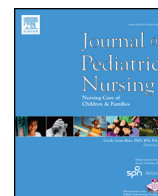




Contents lists available at ScienceDirect

Journal of Pediatric Nursing



Case: A Second Victim Support Program in Pediatrics: Successes and Challenges to Implementation

Vadim Dukhanin, MD, MHS^a, Hanan H. Edrees, DrPH, MHSA^{a,b}, Cheryl A. Connors, MS, RN, NEA-BC^c, Eric Kang, BA^e, Matt Norvell, MDiv, MS, BCC^d, Albert W. Wu, MD, MPH^{a,c,*}

^a Department of Health Policy and Management, Johns Hopkins Bloomberg School of Public Health, Baltimore, MD, USA

^b National Guard Health Affairs, Quality Management, King Abdullah International Medical Research Center, King Saud bin Abdulaziz University for Health Sciences, Riyadh, Saudi Arabia

^c Johns Hopkins Armstrong Institute for Patient Safety and Quality, Baltimore, MD, USA

^d Johns Hopkins Hospital, Baltimore, MD, USA

^e Krieger School of Arts and Sciences, Johns Hopkins University, Baltimore, MD, USA

ARTICLE INFO

Article history:

Received 17 July 2017

Revised 11 January 2018

Accepted 11 January 2018

Available online xxx

Keywords:

Second victim

Medical error

Patient safety

Burnout

Organizational culture

Organizational support

ABSTRACT

Purpose: While there is growing attention to making health care safer, there has been less emphasis on helping health care workers to cope with stressful patient related events (these workers are commonly referred to as second victims). We used the RISE (Resilience In Stressful Events) peer support program at the Johns Hopkins Hospital as a case study for evaluating effectiveness, and identifying barriers to addressing the needs of second victims.

Design and Methods: The study used a mixed-method approach that included: 1) quantitative analysis of surveys of health care workers in the Department of Pediatrics before RISE implementation and four years after, and 2) content analysis of open-ended commentaries about respondents' experience with seeking second victim support, as well as feedback on RISE.

Results: Survey response rates were 22.4% and 23.3% respectively. Quantitative analysis showed that respondents at the later time point were more likely to contact an organizational support structure, and had greater awareness of the availability of support. Respondents were very likely (93%) to recommend RISE to others. Content analysis identified barriers to using RISE: overcoming blame culture, need to promote the initiative, and need for more staff time to handle adverse events. Respondents reported varied preferences for the support format and specific support interventions.

Conclusions: The mixed-method approach allowed a comprehensive evaluation of RISE and provided some evidence for its effectiveness in supporting pediatric health care workers.

Practice Implications: The findings suggest an important role of organizational culture in second victim support program implementation and evaluation.

© 2018 Elsevier Inc. All rights reserved.

Introduction

Medical errors and adverse events in health care have a significant impact on patients, health care organizations and health care providers (Kohn, Corrigan, & Donaldson, 2000). Involvement in adverse events can traumatize health care providers, leaving them emotionally distressed and insecure about their professional competence. These providers are commonly referred to “second victims” of adverse events, and may benefit from institutional and peer support to help them recover (Edrees, Paine, Feroli, & Wu, 2011; Scott et al., 2009; Wu, 2000). In response to this problem, the Joint Commission and the National

Quality Forum have recommended that health care institutions establish support structures to help health care workers recover after traumatic events in the workplace (Joint Commission, 2010; National Quality Forum, 2010).

A few organizations have created programs and institutional support structures to address the second victim problem (Krzan, Merandi, Morvay, & Mirtallo, 2015; Pratt, Kenney, Scott, & Wu, 2012; Scott et al., 2010). Several factors appear to promote successful implementation (Krzan et al., 2015; Scott et al., 2010; Waring, 2005). In general, a “culture of safety” is necessary to implement patient safety initiatives (Pronovost et al., 2005). However, some health care organizations are better described as possessing a “culture of blame” in which there is a norm of blame and punishment in the wake of adverse events (Waring, 2005). This poses a challenge to implementing patient safety programs (Pratt et al., 2012; Waring, 2005).

* Corresponding author at: 624 N. Broadway, Room 653, Baltimore, MD 21205, USA.
E-mail address: awu@jhu.edu (A.W. Wu).

There have been a few descriptions of support programs for second victims, accompanied by documentation of the design process (Edrees, Connors et al., 2016; Krzan et al., 2015; Scott et al., 2010). However, there is still a need to develop methods for evaluating the effectiveness of second victim peer-support programs (Edrees, Connors, et al., 2016; Pratt et al., 2012). To fill this gap, this paper describes an approach taken to evaluate the RISE (Resilience In Stressful Events) second victim program in the Department of Pediatrics at a large teaching hospital.

The RISE Second Victim Support Program

RISE is a peer support program for hospital workers that was pilot tested in the Johns Hopkins Hospital (JHH) Department of Pediatrics in 2011–2012. The Department of Pediatrics is one of the divisions of a 1075-bed, urban, academic medical center in the Mid-Atlantic region of the US. Pediatrics was selected for the pilot in part because several second victims were identified after the tragic and highly publicized death of Josie King there in 2001 (King, 2009). In addition, there are indications that pediatric staff have a special vulnerability to psychological trauma in cases of a child's death (dos Santos & Moreira, 2014), and leaders in the department were supportive of the program aimed to address their staff needs.

The mission of RISE is to provide timely support to employees who encounter stressful patient-related events - defined as including adverse events, medical errors, deaths, unexpected outcomes, non-accidental trauma, and difficult or violent interactions. Support is offered 24 hours per day and seven days per week in a peer-to-peer or group format depending on the request. The support is provided by peers: colleagues who work in the hospital environment and who have been trained to provide appropriate support. The service is designed to complement other hospital assistance programs, such as the existing Faculty and Staff Assistance Program, by providing a safe and confidential psychological first aid and emotional support. Notably, 63% of the volunteered peer-responders are nurses, and 50% are from the Department of Pediatrics (Edrees, Connors, et al., 2016).

A review of the Josie King incident emphasized the need for additional support of health care workers. The JHH's leadership made a commitment to support its providers and strive to promote a blame-free culture. Leaders identified as one of the RISE goals to "foster a culture in which all employees were resilient and mutually supportive before, during and after stressful events." RISE launched an awareness campaign that included a dedicated website, promotional videos, internal publications, screen savers on clinical computer workstations, presentations to clinical units, and recruiting unit-level champions. As of June 2012, RISE was extended to the other departments in the hospital.

The purpose of this paper is to describe the approach taken to evaluate a second victim program, using as an example the successes and barriers of implementing RISE.

Methods

Overview

The design was a mixed-method evaluation using: 1) quantitative analysis of two consecutive staff surveys and 2) content analysis of responses to open-ended questions on the surveys. The RISE development team made a deliberate decision not to collect data directly from those health care workers who made calls to RISE in consideration of the vulnerable emotional state of callers, and to preserve the confidentiality of the service. Therefore, as part of the evaluation, the RISE development team created an anonymous survey to be administered to all department workers to better understand their second victim experiences collectively. Approval for the study was obtained from the Johns Hopkins Institutional Review Board.

Survey Design, Setting, Sample and Recruitment

Invitations to participate in a pre-implementation online survey were sent in October 2011 using an email address list that included all Department of Pediatrics employees (approximately 900 people). The email invitation described the purpose of the survey, indicated that the survey completion constituted the consent to participate, and noted that the participation was voluntary and anonymous. The provided link led to a survey hosted online at SurveyMonkey™ (SurveyMonkey Inc. 2015. www.surveymonkey.com. Palo Alto, California, USA) where it was available for 4 weeks. The respondents were given the option to skip any question. A reminder email was sent to the original email addresses on the second week.

The survey included newly developed questions drawing from a review of relevant literature on conceptual frameworks for health care worker support and related surveys (Edrees, Brock et al., 2016; White et al., 2015; Appendix A1). The questions assessed pediatric health care workers' awareness of the second victim problem, their willingness to reach out for organizational support, and the staff's perceptions on the type of support that should be offered. The survey was reviewed and revised through an iterative process involving the development team and subject-matter experts in patient safety, clinical services, risk management, and pastoral care.

The second survey, building upon the first, was designed as follow-up evaluation, and was administered 4 years after the original survey. Additional questions were included to gather staff feedback on RISE and utilization of its services (Appendix A2). The survey invitations were sent in December 2014 using the all-department employees' email list and the same survey administration procedures. The survey was available for 11 weeks.

Survey Data Analysis

Data from the surveys were downloaded from SurveyMonkey™ as portable document format (PDF) texts. We used descriptive statistics to analyze survey responders' demographic characteristics. We calculated proportions for the quantitative responses, which included categorical/multiple choice and Likert-type scale questions (1 = strongly disagree; 5 = strongly agree) and counts. The Chi-square test was used to evaluate the difference in those proportions between the two survey's responses as well as between physicians and nurses' responses in the 4-year follow-up. Differences were considered statistically significant at $p \leq .05$. Stata 14 software was used for the statistical analysis (StataCorp. 2015. Stata Statistical Software: Release 14. College Station, TX: StataCorp LP).

The open-ended responses included respondents' reflections on helpful and unhelpful features, desired features and services of an organizational support program, and feedback on the RISE program itself based on personal or indirect experience. Responses were reviewed independently by three researchers (HE, EK, MN) using content analysis and standard qualitative analysis methods (Malterud, 2001). Codes were assigned for each individual response and themes were generated accordingly. Disagreements in coding between the researchers were resolved by consensus and a mediating party (VD). Frequencies of common responses were calculated as percentages.

Results

Respondent Characteristics

All employees in the Department of Pediatrics, approximately 900 people, were invited to complete the pre-implementation survey and the 4-year follow-up survey; the estimated response rates were 22.4% and 23.3%, respectively. The composition of respondents from the baseline survey was not available. Among respondents to the follow-up survey, 49% were nurses, 20% physicians, 10% managers and 21% others.

Download English Version:

<https://daneshyari.com/en/article/8573792>

Download Persian Version:

<https://daneshyari.com/article/8573792>

[Daneshyari.com](https://daneshyari.com)