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Implementation of a Second Victim Program: HOPE Team

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Implementation of a Second Victim Program: HOPE Team

by

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Abstract

The healthcare workforce is composed of a variety of roles and disciplines that do their best ensuring patient safety and quality care. Nurses spend more time with the patient than any other discipline. They not only are responsible for the care of their patients but their families during hospitalization. The role and responsibilities of a nurse puts them in a position for making mistakes. After a mistake is made, the patient becomes the first victim, the nurse becomes the second victim, and the organization becomes the third victim. A second victim is a healthcare worker who makes a mistake and the patient suffers injury, harm, or death. Organizations have not done a good job providing support or resources for a second victim after the error occurs. The literature review provided a basic understanding of the emotions and reactions a healthcare worker experiences after an adverse event occurs. The purpose of this Capstone Project was to develop and implement a second victim response team and identify the effect of an adverse event on a nurse's professional identity and desire to remain in the profession. A staff support survey was used to collect the data used to develop the response program. Return rate for the survey was 11% and findings revealed that either formal or informal emotional support for healing did not have an effect on a nurse's desire to remain in the profession in a rural community hospital.

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CHAPTER I

Introduction

Recently, healthcare organizations have been focusing on quality patient care and outcomes while providing a culture of safety. Declining reimbursement, staffing shortages, decreasing capital, and operational budgets are challenges for leaders, administrators, employees, and ultimately the consumer (Pappas, 2008). By the nature of the work and often times the workload, the healthcare provider is at risk for making an error. The emotional impact of adverse events causes an individual to feel personally responsible for the patient outcome. Many healthcare workers feel as if they have failed the patient when an adverse event happens and often second guesses their clinical skills and knowledge (Scott, 2010a).

Patients are considered the first victim of an adverse event. However, the healthcare worker and the organization become victims as well. In 2000, a physician introduced the term "second victim" to describe the healthcare worker involved in an error (Wu, 2011). Along with the unfortunate experience, emotional, and professional distress can be present. Tragedies such as loss of life or permanent harm can affect the most experienced, knowledgeable, and skilled veteran healthcare worker (Scott et al., 2010c).

According to Wu (2012), second victims go through two stages after an adverse event occurs. The first stage is shock in which there are reoccurring thoughts of the event. They may lose sleep, become irritable, and distracted; internalizing feelings of guilt. The second victim may also experience shame and anger towards self, the patient, and the organization (Wu, 2012). Their moods and personality traits may change as they

progress through the first stage which may last for days or weeks. Some people go on to develop posttraumatic stress syndrome that may last for years and even decades. This is the second stage for the second victim of an adverse event (Wu, 2012).

An adverse event can destroy the nurse's personal and professional identity. A healthcare system needs to acknowledge this can happen to anyone and work to keep nurses in the profession by providing resources and support to second victims. Providing support to the second victim after the adverse event results in three outcomes: confirms the nurse has valuable clinical skills and abilities, shows support and respect, and reassures the nurse that he or she is a valuable and trusted member of the team (Scott, Hirschinger, & Cox, 2010b).

The second victim has long suffered in silence, unsupported during career-related anxiety and stress (Scott et al., 2010c). For this project, the goal was to develop and implement a crisis response program to be called HOPE (Helping Others Process the Event). Wu (2011) suggested that a policy is the first step in the development of a support team. The policy should include the acknowledgement that there will always be second victims and the organization will support and value the mission of the response team (Wu, 2011). The referral process must be clearly defined with the second victim needs being met both personal and professionally (Scott et al., 2010c). A draft policy was developed and will be reviewed and approved as the project moves forward (See Appendix A Development and Implementation of a Second Victim Response Team HOPE).

The healthcare environment will always be a vulnerable place for an employee to work, and those involved in providing patient care will be at risk for mistakes and errors.

Many patients will suffer errors with unexpected outcomes and adverse events that cause distress to the care provider (Manfuso, 2010). Therefore, the development and implementation of a second victim response team becomes important for the healing of the employee and the organization.

Problem Statement

In 1999 a report, *To Err Is Human: Building a Safer Health System,* was released laying out a comprehensive strategy for government, industry, healthcare providers, and consumers to reduce preventable medical errors. The report concluded that healthcare has the knowledge to prevent many of the mistakes that occur (Institute of Medicine, 1999). It is reported that medical errors kill up to 100,000 people each year in the United States. By comparison, for every person killed in the United States by a drunk driver, two people are killed by medical errors (Blalek, 2013).

A medical error is the failure of planned actions to be completed as intended or the use of a wrong plan to achieve an outcome (Institute of Medicine, 1999). The most commonly identified problems occurring during the course of providing health care are adverse drug reactions, improper transfusions, surgical injuries including wrong-site surgeries, suicides, restraint-related injuries or death, falls, burns, pressure ulcers, and mistaken patient identities (Institute of Medicine, 1999). Errors are costly in terms of lost income, household productivity, and disability. Patients and their families may lose trust in the healthcare system, experience longer hospital stays, and have physical or psychological discomfort resulting from medical errors (Institute of Medicine, 1999).

Additionally, healthcare professionals are affected by medical errors. The effects of medical errors can trigger a variety of emotions. An individual may have low morale,

frustration of not being able to provide the best care possible for the patient, loss of self-confidence, and loss of professional identity (Institute of Medicine, 1999). In some cases, healthcare workers have reported experiencing the symptoms of posttraumatic stress disorder after being involved in a medical error (Hofelct & McCotter, n.d.). Common symptoms of psychological distress in the healthcare worker involved in a medical error may include grief, extreme sadness, guilt, repetitive and intrusive memories, flashbacks, isolation, fear, remorse, difficulty concentrating, loss of confidence, self-doubt, frustration, anger, irritability, depression, anxiety, and second guessing their career choice (Hofeldt & McCotter, n.d.).

Healthcare workers may also experience physical symptoms after involvement in a medical error. Physical symptoms often seen include eating disturbances, sleep disturbances, headache, fatigue, diarrhea, nausea or vomiting, rapid heart rate, rapid breathing, and muscle tension (Hofeldt & McCotter, n.d.). Unfortunately, the risk of making a subsequent error will increase when the healthcare worker experiences the stress and symptoms of a medical error or mistake (Hofeldt & McCotter, n.d). Healthcare will be imperfect because it involves humans and humans make mistakes. Any process involving humans will be prone to mistakes and errors. Nurses are part of a vulnerable group experiencing the stress and symptoms of involvement in a medical error and too few of them will be supported by their organization following a medical error or mistake (Hofeldt & McCotter, n.d.).

Justification of the Project

The term second victim is used to describe the healthcare worker involved in making an error. The first victim is identified as the patient and the organization

becomes the third victim (Wu, 2011). It is normal for a healthcare worker to experience unfortunate events with their patients. Along with the unfortunate experience, emotional and professional distress can be present in the lives of a second victim. Tragedies, such as the loss of life of a patient or permanent harm can affect the most experienced, knowledgeable, and skilled veteran healthcare worker (Scott et al., 2010c). Emotional turmoil, including personal, social, spiritual, and professional crisis is often the response to an adverse clinical event and may be life changing (Mosby's Nursing Suite, 2012).

A fair and just culture that values the employee and is anchored in respect is the type of environment that will make a difference in the life of a second victim (Conway, n.d.). The development and implementation of a second victim response team becomes important for the healing of the employee in the organization. The program goals were to provide crisis intervention, and to promote an on-going support system to nurses who experience an adverse patient event while in a fair and supportive environment.

In the healthcare environment, an adverse event can affect the patient, their family, the healthcare worker, and the organization. Many patients will be affected by errors with unexpected outcomes. These outcomes may cause distress to the health care provider (Manfuso, 2010). Second victims of adverse events need support and often the organization does not have a coordinated program or system that provides support to the affected second victim (Manfuso, 2010).

Examples of support models and tool kits for second victims are available by searching the Internet (Hofeldt & McCotter, n.d.). However, using a crisis management plan could provide foundational guidelines in the development of a second victim response team (Conway, Federico, Stewart, & Campbell, 2010). Steps in a crisis

management plan may include: taking an inventory of what presently exists in the organization, assessment of the event, successes, what didn't work, and opportunities for improvement. Also included in a crisis management plan, is an action plan based on the assessment and the evaluation of what lessons learned while developing the plan. The action plan should be implemented by using a drill or an actual adverse event, and continually revising this plan (Conway et al., 2010). Best practice recommendations have not emerged but information on program successes, barriers, and opportunities are developing areas of focus (Kenney, 2009).

Once the support team HOPE (Helping Others Process the Event) is developed and implemented, the team will include a representative from several areas including; a representative from Human Resources, the Chaplain, Safety and Risk Management, a Nurse Director, a Staff Nurse, Nursing Supervisor, and the Coordinator of the support program. An out-side representative from the Employee Assistance Program (EAP) will serve as an ad hoc member on the team. The team members will meet to collaborate and develop policies, procedures, and practices for the support program. The Medically Induced Trauma Support Services (MITSS) granted permission to use the Clinician Support Toolkit for Healthcare (See Appendix B for email permission) as the basis for the survey (L.K. Kenney personal communication, April 2, 2013). The toolkit provided an assessment of the organization's response to an adverse event and evaluates any procedures or support currently available.

Purpose

The purpose of this project was to develop and implement a second victim support team and identify the effect of an adverse patient event on a nurse's professional

identity and desire to remain in the profession of nursing. The focus for the project included nurses in a rural 247 - bed community hospital and included errors causing an adverse patient event. Near misses were not included in the project, although they do not result in full-scale harm; the surrounding events often offer data to be studied as a means of avoiding a similar event in the future. Discussion around the near-misses allows an organization to evaluate specific products or procedures and develop recommendations with involvement of the person making the error (Porter-O'Grady & Malloch, 2011).

The approach to responding to an adverse reaction has long been "name, blame, and shame" (Clancy, 2012, p. 3). However, more and more healthcare providers are working at balancing the system's approach to patient safety and correcting the individual behavior when appropriate. One way to test a patient safety culture is to evaluate the culture after the adverse event occurs. Current culture wants to be open to patients and the public but the legal system does not want the same thing (Clancy, 2012).

Adverse patient events that cause harm or injuries to a patient are a frequent occurrence in hospitals in the United States (US). It is estimated that adverse events can cause as many as 187,000 deaths and 6.1 million injuries yearly inside and outside of hospitals (Goodman, Villarreal, & Jones, 2011). A patient's risk of dying from an adverse event is 1 in 200. In 2006, the cost of adverse events in the U.S was $393 billion to $958 billion. These amounts are equivalent to 18% and 45 % of total US spending (Goodman et al., 2011). Although unable to identify specific numbers, there is a correlation of the nurse involved in adverse patient event and the rates for burnout, depression, and suicide (Jones, 2011a).

A study conducted in 2008 was the first to link actual patient-level clinical and financial outcome data. The study linked the occurrence of adverse events to actual patient-level cost per case. It was determined that the additional cost for an adverse event is $300 to $2,400 per case (Pappas, 2008). Adequate nurse staffing patterns and nurse to patient ratio can reduce adverse events and avoid additional costs to the patient and hospital (Pappas, 2008).

As a part of this project, the comparison groups were nurses who have the opportunity to be involved in the HOPE program with a group of nurses who did not receive formal crisis intervention. The outcome to be measured was the implementation of a formal crisis response team for the nurse who has experienced an adverse patient event. Outcome evaluation included the effect the crisis intervention may have on professional identity and the desire to continue practicing as a nurse.

Project Question

The clinical question for this Capstone Project is: "Does a second victim response team and support program provide the nurse with emotional support needed to heal personally and professionally while remaining in the profession of nursing?"

Definition of Terms

The term second victim is used to describe the healthcare worker involved in making an error. The first victim is identified as the patient and the organization becomes the third victim (Wu, 2011). Helping Others Process the Event (HOPE) is the name of the second victim response team at the 247-bed community hospital and includes representatives from within the healthcare system. The Medically Induced Trauma Support Services (MITSS), Inc. is a non-profit organization with a purpose of supporting

healing and restoring hope to patients, families, and healthcare workers who have been affected by an adverse event (Medically Induced Trauma Support Services, 2010). An adverse event is injury, harm, or death caused by an unintended medical management (Harvard Hospitals, 2006). An error is defined as "an act that produces a preventable adverse outcome compared to a natural progression of disease that leads to injury or death" (Unland, 2012, p. 2).

Scott et al. (2010b) more recently described a second victim as "a healthcare provider involved in an unanticipated adverse patient event, medical error and/or a patient related injury who becomes victimized in the sense that the provider is traumatized by the event" (p. 233). An adverse event is defined by the World Health Organization as "an injury related to medical management, in contrast to complications of disease. Medical management includes all aspects of care, including diagnosis and treatment, failure to diagnose or treat, and the systems and equipment used to deliver care. Adverse events may be "preventable or non-preventable" (World Health Organization, 2005, p. 8). A preventable adverse event is an event related to treatment and can be measured by its disability. An unpredictable event is a complication that cannot be prevented given the current level of medical knowledge ("Adverse Events," n.d.).

Summary

Organizational support of the healthcare worker following an adverse event may enable them to communicate with the patient and the family and return to their professional duties. Like patients and families, healthcare workers are impacted emotionally, functionally, and even physically following an adverse event (Harvard

Hospitals, 2006). The development and implementation of a second victim program, HOPE assists the nurse and the organization in the healing process. Through the support of a second victim response team, a nurse may continue to practice professionally and skillfully.

CHAPTER II

Research Based Evidence

The first priority after any adverse event is the patient and their family who are considered to be the first victim. However, the healthcare worker who is the second victim becomes a victim in the sense they are traumatized by the event as well. One in seven patients is involved in an adverse events, and it is estimated that nearly half of healthcare workers experience the impact as a second victim at least once in their career (Seys et al., 2012). Second victim support is needed for the healthcare worker and to improve quality of care. The support should be provided at the individual and at the organizational level to include post adverse event support, middle long term support and long term basis support (Seys et al., 2012).

Literature Review

The purpose of the literature review was to evaluate the programs and the support systems already in place for second victims and explore the types of evidence available for guidelines. There is growing acknowledgement in healthcare that patients are not the only victims when a near miss or adverse event occurs (Clancy, 2012). Now more than ever, hospitals are promoting a culture of patient safety and quality. A good system will recognize that near misses and adverse events are an integral part of improving patient safety, advancing quality, and learning from mistakes (Clancy, 2012).

The literature review included searches in Medline, Cumulative Index to Nursing and Allied Health (CINAHL), and Goggle. Key terms explored included: second victim, adverse event, harm causation, hospital loss prevention, compassion fatigue, medical error, no blame culture, risk management, sentinel events, emotional first aid, wounded

healers, patient safety, just culture, and employee assistance program. Healthcare workers and nurses were included in the literature review and industry, business, physicians, psychiatric, pharmacy, natural health, and the airline industry were excluded from the search. A manual search began May 2012 and has been on-going.

A study in 2010 by the Office of the Inspector General, US Department of Health and Human Services, found that one in seven Medicare fee-for-service patients experienced a serious adverse reaction, and an additional one in seven experienced a less serious adverse reaction. It would be safe to assume that every nurse has been involved in an adverse event or is close to someone who has experienced an adverse event (Levinson, 2008). Healthcare leaders are responsible for making decisions that create safe clinical practice conditions and for improving medical care to reduce errors (Porter-O'Grady & Malloch, 2011).

Advanced planning for adverse events with a balance of prioritizing the needs of the patient, family, staff, and the organization is needed. Over the years, several discoveries have been made related to the responses of all levels of parties involved. The patient is the first victim and the focus of care once an adverse event has occurred. Staff begins to worry about the patient and begins asking themselves questions: Is the patient okay? Can care be provided to stop the harm or hurt? Does the patient need a rapid rescue? (Scott, 2010d).

The second victim is the person who has caused the adverse event. Worry about self and peers becomes a focus of the second victim. Questions arise regarding termination of job, legal concerns of being sued, and maintaining licensure in the profession (Scott, 2010d). A program to support the nurse provides immediate response,

empathy, support, resolution, learning, and improvement. Clinical adverse events impact the psychological, and/or physical harm (or death) on one person or many and are referred to as a sentinel event (Conway et al., 2010).

The third victim in the adverse event is the organization or agency. Medical errors and adverse events can be equally devastating to the organization or agency causing financial strain, loss of trust, and loss of competence in the staff (Lavin, 2012). In some cases of an adverse event, the third victim is placed before the second victim as risk management and legal counsel become involved. Over the years, common second victim physical and psychological symptoms have been identified and the steps and processes for the development of a crisis response team defined (Scott et al., 2010c). Adverse events are told as stories, interviews, and case studies to serve as examples for those healthcare workers who experience adverse clinical events and have no intervention. Symptoms if untreated, can lead to posttraumatic stress disorder and even death (Lavin, 2012).

Policies, guidelines, procedures, and practices are used to build a culture of safety and improvement, and aid staff in using tools and resources available to them when an adverse event occurs (Conway et al., 2010). The event is a crisis for everyone involved. Leadership and employees must ensure everything possible is done to understand what happened, why it happened, and prevent it from happening again.

There is an overall focus on the involvement of the organization from the top down in each review of an adverse event. The attitudes of the organization and leadership will contribute to the design and implementation of a second victim program. While hospitals are placing more emphasis on providing a safe culture for patients and

their families, the risk management departments and human resource departments are focusing their efforts on how to handle patients and families harmed while in the care of the healthcare provider.

It is time to recognize that patients are not the only victims when adverse events occur (Wu & Conway, 2012). Research on the effects of adverse patient events on healthcare workers started over a decade ago and has drawn attention to the second victim. Second victims can be described as providers who have been involved in adverse patient events and have difficulty dealing with their emotions (Edrees, Paine, Feroli, & Wu, 2011).

The evidence from the literature review indicated that:

1. Advanced planning for adverse events with a balance of prioritizing the needs of the patient, the family, the staff, and the organization is needed (Conway et al., 2010).
2. A program to support the nurse provides immediate response, empathy, support, resolution, learning, and improvement (Wu & Conway, 2012).
3. Clinical adverse events impact the psychological, and/or physical harm (or death) on one person or many and are referred to as a sentinel event (Conway et al., 2010).
4. Common second victim physical and psychological symptoms have been identified and the steps and processes for the development of a crisis response team defined (Scott et al., 2010c).
5. Stories, interviews, and case studies are available as examples of healthcare workers who experience adverse clinical events and have no intervention.

Symptoms if untreated, can lead to posttraumatic stress disorder and even death (Lavin, 2012).

6. Policies, guidelines, procedures, and practices are used to build a culture of safety and improvement and aid staff in using tools and resources available to them when an adverse event occurs (Conway et al., 2010).

Adverse events are the result of bad systems and not bad people (Conway et al., 2010). The event is a crisis for everyone involved. Many patients will suffer errors with unexpected outcomes and adverse events that cause distress to the care provider. Therefore, the development and implementation of a second victim response team becomes important for the healing of the employee and the organization.

Gaps in Literature

There are few second victim support programs that are designed to provide effective care for the first and second victims of an adverse event. The researcher identified two organizations providing care and support for healthcare workers in an adverse event. The most prominent is the non-profit organization Medically Induced Trauma Support Services (MITSS). The mission of MITSS is to provide support for healing and provide hope (Seys et al., 2012). A more general program that may be used in the clinical area is the Critical Incident Stress Management (CISM). This program aims to decrease the effect of stress by providing a team-based approach using mental health professionals and peer support personnel (Seys et al., 2012).

The majority of second victims desire to have resources and support systems available to them after an adverse event (Jones, 2011). However, very few programs are sufficient to meet the needs of the healthcare worker because of the organization's

internal culture (Jones, 2011). Support programs must be designed to reflect the culture of the organization and its employees. The culture can be the single largest barrier to positive change in a hospital setting (Pine, 2012). It provides structure for hospital employees, defining how the hospital will provide care and conduct business (Pine, 2012). The second victim may be influenced by the culture. Therefore, a response to an adverse reaction may reflect the overall health of the organization.

Literature shows there is no consensus of how to design a support program to effectively support a second victim (Seys et al., 2012). There are few considerations for the use of medical errors for learning and improvement to provide positive results. A need has been identified for future research to provide organizational tools to assess effectiveness of support programs (Seys et al., 2012).

Strengths and Limitations of Literature

The purpose of the literature review was to evaluate the programs and the support systems already in place for second victims, and explore the types of evidence available for guidelines and development of a response team. The majority of literature reviewed for second victims, the signs and symptoms of emotional trauma, and the development of a response team was qualitative. Based on the Forsyth Nurse scale, the rating of the evidence was on Level IV and Level V and included interviews and surveys as a collection tool for data (Kring, 2009). The modes of inquiry included empirical, descriptive, and correlational in the literature review (Fawcett & Garity, 2009). An example of a descriptive study was found in the article, *Caring for Our Own: Deploying a Systematic Second Victim Rapid Response Team* (Scott et al., 2010c). The example of the second victim survey, the interventions, and the design of a support program provide

a basic understanding and direction for starting a second victim program. The qualitative findings can assist in understanding the feelings and reactions of a nurse who is involved in an adverse event.

An overall focus on the involvement of the organization, leaders, and administration was identified in each review. The attitudes of the organization and leadership will contribute to the design and implementation of a second victim program. Therefore, the literature review has provided the researcher with a basic understanding of the experiences and beliefs of a nurse who has experienced an adverse event with harm, disability, or death as a patient outcome. The qualitative research reviewed can provide ideas for change, development of policies and procedures, and support the second victim in healing. However, the literature did not review the effects of a second victim response team on a healthcare worker or the benefits of a support team.

Theoretical Framework

Watson's Theory of Human Caring was the theory chosen as a framework for the Capstone Project. The theory's major concepts include 10 carative factors, the transpersonal caring relationship, the caring moment, and the caring-healing modalities. The 10 carative factors are: the promotion and/or assistance with a humanistic-altruistic value system, faith-hope, sensitivity to self and others, helping-trusting relationship, expression of feelings, creative problem solving, transpersonal teaching/learning, supportive environment, need for gratification, and existential-phenomenological-spiritual forces. The transpersonal caring relationship describes the intentional connection with another person through caring. The caring moment is when the nurse and another person interact. The caring-healing modalities are acts, words, behaviors,

and communication techniques used by the nurse in the process of helping the patient heal (Watson, n.d.).

Applying Watson's Theory of Human Caring to the most reported error in healthcare, medication administration can include a nurses' focus of self when administering medications using the caritas processes. The caritas processes modify the 10 carative factors and includes a spiritual dimension and is more fluid and evolutionary in language (Nelms, Jones, & Treiber, 2011). The caritas process would allow nurses to enhance their focus on self when administering medications. This can be accomplished by a quiet zone, brightly colored sashes, and signs. Caritas focuses on the nurse finding ways to stop and reflect before moving forward in patient care activities (Nelms et al., 2011). Exploring ways to reduce medication errors and improve patient care and safety is part of the nurse's practice environment and may provide resources and a practice environment free of the risk of errors.

Summary

Since 2000, there has been an increase in publications related to second victims and support systems for second victims. With the introduction of the term second victim, an increase of gray literature is available (Seys et al., 2012). Future research will be necessary to assess the effectiveness of a support program on the first, second, and third victim. Nurses are the most represented group of professionals in an institution. Organizations need to be aware of the impact an adverse event can have on a nurse and provide support (Seys et al., 2012). The outcomes of a support program on a nurse both personally and professionally may require additional research and review.

CHAPTER III

Project Description

In 1999, Linda Kenney was the victim of an adverse event. Admitted to a United States hospital for surgery, she received a nerve block that was inadvertently administered into her circulatory system. Linda went into cardiac arrest requiring open heart massage and bypass surgery to save her life. She awoke days later with tubes coming from her chest and unaware of the event that had occurred. The only conversation she had was with a physician who told her she had an allergic reaction to an anesthetic used for her surgery. Linda intuitively knew that this was not what had occurred (Tobin, 2013).

Linda was discharged home10 days later and received a letter from the anesthesiologist responsible for her care during the surgery. He was ready to talk about what had gone wrong with the surgery. Over the next six months, Linda experienced anxiety, sadness, guilt, and fear. She contacted the hospital where the event had occurred in hopes of connecting with others who had similar experiences with medical errors (Tobin, 2013). There were no resources or services available at the hospital or on the Internet. Linda believed there was a need to change the system that had failed her, her family, and the clinicians involved in her care, so she founded the Medically Induced Trauma Services (MITTS).

The organization was incorporated in 2002 and MITSS defined a medically induced trauma as an “unexpected complication due to medical/surgical procedures, medical/systems error, and other medical circumstances that affect the wellbeing of an

individual and/or family member(s)" (Tobin, 2013, para 7). Linda witnessed firsthand the emotional impact of an adverse medical error.

Over the next eight years, Linda spent her time educating clinicians, patients, and organizations on the importance of emotional support in the aftermath of an adverse medical event. Early in 2010, a group of clinicians, patient advocates, hospital leaders, and published experts formed an advisory group to assist organizations in developing a program for second victims (Kenney & Tobin, 2012). They convened and held meetings to develop a tool kit with core elements to help support patients, families, clinicians, and organizations (Kenney & Tobin, 2012). The tool kit is available to any organization developing and implementing a second victim program and response team. The tool kit can be accessed via the Internet at http://www.mitss.org.

Project Implementation

MITSS is a non-profit organization who provides support, healing, and restoration of hope to patients, families, and clinicians impacted by an adverse event (MITSS, 2002). Since 2002, MITSS has provided documents, forms and programs to the victims of an adverse event. MITSS had two documents that provided the researcher with data needed for the project. The first document was an assessment tool for the organization. (See Appendix C for MITSS Organizational Tool for Clinician Support). The assessment identifies nine core elements for an organization to consider when in the process of developing a staff support (MITSS, 2010).

There are nine core elements in the MITSS Toolkit that provided the foundation for actions directed at achieving the project goals. The core elements are as follows:

1. Assessment of the internal culture of safety
2. Organizational awareness of adverse events and the response of clinicians and staff
3. Formation of a multi-disciplinary advisory group: the HOPE Team
4. Leadership buy-in from the senior administrative team
5. Risk management considerations regarding rapid disclosure and support
6. Policies, procedures, and practices regarding the handling of adverse events and crisis management
7. Operational core element is defined by determining the who/what/when/how to activate the support mechanism
8. Dissemination/Communication plan to increase the awareness and educate employees on all levels
9. Learning and improvement opportunities for the development of strategies to continually evaluate and improve the support program (MITSS, 2002).

The researcher completed four of the nine core elements. An assessment of the internal culture of safety, the organizational awareness of adverse events, and responses of clinicians, and staff and the formation of a multi-disciplinary advisory group were the four core elements completed. The assessment of the internal culture of safety was completed in August 2012 by the Quality and Clinical Outcomes Department of the hospital. Commination openness was evidenced by the employees being honest to the patient and family as appropriate to the situation. This revealed a strong ethical responsibility (Donna Collins, personal communication, April 2, 2014). An assessment of organizational policies related to ethics and reporting of adverse patient events

revealed that the hospital has established core values of compassion and respect. On-going communication, truthfulness, and transparency are goals of all leadership.

There will always be situations that require administrative, risk/safety and legal counsel, and intervention after an adverse event, therefore guiding the employee actions and conversations. The Just Culture model allows the error to be reviewed and evaluated. The Just Culture algorithm assists the leader in determining the cause of the error and allows the error to be seen as the failure of systems and not people (MITSS, 2010).

The core element of organizational awareness was assessed through the support and approval of the Capstone Project. The researchers mentor and administrative team at the community hospital were aware of the emotional distress an adverse event can have on an employee. The hospital leadership on various levels supports the employee when an adverse event occurs. However, there was not an organized support team available to the employees and there were no policies in place to directly support clinicians and staff.

The formation of a multi-disciplinary advisory group was begun. The first step in forming a support team was to determine what formal and informal support was available inside and outside the organization. The researcher obtained a data report listing all the adverse events for a 12 month period from the Data Coordinator at the community hospital. The report listed the name of the employee, floor or unit, date of the incident, description of the adverse event, and the category of the adverse event. Since nurses were the focus of the study, all other healthcare workers were excluded from the study. The names of the nurses were compiled into a list with addresses and a survey was mailed to any nurse who had an adverse event over the last 12 months. The survey was used to assess resources for formal and informal emotional support. The researcher had a

low return rate on the survey so a reminder card was mailed and the survey remained open for an additional 13 days.

A support team was not organized. Several of the key stakeholders met regularly to discuss and develop a draft policy. Upon the close of the survey, a total of six employees logged into the survey but only four completed the survey. After reviewing the results of the survey, the key stakeholders made the recommendation not to develop the support team HOPE but to put the project on hold until May or June, 2014. At that time, a revised survey will be posted on the hospital's Learning Management System for all employees to complete.

Setting

The project took place in a 247 - bed rural community hospital with acute care and skilled nursing beds. The hospital designated in this project was one of three hospitals in the county and is located in the piedmont of North Carolina. In 2011, the county listed 162,708 people residing in the county where the study will take place (www.co.iredell.nc.us/about.aspx, 2012). The hospital involved in the study employees 1,600 people and is the second largest employer in the county. Of the 1,600 hospital employees, approximately 502 were nurses.

Project Design

The goal of the capstone project was to provide emotional support for the second victim by assisting the employee in managing responses that might threaten personal and professional identity, and cause the nurse to leave the profession. A survey was used to obtain useful, reliable and valid data (Schaeffer, Dykema, Elver, & Stevenson, 2010). The data was analyzed and conclusions drawn about the target population in order to

develop and implement a response team for second victims. The purpose of the survey and what will be done with the results was communicated to the participants. The target population was any nurse involved in an adverse patient event at Category D, E, F, G, H, or I in Medical Integrated Data Administration Solutions (MIDAS) within the last 12 months. MIDAS is a reporting and data mining system used by the community hospital. One of its functions is to record and track adverse events. The categories for events are defined as follows:

Category D – an event occurred that reached the patient and required monitoring to confirm that it resulted in no harm to the patient and/or required intervention to preclude harm.

Category E – an event occurred that may have contributed to or resulted in temporary harm to the patient and required intervention.

Category F – an event occurred that may have contributed to or resulted in temporary harm to the patient and required initial or prolonged hospitalization,

Category G – an event occurred that may have contributed to or resulted in permanent patient harm.

Category H – an event occurred that required intervention necessary to sustain life

Category I – an event occurred that may have contributed or resulted in the patient's death (MIDAS, 2010).

A second victim is a healthcare provider who is traumatized by an unanticipated adverse event or medical error and has difficulty coping with emotions (Wu, 2011).

Communication between the researcher and the participants included written correspondence, phone conversations, and face to face meetings. The identity and

personal information of the participant has been kept confidential and participation in the project was voluntary.

Protection of Human Subjects

Participants were informed on the consent form that they may choose to answer or not answer any particular question (See Appendix D Informed Consent). They had no obligation to complete answering the questions once they started. The informed consent provided the purpose of the study, subject's rights for participating in research, potential risks and benefits, and contact information for the researcher. There were no incentives to participate. The employees were free to decline participation in the study at any time. A copy of the consent form was attached to each survey. The copy remains with the participant. Consent to participate was determined by completion of the survey.

Surveys were completed in the participant's own environment. Participants were informed of their rights to participate and the informed consent form was explained. Participants were asked to complete the survey within the two weeks. Participants were asked not to include their names or any other identifying information on the survey. Completion of the survey took approximately 30 minutes.

Data for the study was collected through the two MITSS data collection instruments. The data was collected using an anonymous online survey and recorded using Microsoft Excel®. This data was analyzed using SAS® (SAS Inc., Cary, NC, USA). The P-value ($p < 0.05$) was used to define statistical significance. Raw survey data and results were stored using the researcher's computer. This computer was password protected. Any hard copies of the data were secured in a file. Data collection for the project occurred between December 1, 2013 and January 15, 2014.

There was little to no risks to the participants. Mild anxiety or distress may have occurred related to the recall of the adverse events. No deception was used and no incentives were offered. This information was also included on the informed consent form. Participants were free to discontinue their participation in the study at any point in time. The data will be kept for 10 years.

Instrument

Since 2002, MITSS has provided documents, forms, and programs to the victims of an adverse event. MITSS provides two documents that provided the researcher with data needed for the project. The first document was an assessment tool for the organization. The assessment identifies 10 core elements for an organization to consider when in the process of developing a staff support program (Medically Induced Trauma Support Services, 2010).

The second document available for use was the MITSS Staff Support Survey. (See Appendix E MITSS Staff Support Survey). The survey allows a clinician to assess the support systems presently available to staff in the organization. The survey was an anonymous, confidential survey that had six different sections (MITSS, 2010). The MITSS is divided into five sections of questions and one section for background information (MITSS, 2010).

The first section was composed of 13 questions related to the availability of services following the adverse event with the responses: actively offered, offered after I asked, found on my own, or not available. Examples of questions asked: (1) Formal support (2) Informal support, and (3) Prompt debriefing, crisis intervention stress management (either for individual or for the group/team). The second group of 13

questions asks about the use of services made available to the second victim with the responses of Yes, No, or N/A. The questions ask the same 13 questions as in the first section with a different response. The third group of 13 questions was related to the usefulness of the services with the responses of not useful, somewhat useful, useful, very useful, or N/A. These questions are the same as the first and second group of questions but with a different response. The next section was one question asking the second victim to describe and list any other forms of support offered with the responses of offered, used, found useful or would have found useful (MITSS, 2010).

Another section of 25 questions was answered based on the level of agreement or disagreement about the second victim's experiences following the adverse event. The responses are strongly disagree, disagree, agree, strongly agree, or do not know. Examples of questions asked include: (1) I was always clearly briefed about the "next steps" in the hospital's processes for following up after a serious adverse events, (2) Memories of what happened to the patient kept troubling me for a long time after the event, (3) I worried a lot about what my clinical peers would think about me after the event. The final section asks for background details about the second victim and when and where the adverse event occurred (MITSS, 2010).

The survey was returned within a designated time frame in order to compile and report data. The survey was completed by the participant using a computer, tablet, or smartphone. The survey clearly assessed the second victim's availability and use of support system already in place. The survey was confidential and the information provided would be used to provide important and sustainable staff support (MITSS, 2010).

Data collection

The goal of the Capstone Project was to provide emotional support for the second victim by assisting the employee in managing responses that might threaten personal and professional identity, and cause the nurse to leave the profession. A survey was used to obtain useful, reliable, and valid data (Schaeffer et al., 2010). The web based survey was hosted by Constant Contact, Inc. The survey and secure web link was created by the researcher based on the MITSS survey model and provided to the target group to be completed in the privacy and the convenience of each participant. The survey was completed using the participant's personal computer, tablet or smartphone.

A summary report for adverse patient events was obtained for a 12 month period from the community hospital. There were 85 reported errors and 68 nurses involved in the errors. There were four process errors that were excluded as well as one terminated employee. Termination of the employee was not related to the error. There were a total of 80 errors involving 68 nurses. Event categories used were Category D, E, F, G, H, I and provided categories for data collection of adverse patient events. Medication errors, patient falls, and patient injuries, are included summary report.

Data Analysis

The survey results were collected by the researcher and with the assistance of a statistician input into several graphs. Three different graphs were used to describe the frequency or pattern of data (Geary & Clanton, 2011). Several frequency graphs were used to describe the target population, the occurrence of an adverse event over the last five years, formal emotional support, and informal emotional support. Bar graphs are used in the analysis of data to compare and conclude information (Geary & Clanton,

2011). Only nurses involved in adverse events over the past 12 months were included in the survey. A bar graph was also used with a yes or no question regarding involvement in an adverse event over the past five years. And finally bar graphs were used to compare the availability of formal and informal emotional support.

Two cross classification charts are used for comparison. One chart compares formal emotional support over the past five years and the second one compares informal emotional support over the last five years. In May or June, 2014, when the survey is given to all employees, the same types of graphs will be used to analyze the data. The data will then be used to determine the type of support needed for the organization (MITSS, 2010).

Timeline

Capstone project HOPE was started in May, 2012 and progressed to completion May, 2014 (Figure 1).

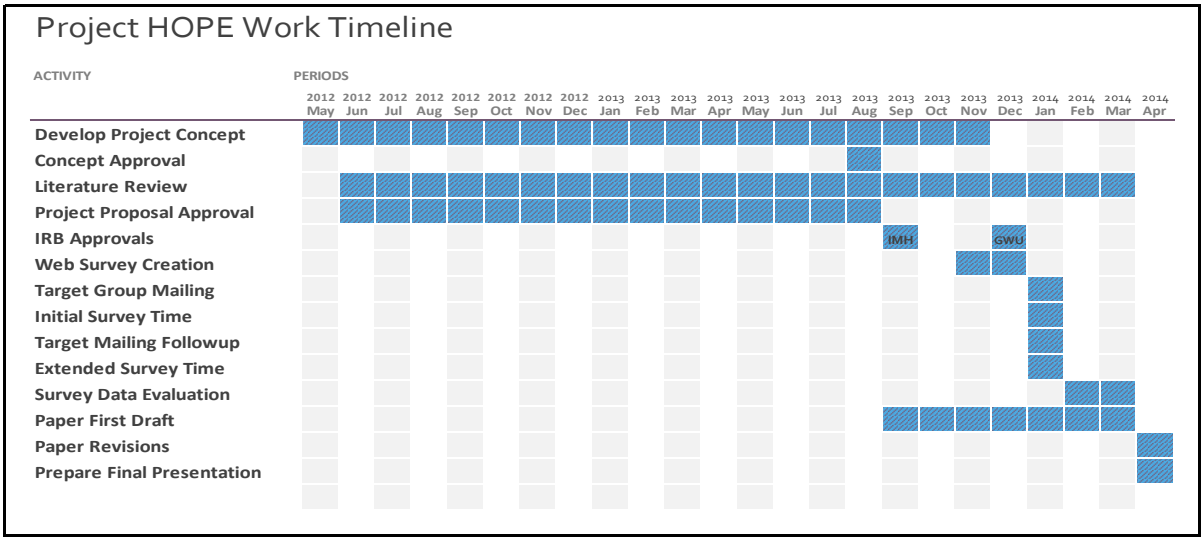

Figure 1. Project HOPE Work Timeline

Budget

Costs for the Capstone are found in the table below (Figure 2).

Cost for Capstone Project

Item	Cost	Number	Total
Paper for Informed Consent	$0.15	69	$10.35
Envelopes for letters	$0.20	69	$13.80
Postage for letters	$0.29	69	$20.01
Paper for Reminder Cards	$0.06	69	$4.14
Postage for reminder Cards	$0.34	69	$23.46
Statistician for data evaluation	$632.00	1	$632.00
Project total			$703.76

Figure 2. Cost for Capstone Project

Limitations

Even with a strong second victim program, barriers can still exist. Barriers are defined as those circumstances or obstacles that impede progress (Free dictionary, n.d.). Examples of barriers for the HOPE program include lack of support and commitment from administration or medical staff, fear of the stigma that comes with making an error, legal action following an adverse event, lack of investment in the workforce, no ongoing communication, honesty or transparency, and the adverse event being seen as a failure in people and not systems (Kenney, 2009). Examples of benefits of the HOPE program are the immediate reaction to a crisis, support and investment in the clinician, patient and organization, open communication, and safe patient care (Kenney, 2009).

Stakeholders met regularly to discuss the progress of the development and implementation of the HOPE team. Discussion at the meetings included policy and

procedure development for the HOPE team, review of the survey, a check on the culture of the hospital including morale and attitudes, trends of errors, frustrations and progress for the program were also discussed (Kenney, 2009). Discussions at other meetings with larger groups of employees were more formal and included an agenda with updates on the second victim team development process, IRB approval, and the progress of the survey. Once the surveys had been returned and the data analyzed, the researcher reviewed the results and asked for discussion and recommendations from the stakeholders and other committees invested in the success of the program. No on-going communication was identified by the stakeholders or committee members. Lack of trust, poor attitudes, and low morale were also identified as limitations to the Capstone Project.

Summary

The HOPE program will assist in increasing awareness of how to handle the effects of an adverse event in a more integrated and comprehensive manner. Included in the evaluation will be the knowledge and skill of the nurse, resources available at the time of the adverse event, leadership support, staff ratios and skill mix (Edrees et al., 2011). HOPE will allow the hospital to recognize and support healthcare workers who are involved in adverse medical error and become second victims.

An organization that invests in the emotional needs of its clinicians and staff members following an adverse event is protecting the most valuable asset, its workforce. The collateral benefits of providing support to a second victim include better communication with colleagues, patients, and families (Kenney, 2009). It will also improve staff satisfaction and willingness to report errors (Kenney, 2009). A culture of transparency and trust will be an organizational outcome that will specifically benefit the

second victim. Transparency can be defined as the visibility or accessibility of information (Kirschner, 2010). The Institute of Medicine defines transparency as "making available to the public, in a reliable and understandable manner, information on health care system's quality data so as to influence the behavior of patients, providers, payers, and others to achieve better outcomes (quality and cost of care)" (Institute of Medicine, 2001, p. 52).

The goal of the survey was to identify employees who had encountered an adverse event and assess what emotional support was available to the employees after the adverse event. In most organizations, nurses have the highest levels of direct patient care. As a result, their actions or mistakes can affect the financial performance of the organization (Hunt, 2009). By identifying the type of support the nurse had received after an adverse event, the researcher had planned to develop the support team HOPE.

The culture of an organization may have an impact on how well the second victim and patient will recover after an adverse event (Mayer, 2012). The healthcare worker will respond to the adverse event in a variety of ways. There are three most common emotional effects that may occur after an adverse event; thriving, surviving, or dropping out. These effects may occur after harm or death occurs in a patient (Mayer, 2012). If the healthcare worker thrives, they continue to care for patients with support and resources the need to recover from an adverse event. Survival after an adverse event may affect the physical or emotional health of the worker. The healthcare worker may lack the skills to recover and without support, the emotion of survival leads to dropping out of the profession. Dropping out is most likely to happen to a second victim if there is not a support team. The outcome is often dependent on how well an organization and support

systems respond to the second victim (Mayer, 2012). A support program for a second victim may provide a nurse with the resources and support to begin the healing process.

CHAPTER IV

Results

The complexity of the healthcare system and the uncertainty caused by reimbursement limitations and workforce shortages has caused healthcare workers and leaders to be challenged beyond their ability to cope. As a result of these challenges, leaders and workers are fearful of making the wrong decision or doing the wrong thing. Breakdowns and errors can be caused by poor healthcare provider performance, systematic problems, and unavailability of resources (Porter- O'Grady & Malloch, 2011).

The purpose of this project was to develop and implement a second victim support team and identify the effect of an adverse patient event on a nurse's professional identity and desire to remain in the profession. A second victim crisis response team called HOPE (Helping Others Process the Event) will provide intervention and ongoing support to the nurse who has experienced an adverse event. Prior to the development and implementation of the program, a survey was conducted to assess what processes and resources the staff perceived were in place for assistance after an adverse event.

Second victims are healthcare workers who are involved in a stressful or traumatic event. Examples of these events include: failure to rescue, an event related to a medical error, an adverse patient outcome, death, or any event that is unusually challenging. When a healthcare worker is involved in any one of the examples listed above, they become victimized by the trauma and begin second guessing their knowledge and clinical skills. Stressful or traumatic events may occur in the healthcare environment or in their personal lives (Quinn, 2012).

Sample Characteristics

The target population was any nurse involved in an adverse patient event at Category D, E, F, G, H, or I in MIDAS within a 12 month period (MIDAS, 2010). The nurses in the target population had a recorded adverse patient event between October 2012 and October 2013. A total of 85 errors were reported over the 12 month period involving 68 nurses. After reviewing the report, four of the events were considered a process error which meant it was not related to human error and one error was reported by a terminated employee. The survey had five exclusions with a total of 80 errors reported by 68 nurses.

Data for the study was collected through two data instruments. The data was recorded using an Internet based survey and was stored electronically. The survey was completely anonymous. No demographic or personal information was collected that could personally identify any of the respondents. Survey administration was provided by Constant Contact web administration portal that is only available to the researcher. This portal can be accessed with a username and password over a secure web link to Constant Contact.

The first mailing for informed consent was sent on December 31st, 2013. The survey was opened for completion on the same day and the survey was closed January 14th, 2014. A total of four surveys were completed. A second mailing was sent to notify the participants of an extension of the survey deadline of January 26th, 2014 (See Appendix F Survey Reminder). The survey was left open for an additional 13 days. At the conclusion of the second deadline an additional two participants had logged into the

survey. One participant completed the survey and one participant logged into the survey but did not complete the survey.

Major Findings

To obtain survey sample data, the researcher developed a website and posted survey/assessment questions/comment section(s). There were 69 survey/assessment questions/comment section(s) posted (See Appendix G). Out of the 69 survey questions, 68 were multiple choice questions and one question was a comment section. The comment section allowed the employee to comment using his/her own opinions and words (See Appendix H). Due to the low response on the survey, the researcher could not make a correlation using the data collected. The researcher obtained a total of six anonymous responses; four responses in the first run, and two additional responses after mailing and extension. (Figure 3)

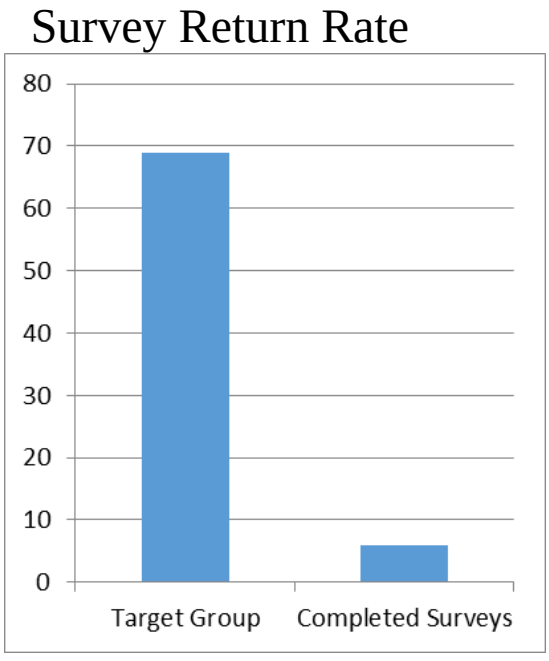

Figure 3. Survey Return Rate

Figure 3: Describes the number of surveys returned to the researcher. The low return rate makes statistical analysis difficult when choosing a standard P-value to indicate statistical significance. The returned data was analyzed using SAS® (SAS Inc., Cary, NC, USA). The P-value ($p < 0.05$) was defined to be statistically significant. The population of interest for this study was defined as nurses that have experienced adverse events during the last 12 months. There were 68 nurses involved in an adverse event. The population size was, $N = 68$.

The main hypothesis of interest was "Does a second victim response team and support program provides the nurse with emotional support needed to heal personally and professionally while remaining in the profession of nursing?"

Frequency table (Table 1) and bar graph (Figure 4) was used to describe the number of target individuals that have been involved in a serious patient adverse event in the past five years.

Table 1.

Frequency Table

In the past five years, have you ever been directly involved in a serious patient adverse event?	Frequency	Percent
No	2	33.33
Yes	4	66.67

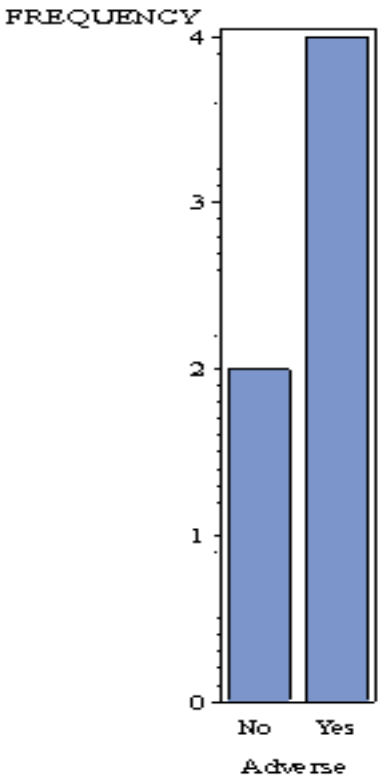

Figure 4. Occurrence of an Adverse Event in the Past Five Years

Frequency table (Table 2) and bar graph (Figure 5) was used to describe the availability of Formal Emotional Support offered to the target individuals involved in an adverse patient event.

Table 2.

Formal Emotional Support Frequency Missing =1

Formal Emotional Support	Frequency	Percent
Not Available	3	60
Offered After I Asked	2	40

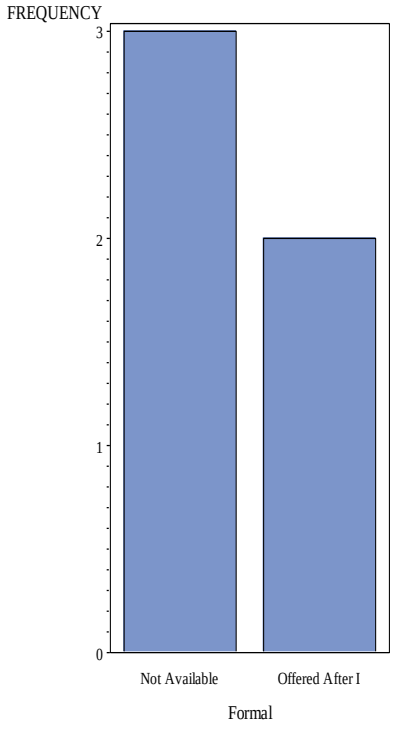

Figure 5. Bar chart for Formal Emotional Support

Formal Emotional Support

Table 3.

Cross Classification of Formal Emotional Support

	In the past five years, have you ever been directly involved in a serious patient adverse event?		
Formal Emotional Support	No	Yes	Total
Not Available	0	3	3
Offered After I Asked	1	1	2
Total	1	4	5

Cross Classification of Formal Emotional Support in the past five years, have you ever been directly involved in a serious patient adverse event? (Table 3)

The appropriate null and alternative hypotheses:

H_0: There was no statistical significant relationship between the categorical variables: "In the past five years, have you ever been directly involved in a serious patient adverse event?" And "Formal Emotional Support" (the categorical variables: "In the past five years, have you ever been directly involved in a serious patient adverse event?" And "Formal Emotional Support" are independent).

H_a: the categorical variables: "In the past five years, have you ever been directly involved in a serious patient adverse event?" And "Formal Emotional Support" are dependent.

From the Fisher's Exact Test, p-value=0.4000

Since the p-value was more than the significance level (α=0.05), we fail to reject H_0. There was not a statistical significant relationship between the categorical variables: "In the past five years, have you ever been directly involved in a serious patient adverse event?" And "Formal Emotional Support".

Informal Emotional Support

Table 4.

Cross Classification of Informal Emotional Support

Cross Classification of Informal Emotional Support by In the past five years, have you everbeen directly involved in a serious patient adverse event? (Table 4)

	In the past five years, have you ever been directly involved in a serious patient adverse event?		
Informal Emotional Support	No	Yes	Total
Actively Offered	0	2	2
Found on my own	0	1	1
Not Available	0	1	1
Offered After I Asked	1	0	1
Total	1	4	5

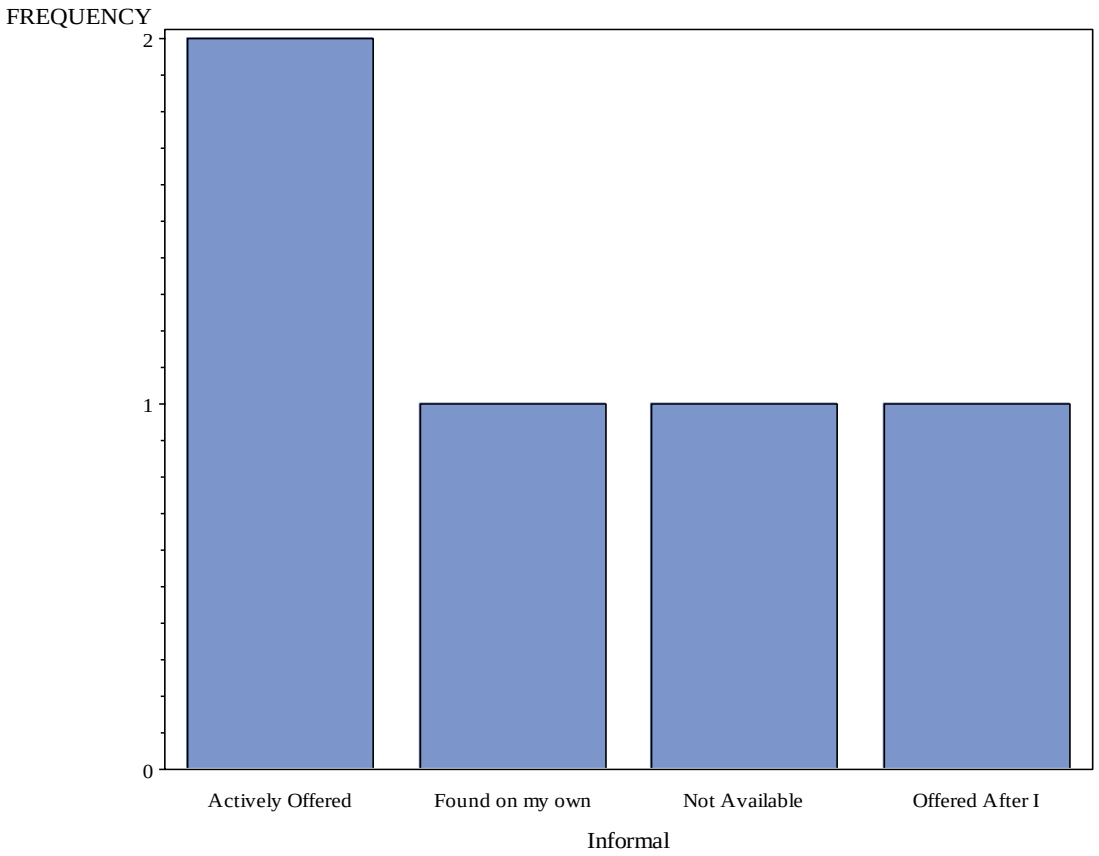

Figure 6: Bar chart for Informal Emotional Support

Table 5.

Frequency Missing=1 - Cross Classification of Informal Emotional Support by In the past five years, have you ever been directly involved in a serious patient adverse event?

	In the past five years, have you ever been directly involved in a serious patient adverse event?		
Informal Emotional Support	No	Yes	Total
Actively Offered	0	2	2
Found on my own	0	1	1
Not Available	0	1	1
Offered After I Asked	1	0	1
Total	1	4	5

The appropriate null and alternative hypotheses are:

H_0: There was no statistically significant relationship between the categorical variables: "In the past five years, have you ever been directly involved in a serious patient adverse event?" And "Informal Emotional Support" (the categorical variables: "In the past five years, have you ever been directly involved in a serious patient adverse event?" And "Informal Emotional Support" are independent).

H_a: the categorical variables: "In the past five years, have you ever been directly involved in a serious patient adverse event?" And "Informal Emotional Support" are dependent from the Fisher's Exact Test, p-value=0.6000. Since the p-value was more than the significance level (α=0.05), we fail to reject H_0. There was not a statistically

significant relationship between the categorical variables: “In the past five years, have you ever been directly involved in a serious patient adverse event?” And “Informal Emotional Support.” (Sathish Indika, personal communication, March 25, 2014). (Table 5 and Figure 6)

Summary

The collected data did not indicate that formal or informal emotional support provided the nurse any assistance required to heal personally and professionally. The survey also revealed there is not a formal support team in place for a second victim. The survey return sample size was found to be small in comparison to the target population; therefore the sample was not large enough to show statistical significance. The researcher observed that 68 nurses were recorded to have been involved with an adverse patient reaction in the past twelve months. Of those 68 nurses, all 68 or 100% of the nurses remain in the nursing profession at the same community hospital. Formalized support was offered to 60% of the respondents while informal emotional support was actively offered 40% of the time to the nurse involved in an adverse event. For the target population, there is no relationship between formal or informal emotional support for the nurse and the desire to remain in the profession of nursing.

CHAPTER V

Discussion

A nurse's competency and practice environment have implications for safe nursing practice and prevention of nursing errors. Clinical judgment errors are often associated with a nurse's knowledge deficit or the nurse's failure to recognize, interpret or monitor signs and symptoms (Board of Registration in Nursing Division of Health Professions Licensure Massachusetts Department of Public Health, 2007). The healthcare staff or second victim sustains psychological harm when they are involved in errors that injure the patient in their care (Smetzer, 2012). The purpose of this project was to develop and implement a crisis response program for the second victim called HOPE. This program would provide intervention and ongoing support to the nurse who has experienced an adverse event while identifying the effects of the adverse event on professional identity.

Implication of Findings

The review and evaluation of the type of support and resources currently available to staff after an adverse event would be an important step in development of a second victim response team. However, the findings of the survey would lead the researcher to conclude that there is not a formalized standard response for the second victim at the community hospital. The type of emotional support received was not determined by the survey and its effectiveness was not evaluated.

Application to Theoretical/Conceptual Framework

No healthcare provider intends to harm their patient or make an error. Caring for others includes assisting them to manage their health, relieving pain and distress,

restoring functionality, or assisting the patient in a peaceful death. Healthcare providers feel a sense of satisfaction and accomplishment when they assist a patient in achieving one or more of their goals. However, the healthcare worker may feel guilt and discontent when their care and patient outcomes become poor and unanticipated (Porter-O'Grady & Malloch, 2011).

The focus of the project included nurses with an adverse event recorded over a 12 month period. Medication errors were the number one adverse event occurring in the hospital where the survey for this project was conducted. Jean Watson's Theory of Human Caring was used to guide this Capstone Project. Nursing leaders and staff often use Watson's theory in clinical practice when they focus on what is taking place at a particular moment rather than the list of tasks yet to do. Nurses also apply this theory when listening to the patient and seeing the patient behind the disease. Lastly, Watson's theory is used when we show respect for our colleagues and practice good health and healing by caring for ourselves as well as others (Domrose, 2010).

Medication administration is a primary responsibility of a nurse. It is a role in which distractions and interruptions are common. Multitasking contributes to human errors and is associated with medication administration errors (Nelms et al., 2011). Hospitals around the country are asking nurses to center or focus on themselves prior to performing a procedure on a patient. Using the practice of centering has been useful for nurses administering medications as they focus on the patients' needs and care. Another practice used in the efforts to eliminate medication errors is to protect the nurse from distractions or interruptions. The use of a visible sign indicating the nurse is not to be distracted or interrupted has shown to be successful (Nelms et al., 2011).

Watson's Caring Theory, specifically her Caritas Mode,l can be applied to the interventions being used to alleviate distractions and interruptions. The focus of caritas processes for nursing is finding ways to stop and reflect on self before providing care to the patient. Three of Watson's 10 caritas processes are congruent with medication administration: (1) practicing loving kindness and composure with caring mindfulness, (2) being reliable and present, and (3) developing and maintaining a trustful, helpful, caring relationship (Nelms et al., 2011).

Practicing loving kindness and keeping one's composure includes the patient, families, fellow co-workers, and other hospital employees. To maintain composure, a nurse is to remain calm under stress. Medication administration is considered to be part of the helping and trusting care nurses give patients. Nurses must exhibit knowledge and practices to enhance the safe and accurate administration of medications (Nelms et al., 2011). The part of the caritas known as centering occurs when the nurse centers inward. This occurs before beginning any activity and before having an interaction with each new patient and family. Using Watson's framework assists nurses in working together as a team and collaborating with all levels of healthcare workers. Environments where nurses give more competent nursing care has shown to increase job satisfaction and nurse retention (Nelms et al., 2011).

The number of adverse events reported at the community hospital where the study was conducted was appropriate for this Capstone Project. Applying at least three of the ten processes of the caritas to medication errors may assist the nurse in reducing the number of medication errors, improving patient care and safety while eliminating second victimhood. Using Watson's Caring Theory for the medication errors and the patient was

congruent with her framework. However, other caritas processes can be used by the nurse and the organization involved in an adverse event. Application of the caritas process by the nurse would include being sensitive to self and others by nurturing personal beliefs and values. Promoting and accepting positive and negative feelings as you listen to patients is another example of using the caritas process (*Watson's Caring Science*, 2013).

The nurses experiencing the adverse patient event may find themselves applying other caritas processes from the list of ten. After the error has happened, the nurse may use creative scientific problem-solving methods for caring decision making. An environment for healing the physical and spiritual self with respect for human dignity is necessary for the nurse, the patient, and the organization after an adverse patient event. Watson's concept of a human being was congruent with the care necessary for the healing of all parties involved in an adverse patient event.

Watson states that a human being is "a person that is to be cared for, respected, nurtured, understood and assisted" (Watson's Theory, n.d.). She defines transpersonal as "a relationship between the nurse and another person in which the nurse both affects and is affected by the other person" (Watson's Theory, n.d.). Given the definition of a human being and the meaning of a transpersonal relationship, a nurse and the patient will be affected by the adverse event. The public sees the nurse as the most trusted healthcare professional but the public also knows that medication errors are most likely to involve a nurse. Interventions must be developed to increase public trust of the nurse when administering medications. The goal of the interventions would be to give patients and

families confidence in the safety and accuracy of nursing care received in the hospital (Nelms et al., 2011).

Limitations

The identified limitations in the Capstone Project were the survey length and return rate, the culture of the organization, the perceived lack of trust of the stakeholders, and knowledge deficit of second victim response team concept. The survey included 69 questions from the MITSS Staff Support Survey. One of the identified factors affecting response rate was the length of the survey ("Survey Shack," 2014). The shorter the survey the better; five minutes to fifteen minutes is ideal. The researcher should strive to keep the survey under 15 minutes ("Survey Shack," 2014). Keeping the survey short and simple is ideal for the participant and will provide a better return rate for the researcher.

The culture is important to an organization. An organization consists of inputs, throughputs, and outputs. All these systems that make up the environment can be healthy or toxic (Porter-O'Grady & Malloch, 2011). Delivering care is complex and emotional. Healthcare workers care for people at their most vulnerable time, requiring personal involvement and commitment on a high level. When there is a prolonged period of time where employees perceive they do not have enough staff, they are over-worked and under-appreciated; the culture becomes negative, ineffective, and destructive (Porter-O'Grady & Malloch, 2011).

Trustworthy leaders have consistency between what the employee believes, what the employee says, what the employee does, and what is morally right to do (Josephson, 2011). Characteristics of trustworthy leaders include honor, inclusion, and engagement of followers, sharing information, developing others, and moving through uncertainty.

The employees, who have a passion for the work they do and love the place they work, are committed to the organization's success ("Trustworthy Leader," 2014).

The time in which the survey was offered to the employees was at a time when morale was low, attitudes were negative, and a large electronic health records project was being implemented. A second victim support program was a new concept for the staff. Introduction of a new concept during a high stress time could lead to a lack of interest or poor participation in the program. Trusting the people on the HOPE Team was also a concern for the participants. Morale, attitudes, perceived lack of trust, a survey that took up to 30 minutes to complete, and lack of knowledge about a second victim program are the four major constraints for the Capstone Project. It was difficult to determine the type of crisis support needed in the organization due to the low return rate and feedback on the survey.

Implications for Nursing

A nurse's response, healing, and future from an adverse event is affected by the organization's response and support after the adverse event. A culture in which an error is looked upon as an opportunity for improvement and not blame or shame will require leaders to reconsider how power is perceived and used in the organization. The hospital and community benefits when adverse events are viewed as opportunities to improve services and improve patient safety. Second victims feel personally responsible for the error and patient outcome. They are overwhelmed by guilt and lack of self-confidence. Second victims run out of coping skills as they struggle to face the situation, the patient, the family and their colleagues (Dekker, 2013).

An organization should have procedures and systems in place to help the second victim deal with the aftermath of the error. Reports indicated that one in seven healthcare workers report experiencing a patient safety event within the last year that caused anxiety, depression, or doubts about performing their job (Dekker, 2013). Personal accounts from second victims reveal that the aftermath of an error is surrounded by guilt, shame, and embarrassment, as well as distancing of co-workers and anger from the organizational leaders where the error occurred (Dekker, 2013). Often times the circumstances, the people, the organizational policies, and procedures become too much for an individual to cope with.

Loss represents failure for the second victim; loss of confidence, loss of a job, loss of income, loss of a professional and psychological identity, loss of colleagues, and reputation (Dekker, 2013). The first, second, and third victims can suffer a loss. However, the second victim is set apart from the first victim by the feeling of guilt. The second victim's job was to prevent the error and keep the patient safe. The second victim creates the first victim and the third victim, placing enormous guilt on the healthcare worker. Guilt is an emotion saturated with wish and impossibility of the second victim to undo the past (Dekker, 2013).

The second and third victims must realize that the past cannot be undone but the future can be changed. In order to change the future, energy must be put into what can be changed. This means the second victim's attention should turn to their actions or omissions. However, shame as an emotion can influence change and will prompt a healthcare worker to hide or escape. The second victim may lack empathy and possess bitterness, anger, and resentment (Dekker, 2013). A second victim must be part of the

process, not the object of the process as an organization begins to investigate any adverse event.

An organization should use the ones who were closest to the event when things began to unfold and go wrong. The investigation into the event should be about the event, about learning from it, improving the conditions surrounding the event at the time the event occurred (Dekker, 2013). Offering the second victim a chance to contribute to identifying the risk and search for systematic vulnerabilities can be empowering to the second victim. The second victim wants to make a difference in the lives of their patients and in their profession.

Based on the findings from the Capstone Project, the researcher will bring the key stakeholders back to the table in two to three months to discuss an action plan. Once the action plan is developed, other stakeholders and committees will be included in the discussion. Revision of the survey, marketing of the program and involvement of the hospital Directors will be part of the roll-out. The survey will be posted in the Learning Management System (LMS) to all employees. The researcher can monitor the participation in the survey and send reminders to the employees using the LMS. The researcher will use the data collected to design and develop a second victim team to meet the origination's needs.

The Second Victim Response Team (HOPE) will focus on the second victim's immediate physiological and psychological reactions and needs. A team would assist in defusing the situation and allow the second victim to debrief. This process usually occurs 24 to 72 hours after an adverse event and is an important part of the healing process (Dekker, 2013). Support from a second victim response team can assure a second victim

that they do not stand alone and they will get social and professional support when needed allowing healing to begin.

Recommendations

Development and implementation of a Second Victim Response Team (HOPE) will allow healing for the healthcare professional and for the organization. Prevention of the consequences of being a second victim will assist the organization in becoming more resilient (Dekker, 2013). Recommendations for further study include: evaluation of the target population, inclusion of all clinical staff, evaluation of nurse staffing ratios using benchmarks and acuity levels, and preparation and buy-in of all levels of management.

The target population for the survey was any nurse involved in an adverse patient event within the last 12 months. The first recommendation would be to focus on a different target population. Healthcare workers involved in an adverse event may not be ready to reflect on a new process for support. The researcher received emails from directors whose staff had not been in the inclusion group but were inquiring about the survey and wanted to complete it. People process an adverse experience in different ways. For some, they may choose to talk and be around other people. Yet, others may decide to retreat and not talk about the experience. It is difficult to determine what group an individual involved in an adverse event will be in. Therefore, involving all clinical staff in a simple, less time consuming survey would increase the return rate and provide more data for the researcher.

Staff continues to express concern regarding staffing ratios and patient safety. Safety of both the patient and the nurse is an on-going concern that relates to staffing issues. The rising patient acuity and shortened hospital stays have created different

challenges for hospitals ("American Nurses Association Nursing World," 2014). Hospitals with low staffing levels tend to have a higher rate of poor patient outcomes. Pneumonia, shock, cardiac arrest, and urinary tract infections are related to lower nurse staffing levels (Stanton, 2004). Staffing levels have been found to directly affect the nurse, the patient, and the organization. Research related to nurse staffing has shown:

1. Lower levels of staff have been associated with more adverse events.
2. Patients have a higher acuity but the levels of the nursing staff has decline.
3. Higher acuity patients add responsibility to the nurse workload.
4. Higher levels of nurse staffing has a positive impact on the quality of care and nurse satisfaction (Stanton, 2004).

Evidence has shown that patient care is most safely delivered when there are enough RNs and RN care hours. The cost associated with an error must be balanced against the cost associated with staffing for patient care hours and an adverse event (Frith, Anderson, Tseng, & Fong, 2012).

The evaluation of a patient acuity tool to measure the nursing care for a patient would be beneficial to the organization. The staffing levels would be comparable to hours of nursing care given. The nurse does not give each patient the same hours of nursing care. An objective measurement would assist in providing evidence that the staffing ratios are sufficient or the ratios need to be adjusted. The staff nurses must be involved in staffing issues and decisions regarding their workload.

The final recommendation is to have better buy-in from all levels of management. The involvement of a house-wide education committee was the outlet the researcher chose to promote and support the project. Although the committee was very supportive,

the project needed a wider base for buy-in. If the organization has invested in their practitioners, there is a belief that they will do no harm. But if an adverse event brings a poor outcome, the organization must take action. Caring for the patient is the first step when an adverse event occurs, followed by caring and supporting the practitioner. Educating managers and staff on the psychological processes that follow an adverse event, discussing crisis and trauma reactions, identifying how to recognize the signs and symptoms of victimhood, and explaining how to provide support to the second victim are basic steps in preparing the organization for a second victim response team (Dekker, 2013).

Conclusions

When an adverse event occurs, a hospital has three priorities: to care for the patient who is the direct victim and their family members, to care for the healthcare worker involved in the adverse event, and to address the needs of the organization (American Data Network, 2013). The healthcare industry has had a long standing reluctance to address the physical and psychological needs of healthcare workers linked to undesirable outcomes. Hospitals have an ethical obligation to assist the healthcare workers heal. To replace a burned out second victim can cost a hospital in excess of $100,000 (American Data Network, 2013).

The researcher was unable to find any literature or research on community hospital based second victim response teams. The results of the search included many larger hospitals or hospital systems but no free standing community hospitals. The personal experiences of healthcare workers who experienced the second victim phenomenon in terms of prevalence, past support, and desired interventions can be

helpful in developing and implementing a second victim response team (Scott et al., 2009). There are challenges to providing support to a second victim. Many healthcare workers fear the stigma of reaching out; fear the unknown, fear of compromising the relationships of co-workers, and fear of legal woes (Scott, 2011).

When an adverse event occurs the organization should seek to provide empathy, disclosure, financial support, apology, resolution, learning, and improvement for the patient, family, and staff (Scott, 2011). Having a positive and safe working environment will influence the quality and safety of care. In preventing the undesired outcomes of adverse events, the organization is well on its way to preventing the events that create a first, second, and third victim.

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Appendix A
Development and Implementation of a Second Victim
Response Team HOPE

Iredell Health System	*Second Victim Response Team HOPE (Helping Others Process the Event)*	*Written By: Sherrie Lee, MSN, RN-BC Reviewed By:*	
	Subject **Development and Implementation of a Second Victim Repose Team HOPE**	*Date:*	September 2013
		Policy # New	Approved by:

Second Victim Response Team – HOPE

What is a Second Victim?
A second victim is a healthcare member who is involved in an unanticipated patient event, stressful situation or patient related injury and who has become hurt in the sense that he/she has become traumatized by the event.

Second victims will feel as if they have failed the patient, feel as if they are personally responsible for the outcome and question or second guess their clinical skills and knowledge.

Purpose: Provide care to employees (second victim) experiencing a normal reaction to a stressful event or outcome. Our goal is to assist healthcare members understand the second victim phenomenon and help employees return to their professional practice.

The HOPE Team will:

- Provide the second victim with a safe place to express thoughts and reactions in order to enhance coping skills.
- Ensure information shared is strictly confidential
- Provide one-on-one peer support
- Provide assurance the he/she is experiencing a normal reaction

Members: The HOPE Team is comprised of a variety of disciplines.

Meetings: HOPE meetings will be held monthly for one hour on the second Thursday of each month at 11:00am
Team Meeting will provide: reflection and review of the successes and challenges from the previous encounters provide on-going educational programs, establish a forum for the exchange of ideas and brainstorming, support team members when necessary, and increase team cohesion and provide an opportunity for members to network more effectively.

Appendix B

Permission to Use the Tool

Dear Sherrie:

Thank you for your interest. We are happy for the opportunity to share our work. Our major goal putting this Tool Kit together was to create a virtual community for us to share collective learning and to continually upgrade the tools and resources in the tool kit. To that end, we will touch back with you with 3 – 6 months. We hope at that time you will share your comments, feedback, and experience. Feel free to use anything that is in the tool kit. We have permission from everyone to make these tools available for everyone.

Good luck with your undertaking of building a program. If you have any questions, please feel free to contact me directly at any time.

Warm regards,
Linda

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Appendix C

MITSS ORGANIZATIONAL ASSESSMENT TOOL FOR CLINICIAN SUPPORT

	CORE ELEMENTS	Y	+/-	N
INTERNAL CULTURE OF SAFETY	The organization is grounded in the core values of compassion and respect and the ethical responsibility to always tell the truth to the patient and family.			
	There is an expectation for ongoing communication, honesty, and transparency that is set from the board and leadership and closely monitored.			
	Error is seen as the failure of systems and not people.			
ORGANIZATIONAL AWARENESS	It is generally accepted throughout the organization that adverse events can cause significant emotional distress to clinician(s) involved.			
	There is an expectation that clinicians at the sharp end of unanticipated outcomes and near misses will be supported.			
	There are policies in place to support clinicians and staff.			
FORMATION OF A MULTI-DISCIPLINARY ADVISORY GROUP	An environmental scan has been done to determine what supports (formal and informal) are available both inside and outside the institution.			
	Key stakeholders from various departments have been identified to determine how support will be provided in the institution.			
	A survey conducted of staff needs after an adverse event occurs has been done.			
	The type of support that might work in your particular institution has been determined.			
LEADERSHIP BUY-IN	A c-suite member is on board to champion this effort.			
	If not, the case to influence leadership buy-in has been prepared.			
RISK MANAGEMENT CONSIDERATIONS	There is an organizational commitment to rapid disclosure and support.			
	Support is provided to the clinician(s) before, during, and after the disclosure process.			
	There is a written understanding of how cases will be managed (support included) and how hand-offs will occur with staff, patients/families, organization, and malpractice carrier.			
	Consideration has been given to including the support process under privileged communications umbrella.			
POLICIES, PROCEDURES, AND PRACTICES	Policies and procedures regarding handling of adverse events are accessible to all clinicians and staff throughout the organization.			
	Organization has a crisis management plan in place.			
	Staff has been sufficiently trained about organization's crisis management plan.			
	Results of RCA's are shared with both patients and staff.			
OPERATIONAL	Research has been done regarding various support models utilized by other healthcare organizations.			
	It has been determined where support program will be anchored within the institution.			
	The who/what/when/how to activate the support mechanisms have been determined.			
	Written guidelines have been established for all clinician supporters			
	The institution has training and a tool box available for clinician supporters.			
	Internal Micro-site –Clinicians can access information about clinicians/staff program via the institution's intranet at any time.			
DISSEMINATION/ COMMUNICATION PLAN	The organization has developed a dissemination and strategic communication plan to increase awareness and educate staff at all levels re: the clinician/staff support program.			
LEARNING AND IMPROVEMENT OPPORTUNITIES	Regular meetings are scheduled to discuss the support program to determine strategies for improvement.			
	Feedback is gathered routinely from actual users of the support program.			

Appendix D

Informed Consent Form

December 31st 2013

Informed Consent Form

Study Title: Implementation of a Second Victim Response Program: HOPE Team
Investigator: Sherrie G. Lee, MSN, RN-BC

Dear Colleague,

As part of the requirements for the Doctor of Nursing Practice degree, I am conducting a study on the impact a second victim response team can have on a second victim, the nurse, involved in an adverse event. Because you are an employee of Iredell Health System and have been involved in an adverse event, I am inviting you to participate in this research study by completing the web-based survey. My research question is: "Does a second victim response team and support program provide the nurse with emotional first aid needed to heal personally and professionally while remaining in the profession of nursing?" Before you decide to participate in the study, it is important that you understand why the research is being done and what it will involve. Please take time to read the following information carefully.

The purpose of this study is to develop a crisis response program for the second victim called the HOPE (Helping Others Process the Event) Team who will provide intervention and ongoing support to the nurse who has experienced an adverse patient event. Your expected time commitment for this study is 20-30 minutes. You will be asked to complete a computerized survey and assessment. Please answer each question using your best judgment.

The risks of the study are minimal. The risks are similar to those you experience when disclosing information to others. You may decline to answer any or all of the questions and you may terminate your involvement at any time you choose. There may be risks that are not anticipated. However, every effort will be made to minimize any risks.

There will be no direct benefit to you for your participation in this study. However, I hope the information obtained from the study may support the need for a second victim response team at Iredell Health System. There is no monetary compensation to you for your participation in this study.

If you do not want to be in this study, you may chose not to participate and leave your answers blank. Your participation in this study is voluntary. It is up to you to decide whether you take part in this study. If you decide to take part in this study, your return of the survey will be considered your consent. If you decide to take part in this study, you are still free to withdraw

at any time and without giving reason. You are free to not answer any question or questions if you choose. This will not affect your employment.

Your response will be anonymous and confidential. Please do not write any identifying information on the survey. Should you have any questions about the research or any related matters, please contact the researcher at sherrie.gregory.lee@gmail.com or my professor, Dr. Anna Hamrick, DNP, FNP-C, ACHPN at ashamrick@gardner-webb.edu.

By returning the survey via computer, you confirm that you have read and understood the information; you understand that you participation is voluntary and that you are free to withdraw at any time.

To participate please enter the following address into Internet Explorer, Chrome or Firefox browser:
http://sherriegregorylee.wix.com/sherrie

Click on the **Second Victim Survey** tab to get more detailed information about the Second Victim Survey and proceed by clicking on the **Take Survey** button to begin. Please complete the survey by
January 14th, 2014.

Thank you for your participation.

Sherrie G. Lee, MSN, RN-BC

Appendix E

MITSS Survey 2010

MITSS STAFF SUPPORT ASSESSMENT TOOL

In order to assess the support mechanisms currently in place at your institution for clinicians involved in or affected by serious adverse patient events, staff can fill out the survey below. For purposes of this survey, we have defined serious adverse patient event as any unexpected, unanticipated incident that is not related to the patient's underlying condition or reason for treatment that results in harm to the patient. The event may or may not be due to medical error.

In the past 5 years, have you ever been directly involved in a serious adverse patient event? Y Δ N Δ
(E.g.: member of team caring for patient who expires during care unexpectedly, etc.)

If you have answered yes, please go on to the following sections regarding services or interventions relating to staff support. If you have been involved in more than one adverse patient event, please base your answers on your most recent experience.

For the services or interventions listed below, please indicate their availability to you following the event:	**Actively Offered**	**Offered After I Asked**	**Found on my own**	**Not Available**
For each line, please mark the one response that best reflects your experience				
Formal emotional support	O	O	O	O
Informal emotional support	O	O	O	O
Prompt debriefing, crisis intervention stress management (either for individual or for group/team)	O	O	O	O
Access to counseling, psychological or psychiatric services	O	O	O	O
An opportunity to discuss any ethical concerns you had relating to the event or the processes that were followed subsequently	O	O	O	O
An opportunity to take time out from your clinical duties	O	O	O	O
Supportive guidance/mentoring as you continued with your clinical duties	O	O	O	O
Help to communicate with the patient and/or family	O	O	O	O
Clear and timely information about the processes that are followed after serious adverse events (e.g. peer review committees, root cause analyses, preparation of incident reports)	O	O	O	O
Guidance about the roles you were expected to play in the processes that are followed after serious adverse events	O	O	O	O
Help to prepare to participate in the processes that were followed after the serious adverse event	O	O	O	O
A safe opportunity to contribute any insights you had into how similar events could be prevented in the future	O	O	O	O
Personal legal advice and support	O	O	O	O

For other forms of support please see question 4 below

For the services or interventions that were available to you following the event, please indicate whether you used any of them:	**Yes**	**No**	**N/A**
For each line, please mark one response that best reflects your experience			
Formal emotional support	O	O	O
Informal emotional support	O	O	O
Prompt debriefing, crisis intervention stress management (either for individual or for group/team)	O	O	O
Access to counseling, psychological or psychiatric services	O	O	O
An opportunity to discuss any ethical concerns you had relating to the event or the processes that were followed subsequently	O	O	O
An opportunity to take time out from your clinical duties	O	O	O
Supportive guidance/mentoring as you continued with your clinical duties	O	O	O
Help to communicate with the patient and/or family	O	O	O

Clear and timely information about the processes that are followed after serious adverse events (e.g. peer review committees, root cause analyses, preparation of incident reports)	O	O	O
Guidance about the roles you were expected to play in the processes that are followed after serious adverse events	O	O	O
Help to prepare to participate in the processes that were followed after the serious adverse event	O	O	O
A safe opportunity to contribute any insights you had into how similar events could be prevented in the future	O	O	O
Personal legal advice and support	O	O	O

For other forms of support please see question 4 below

For the services or interventions that you used please indicate how useful you found each of them:	**Not Useful**	**Somewhat Useful**	**Useful**	**Very Useful**	**N/A**
For each line, please mark the one response that best reflects your experience					
Formal emotional support	O	O	O	O	O
Informal emotional support	O	O	O	O	O
Prompt debriefing, crisis intervention stress management (either for individual or for group/team)	O	O	O	O	O
Access to counseling, psychological or psychiatric services	O	O	O	O	O
An opportunity to discuss any ethical concerns you had relating to the event or the processes that were followed subsequently	O	O	O	O	O
An opportunity to take time out from your clinical duties	O	O	O	O	O
Supportive guidance/mentoring as you continued with your clinical duties	O	O	O	O	O
Help to communicate with the patient and/or family	O	O	O	O	O
Clear and timely information about the processes that are followed after serious adverse events (e.g. peer review committees, root cause analyses, preparation of incident reports)	O	O	O	O	O
Guidance about the roles you were expected to play in the processes that are followed after serious adverse events	O	O	O	O	O
Help to prepare to participate in the processes that were followed after the serious adverse event	O	O	O	O	O
A safe opportunity to contribute any insights you had into how similar events could be prevented in the future	O	O	O	O	O
Personal legal advice and support	O	O	O	O	O

For other forms of support please see question 4 below

Other forms of support:

Were there were other forms of support that are not covered in the lists above that were offered to you, that you used, found useful or would have found useful?

Are there any other types of support, not listed above, that you were offered, used, found useful, or think you would have found useful? *Please describe briefly below and tick as many options as apply to the right*:	**offered**	**used**	**found useful**	**would have found useful**
	O	O	O	O
	O	O	O	O
	O	O	O	O
	O	O	O	O
	O	O	O	O
	O	O	O	O
	O	O	O	O
	O	O	O	O
	O	O	O	O
	O	O	O	O

Clear and timely information about the processes that are followed after serious adverse events (e.g. peer review committees, root cause analyses, preparation of incident reports)	O	O	O
Guidance about the roles you were expected to play in the processes that are followed after serious adverse events	O	O	O
Help to prepare to participate in the processes that were followed after the serious adverse event	O	O	O
A safe opportunity to contribute any insights you had into how similar events could be prevented in the future	O	O	O
Personal legal advice and support	O	O	O

For other forms of support please see question 4 below

For the services or interventions that you used please indicate how useful you found each of them:	**Not Useful**	**Somewhat Useful**	**Useful**	**Very Useful**	**N/A**
For each line, please mark the one response that best reflects your experience					
Formal emotional support	O	O	O	O	O
Informal emotional support	O	O	O	O	O
Prompt debriefing, crisis intervention stress management (either for individual or for group/team)	O	O	O	O	O
Access to counseling, psychological or psychiatric services	O	O	O	O	O
An opportunity to discuss any ethical concerns you had relating to the event or the processes that were followed subsequently	O	O	O	O	O
An opportunity to take time out from your clinical duties	O	O	O	O	O
Supportive guidance/mentoring as you continued with your clinical duties	O	O	O	O	O
Help to communicate with the patient and/or family	O	O	O	O	O
Clear and timely information about the processes that are followed after serious adverse events (e.g. peer review committees, root cause analyses, preparation of incident reports)	O	O	O	O	O
Guidance about the roles you were expected to play in the processes that are followed after serious adverse events	O	O	O	O	O
Help to prepare to participate in the processes that were followed after the serious adverse event	O	O	O	O	O
A safe opportunity to contribute any insights you had into how similar events could be prevented in the future	O	O	O	O	O
Personal legal advice and support	O	O	O	O	O

For other forms of support please see question 4 below

Other forms of support:

Were there were other forms of support that are not covered in the lists above that were offered to you, that you used, found useful or would have found useful?

Are there any other types of support, not listed above, that you were offered, used, found useful, or think you would have found useful? *Please describe briefly below and tick as many options as apply to the right*:	**offered**	**used**	**found useful**	**would have found useful**
	O	O	O	O
	O	O	O	O
	O	O	O	O
	O	O	O	O
	O	O	O	O
	O	O	O	O
	O	O	O	O
	O	O	O	O
	O	O	O	O
	O	O	O	O

Appendix F

Survey Reminder

Over the past week, you received a survey seeking your opinion about the resources available to the second victim at Iredell Memorial Hospital. Your name was chosen because you were involved in an adverse event over the last 12 months. The data collected will be used to develop and implement a second victim response team, HOPE (Helping Others Process the Event).

If you have already completed the survey, thank you very much. If not, please do so as soon as possible. The survey deadline has been extended to January 26th, 2014. I appreciate your help and remind you all the information collected will be anonymous. Thank you for being part of a project that could help all employees at Iredell Memorial Hospital.

Sincerely,

Sherrie G. Lee, MSN, RN-BC

http://sherriegregorylee.wix.com/sherrie

Click on the **Second Victim Survey** and proceed by clicking on the **Take Survey** button to begin

Appendix G

Questionnaire

Question1		Question 2				Question 3			
In the past five years, have you ever been directly involved in a serious patient adverse event?		**Formal Emotional Support**				**Informal Emotional Support**			
Yes	No	Actively Offered	Offered After I Asked	Found on my own	Not Available	Actively Offered	Offered After I Asked	Found on my own	Not Available
66.7%	33.3%	0.0%	33.3%	0.0%	50.0%	33.3%	16.7%	16.7%	16.7%

Question 4				Question 5			
Prompt debriefing, crisis intervention stress management (either for individual or group/team)				**Access to counseling, psychological, or psychiatric services**			
Actively Offered	Offered After I Asked	Found on my own	Not Available	Actively Offered	Offered After I Asked	Found on my own	Not Available
16.7%	16.7%	0.0%	50.0%	33.3%	0.0%	16.7%	33.3%

Question 6				Question 7			
An opportunity to discuss any ethical concerns you had relating to an event or the processes that were followed subsequently				**An opportunity to take time out from your clinical duties**			
Actively Offered	Offered After I Asked	Found on my own	Not Available.	Actively Offered	Offered After I Asked	Found on my own	Not available
0.0%	33.3%	16.7%	33.3%	0.0%	0.0%	16.7%	66.7%

Question 8				Question 9			
Support/guidance/mentoring as you continued with your clinical duties				**Help to communicate with the patient and/or family**			
Actively Offered	Offered After I Asked	Found on my own	Not Available	Actively Offered	Offered After I Asked	Found on my own	Not Available
0.0%	33.3%	16.7%	33.3%	0.0%	16.7%	16.7%	50.0%

Question 10				Question 11				Question 12			
Clear and timely information about the processes that are followed after serious adverse events (e.g. peer review committees, root cause analysis, preparation of incident reports.)				**Guidance about the roles you were expected to play in the processes that are followed after serious adverse events**				**Help to prepare to participate in the processes that were followed after serious adverse event**			
Actively Offered	Offered After I Asked	Found on my own	Not Available	Actively Offered	Offered After I Asked	Found on my own	Not Available	Actively Offered	Offered After I Asked	Found on my own	Not Available
33.3%	0.0%	0.0%	33.3%	50.0%	16.7%	0.0%	16.7%	50.0%	16.7%	0.0%	16.7%

Question 13				Question 14				Question 15		
A safe opportunity to contribute any insights you had into how similar events could be prevented in the future				**Personal legal advice and support**				**Formal emotional support**		
Actively Offered	Offered After I Asked	Found on my own	Not Available	Actively Offered	Offered After I Asked	Found on my own	Not Available	Yes	No	N/A
16.7%	16.7%	0.0%	50.0%	50.0%	16.7%	0.0%	16.7%	16.7%	50.0%	16.7%

Question 16			Question 17			Question 18		
Informal emotional support			**Prompt debriefing, crisis intervention stress management (either for the individual or the group)**			**Access to counseling, psychological, or psychiatric services**		
Yes	No	N/A	Yes	No	N/A	Yes	No	N/A
66.7%	0.0%	16.7%	16.7%	50.0%	16.7%	16.7%	50.0%	16.7%

Question 19			Question 20			Question 21		
An opportunity to discuss any ethical concerns you had relating to the event or the processes that were followed subsequently			**An opportunity to take time out from your clinical duties**			**Supportive guidance/mentoring as you continued with your clinical duties**		
Yes	No	N/A	Yes	No	N/A	Yes	No	N/A
33.3%	33.3%	16.7%	0.0%	50.0%	33.3%	33.3%	33.3%	16.7%

Question 22			Question 23			Question 24		
Help to communicate with the patient and/or family			**Clear and timely information about the processes that are followed after serious adverse events (e.g. peer review committees, root cause analysis, preparation of incident reports)**			**Guidance about the roles you were expected to play in the processes that are followed after serious adverse events**		
Yes	No	N/A	Yes	No	N/A	Yes	No	N/A
33.3%	16.7%	33.3%	16.7%	50.0%	16.7%	50.0%	16.7%	16.7%

Question 25			Question 26			Question 27		
Help to prepare to participate in the processes that were followed after a serious adverse event			**A safe opportunity to contribute any insights you had into how similar events could be prevented in the future**			**Personal legal advice and support**		
Yes	No	N/A	Yes	No	N/A	Yes	No	N/A
33.3%	33.3%	16.7%	16.7%	50.0%	16.7%	16.7%	50.0%	16.7%

Question 28					Question 29				
Formal emotional support					**Informal emotional support**				
Not Useful	Somewhat Useful	Useful	Very Useful	N/A	Not Useful	Somewhat Useful	Useful	Very Useful	N/A
0.0%	16.7%	16.7%	0.0%	50.0%	0.0%	16.7%	33.3%	33.3%	0.0%

Question 30			Question 31				
Prompt debriefing, crisis intervention stress management (either for individual or for group/team)			**Access to counseling, psychological services or psychiatric services**				
Not Useful	Somewhat Useful	Useful	Not Useful	Somewhat Useful	Useful	Very Useful	N/A
0.0%	16.7%	16.7%	0.0%	0.0%	16.7%	16.7%	50.0%

Question 32					Question 33				
An opportunity to discuss any ethical concerns you had relating to the event or the processes that were followed subsequently					**An opportunity to take time from your clinical duties**				
Not Useful	Somewhat Useful	Useful	Very Useful	N/A	Not Useful	Somewhat Useful	Useful	Very Useful	N/A
0.0%	0.0%	33.3%	16.7%	33.3%	0.0%	16.7%	0.0%	0.0%	66.7%

Question 34					Question 35				
Supportive guidance/mentoring as you continued with your clinical duties					**Help to communicate with the patient and/or family**				
Not Useful	Somewhat Useful	Useful	Very Useful	N/A	Not Useful	Somewhat Useful	Useful	Very Useful	N/A
0.0%	16.7%	33.3%	16.7%	16.7%	0.0%	33.3%	0.0%	16.7%	33.3%

Question 36					Question 37				
Clear and timely information about the processes that were followed after serious adverse events (e.g. peer review committees, root cause analysis, preparation of incident reports)					**Guidance about the roles you were expected to play in the processes that are followed after serious adverse events**				
Not Useful	Somewhat Useful	Useful	Very Useful	N/A	Not Useful	Somewhat Useful	Useful	Very Useful	N/A
0.0%	0.0%	33.3%	16.7%	33.3%	0.0%	16.7%	33.3%	16.7%	16.7%

Question 38					Question 39				
Help to prepare to participate in the processes that were followed after serious adverse event					**A safe opportunity to contribute any insights you had into how similar events could be prevented in the future**				
Not Useful	Somewhat Useful	Useful	Very Useful	N/A	Not Useful	Somewhat Useful	Useful	Very Useful	N/A
0.0%	0.0%	33.3%	16.7%	33.3%	0.0%	16.7%	16.7%	16.7%	33.3%

Question 40					Question 42				
Personal legal advice					**I was always clearly briefed about the 'next steps' in the hospital's processes for following up after serious adverse events**				
Not Useful	Somewhat Useful	Useful	Very Useful	N/A	Strongly Disagree	Disagree	Agree	Strongly Agree	I don't know
0.0%	0.0%	0.0%	33.3%	50.0%	33.3%	16.7%	33.3%	0.0%	0.0%

Question 43					Question 44				
Memories of what happened to the patient kept troubling me for a long time after the event					**I worried a lot about what my clinical peers would think about me after the event**				
Strongly Disagree	Disagree	Agree	Strongly Agree	I don't know	Strongly Disagree	Disagree	Agree	Strongly Agree	I don't know
0.0%	33.3%	33.3%	16.7%	0.0%	0.0%	66.7%	0.0%	16.7%	0.0%

Question 45					Question 46				
I knew how to access confidential emotional support within the institution if I needed it					**The hospital had a clear process through which I could report any concerns I had about patient safety without fear of retribution or punitive action**				
Strongly Disagree	Disagree	Agree	Strongly Agree	I don't know	Strongly Disagree	Disagree	Agree	Strongly Agree	I don't know
16.7%	16.7%	33.3%	16.7%	0.0%	16.7%	16.7%	16.7%	0.0%	16.7%

Question 47					Question 48				
I found it difficult to practice effectively after the event					**I worried a lot about a lawsuit (or the possibility of one)**				
Strongly Disagree	Disagree	Agree	Strongly Agree	I don't know	Strongly Disagree	Disagree	Agree	Strongly Agree	I don't know
33.3%	50.0%	0.0%	0.0%	0.0%	0.0%	50.0%	16.7%	16.7%	0.0%

Question 49					Question 50				
I felt (or would have felt) embarrassed about seeking psychological support after the event					**My clinical colleagues provided meaningful and sustained support after the event**				
Strongly Disagree	Disagree	Agree	Strongly Agree	I don't know	Strongly Disagree	Disagree	Agree	Strongly Agree	I don't know
0.0%	50.0%	33.3%	0.0%	0.0%	16.7%	0.0%	16.7%	50.0%	0.0%

Question 51					Question 52				
There were times I felt less able to work safely and effectively because of what happened					**My clinical line manager provided meaningful and sustained support after the event**				
Strongly Disagree	Disagree	Agree	Strongly Agree	I don't know	Strongly Disagree	Disagree	Agree	Strongly Agree	I don't know
0.0%	50.0%	33.3%	0.0%	0.0%	16.7%	16.7%	33.3%	16.7%	0.0%

Question 53					Question 54				
For a while after the event I felt shunned by some of my clinical colleagues					**My family and friends were the mainstay of my support after the event**				
Strongly Disagree	Disagree	Agree	Strongly Agree	I don't know	Strongly Disagree	Disagree	Agree	Strongly Agree	I don't know
50.0%	16.7%	16.7%	0.0%	0.0%	16.7%	16.7%	16.7%	16.7%	16.7%

Question 55					Question 56				
I moved or seriously considered moving to another institution because of the event or what happened afterwards					**I left or seriously considered leaving my profession because of the event or what happened afterwards**				
Strongly Disagree	Disagree	Agree	Strongly Agree	I don't know	Strongly Disagree	Disagree	Agree	Strongly Agree	I don't know
33.3%	0.0%	33.3%	0.0%	0.0%	50.0%	16.7%	16.7%	0.0%	0.0%

Question 57					Question 58				
I was enabled to communicate appropriately with the patient and/or family after the event					**There was a designated member of the organization who did a good job guiding me through the processes that are followed after a serious adverse event**				
Strongly Disagree	Disagree	Agree	Strongly Agree	I don't know	Strongly Disagree	Disagree	Agree	Strongly Agree	I don't know
16.7%	33.3%	33.3%	0.0%	0.0%	16.7%	16.7%	50.0%	0.0%	0.0%

Question 59					Question 60				
I felt adequately supported by the organization and associated structures					**I think that the organization learned from the event and took appropriate steps to reduce the chance of it happening again**				
Strongly Disagree	Disagree	Agree	Strongly Agree	I don't know	Strongly Disagree	Disagree	Agree	Strongly Agree	I don't know
33.3%	16.7%	33.3%	0.0%	0.0%	0.0%	33.3%	16.7%	0.0%	33.3%

Question 61					Question 62				
I feared having to speak to the patient and/or family					**I had the opportunity to speak to the patient and/or family**				
Strongly Disagree	Disagree	Agree	Strongly Agree	I don't know	Strongly Disagree	Disagree	Agree	Strongly Agree	I don't know
0.0%	33.3%	16.7%	33.3%	0.0%	16.7%	33.3%	16.7%	16.7%	0.0%

Question 63					Question 64				
I wanted to speak to the patient and/or family but was told not to do so					**I was supported trained in how to disclose to the patient and or family**				
Strongly Disagree	Disagree	Agree	Strongly Agree	I don't know	Strongly Disagree	Disagree	Agree	Strongly Agree	I don't know
33.3%	0.0%	50.0%	0.0%	0.0%	33.3%	16.7%	16.7%	0.0%	16.7%

Question 65					Question 66				
I had extreme anxiety about disclosing to the patient and/or family					**The organization ensured the need of the patient and/or family after the event were appropriately met**				
Strongly Disagree	Disagree	Agree	Strongly Agree	I don't know	Strongly Disagree	Disagree	Agree	Strongly Agree	I don't know
0.0%	16.7%	0.0%	33.3%	33.3%	0.0%	0.0%	33.3%	0.0%	50.0%

Question 67			Question 68			Question 69			
The adverse event occurred:			**Since then, do you think support for clinicians involved in serious adverse events in the organization in which it occurred has:**			**Which of the following best describes your profession**			
Less than 1 year ago	Between 1 and 3 years ago	More than three years ago	Improved	Stayed about the same	Got worse	Nurse	Pharmacist	Physician	Other
50.0%	0.0%	33.3%	33.3%	50.0%	0.0%	83.3%	0.0%	0.0%	0.0%

Appendix H

Comment Section

Is there any other type of support, not listed above, that you were offered, used, found useful, or think you would have found useful?
Peer support is always available and is the main source of debriefing. This does prove useful when better medical responses can be determined. Improvements are rarely found in most of the situations I have experienced but emotions are involved and need to be under control.
no response
no response
No formal support offered. Fellow staff members offered support. I received no follow up.
An outpouring of support from both colleagues and administration.
no response