainability.	**Level of Evidence: VI** **Quality of evidence:** Evidence from a single descriptive or qualitative study

Appendix C: Action Plan

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Doctor of Nursing Practice

Action Plan

Student Name: Karen Adamouski-Marion

Purpose: This action plan outlines specific components of a plan to promote: Phase I Peer Support Training Program

Original PICO Question: Does peer supporter training (I) prepare (O) the peer supporter (C) for a second victim (P)encounter?
Updated PICO Question: Within the peer supporter role, how effectively does the training (I) used during implementation of the Peer Support Program prepare(O) the attendee to support peers(P) during an event (C)?

SECTION	OBJECTIVES	ACTION STEPS	ACCOUNTABLE PERSON(S)/ PROJECTED COMPLETION DATES
I.	I. To identify potential topics for an evidence-based practice project.	A. Identifying the Phenomenon of Interest is the first step. Initial conversation with Dr. Garcia in Spring 2020 to discuss topics. Determined Second Victim program was a topic of interest and that it can influence both the health of the team member and the patients they care for. The topic also fits well with DNP student's area of expertise, patient safety. B. The topic was prioritized based on: Area of interest, expertise and knowledge, and to match organizational need. C. Potential topics will be discussed with Dr. Christina Garcia and Kathy Helak by using DNP Phenomenon and areas of interest to explore topics and by researching current EBP projects that are being published, and critically appraising evidence for decision making. Initial meeting with Kathy Helak in May 2020 and informed that there was interest from the Organization. Discussed possible opportunities for DNP project.	May 2020

Saint Francis Medical Center College of Nursing
Doctor of Nursing Practice

SECTION	OBJECTIVES	ACTION STEPS	ACCOUNTABLE PERSON(S)/ PROJECTED COMPLETION DATES
		D. Topics will be prioritized by Karen and the project advisor, Dr. Garcia will be involved. Topics will be prioritized by utilizing the template and critical appraisal checklist to determine which project will make the greatest impact, meet the needs of the organization, and meet the requirements of this project. Topics considered included: 1. Second Victim Awareness 2. Second Victim Pilot Program (1 Unit) 3. Peer to Peer Support Program (System Wide) 4. Peer to Peer Support Program Phase I Evaluation of Training (Units from All Hospitals) Meeting in early June 2020 to discuss possible projects with Dr. Garcia and Kathy. Determined a quality project evaluating the effectiveness of the training for the Phase I implementation of a Peer Support program would work best.	June 2020
		E. Contact key stakeholders outside team to elicit their support. • Dr. Mary Ann Friesen- Professional Practice • Dr. Venkatesan- Quality & Safety • Dr. Theresa Davis- Holistic Council and e-ICU • Sarah Pavlick- HR Director Karen Adamouski-Marion- Contacted each person, had discussion regarding project, obtained appropriate sign-off on forms and contracts. June 2020	June 2020

Saint Francis Medical Center College of Nursing
Doctor of Nursing Practice

SECTION	OBJECTIVES	ACTION STEPS	ACCOUNTABLE PERSON(S)/ PROJECTED COMPLETION DATES
	II. To find and critique evidence on the topic of Peer Support.	A. Do an electronic search. PubMed CINNAHL Google Scholar Search criteria included: second victims, clinicians as second victims in health care adverse events, clinician support programs for second victims, peer support programs for second victims, clinician support programs and health care adverse event second victims.	Search completed initially in April 2020. Another search completed in May 2020, and final search completed June 25, 2020.
		B. Retrieve articles and other written materials identified in search. Articles obtained in PDF format for electronic review. Reviewed in Appendix A Literature Template	Articles obtained in PDF format for electronic review.
		C. Critique of evidence-based practice guidelines. By examining the different articles for positive and negative items within the discussion, gaps and consistencies can be determined. Some of the questions considered when completing this literature review include: 1. Is the literature review thorough and detailed? 2. Is the literature current- within the last 10 years? 3. Are there benchmark publications? 4. Are the sources primary or secondary? 5. Is the purpose understandable? 6. Is it applicable to this topic? 7. Will the study add to the nursing knowledge?	Completed June 2020

Saint Francis Medical Center College of Nursing
Doctor of Nursing Practice

SECTION	OBJECTIVES	ACTION STEPS	ACCOUNTABLE PERSON(S)/ PROJECTED COMPLETION DATES
		D. Critique of systematic reviews. Of the topics and articles that were reviewed, it was concluded that the topic evaluating the effectiveness of a peer support program was supported. There is plenty of literature on peer support and second victim programs to provide appropriate strategies and project expert and project advisor agree.	Completed June 2020- Project Advisor making recommendations and Project Expert will review revisions- July 2020
		E. Critique and synthesis of primary research articles. See Appendix A Literature Review Template	June 2020 with several revisions. Not completed at this time.
		F. Contact experts (if needed) for information. Work with Dr. Venkatesan, Dr. Friesen, and Kathy on any issues/concerns related to details of project.	May/June 2020

Saint Francis Medical Center College of Nursing
Doctor of Nursing Practice

SECTION	OBJECTIVES	ACTION STEPS	ACCOUNTABLE PERSON(S)/ PROJECTED COMPLETION DATES
		G. Write summary recommendations/ evidence-based practice guideline from c, d, e, f. **Findings from the Reviews:** The survey results reflected a need in "second victim" support strategies within health care organizations. From the literature, it is evident that clinician feelings of shame, anxiety, depression, and other negative emotions are genuine and a real concern. The second victim phenomenon can be devastating for affected healthcare professionals but also for patients and the healthcare system. The general recommendation was that it was irresponsible on the part of the organization to allow these clinicians to continue providing patient care without any acknowledgement regarding the ability to process what occurred, and without peer and/or professional support. It is not only good practice for the care of the individual clinician, but also for the future patients being cared for by these second victims. Peer supporters, patient safety, and risk management all play a crucial role in ensuring the second victim has a safe space to recover from the event. Potential solutions in the literature are proposed to include learning from mistakes without fear of punishment, discussing mistakes with peers, counseling, and emphasizing clinician wellness	June 2020- First and Second Draft

Saint Francis Medical Center College of Nursing
Doctor of Nursing Practice

SECTION	OBJECTIVES	ACTION STEPS	ACCOUNTABLE PERSON(S)/ PROJECTED COMPLETION DATES
II.	III. To determine if there is enough evidence to guide practice.	A. Discuss strength of evidence. 1. The literature states that if not treated, a second victim experience can harm the emotional and physical health of the healthcare care provider and subsequently compromise patient safety (Quillivan et al, 2016). 2. Psychological distress after an adverse event has a long-lasting impact on the clinician's quality of life and it may affect the job performance and the ability to provide safe patient care (Ozeke et al, 2019). 3. Almost one in seven staff (175/1160) reported they had experienced a patient safety event within the past year that caused personal problems such as anxiety, depression or concerns about the ability to perform one's job. Furthermore, 68% of these reported they did not receive institutional support to assist with this stress. (Scott, 2011 & 2009) 4. The Joint Commission (TJC) urges health care organizations to support second victims as soon as possible after an adverse event occurs. By addressing the traumatized health care worker, organizations can help ensure that other patients are protected from the domino effect that adverse events can have on clinician performance (Quick Safety 39, 2018). 5. Despite the need for support, established services are underused among the resident and attending physicians, 79% experienced either a serious adverse patient event and/or a traumatic personal event within the preceding year. (Yue-Yung, 2011) 6. Qualitative study& literature review (Hall & Scott, 2012) Health systems should develop early warning systems to alert unit or team leaders when health workers are at risk of harm from such events 7. A complete understanding of this phenomenon is essential to design and test supportive interventions that achieve a healthy recovery (Scott, 2009).	May/June 2020

Saint Francis Medical Center College of Nursing
Doctor of Nursing Practice

SECTION	OBJECTIVES	ACTION STEPS	ACCOUNTABLE PERSON(S)/ PROJECTED COMPLETION DATES
		B. Contact additional experts, as necessary.	
		C. Use other sources of evidence, as necessary. Additional resources within last 6 years (2015 to present) obtained. Ovid Medline Search Search Strategy: #1 second victims.mp. 83 #2 second victim.mp. 114 #3 1 or 2 156 #4 peer support.mp. or exp Social Support/ 61173 #5 3 and 4 37 #6 limit 5 to english language 35 #7 limit 6 to yr="2015 -Current" 30 #8 limit 7 to ("systematic review" or systematic reviews as topic) 1 #9 7 not 8 29	June 2020
		D. Decide if conduct of research is necessary and feasible. From the review of the literature, it does appear that a second victim peer support program is a cost-effective way to reduce both adverse events and clinician harm. It appears to be a feasible alternative to Employee Assistance Programs (EAP) alone and worth pursuing.	June 2020

Saint Francis Medical Center College of Nursing
Doctor of Nursing Practice

SECTION	OBJECTIVES	ACTION STEPS	ACCOUNTABLE PERSON(S)/ PROJECTED COMPLETION DATES
		E. If enough evidence to proceed, draft/revise policy, procedure, standards using information from III. **Purpose:** To create a supportive environment that is instrumental in reducing the significant toll an adverse event can have on clinicians. **Policy statement:** The culture of a healthcare organization has a great deal to do with how a clinician responds after an adverse event occurs. By limiting the negative effects of second victim experiences, organizations can improve their safety culture and reduce adverse patient events. Organizations are urged to address second victims to avoid further distress to the clinician and ensure patient safety. **Applicability:** Requires a robust and sustainable peer support training program. **Implementation procedures:** Evaluate effectiveness of the initial peer support training during implementation of program to ensure applicability, sustainability, and that it meets the needs of the organization.	June 2020

Saint Francis Medical Center College of Nursing
Doctor of Nursing Practice

SECTION	OBJECTIVES	ACTION STEPS	ACCOUNTABLE PERSON(S)/ PROJECTED COMPLETION DATES
	IV. Set clear objectives for project implementation and align with the DNP Essentials. 1.Develop support from key stake holders that will be needed for approval, support and execution of phase I peer support project implementation by reaching out to unit leaders across the health system in an effort to identify units that will be used for the phase I implementation. Essential III;VI 2.Participate in training to become a Peer Support trainer and recruit/educate peer supporters that will participate in the Phase I pilot. Essential VI;VIII 3.Identify resources needed to support a second victim program at the organizational, hospital, and unit level by reviewing/analyzing and critically appraising the evidence to implement the best evidence based practice from the literature as well as completing a needs assessment/cost benefit analysis. Essential II, Essential I 4.Develop a questionnaire to assess peer supporter knowledge of peer support prior to training and the effectiveness of peer supporter training after interaction with team member and analyze data; link data to peer support training and modify training based on feedback. Essential IV 5.Identify units for Phase I implementation of Peer Support Program by evaluating Safety Culture Survey data from 2019 and unit turnover data from 2019 and first quarter of 2020. Essential VIII 6. Completion of the IRB protocol for Inova as well as for the Peoria community IRB to study the Phase I implementation of the peer support program pilot. Essential II	A. How will objectives be measured? •Objective #1: Project plan will be developed over the Summer Semester and presented to Inova Professional Practice Council. Acceptance of the project will meet this objective. •Objective #2: Complete power point presentation on peer support project. Conduct interview sessions prior to implementation. •Objective #3: Critically appraise literature and identify best practice that meets organizational needs. Complete a needs assessment, cost-benefit analysis, and get approval for phase I implementation. •Objective #4: Develop a questionnaire to assess if team members retained knowledge. Objective #5: Identify units based on turnover rates and adverse events obtained from Human Resources and Patient Safety. Completed/Modified to utilize Leaders to identify team members through Leader workshops. Two additional Objectives added: The sixth objective: Completion of the IRB protocol for Inova as well as for the Peoria community IRB to study the Phase I implementation of the peer support program pilot (Essential II: Organizational and Systems Leadership for Quality Improvement and Systems Thinking). The seventh objective: After attending the peer support training, learners are expected to verbalize how to apply active listening, how to identify if a peer requires additional support, how to refer a peer for higher level support, and how to follow up with a peer. (Essential II: Organizational and Systems Leadership for Quality Improvement and Systems Thinking; Essential III: Clinical	Presentation at Professional Practice Council- June 2020 Presentation at Holistic Council Power point presentation completed; Questionnaire July/Aug 2020 June 2020 June 2020 June/July 2020 July/Aug 2020 Sept to Dec 2020

Saint Francis Medical Center College of Nursing
Doctor of Nursing Practice

SECTION	OBJECTIVES	ACTION STEPS	ACCOUNTABLE PERSON(S)/ PROJECTED COMPLETION DATES
III.	V. Implement evidence-based changes in practice.	A. Form a team for the project.	June 2020
		B. List the following with names and responsibilities: • Team /project leader Karen Adamouski-Marion • Opinion leader Kathy Helak • Change champion- Terry Davis • EAP Input/Support- Brian Petz	Aug 2020 to Feb 2021
		C. Team Activities • Set meeting times and location as needed. Plan to work with Holistic Council and meet on Monthly basis. Will also report updates to Quality and Patient Safety at Monthly meetings. • Method to keep team members informed E-mails will track and be used following phone calls as a thank you, this is what we discussed, and ensure agreement. Educate staff • Revise systems (e.g., documentation forms) to support practice change- power point presentation and certificates following training. Responses from questionnaire will be captured through conversation and documentation • Develop practice prompts TBD • Decide on length of "trial" before collecting post implementation data. Evaluation will be 4 months- Aug to Nov 2020.	Aug to Nov 2020 Ongoing meetings and email communications. Did not do trial; Did implementation based on feedback from hospital. Evaluation was 4 months.

Saint Francis Medical Center College of Nursing
Doctor of Nursing Practice

SECTION	OBJECTIVES	ACTION STEPS	ACCOUNTABLE PERSON(S)/ PROJECTED COMPLETION DATES
		D. Select, collect and analyze outcome and process indicator data.	Aug to Nov 2020
		E. Refine/revise policy and procedure standards.	No policies required revision
	VI. Implement evidence-based practice changes in practice beyond pilot.	A. Education plan for project. 1. Methods- In person or via Zoom- Discussions with team 2. When- Dates of training were in August for Phase I 3. Training was in-person and limited to 15 team members 4. Slides modified to 4 hour presentation workshops	Aug to Nov 2020
		F. Plan for education of new staff- Remains based on leader selection; Web site creation	Nov 2020 Feb/March 2021

Saint Francis Medical Center College of Nursing
Doctor of Nursing Practice

SECTION	OBJECTIVES	ACTION STEPS	ACCOUNTABLE PERSON(S)/ PROJECTED COMPLETION DATES
		G. Plan for annual competency review. There will be check-in's on an ongoing basis to assess how peer supporters are doing. There is no current annual competency planned (however, one may be developed or recommended based on findings of this project).	Sept 2020 Network Check-ins
		H. Decide on written resources needed for implementation, such as: 1. Quick reference guides such as open ended questions that can be used when not certain what to say. 2. Education forms about the program for team members and leaders. 3. Algorithm for expectations from initial encounter, to follow-up, to referrals, and so forth.	Sept 2020 to Feb 2021

Saint Francis Medical Center College of Nursing
Doctor of Nursing Practice

SECTION	OBJECTIVES	ACTION STEPS	ACCOUNTABLE PERSON(S)/ PROJECTED COMPLETION DATES
		I. Plan for and make system changes as needed (e.g., documentation forms, etc.) This will occur after post implementation questionnaire is completed and data is compiled.	Dec 2020
IV.	VII. Evaluate the change in practice.	A. Plan baseline data collection and analysis method. 1. Process indicators (indicators that note that progress in practice change is occurring) a. Data Source- Questionnaire b. Collection process- Discussions c. Frequency- Pre/Post Training and after encounter d. Tool- Questionnaire	July 2020 to Dec 2020

Saint Francis Medical Center College of Nursing
Doctor of Nursing Practice

SECTION	OBJECTIVES	ACTION STEPS	ACCOUNTABLE PERSON(S)/ PROJECTED COMPLETION DATES
		2. Outcome indicators (final outcomes that you plan to see a change in upon completion of the project) a. Data Source- Improved understanding of role and confidence in knowing expectations b. Collection process- Discussions (collected by DNP student) c. Frequency- After encounter d. Tool-Questionnaire	
		3. Frequency- will also be keeping an issues log	June 2020 to Nov 2020
		4. Initial feedback to Holistic Council- Research Council • Graphs • Who- Karen presents • When- Zoom Meeting Power point presentation • Posting	Nov 2020/Dec 2020
		B. Audit and feedback of data • Chart- based on number of encounters, units, and hospitals- Did not implement based on Team Expert. Will work to get electronic encounter forms	Nov 2020- HOLD
		• Frequency- quarterly	TBD

Saint Francis Medical Center College of Nursing
Doctor of Nursing Practice

SECTION	OBJECTIVES	ACTION STEPS	ACCOUNTABLE PERSON(S)/ PROJECTED COMPLETION DATES
		• Where to post- information presented to Quality/Safety/Holistic Council and TBD where else.	Q4 2020 and ongoing. Presented monthly
	VIII. Plan for sustainability.	A. Discuss how the project will be sustained. Will be developing a monthly check-in with peer supporters that will occur on a regular basis.	Sept 2020 and ongoing. Turned over to patient safety office
		B. Identify strengths and areas of opportunity related to the following areas: 1. Ethics 2. Legal 3. Cultural 4. Socioeconomic	Oct 2020

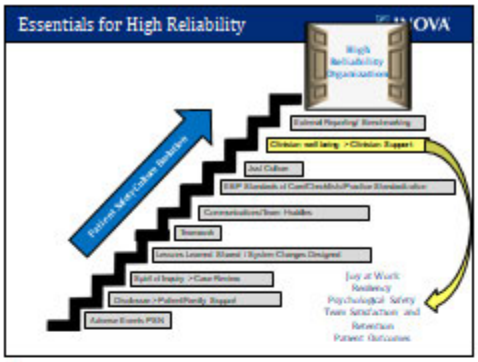
Saint Francis Medical Center College of Nursing
Doctor of Nursing Practice

SECTION	OBJECTIVES	ACTION STEPS	ACCOUNTABLE PERSON(S)/ PROJECTED COMPLETION DATES
	Section V: For results, outcomes, and recommendations and conclusions, see DNP Project Evaluation on page __ in DNP Project Guide.	Created charts/recommendations and presentation	Jan/Feb 2021

AP for leaders/kjc/clg/2020

Appendix D: Leader Overview Slides

1



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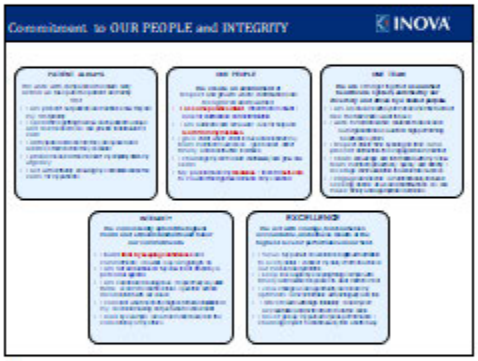

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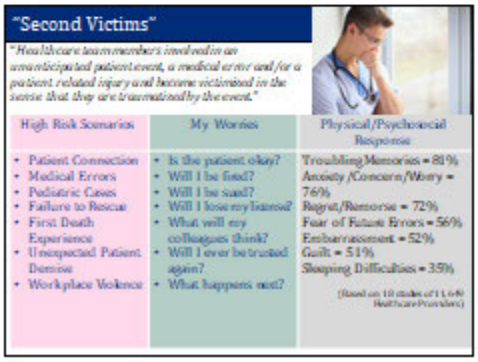

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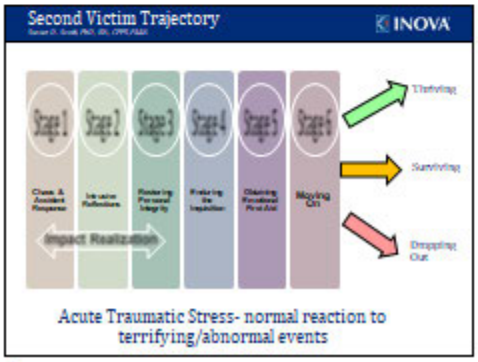

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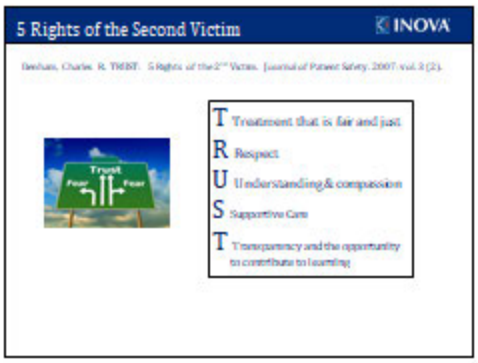

5 Rights of the Second Victim
INOVA
Trust
Fear
Fear
T Treatment that is fair and just
R Respect
U Understanding & compassion
S Supportive Care
T Transparency and the opportunity to contribute to learning

7


Types of Support Models
INOVA
Most Preferred: Peer-Peer Support Program
Individual Providing Support – Patient Safety, Various Administrators & Medical Leaders, Risk Managers
Employee Health or Wellness Center
Employee Assistance Program (EAP) referrals
S, U, P, P, O, R, T

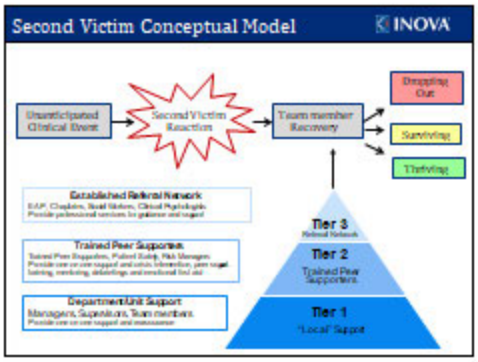
8


Benefits of a Clinician Peer-Peer
INOVA
Real Time Supportive Presence
• Immediate support through active listening, empathy, and compassion
• Reduction of the harmful effects
• Normalization
• Continuation of productive careers
• Minimize the human toll
• Offers a SAFE ZONE

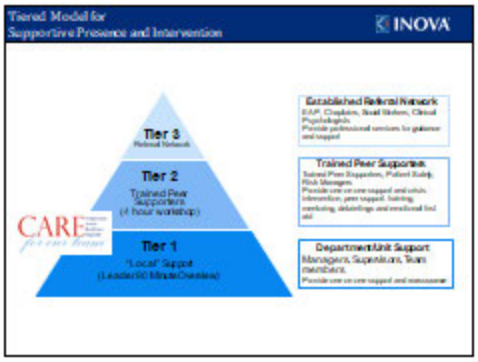
9


Introducing Inova's Peer Support Program
INOVA
CARE
Compassion
Action
Resilience
Empathy
for our team

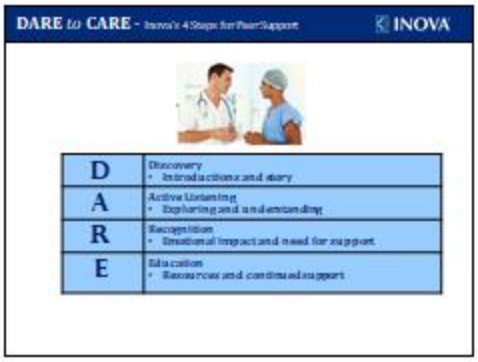
10


Second Victim Conceptual Model
INOVA
Unanticipated Clinical Event
Second Victim Reaction
Team member Recovery
Dropping Out
Surviving
Thriving
Established Referral Network
Trained Peer Supporters
Department/Unit Support
Managers, Supervisors, Team members
Tier 3
Tier 2
Trained Peer Supporters
Tier 1
"Local" Support

11


Tiered Model for
Supportive Presence and Intervention
INOVA
Tier 3
Tier 2
Trained Peer Supporters
(4 hour workshop)
Tier 1
"Local" Support
CARE
for our team
Established Referral Network
Trained Peer Supporters
Department/Unit Support

12


DARE to CARE - Inova's 4 Steps for Peer Support
INOVA
D
Discovery
• Introductions and story
A
Active Listening
• Exploring and understanding
R
Recognition
• Emotional impact and need for support
E
Education
• Resources and continued support

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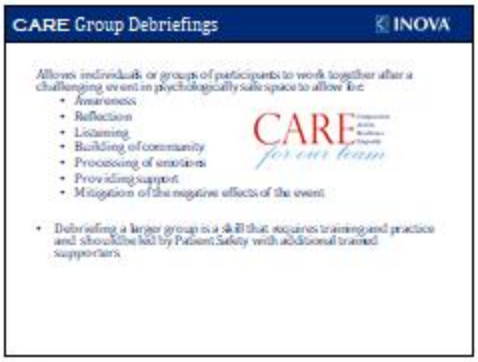
CARE Group Debriefings
INOVA
Allows individuals or groups of participants to work together after a challenging event in psychologically safe space to allow for:
• Awareness
• Reflection
• Listening
• Building of community
• Processing of emotions
• Providing support
• Mitigation of the negative effects of the event
CARE
for our team
• Debriefing a larger group is a skill that requires training and practice and should be led by Patient Safety with additional trained supporters

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Building our Network
INOVA
CARE
for our team

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Questions?

16

Appendix E: CARE Peer Support Training Tool

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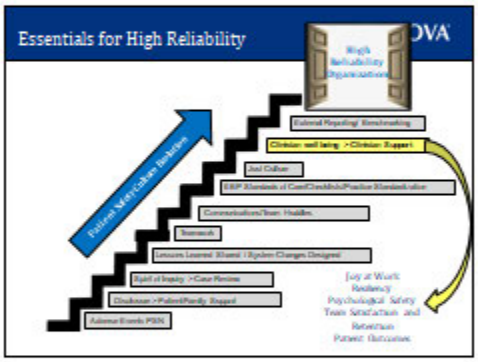

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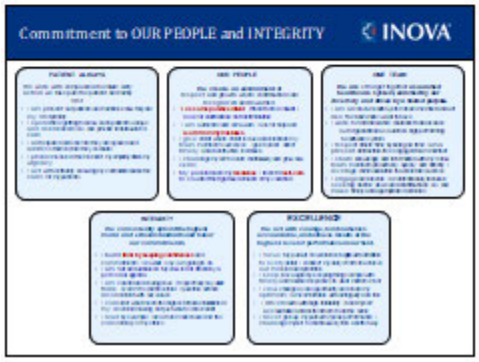
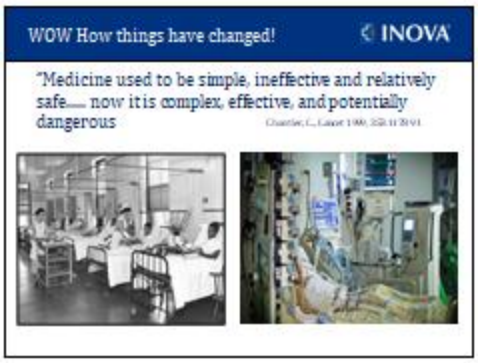



An Occupational Hazard:
The Cost of Caring…
INOVA
Burnout
Vicarious Trauma
Compassion Fatigue
Moral Distress
Second Victim Response

7


Reframing How We Think about Caring Professions and Human Behavior
INOVA
NATIONAL QUALITY FORUM
AHRQ Agency for Healthcare Research and Quality
The Joint Commission
Institute for Healthcare Improvement

8


WOW How things have changed!
INOVA
"Medicine used to be simple, ineffective and relatively safe…… now it is complex, effective, and potentially dangerous

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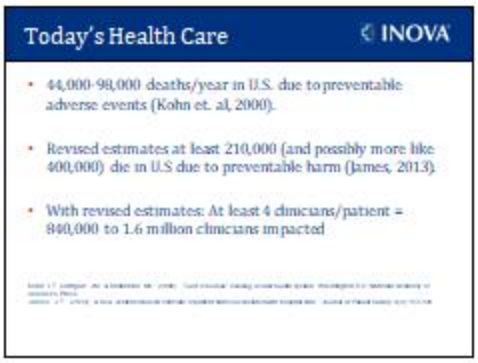
Today's Health Care
INOVA
44,000-98,000 deaths/year in U.S. due to preventable adverse events (Kohn et. al, 2000).
Revised estimates at least 210,000 (and possibly more like 400,000) die in U.S due to preventable harm (James, 2013).
With revised estimates: At least 4 clinicians/patient = 840,000 to 1.6 million clinicians impacted

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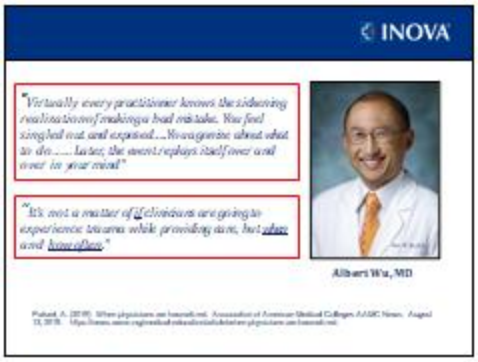
INOVA
"Virtually every practitioner knows the sickening realization of making a bad mistake. You feel singled out and exposed…You agonize about what to do…… Later, the event replays itself over and over in your mind"
"It's not a matter of if clinicians are going to experience trauma while providing care, but when and how often"
Albert Wu, MD

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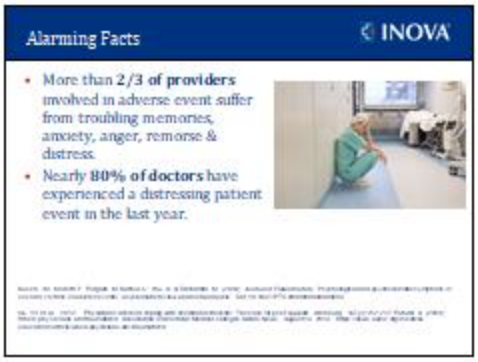
Alarming Facts
INOVA
More than 2/3 of providers involved in adverse event suffer from troubling memories, anxiety, anger, remorse & distress.
Nearly 80% of doctors have experienced a distressing patient event in the last year.

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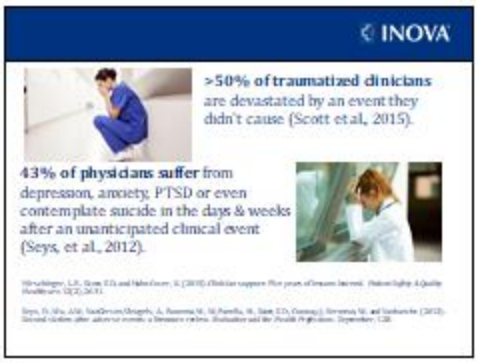

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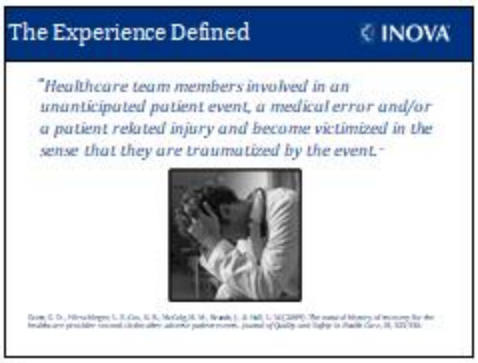

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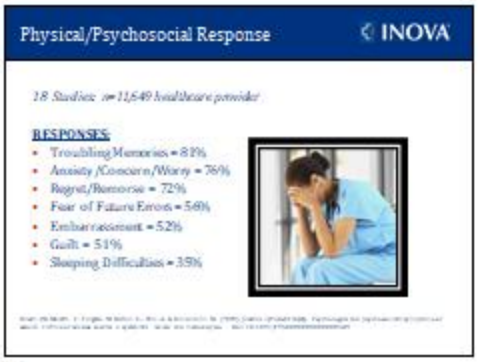

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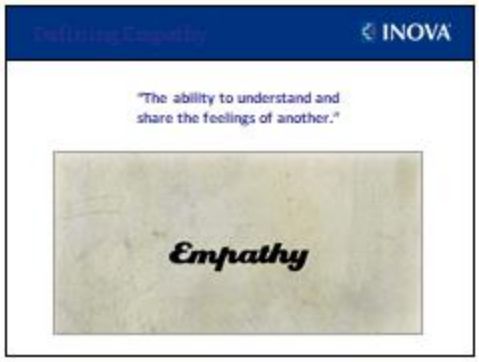

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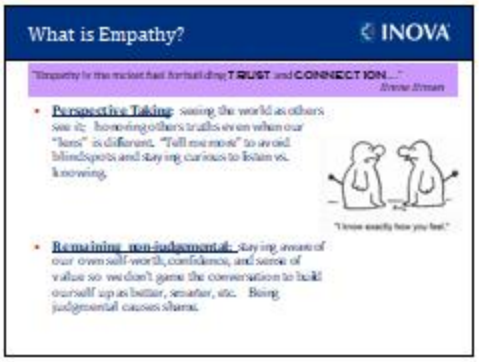

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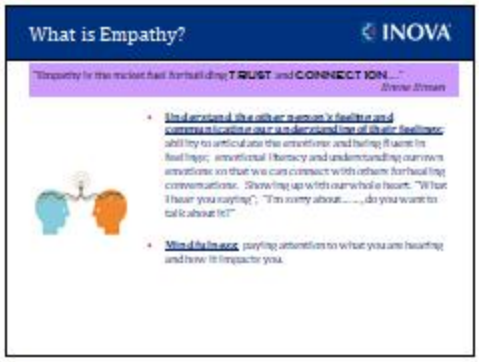

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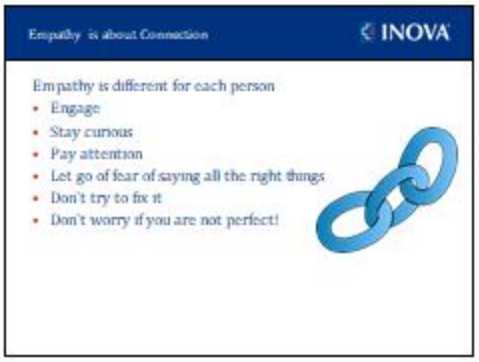

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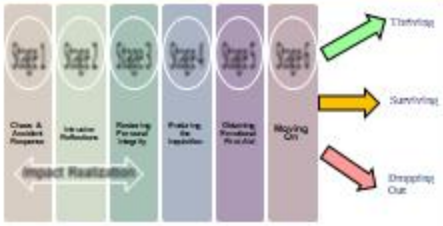
INOVA

"But I didn't mean…."

25

INOVA

Second Victim Trajectory



Acute Traumatic Stress- normal reaction to terrifying/abnormal events

26

Stage 1-Chaos and Accident Response

INOVA

- Error realized/Event recognized/Distracted
- Tell someone/ get help!
- Stabilize/treat patient
- May not be able to continue care of patient
- Acute Stress Reaction sets in within minutes
  - Confusion, impaired judgment, anxiety, hyperarousal

Supportive Presence
Needs support from others to take over during period of shock

"Right after the…code, I was having trouble concentrating. It was nice to have people take over…that I trusted. I was in so much shock I don't think I was useful."

27

Stage 2-Intrusive Reflections

INOVA

- Self-isolation
- Haunted re-enactments of event
- Feelings of internal inadequacy

Supportive Presence
Most important phase to pay attention to
Needs stability and support
Assistance with "normalizing"
Watch for verbal and non-verbal cues of the emotional burden
Peer support is essential

"I started to doubt myself… There were some things that I thought maybe if I'd have done it this way it wouldn't have happened…but everything was more clear looking at things in retrospect. I lost my confidence for some time."

28

Stage 3-Restoring Personal Integrity

INOVA

- Fear is prevalent ('what's going to happen to me?)
- Loss of confidence
- Looking for acceptance/validation among work/social structure

"I thought every single day for months I'd walk in and they everyone knows what happened…I thought these people are never going to trust me again."

Supportive Presence
Understand the fears
Reinforcing strengths and value
Manage the grapevine

29

Stage 4-Enduring the Inquisition

INOVA

- Physical and psychosocial symptoms
- Realization of level of seriousness
- Reiterate case scenario
- Respond to multiple "why's" about the event
- Interact with many different event responders
- Understanding event disclosure to patient/family

Supportive Presence
Patient Safety and RM are key to peer support and providing information
Psychological Safety
"Here's what you can expect"

"I didn't know where do, or who to ask to professionally or legally."

"Clearly…I know we needed to keep that quiet- it might have been helpful to be able to talk to someone else but I couldn't do that."

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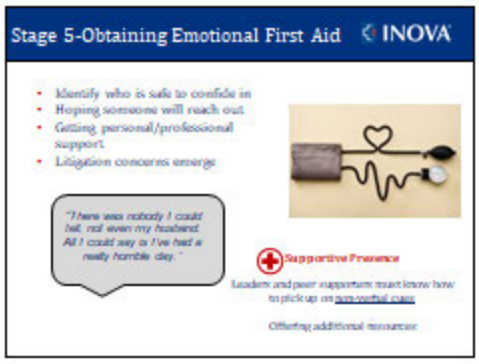

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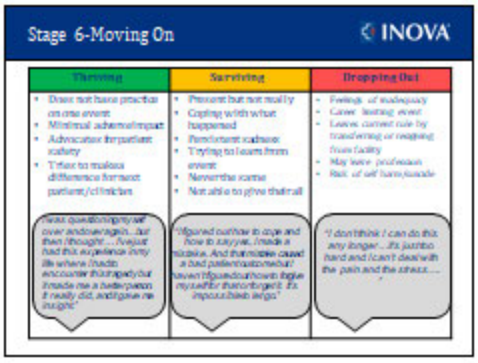

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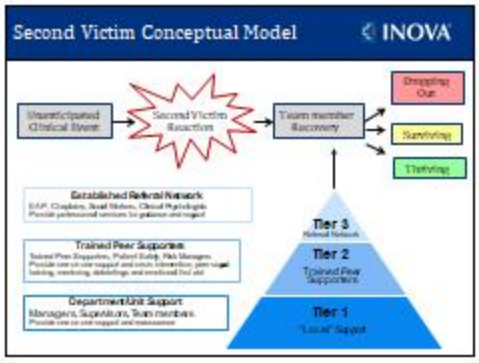

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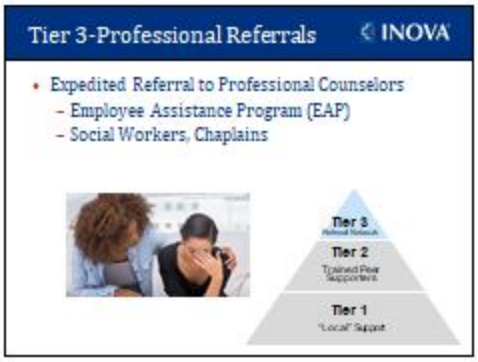

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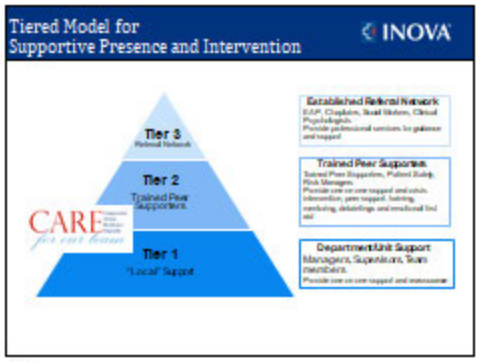

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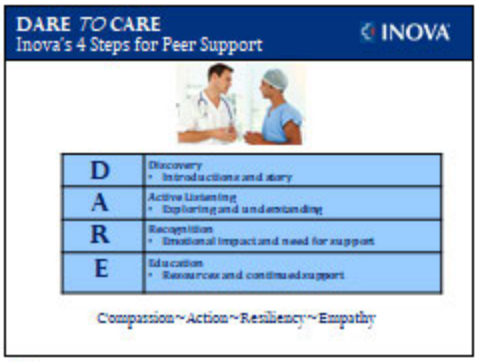

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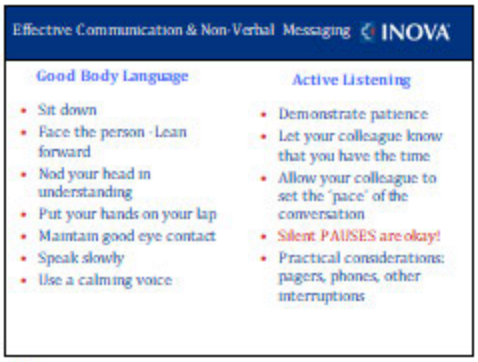

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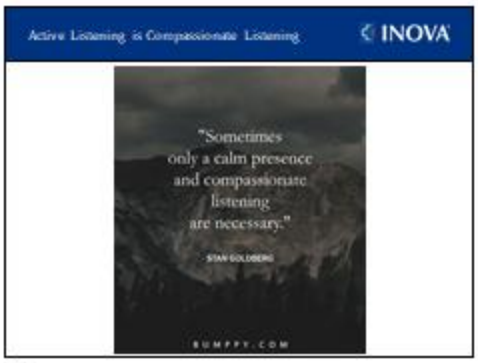

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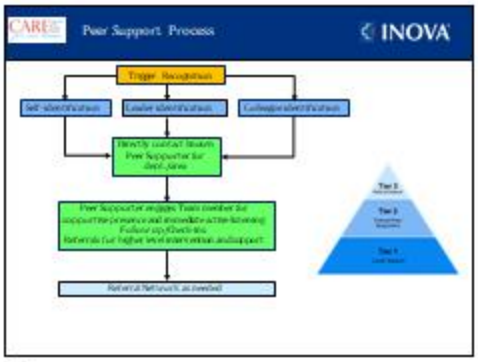

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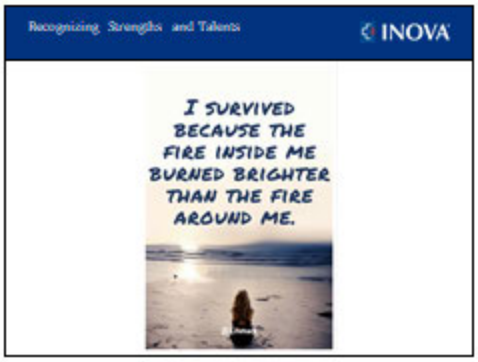

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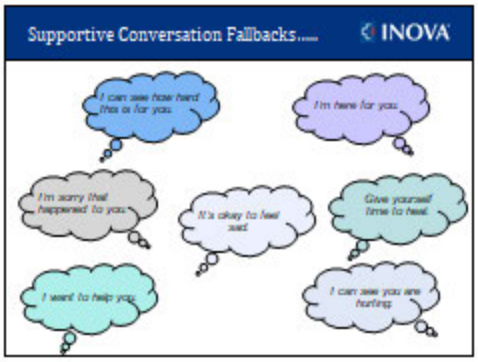

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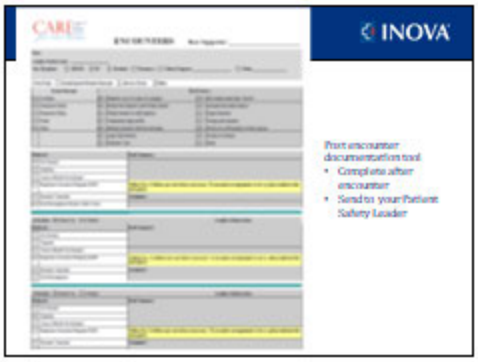

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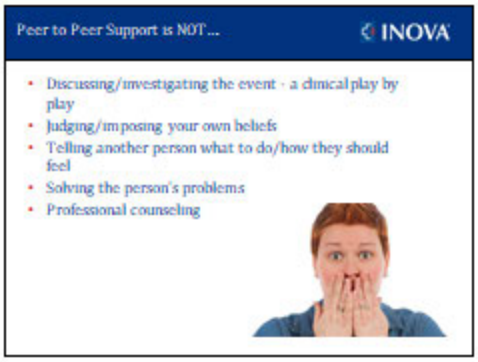

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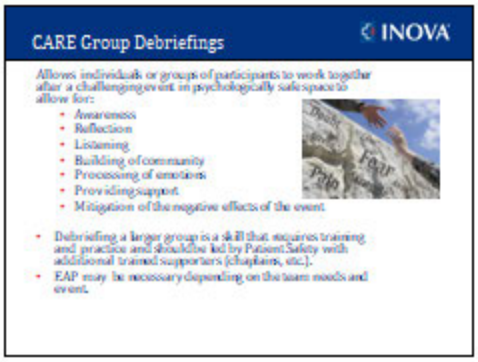

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Let's Practice
INOVA
CARE
Compassion
Action
Resilience
Empathy
for our team

61


Final thoughts and next steps
INOVA
1. Talk with your leader about your new role and peer support for your team
2. Reach out to your patient safety team with any questions
3. Use the Talking Points to share general information about CARE
4. Participate in the monthly CARE Check-Ins 3rd Thursdays for continued learning and growing in the peer supporter role.
5. Use the post-encounter documentation form for collecting generic "data" for the program

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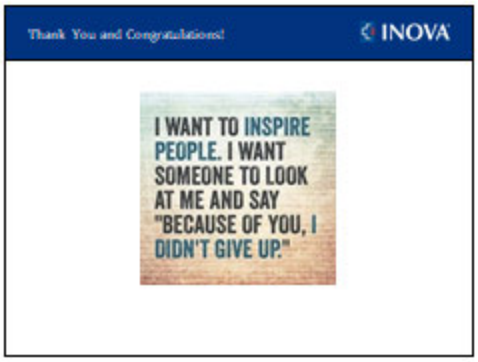

Thank You and Congratulations!
INOVA
I WANT TO INSPIRE PEOPLE. I WANT SOMEONE TO LOOK AT ME AND SAY "BECAUSE OF YOU, I DIDN'T GIVE UP."

63

Appendix F: DNP Questionnaire for Scheduled Discussions

1. Are you aware of any intervention strategies used to support colleagues who require peer support?

2. How do you apply active listening?

3. How do you schedule time to meet with a team member for peer support?

4. How do you refer a team member for higher level support?

5. Do you understand the requirements of a peer supporter?

The next question would be asked after an actual encounter with a team member:

6. Did you feel prepared by the training for your role as a peer supporter during this encounter with a team member? If not, please tell me how we can improve this training.

Appendix G: Encounter Form

CARE for our team (Compassion, Action, Resilience, Empathy)

ENCOUNTERS Peer Supporter:_____

Date:

Length of Interaction: _____

Peer Recipient: ☐ MD/DO ☐ RN ☐ Resident ☐ Pharmacy ☐ Clinical Support:_____ ☐ Other_____

Event Type: ☐ Unanticipated Patient Outcome ☐ Adverse Event ☐ Other

Event Outcome	Risk Factors	
☐ No Harm	☐ Pediatric case (21 years & younger)	☐ First death under their "watch"
☐ Temporary Harm	☐ Patient that reminds staff of their family	☐ Unexpected patient demise
☐ Permanent Harm	☐ Patient known to staff members	☐ Organ donation
☐ Death	☐ Community high profile	☐ Young adult patients
☐ Other	☐ Multiple patients with bad outcomes	☐ Death of a staff member or their spouse
	☐ Long Term Patient	☐ Victim of violence
	☐ Palliative Care	☐ Other

Referrals	Brief Summary
☐ Not Needed	
☐ Chaplain	
☐ Clinical Health Psychologist	
☐ Employee Assistance Program (EAP)	Follow-Up: (A follow up is not always necessary. If you make arrangements to do so, please indicate this took place)
☐ Personal Counselor	Comments:
☐ Risk Management/Patient Safety Team	

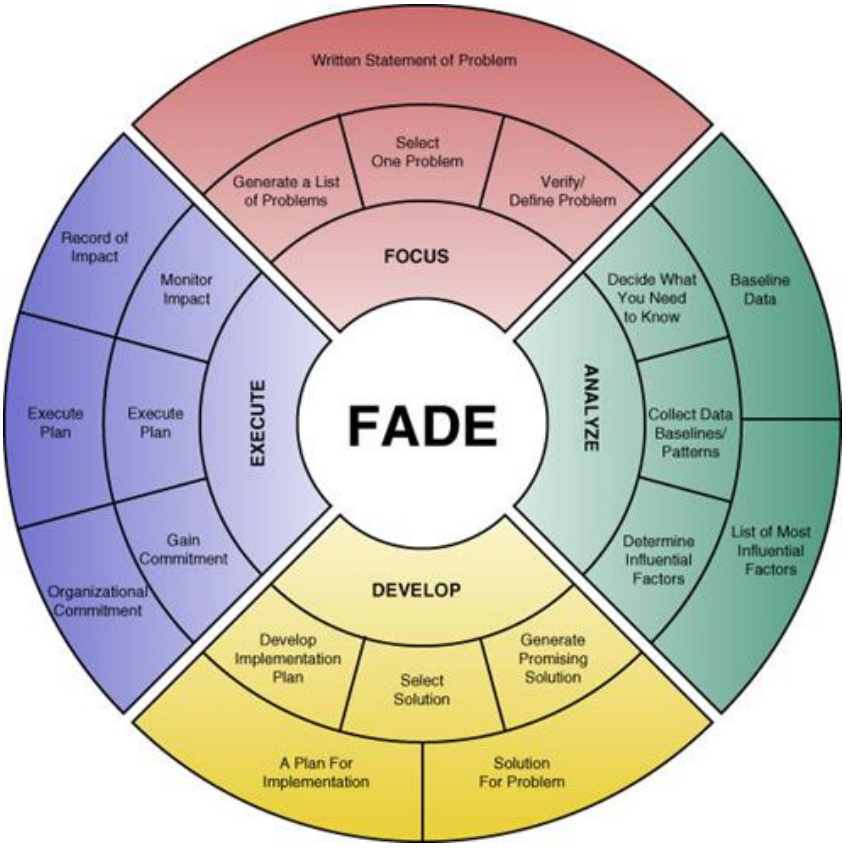
Activation: ☐ Follow-Up ☐ 3 Month Length of Interaction:

Referrals	Brief Summary
☐ Not Needed	
☐ Chaplain	
☐ Clinical Health Psychologist	
☐ Employee Assistance Program (EAP)	Follow-Up: (A follow up is not always necessary. I you make arrangements to do so, please indicate this took place)
☐ Personal Counselor	Comments:
☐ Risk Management	

Activation: ☐ Follow-Up ☐ 3 Month Length of Interaction:

Referrals	Brief Summary
☐ Not Needed	
☐ Chaplain	
☐ Clinical Health Psychologist	
☐ Employee Assistance Program (EAP)	Follow-Up: (A follow up is not always necessary. If you make arrangements to do so, please indicate this took place)
☐ Personal Counselor	Comments:

Appendix H: FADE Model



Note: From *FADE* by Duke University, 2021

(http://josieking.org/patientsafety/module_a/methods/fade.html). Copyright 2021 by Duke University.

Appendix I: Budget

Program Expenses	Hourly	Total: $11,700.00
Salary/Wages: • Instructor salary:	Patient safety consultant: 20 hrs/mo including time presenting, $44.00 x 20 hrs	$880.00
	Leader training via Zoom (40 leaders including trainer) Est. ave: $50.00/hr x 40 x 1	$2,000.00
• Team members (peer supporters) training	Training (15 team members per class x 3 classes for evaluation) Ave: $40.00/hr x 15 x 3	$7,200.00
• Peer supporter (time each month	$38.00 x 5 hrs	$190.00
• Evaluation and feedback- DNP student/team members' time	17 team members for pre/post interview discussions x 1 hr Ave: $40.00/hr x 17 x 2	$1,360.00
Start-up Costs	**Per Class**	**Annual: $213.00**
• Educational materials (handouts, folders, pens) • Communication software if used	Flyers: informational Brochure: marketing	$65.00
	Reference tools (training) x 45	$20.00
	Newsletters	$20.00
	Encounter forms (Word doc)	$10.00
	Create Dashboard- PSC Salary 44.00 x 2 hrs	$88.00
	Survey Tool/Form	$10.00
Capital Costs		$322.00
Equipment: laptop, projector, tables, chairs, PPE	Computer	$300.00
	Phone	$22.00
Operational Costs		

Occupancy/in-hospital classroom space		$0.00
Total Project Expenses		$12,235.00
Program Revenue		
• Nursing turnover rates • Nursing hiring and onboarding		$22,600.00 *Estimate is minimum for one employee
Total Project Revenue		$22,600.00

Appendix J: Issues Log

- Dates predetermined by organization (less time than needed to identify units and meet with all leaders). Consider leader introduction sessions to identify peer supporters.

- In-person training is limited due to social distancing. Need to identify conference space that will allow for a minimum of 15 peer supporters per session.

- List obtained prior to training to enlist participation prior to project may not have all attendees, because team members can sign up the day before the training if capacity allows.

- Not all team members read their email on a routine basis and may not have had the opportunity to participate if they received the message after their initial training.

- Opportunities raised regarding how project operationalized not within control of DNP student. DNP student asked to focus on training and sustainability.

- Obtaining time for discussions difficult during pandemic with team members having many competing priorities.

- Agenda at first system-wide check-in could not be completed; peer supporters needed more direction on operationalizing project and how to work with leaders.

- Consider additional training for patient safety consultants who will be point of contact for peer supporters at each hospital.

Appendix K: Badge Buddy

Appendix L: CARE Training Certificate