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Reducing the Second Victim Phenomenon: Promoting Healing with Caritas Coaching

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DNP Project

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Section I. Title and Abstract

Reducing the Second Victim Phenomenon: Promoting Healing with Caritas Coaching

Abstract

Problem: The second victim phenomenon is one in which healthcare providers use dysfunctional mechanisms, such as anger, projection of blame, or drugs and/or alcohol to cope with serious mistakes in the absence of a healthier means for healing (Wu, 2000). This phenomenon can be caused by adverse events or other personal/professional crises and can lead to healthcare professional absenteeism, leaving the job or leaving the profession altogether (Burlison et al., 2018; Hirschinger et al., 2015).

Context: The second victim phenomenon was identified as a problem within this DNP student's organization and support was obtained for conducting the project. A conceptual framework was designed using Watson's theory of transpersonal caring science, Conti-O'Hare's theory of nurse as wounded healer, and Scott's three-tier interventional model of second victim support. This framework guided the provisions of support to clinical employees following an adverse traumatic clinical event and/or other personal or professional crises.

Interventions: This project consisted of the development of a Caritas peer support program wherein Caritas first aid was provided to clinicians following adverse traumatic clinical events or personal/professional crises.

Measures: Qualitative and quantitative methods were utilized to collect data through surveys, meetings, and interviews with clinical employees throughout the course of this project.

Results: This DNP project utilized authentic transpersonal caring practices to support clinician wellbeing.

Section II. Introduction

There is a silent epidemic growing in our healthcare organizations: the second victim phenomenon. The National Academy of Medicine or NAM (2000) began a movement to bring this problem to light in their report: *To Err is Human: Building a Safer Health System*. In that same year, Wu (2000) cited the lack of organizational systems aiding in the grieving process of physicians who make mistakes. In the absence of such systems, physicians who make errors can respond with anger, projection of blame, and scolding of staff and patients. Such behaviors reveal the deep wounds caused by these errors that may lead to burnout and drug or alcohol overuse. Work by the National Academy of Medicine's *Action Collaborative on Clinician Well-Being and Resilience* has shown that these behaviors are not isolated to physicians alone, but also occur among nurses and other healthcare professionals (NAM, 2018). Wu (2000) was the first person to use the term *Second Victim* to describe this phenomenon and it has slowly gained momentum as healthcare providers and researchers attempt to understand and create systems and processes to prevent and alleviate it in our healthcare system.

Problem Description

The setting for this DNP project is a for-profit level I trauma center with medically complex patient populations. It has 535 beds within the main hospital, rehabilitation hospital, behavioral health hospital, and a long-term care facility on its 42-acre campus. Clinical services provided include a 24-hour emergency room and behavioral health emergency room, advanced cardiovascular care, a comprehensive stroke center, a neurosciences department, behavioral health services, inpatient and outpatient rehabilitative services, a center for advanced orthopedic care, wound treatment center, and dream sleep disorder center among many other services. In 2017, this level I trauma center had 18,447 admissions and 88,084 outpatient visits.

The second victim phenomenon was identified as a problem within this DNP student's organization. The recognition of this phenomenon followed recent organizational events, past culture, the need for best practice strategies to support clinical employees following an adverse event, and the recognition of the problem by the National Academy of Medicine's *Action Collaborative on Clinician Well-Being and Resilience* (NAM, 2018). Burnout and compassion fatigue were identified through interviews with clinicians and leaders in this DNP student's organization. A lack of feeling supported by leadership on a day-to-day basis leaves employees feeling they are not supported when errors occur or when adverse events happen, all of which can lead to the second victim phenomenon (Wu, 2000).

A gap analysis for this project was done and showed transactional leadership, blaming of clinicians for errors, lack of support for clinicians, and lack of a crisis management plan for supporting clinicians following adverse traumatic clinical events. The gap analysis for this project is located in Appendix A.

Available Knowledge

There is currently no national benchmark data on the second victim phenomenon in our national healthcare system. There is also no collected data in the DNP student's organization on this phenomenon. The PICOT question to direct the search for evidence for this project was: In a Level I Trauma Center, how does a Caritas peer support program decrease second victim symptoms and support employee satisfaction following an adverse traumatic clinical event over four months?

Summary of Evidence. A systematic search of the evidence was conducted using the computerized databases of CINHAL Complete, Health Source: Nursing/Academic Edition, PubMed and Cochrane Database of Systemic Reviews. The term *second victim phenomenon*

was used to guide the search. The initial search in 2018 looked at evidence published between 2010 to 2018 with the term *second victim phenomenon* in the abstract and yielded 20 publications. A second search of the evidence was done in 2020 to update the literature review and looked at evidence published between 2018 to 2020 with *second victim phenomenon* in the abstract and yielded seven new publications. Publications were included in this review if they studied and discussed the definition of the second victim phenomenon, causes of the second victim phenomenon, the experience of the clinician experiencing the second victim phenomenon, and/or support mechanisms to support clinicians following an adverse traumatic clinical event. Publications were excluded if they did not meet the criteria of high-quality evidence as measured by the Johns Hopkins Research Evidence Appraisal Tools (Dearholt & Dang, 2018). These tools use evidence-based rating scales to appraise the level and quality of research (Schaffer at al., 2013). Seven articles met all of these criteria and were selected for inclusion in this project. A critique of these reviews is depicted in an Evaluation Table (Appendix B) and in an Evidence Synthesis Table (Appendix C).

Definition of the Second Victim. There have been several definitions of the *second victim* in the literature since Wu (2000) first wrote about it. Each of the articles selected for this review gave one or more definitions with an in-depth description. However, the definition given by Scott et al. (2010) has become the most widely used definition:

> A second victim is a health care provider involved in an unanticipated adverse patient event, medical error and/or a patient-related injury who become victimized in the sense that the provider is traumatized by the event. Frequently, second victims feel personally responsible for the unexpected patient outcomes and feel as though they have failed their

patients, second-guessing their clinical skills and knowledge base (Scott et al., 2010, p. 233).

Prevalence, Symptoms, and Impact of the Second Victim Phenomenon. The prevalence of the second victim phenomenon is a growing problem in our increasingly complex healthcare system. Prevalence rates from this review range from 2.5% to high (Cabilan & Kynoch, 2017; Lewis et al., 2015; Seys et al., 2012). The symptoms found in healthcare professionals who are second victims can manifest as stress, anxiety, depression, worry, shame, inadequacy, difficulty concentrating, and guilt (Miller et al., 2019). These symptoms and their degree of severity are related to the outcome of the error, the degree of personal responsibility the clinician holds for the event, and the support the clinician receives in order to aid them in recovering from the event (Seys et al., 2012; Miller et al., 2019).

Cabilan & Kynoch (2017) point out that there is minimal published evidence of the second victim phenomenon in nursing. This is a great concern given the impact the second victim phenomenon can have on not only the nursing professional, but also the patient. The symptoms of the second victim phenomenon can lead clinicians to make medical errors and increases their risk for deciding to leave their organization or their professional all together (Miller et al., 2019).

Strategies to Reduce the Second Victim Phenomenon. Disclosing facts to patients following an adverse event can reduce the impact of the second victim phenomenon (Lewis et al., 2015). It is important to support the clinician who is involved in an adverse traumatic clinical event and to disclose the results of the event to patients in order to bring closure and healing to the clinician (Cabilan & Kynoch, 2017). A comprehensive study done at Johns Hopkins Hospital, using the RISE (Resilience in Stressful Events) peer support programme,

found the importance of healthcare organizations developing support systems within the healthcare organization to help healthcare professionals handle and deal with traumatic medical and nursing events (Edrees et al., 2016).

A strategy that is not new in the care of patients, but novel in the care of second victims, is mindfulness-based interventions. This is a strategy supported by Watson (2018a), and taught by colleagues within the Watson Caring Science Institute (2020) in their free online course *Caring Science, Mindful Practice*. The practices of mindfulness during the recovery stages of the second victim experience have been found to have the potential to increase the resilience of clinicians by positively impacting their state of mind, altering how they view themselves, and empowering them to move beyond the event (Miller et al., 2019).

These findings highlight the importance of supportive interventions for healthcare professionals following an adverse event and the need for national and local quality improvement initiatives regarding the second victim phenomenon. In the absence of these types of supportive programs for healthcare professionals following adverse events, the healthcare organization itself can become the third victim through the financial cost of the error, losing clinical employees, and through an increase of errors in care (Seys et al., 2012).

Rationale

Since Dr. Albert Wu's initial identification of the second victim in 2000, there has been a growing body of research and evidence on this phenomenon within the U.S. national healthcare system. One finding identified is that healthcare professionals often experience physical and emotional distress following an adverse event. This often leads to future errors and adverse events within the healthcare system if the clinician is not supported at the personal and/or organization level through organizational support programs (Seys et al., 2012).

Framework. Watson's theory of Human Caring Science (Watson, 2012a), Conti-O'Hare's theory of the Nurse as Wounded Healer (Conti-O'Hare, 2002), and Scott's Three-tier Interventional Model of Second Victim Support (Scott et al., 2010) were used to form the conceptual framework that guided this project. Each of these theories/models will be described in detail.

Theory of Human Caring Science. The core aspects of Watson's (2012b) Theory of Human Caring Science include: 1) relational caring as ethical-moral-philosophical values-guided foundation; 2) caring core:10 caritas factors/caritas processes-love-heart-centered caring/compassion; 3) transpersonal caring moment-the caritas field; 4) caring as consciousness-energy-intentionality-heart-centered human presence; and 5) caring healing modalities. These core aspects of the science of human caring and the human caring relationship supported the goals of this project. This theory has been utilized by healthcare leaders, most prominently seen in Kaiser Permanente Northern California's Patient Care Delivery Services, to make systems changes that have positively impacted the care delivered to patients and the culture of the healthcare system itself (Durant et al., 2015).

Theory of the Nurse as Wounded Healer. The three core concepts of Dr. Marion Conti-O'Hare's (2002) Theory of the Nurse as Wounded Healer include: 1) reflective practice or reflecting on the trauma as the first step toward exposing the pain; 2) transformation or expanding the consciousness to generate insight into patterns of behavior following the trauma; and 3) transcendence, or as Maslow equated this experience, self-actualization (D'Souza & Gurin, 2016). Conti-O'Hare (2002) points out that transcendence of a trauma's aftereffects must take place before healing can occur through self in others.

Scott's Three-Tier Interventional Model of Second Victim Support. The Three-Tier

Interventional Model of Second Victim Support guides how to support these clinicians within three different tiers, each of which identifies the type of support and who will provide it (Scott et al., 2010). Tier one support is offered immediately following an adverse clinical event by unit leaders and peers to reduce possible second victim responses following an event. Tier two support is provided by trained peer supporters who provide one-on-one crisis intervention, peer support mentoring, team debriefings, and support for clinicians who are showing signs and symptoms of the second victim response. Tier three support is provided within an organizational established referral network that can include an employee assistance program, chaplain, social worker, or clinical psychologist to support the second victim when their emotional stress response escalates to a point outside the expertise of the peer support team (Scott et al., 2010).

Together, the theories of Watson and Conti-O'Hare along with Scott's model make up the conceptual framework that guided each phase of this project. The core aspects of Watson's (2012b) theory were used to help understand, transform, and transcend the trauma experienced as described in Conti-O'Hare's (2002) theory and Scott's model was used to provide caring strategies.

Specific Aims

The purpose of this project was to reduce the second victim phenomenon in healthcare professionals and enhance staff well-being following adverse traumatic clinical events within a level one trauma center.

AIM Statement. The AIM statement for this project was: By January of 2020, a system utilizing caring science and led by a Caritas Coach to support professionals following adverse traumatic clinical events will be implemented and evaluated to reduce the effects of the second victim phenomenon in this DNP student's organization. A description of the Caritas Coach

Education Program can be found in Appendix D and the DNP Statement of Non-Research Determination Form can be found in Appendix E.

Section III. Methods

Three project tools and a communication plan guided this change of practice project. The tools included a SWOT analysis, a GANTT chart, and a work breakdown structure (WBS).

The GANTT chart provides a graphical outline in a horizontal bar chart that can be used to plan a project or improvement initiative (Nelson et al., 2007). The GANTT chart for this project can be found in Appendix F.

The WBS portrays the scope of a project and how objectives and goals of a project will be met (Moran et al., 2017). The WBS for this project can be found in Appendix G.

The communication plan provides a structured outline of how communication will occur during the project (Moran et al., 2017). In order for a project to be successful, there must be a sustainable communication plan. The communication plan for this project involved key stakeholders including members of senior leadership, human resources leadership, house nursing supervisors, department/unit directors and managers, assistant nurse managers and clinical and non-clinical employees.

The goals of the communication plan were: (a) timely communication of a traumatic clinical event to the Caritas Coach or designated member of the Caritas peer support team, (b) timely communication of steps taken by the Caritas Peer Support Team to the department director, unit manager, and director of risk management, and (c) timely follow-up with the second victim by the Caritas Coach or designated member of the Caritas peer support team. A copy of this project's communication plan including member contact list and event log can be found in Appendix H.

Context

Through the offering of support to clinicians following an adverse traumatic clinical event, organizations can reduce the likelihood of the clinician developing the second victim phenomenon and can also reduce the severity of this phenomenon (Burlison et al., 2017).

One of the executive sponsors of this project was the director of risk management who aided in supporting its success. The letter of support for this project was obtained from the organizations chief nursing officer and can be found in Appendix I. Other key stakeholders for this project included clinical and patient care teams, patients, the project team, and hospital leaders including departmental and unit leaders, human resource leaders, patient safety and patient experience departments, and the department of clinical quality. The stakeholder analysis for this project can be found in Appendix J.

A safety event report is initiated in the DNP students organization using an electronic medical record system when there is an adverse event that causes harm or near-harm to patients. These reports include the type of event, information related to the event, and the organization staff, both clinical and non-clinical, that were involved in the event. There is a reporting ladder for reporting the event. This consists of the nurse or clinician involved in the event reporting it to their direct supervisor who then moves the communication of the event up the ladder as necessary. For this project, notification of the DNP student was added to this ladder so that support could be initiated with those who were involved in the event.

This DNP student was invited to attend daily safety huddles in the organization. These meetings include executive leadership, leaders from human resources and other non-clinical areas, and directors and managers from each clinical department. The introduction of the DNP student as the Project Director to these leaders influenced their involvement in the project.

Through discussions between the Project Director and these leaders it was evident that many were aware of the need for a program to support clinical employees but there was also hesitation by some to get involved in the project.

This hesitation was evident with a director who is no longer with the organization but who had given presentations on compassion fatigue in our organization. Upon meeting with her, the Project Director was told that the organization had been down this road in the past and she was unconvinced that anything would change in the future. Other meetings with hospital leaders revealed the same hesitancy to become involved in this project because of past attempts to do similar work that had failed. Due to these identified issues from the past, the Project Director relied on support from the director of risk management and the few nurses from PNPC who the Project Director was able to recruit for the project.

Interventions

This project consisted of developing a Caritas peer support program. This program was based on the findings of Burlison et al., (2017), Scott et al., (2010), and Merandi et al., (2017) and was developed to support clinicians following an adverse traumatic clinical event. A Caritas Peer Support Program Committee (CPSP) was developed from Professional Nurse Practice Council (PNPC) members that included nurse leaders, unit nurses, and other nurses and healthcare professionals from hospital leadership, education, quality management, patient safety, and patient experience departments. Members of the CPSP convened throughout this project to review and reflect on second victim cases and make recommendations pertaining to the program.

Training of Caritas Peer Responders. Practices of psychological first aid, first developed by the Center for the Study of Traumatic Stress (2019) to help victims in the immediate aftermath of a disaster, were utilized for training Caritas peer responders. These

practices have been adopted by the U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration (2019) for use with emergency and disaster response workers.

The Center for the Study of Traumatic Stress (2019) has recognized the healthcare provider or first responder to a disaster area or event as another victim of the event that needs help too, mirroring the second victim phenomenon. Their team of experts developed primary objectives of psychological first aid: (a) safety, (b) calm, (c) connectedness, (d) self-efficacy or empowerment, and (e) hope. Their recommendations on how to meet these goals when meeting with a victim were integrated into a Caritas Peer Support Training Manual developed for this project to train Caritas peer responders and can be found in Appendix K.

Caritas Peer Support Meeting. The Caritas Coach (DNP student and Project Director) or another trained peer responder met with clinicians who were involved in adverse traumatic clinical events in a one-on-one, nonjudgmental and non-threatening manner within seventy-two hours of the event using the Scott three-tier interventional model of second victim support to guide the meeting. Evidence from the RISE Second Victim Support programme demonstrated that individuals preferred individual support as compared to group support and when group support was offered, they preferred multidisciplinary group support (Edrees et al., 2016). The Scott three-tiered intervention model can be found in Appendix L.

The Caritas peer support meeting was guided by the *Transpersonal Caring Moment Guide*, a tool developed for this project utilizing the work of Scott (2014) and concepts from Watson's (2018b) transpersonal caring science and unitary caring science. The result is a guide that embraces the teachings of the Caritas Coach, bringing transpersonal caring science and Watson's caring moment into the project as an intervention to heal the clinician. Scott's original

dissertation on patient safety and the second victim described her *Caring Moment Guide* as a reference guide only, to help and guide new peer supporters in their initial one-on-one encounters with peers (Scott, 2014). The *Transpersonal Caring Moment Guide* used in this project serves the same purpose and can be found in Appendix M.

Each meeting was recorded utilizing the Second Victim Encounter Form, first developed and utilized by Dr. Susan Scott and the University of Missouri Health Care forYOU team (Miller et al., 2015). This tool is anonymous for the employee and records the date, time, and basic event information including risk factors and outcomes of the event to the employee, referrals made, and follow-up needed after the initial meeting. This tool was revised for this project and renamed as a *Caritas Peer Support Program Encounter Form* with the permission of Dr. Scott and can be found in Appendix N.

Caritas First Aid. Each clinician involved in an adverse traumatic clinical event were given Caritas first aid, which included practices of transpersonal caring and psychological first aid similar to that recommended by the Center for the Study of Traumatic Stress, referrals to available employee assistance programs within the organization, and a Caritas renewal bag. The Caritas renewal bag included: a lavender organza bag with four Yogi calming or stress relieving tea bags, a small tea-light aromatherapy candle, a small bottle of essential aromatherapy oil, an educational brochure on the second victim phenomenon signs and symptoms and renewal exercises, a Watson Caring Science Institute pen, and one of Dr. Watson's touchstone cards which has her ten Caritas processes on one side and a guide to caring and healing self on the other.

Project Budget. The budget for this project was based on Caritas Peer Support member time spent in offering support to clinicians following an adverse traumatic clinical event and

follow-up meeting, as well as the cost of Caritas renewal bags. The time spent with clinicians following an adverse traumatic clinical event and follow-up after the initial intervention was roughly one hour. The cost of a program member to meet with these clinicians for this one-hour meeting was roughly $40 to $50. In addition to the finances of peer support persons and employees in the program, the cost of one Caritas Renewal bag for each employee involved in an event was $12.90.

The total cost of this project per second victim event was roughly $57.90. This cost is not significant when compared to the roughly $82,000 to $88,000 cost of nurse turnover or the cost of roughly $1 million to replace one physician, due to burnout (NAM, 2018). This does not include the high cost of medical errors or medical malpractice suits. The budget for this project can be found in Appendix O and the project pro-forma spreadsheet in Appendix P.

Study of the Intervention

The intervention implemented in this project replicated the work of Scott and colleagues who developed the first national program to reduce the second victim phenomenon in a healthcare organization(University of Missouri, 2019). This intervention was analyzed using a SWOT analysis.

Strengths. The strengths of this intervention were that it had the support of executive leadership, supported clinicians following an adverse traumatic clinical event, had the potential to aid in clinician retention, and supported patient safety and satisfaction of clinicians and patients. This reduced the effects of the weaknesses of this project.

Weaknesses. Weaknesses of implementing this type of program were that there was no policy, procedure, or formal system in the organization on caring for and supporting healthcare professionals following an adverse traumatic clinical event. There was also no formal hospital

education on the effects of these traumatic clinical events on healthcare professionals or on what support is needed following one of these events.

Opportunities. There were several opportunities to successfully implement this type of program in this organization. These included the Project Director's certification as a Caritas Coach and connection with Dr. Susan Scott who gave the DNP student permission to use the University of Missouri Healthcare forYOU program tools.

A new emerging opportunity included the evidence presented by the National Academy of Medicine on the importance of caring for healthcare professionals, in their published consensus study report: *Taking Action Against Clinician Burnout: A Systems Approach to Professional Well-Being* (NAM, 2019).

Threats. Threats to implementing this program included transitions in the organization's administrative leadership, busy and chaotic environments that limited healthcare professionals volunteering time, lack of awareness of the second victim in the organization and many seeing burnout and compassion fatigue as a normal part of their profession. All of these had the potential of leading to difficulty in getting employee buy-in on the importance of this program. The SWOT analysis for this project supports its purpose and need in the organization and can be found in Appendix Q.

Measures

Qualitative and quantitative methods were used to collect and analyze data pre- and post-intervention. Quantitative data was collected with the Second Victim Experience Survey and qualitative data was collected through Caritas peer responder meetings and interviews with employees who had been part of an adverse traumatic clinical event using the Caritas Peer Support Program Encounter Form, and the Caritas Peer Support Event Log.

Second Victim Experience Survey. The Second Victim Experience Survey is a 10-item survey developed by Scott et al., (2010) that consists of four basic demographic questions, three "yes/no" questions to quantify knowledge of the term second victim, and questions about prior experiences as a second victim, recent personal experiences with event-related emotional anguish, institutional support received in the past, and an opened ended question for the individual to recommend supportive interventions that he or she believes would promote healing if they were involved in a serious adverse event. This tool was revised and placed on an electronic platform within the organization. The survey and its results can be found in Appendix R.

Caritas Peer Support Program Encounter Form and Event Log. Data was collected post-intervention from the Caritas Peer Support Program Encounter Form. Data collected from this tool included the clinician type, the unit the event occurred on, the event type, the shift the event occurred on, the event outcome, the event risk factors, if the clinician met with a member of the Caritas team, if they received caritas first aid from the Caritas team, if the clinician utilized the coping strategies given, if the clinician had second victim symptoms following the event, the strategies the clinician used to alleviate symptoms, and any recommendations the clinician might have had. A summary of this data was recorded onto the Caritas Peer Support Program Event Log that tracked the number of events, types of events, the unit the events occurred on, and the shift on which they occurred. The data collected included the clinician type, the unit the event occurred on, the event type, the shift the event occurred on, the event outcome, the event risk factors, if the clinician met with a member of the Caritas team, if they received caritas first aid from the Caritas team, if the clinician utilized the coping strategies given, if the clinician had

second victim symptoms following the event, the strategies the clinician used to alleviate symptoms, and any recommendations the clinician may have had.

Caritas Peer Support Follow-Up Meeting. The Caritas peer support follow-up meeting was scheduled with the clinician to collect post-intervention qualitative data. This data not only aided in this project, but was also utilized to assist in other improvement activities in the future.

Analysis

Qualitative and quantitative data from the Second Victim Experience Survey and the Caritas Peer Support Program Encounter Form were both analyzed. Percentages were calculated for raw data and categories developed from the Second Victim Experience Survey recommendations. The number of Caritas Peer Support Program Encounter Forms completed was calculated and percentages were calculated.

Financial Analysis. This DNP project was an expense reducing project. Through the offering of Caritas support to clinicians following an adverse traumatic clinical event, the organization was able to reduce the likelihood of the clinician developing the second victim phenomenon and also had the potential to reduce the severity of this phenomenon. One significant financial outcome related to this phenomenon is the clinician leaving the job and the organization having to invest in the cost of advertising for, hiring, and orienting a new clinician. The full cost for one RN turnover in an organization is roughly $233,600 (NSI Nursing Solutions, 2016).

The DNP student was unable to obtain the organization data on RN turnovers prior to and with implementation of the project, so a projection was made. Evidence shows that burnout can lead to 17.5% of RNs leaving the job within the first year of hire, 33.5% after two years on the job, and 43% within three years on the job (University of New Mexico, 2016). Using this data,

the DNP student projected ten new RN hires per quarter for twelve months. Using this projection, the organization would see seven RN turnovers in year one at the cost of $1,635,200, thirteen RN turnovers in year two at the cost of $3,036,800, and seventeen RN turnovers at year three at the cost of $3,971,200 bringing the three-year cost to $8,643,200 without the program.

The projection was made that the Caritas Peer Support Program would save one RN from leaving the job per quarter. This would bring RN turnover in year one down to three at the cost of $700,800, in year two to nine at a cost of $2,102,400, and in year three to thirteen at the cost of $3,036,800 bringing the three year cost of RN turnover down from $8,643,200 to $5,840,00 giving the organization a cost savings of $2,728,440. This is depicted in the ROI and predictive financial benefits of the program which can be found in Appendix S. A more concise analysis of the second victim phenomenon and the financial benefits of Caritas Peer support following adverse traumatic clinical events in the organization could be conducted in the future if requested by organization leaders.

Ethical Considerations

Healthcare providers hold an ethical responsibility to disclose and communicate medical errors openly and honestly. This disclosure responsibility is a requirement for organizations accredited by The Joint Commission (Hill-Davis, 2011). The Joint Commission recognizes that the adverse outcomes that occur secondary to these types of errors hold serious ramifications for the clinician involved in the error. Thus, they have a requirement that organization patient safety programs have a defined mechanism for supporting clinicians who have been involved in a sentinel event (Hill-Davis, 2011). There is also a growing call for risk managers to develop second-victim support programs to support second victims involved in serious errors with

respect, compassion, and understanding which was the basis for this Caritas Peer Support Program (Ankowicz, 2011).

Privacy issues surrounding this project were addressed by making the Second Victim Experience Survey confidential and the process voluntary, keeping the CPSP Event Log confidential, and making the CPSP Encounter Form confidential. To ensure this confidentiality, the CPSP Encounter Form used event codes instead of employee names and the form did not include any clinical information about the event. The CPSP Encounter Forms along with the CPSP Event Log were kept in a binder and secured in a locked location only available to Caritas peer responders.

Jesuit Values. The reflective practices of Ignatian Pedagogy guided this project through cura personalis or "care of the individual person" and unity of heart, mind, and soul to develop the whole person and to promote thoughtful, safe patient care (Pennington et al., 2013). This pedagogy is closely related to the compassionate practices developed by Dr. Jean Watson used in the development and implementation of this project.

ANA Ethical Standards. The ANA Ethical Standards followed in this project were:

> (a) Provision 1: The nurse practices with compassion and respect for the inherent dignity, worth, and unique attributes of every person and (b) Provision 5: The nurse owes the same duties to self as to others, including the responsibility to promote health and safety, preserve wholeness of character and integrity, maintain competence, and continue personal and professional growth (ANA, 2015, pp 1-4, 19-22).

Ethic of Belonging. Dr. Watson (2018c) brings Levinas's "Ethic of belonging", or the ethic of facing our own or others' humanity, into her theory of transpersonal caring. Within this ethical context, Watson (2018c) points out:

> In this evolved context of caring science, we can appreciate, honor, and face the reality that life is given to us as a gift; we are invited to sustain and deepen our own and others' humanity as our moral and ethical starting point for professional caring-healing. (p. 166)

This ethic of belonging was evident in the human caring-healing service provided by the Caritas team who opened their hearts to aid in healing their peers throughout this project.

Section IV. Results

Program Evaluation and Outcomes

Prior to the start of this project, the DNP student met with a leader in the organization who had recently completed his DNP. A concern he raised due to his own experience, was the sustainability of the project due to hospital culture and budgetary restraints. These concerns were also raised by other leaders in the organization. This concern was offset by a new Chief Nursing Officer who was coming on board with goals to change our hospitals culture using the relationship-based care model.

The DNP student applied to the Caritas Coach Education Program in the spring of 2018 and later gave a presentation to the hospital's PNPC about it. In this meeting, the CNO announced her excitement about CCEP in our organization and reported that she had already recruited a Nurse Practitioner to complete the program. The CNOs enthusiasm about CCEP and the DNP student's project led to several other leaders within the organization to voice support for the project.

Several events that were not expected occurred following this strong show of support for the project. Two of the most crucial events were the departure of our DNP leader and our new CNO. Following these events, there were several other events demonstrating the need for the Caritas program. There were also significant barriers to the sustainability of the program.

Project Evolution. The organizational letter of support was obtained from our CNO on April 10, 2019. The Second Victim Experience Survey was sent out to 1,035 clinical employees of the organization, including RNs, nurse practitioners, speech therapists, respiratory therapists, physical therapists, certified nursing assistants, emergency department medics, and behavioral health technician on May 28, 2019. The survey was available to these clinicians until June 27, 2019. The survey was not available for long due to changes being made to the electronic platform within the organization where the survey was implemented. Six hundred eleven clinicians completed the survey.

In the week following the completion of the second victim survey, the Project Director met with the organizations director of human resources and fellow members of the PNPC to recruit their support for the project. Information about the organizations Employee Assistance Program was obtained to share with clinicians as part of the project and two nurses from the PNPC joined the Caritas Peer Support team. An educational brochure about the second victim phenomenon and the Caritas Peer Support Program was developed and can be found in Appendix T. The Project Director began attending daily hospital safety huddles to learn about events that could cause the second victim phenomenon and began rounding on the clinical units throughout the hospital to share education and information about the Caritas program during this time period. The following is a chronological summary of the events and progress of the project during the implementation period.

Week One and Two of Implementation. The Project Director trained the clinicians from our PNPC who had volunteered to be Caritas peer supporters for the program and received an invitation from one of these volunteers to present our program at her next unit-based council meeting.

The Caritas team learned of an event that fell under the category of clinician assault. A member of the Caritas peer support team met with the clinician and offered her Caritas first aid and information about the organizations Employee Assistance Program, which she accepted.

Week Three of Implementation. The Project Director continued attending the organization's daily safety huddles to (a) learn of safety events that had risen to the level of needing support from the Caritas team and (b) continue to share information about the program throughout the organization. The Project Director also gave a presentation about the Caritas Peer Support Program at the unit based staff council meeting she was invited to and reached out to the Director of Human Resources and departmental managers and directors offering to present the program at the organizations summer health fair and other unit employee meetings.

Week Four of Implementation. The Project Director continued attending the organizations daily safety huddles to learn of clinicians who may be in need of support following adverse traumatic clinical events and learned of an event that fell under the category of clinician assault. A member of the Caritas team met with this clinician and offered her Caritas first aid. The Project Director received an invitation from the director and manager of the Critical Care Unit (CCU) and Cardiovascular Intensive Care Unit (CVICU) to give a presentation on the Caritas Peer Support Program during their next staff meeting. This outcome from the leaders of CCU/CVICU showed some support among departmental leaders for the programs and formal support for their clinicians following adverse traumatic clinical events.

Week Five and Six of Implementation. The Project Director continued attending the organizations daily safety huddles and received a referral from a member of the Caritas Peer Support Team about one of her fellow nurses who needed support. The Project Director met with this clinician for an event that fell under the category of personal/professional crisis. The

clinician was given support, Caritas first aid, and the Project Director's contact information in the event that she needed further support. This Project Director also gave the presentation about the Caritas Peer Support Program at the CCU/CVICU staff meeting during these two weeks.

Week Seven of Implementation. The Project Director continued attending the organizations daily safety huddles. A nurse came to one of these safety huddles and spoke about her concerns on the unit for an event that fell under the category of personal/professional crisis. The Project Director met with one of the executive sponsors of this project and the decision was made that the Caritas team would offer support to the nurses on this unit. A plan was developed with the assistant nurse manager of the unit to meet with the clinicians on the unit to offer Caritas First Aid.

Week Eight of Implementation. The Project Director learned of two clinicians who were involved in an event that fell under the category of clinician assault. A member of the Caritas team met with both clinicians separately and offered them Caritas first aid. Both clinicians were given information for the Employee Assistance Program and both accepted a follow-up meeting with the Caritas team member that was accommodated.

Week Nine of Implementation. The Project Director learned of an event that fell under the category of clinician assault. A member of the Caritas team met with him and offered him Caritas first aid.

Week Ten of Implementation. The Project Director continued attending the organizations daily safety huddles and learned that one of the Caritas peer responders had made education about the program part of her departments new employee orientation. The member of the Caritas team who had met with the two clinicians from the week before had follow-up meetings with them this week and found there was no further interventions needed.

Week Eleven of Implementation. This week was a turning point in this DNP project. During the daily safety huddle, the Project Director learned of the unexpected death of a clinician. Upon learning about this event, the Project Director deployed the Caritas peer support team to offer support to all clinicians of this unit on both shifts. Sixty Caritas renewal bags were put together and the Project Director met with the director of the unit prior to the Caritas team meeting with the unit clinicians. The Caritas team was able to meet with forty-nine clinicians to offer Caritas first aid, information about the Employee Assistance Program, and support. The Caritas team received a thank you card from one of the clinicians later this week for the strong show of support following this traumatic event.

Later in this week, the Project Director learned of a clinician from another department who had an event that fell under the category of personal/professional crisis. A member of the Caritas team met the clinician and offered her Caritas first aid and information about the Employee Assistance Program. The events of this week showed the importance of the Caritas Peer Support Program and the gratitude held by clinicians who received Caritas support.

Week Twelve and Thirteen of Implementation. The Project Director was notified about two events that involved clinicians, one who was involved in an unexpected patient outcome and another who had an unexpected patient death and who was now having second victim symptoms. Both clinicians accepted Caritas first aid from a member of the Caritas team and both accepted a follow-up meeting the following week. Members of the Caritas team also continued to offer clinicians support and time to talk following their unexpected loss of a team member.

Week Fourteen of Implementation. The Project Director learned of an unexpected patient outcome. Support was declined by the clinicians involved in the incident but information about the Caritas program was left for them, in case they changed their minds.

The Project Director received a referral from the Chief Nursing Officer of our organization following an event with high-risk factors for the second victim phenomenon. The Project Director met with the clinical manager of the unit impacted to set up a plan to meet with clinical employees. Caritas first aid was declined but Caritas renewal bags and program information were left with her to share with her clinicians.

During this week, the Project Director and Caritas team members had a poster presentation and booth at our annual safety fair. The Caritas team discussed the Caritas Peer Support Program with fifty-one clinicians who visited our booth. Each person we spoke to gave overwhelming support for the program and reported its need in our organization.

Final Month of Implementation. The Project Director continued to attend the organization's daily safety huddles and began winding down the project. The Project Director met with the human resources director to discuss sustainability of the program and learned that this would be difficult due to organizational changes that were taking place. The Project Director met with the director of quality management and obtained data to be used for the return on investment analysis to support the sustainment of the project.

A member of the PNPC approached the DNP student with questions about giving another presentation about the Caritas Peer Support Program to the PNPC, including the results of the Caritas project, to get more members involved. However, after we began to do this, the PNPC meetings were changed to focus on other priorities within the organization.

Results from Data Collection Tools.

Second Victim Experience Survey. The Second Victim Experience Survey had 611 respondents (n=611). The survey revealed that 53.36% (n=x) of respondents had not heard of the second victim phenomenon; 12.93% (n=x) of respondents had experienced a clinical event

that caused personal problems such as anxiety, depression, or concerns about their ability to perform their job; and 8.35% (n-x) of respondents reported that they had received support from someone within the organization following the event.

Two hundred seventy-one survey respondents gave recommendations for supportive strategies they would like to have available if they were involved in an adverse traumatic clinical event. These recommendations were broken down into seven categories that included 1) 13 recommendations, or 2.13%, for use of the Employee Assistance Program, 2) 56 recommendations, or 9.17%, for access to personal or organization provided psychologist, therapist, or counselor, 3) 121 recommendations, or 19.8%, for peer or some other type of support system, 4) 67, or 10.97%, gave an opinion or a piece of advice for peers and/or leaders, 5) 4, or 0.65%, requested that the organization raise awareness of the support that is available to clinicians, 6) 6, or 0.98%, gave an experience they have had, and 7) 4, or 0.65%, gave a response that did not fall under any of these categories.

Caritas Peer Support Program Encounter Form. The CPSP team responded to twelve events that affected one-hundred-forty clinicians. Three of these events affected all clinicians on one unit, one event affected two clinicians on one unit, and eight events were single clinician events. Four of these events were categorized as unanticipated patient outcomes. Five of these events were clinicians who were assaulted by a patient. Three of these events were categorized as personal and/or professional crises. The CPSP team responded to events that fell under tier 2 and tier 3 of the Scott three-tier model of second victim support. Eight of the events, or 67%, required tier 2 support. One of the events, or 8%, required tier 3 support, and three of the events, or 25%, required tier 2 and tier 3 support. Four of the one-hundred-forty clinicians that were offered CPS accepted, and received follow-up. Of these, three were using the strategies provided

by the CPS team and two were found to be experiencing second victim symptoms following the event. One-hundred thirty-six of the one-hundred-forty clinicians that were offered CPS declined follow-up and data on their experience as second victims was not available.

Section V. Discussion

Discussion

Summary

This DNP project took place during a time of organizational restructuring, turnover of the chief nursing officer, and loss of the chair of the PNPC. This led to some initial opportunities being lost and a lack of sustainability options. However, despite this, the project aim to implement and evaluate a system utilizing caring science to support professionals following adverse traumatic clinical events was achieved. The success of this implementation was in part due to the support of this DNP student's executive sponsor in the risk management department. This support opened opportunities for the DNP student to attend the daily administrative safety huddles where she was able to learn about adverse traumatic events within the organization and collaborate with leaders to offer support to the clinicians affected by these events.

One issue that was prominent throughout the project was leader hesitancy toward the Caritas program and clinician reluctance to receive support. This outcome speaks to both the clinicians and leaders in this organization not being used to getting formal support following adverse traumatic clinical events and the need for this type of support in the system.

At the start of this project, the new chief nursing officer of our organization requested from the DNP student, a plan to continue the ideas of this DNP project once it was completed. The DNP student developed a dissemination plan that included three options that will be presented in detail.

First Option. The first option is to make no changes within the system and to sustain the status quo.

Rationale. The current status quo in most healthcare organizations is cheating the patient of the promise to deliver safe, quality care and it is also cheating the clinician of a supportive, healthy work environment. This is leading to an increase in clinician absenteeism, decisions to leave the organization, or even more severe decisions to leave the profession (Burlison et al., 2017).

Second Option. The second option to prevent the second victim phenomenon in clinicians would be to implement a chief or clinician wellness officer who would be the leader of a Caritas Peer Support Program. An example of a job description for this position can be found in Appendix U. Lazarus (2019) points out that a reasonable budget for this position, including salary for the chief wellness officer, would be at a minimum, $150,000/year.

Rationale. The National Academy of Medicine (2019) recently presented a prepublication copy of their consensus study report: T*aking Action Against Clinician Burnout*. It is predicted to become a seminal report, just as *To Err is Human* was. The fifth goal of their report states:

> Provide support to clinicians and learners: reduce stigma and eliminate the barriers associated with obtaining support needed to prevent and alleviate burnout symptoms, facilitate recovery from burnout, and foster professional well-being among learners and practicing clinicians. (p. 17)

This type of support is being implemented in high-profile hospitals across the nation including Stanford, John Hopkins Hospital, Mount Sanai in New York City, and at UC Davis in the form of a chief wellness officer (Lazarus, 2019). Dr. Lazarus (2019) points out that the CWO adds

immediate value to the organization and moves forward in evolving the triple AIM to the quadruple AIM. The forth AIM in the Quadruple AIM is: improving the work life of clinicians and staff, which will lead to better care, better health, and lower costs in the long run (Bodenheimer & Sinsky, 2014). While the chief wellness officer would add an extra position and finance to the organization, it would in turn lower medical costs $3.27 for every dollar spent on wellness programs and absentee day costs would fall by roughly $2.37 for every dollar spent on wellness programs (Lazarus, 2019).

Third Option. Given that the status quo is not working and that many organizations are skeptical of adding new positions in the current healthcare climate, a third option must be considered. This option would embed the Caritas Coach and Caritas Peer Support Program leader in an open leadership position within the organization. In this capacity, the Caritas program leader would oversee the Caritas program, assist in following up with and educating clinicians following an adverse traumatic clinical event, and educate new clinicians about the program at new hire orientations.

Rationale. In this compromise solution, the growing national vision of having a designated CWO within the organization would not be met, but basic elements to support clinicians following an adverse traumatic event would be. The DNP student shared a copy of this plan with one of the executive sponsors in the organization. However, due to ongoing regional restructuring of the healthcare organization, a plan to sustain the CPSP within this hospital has been put on temporary hold.

Interpretation

The Caritas peer support program had a significant event, an unexpected death of a clinician, that verified the need for this type of program in the DNP student's organization. The

Caritas peer support team was deployed immediately and a plan was put together to meet with the unit clinicians on both shifts.

The response from over fifty clinicians who were offered Caritas first aid was both insightful into the cause of the event and overwhelmingly grateful and positive with respect to the support offered by the program. This was a devastating event. In the twenty years since the seminal report by the National Academy of Medicine, healthcare organizations have made great strides to make care safer for patients. This event was evidence of the need to turn some of this focus to caring for our healthcare professionals to make sure they are safe as well.

Implications for Advanced Nursing Practice. It is hard to put a cost on caring, as we see an increase in demand to do more with less in healthcare organizations across the country. This includes in some cases, surrendering our ability to care for our patients, ourselves and each other. As organizations such as the Joint Commission (2018), the Agency for Healthcare Research and Quality (2019), and the National Academy of Medicine (2019) continue to promote information on the second victim, clinician burnout, and the importance of healthcare organizations having programs to mitigate these outcomes on clinicians, it is clear that the program being implemented with this project and others like it are needed and must have support to be implemented and sustained.

Limitations

The understanding and research into the second victim phenomenon did not begin until Dr. Albert Wu (2000) identified it in a medical journal editorial. The search for evidence for this project was only able to yield twenty-seven studies on the topic between 2010 and 2020. This highlighted the fact that more research and evidence-based change of practice projects on this topic are needed to alleviate the effects of this growing epidemic. A lack of knowledge about the

second victim phenomenon and its implications in the DNP student's organization were both barriers to this project.

The DNP student's organization is an extremely busy facility that sees a rapid turnover of patients in its emergency department, which leads to the units within the hospital having to meet the demands for beds for these patients. This demand and rapid turnover have been a limitation in the past for the DNP student in implementing other projects or changes in practice because the clinical staff feels as though they have little time to be a part of these projects and changes because of their responsibilities to their patients. The DNP student and members of the Caritas team made the necessary provisions and accommodations necessary in order for all clinicians who were involved in an adverse traumatic clinical event to receive support and allowed clinicians to refuse support without pressure to accept it. The main reason we found for clinicians refusing support or follow-up care was that they were not used to receiving support and some felt as if this showed "weakness" on their part. However, for those who did accept and receive support, their positive recognition and gratefulness for the support they received continue to be shared with the DNP student.

Conclusions

Nurses and other healthcare professionals are compassionate individuals who are constantly trying to give and care for others. Sometimes this constant state of giving can take a toll on them or even traumatize them, especially when a serious medical or nursing error occurs that harms the patient and/or family. This high risk of harm and trauma is ever present in our increasingly complex healthcare system. This makes it all the more important that organizations have programs in place to support healthcare professionals following an adverse traumatic

clinical event in order to lessen the professional's risk for harm and traumatization and to ensure that patients and families continue to receive safe, quality health care.

The interventions of this DNP project provided authentic transpersonal caring practices to help support the healthcare professionals within this organization and to ensure our patients continue to receive safe, high-quality care. The DNP student took the steps to develop this project into an incorporated organization in the state of Florida in order to sustain its support for clinicians in her organization due to being unable to sustain the project in her organization. The business' name is Caritas Renewal and Wellness for Healthcare Professionals Inc. A website for this business was developed and has been shared with the executive sponsor of this project to share with clinicians in our organization who are involved in an adverse traumatic clinical event. This website gives the clinician information about the organization and how to reach the DNP student for support. Services from this business can be contracted by other health care organizations as well. A link to the organizations website can be found in Appendix V.

Section VI. Other Information

Funding

The DNP student self-funded the cost of completing the Caritas Coach Education Program and the expenses for the Caritas Peer Support Program. No funding was provided from the organization where the project took place or from other outside sources.

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Appendix A

Gap Analysis

Best Practice	Best Practice Strategies per MITSS (2010)	How Organizations Practices Differ From Best Practice	Barriers to Best Practice Implementation	Will Implement Best Practice (Yes/No; Why Not?)	Priority
Internal culture of safety	Organizational core values of compassion and respect	In past, organizational core values and communication did not align with an internal culture of safety. Recently, in the past year, a new CNO is striving to implement this	Past transactional leadership and culture of blaming of staff for errors	Yes	High
	Ongoing communication, honesty, and transparency from leadership				
	Error is seen as the failure of systems and not the people				
Organizational awareness	General overall belief that adverse events can cause significant emotional distress to clinicians involved in event	In past, hospital leadership has not acknowledged the need to support staff following an adverse or unanticipated event or near	Past transactional leadership and focus on patient outcomes without understanding the impact on clinicians	Yes	High

	Expectation to support staff following an adverse event, following a negative unanticipated outcome, or near miss	miss.This acknowledgement and support is something our new CNO supports	following adverse or unanticipated events		
Risk management considerations	There is an organizational commitment to rapid disclosure and support of clinicians Support is provided to the clinician before, during, and after the disclosure process There is a written understanding of how cases will be managed and how support will be provided	These best practice strategies are not and have not been present in the past	Past transactional leadership and focus on patient outcomes without understanding the impact on clinicians following adverse or unanticipated events	Yes	High
Policies, procedures, and practices	Policies and procedures regarding handling of adverse events are accessible to all clinicians and staff	The organization has a crisis management plan regarding events bringing more patients than usual	Past transactional leadership and focus on patient outcomes without understanding the impact on clinicians	Yes	High

	throughout the organization	into the hospital from community crises. There is no crisis management plan in place to support staff following an adverse or unanticipated event	following adverse or unanticipated events		
	The organization has a crisis management plan in place				
	Staff has been sufficiently trained about organization's crisis management plan				
Operational	Research has been done regarding various support models utilized by other healthcare organizations	These best practice strategies are not and have not been present in the past	Past transactional leadership and focus on patient outcomes without understanding the impact on clinicians following adverse or unanticipated events	Yes	High
	It has been determined where support program will be anchored within the institution				
	The who/what/when/how to activate the support mechanism have been determined				
	Written guidelines have been established for all clinician supporters				

	The institution has training and a tool box available for clinician supporters				

Appendix B

Evidence Evaluation Table: Second Victim Studies

Citation	Conceptual Framework	Design/ Method	Sample/ Setting	Major Variables Studied	Measurement	Data Analysis	Findings	Appraisal: Worth to Practice; Level/Quality
Burlison, Scott, Brown, Thompson, & Hoffman, 2017. The second victim experience and support tool: Validation of an organizational resource for assessing second victim effects and the quality of support resources	None	Mixed-methods study	N=281 participants	-Second victim-related psychological and physical symptoms -Quality of support resources	-Second Victim Experience and Support Tool (SVEST) used to evaluate experiences with adverse patient safety events	Conceptual analysis	-Preliminary support for use of the SVEST as a reliable and valid instrument to obtain information on the experiences with adverse patient safety events	Strengths: -Adequate sample size of 281 Limitations: - Data collected at a pediatric hospital, which may have limited the generalizability of the results *Critical Appraisal Tool & Score: Johns Hopkins *Research Evidence Appraisal Tool*: IIIA
Cabilan & Kynoch, 2017. Experiences of and support for nurses as	None	Systematic Review	N= 9 studies	-Second victim -Adverse nursing errors	RAMSeS was used in this systematic literature review. The JBI QARI Data Extraction	Conceptual analysis	-An error brings a considerable emotional burden to the nurse that can	Strengths: -Adds research to the topic of "second victims" where

second victims of adverse nursing errors: a qualitative systematic review					Form for Interpretive & Critical Research was utilized		last for a long time. -The type of support received influences how the nurse will feel about the error -After the error, nurses are confronted with the dilemma of disclosure -Reconciliation is every nurse's endeavor. This is achieved by accepting fallibility, followed by acts of restitution	research is limited Limitations: -Study was represented by mostly female nurses -Since 1980, only nine qualitative studies of sound methodological quality investigated the experiences of second victims *Critical Appraisal Tool & Score: Johns Hopkins *Research Evidence Appraisal Tool*: IIIA
Edrees et al., 2016. Implementing the RISE second victim support programme	None	Mixed-methods study	1) # prefer a multidisciplinary peer group to offer support: N=95 2) # prefer nurse manager	-RISE support program -Type of healthcare profession	Organizational staff assessment survey used to collect data from Health care professional	Conceptual analysis	-Increase need for peer support programs to help healthcare professionals following	Strengths: -Adds research to the topic of "second victims" where

at the Johns Hopkins Hospital: a case study			support: N=21 3) # prefer pastoral care: N=18 4) # prefer individual or group support: N=97 5) # prefer access to support soon after event: N=17 6) # prefer access to support a few hours after event: N=34 7) # prefer access to support a couple days after event: N=66 8) # prefer access a week after event: N=11	-Number of years in health care -Staff perceptions on features and services of an organizational second victim support program	on need for support -Peer responder encounter form used to provide de-identified information on the event and nature of the RISE call -Peer responder assessment form used to evaluate the interaction with the caller after each encounter -Peer responder focus group used to assess peer responder perceptions, confidence levels, and self-assessed competence based on the RISE training received		adverse events -Majority (45%) of RISE calls related to death of a patient -Initial Psychological First Aid (PFA) training and on ongoing training helpful in preparing peer responders	research is limited <u>Limitations:</u> - Conflict between evaluating outcomes of encounters and assuring confidentiality; Data collection methods evolved and not previously validated; & used paper forms leading to missing forms and data <u>*Critical Appraisal Tool & Score</u>: Johns Hopkins *Research Evidence Appraisal Tool*: IIB

Lewis, Baernholdt, Yan, & Guterbock, 2015. Relationship of adverse events and support to RN burnout	Theoretical framework using the conceptual model *nurse experience of medical errors*	Cross-sectional survey design	N=218 participants	**Variables:** -Preventable adverse event -Disclosure -Support Index **Support Variables:** -Years of RN practice -Work unit type -Nurse Demographics (gender, education, and hospital) -**Burnout Domains:** -emotional exhaustion -depersonalization -Personal accomplishment	Hospital Survey on Patient Safety Culture (Hospital SOPS) used to collect data about gender and education. One item from the Hospital SOPS was modified to indicate how many adverse events nurses had been involved in during the last 12 months Interventions of disclosure of preventable adverse events to patient and support to RNs were measured using 4 questions developed for this study. Each question was responded to using a Likert-type scale ranging from 1 (never) to 5 (always)	SPSS version 20 was used to analyze -Variable skewness -Outliers -Missing Data -Collinearity t and Mann-Whitney tests utilized to compare characteristics between the 218 participants with complete data and the 71 participants excluded because of missing data	-Involvement in preventable adverse events is associated with 2 burnout domains, higher emotional exhaustions, and depersonalization - Informal and formal mechanisms should be in place to provide support to RN second victims. This support should come from unit managers, peers, and physician colleagues -Importance of immediate and long-term support for second victims -Involvement of healthcare providers to constructively promote	<u>Strengths:</u> -Adequate sample size (N=218) <u>Limitations:</u> -Response rate was low -Use of cross-sectional data limited conclusions about cause and effect -Questions about preventable adverse events, support, and disclosure had not been examined for reliability and validity outside this study <u>*Critical Appraisal Tool & Score</u>: Johns Hopkins *Research Evidence Appraisal Tool*: IIIA

							changes meant to avoid similar adverse events -RNs involved in preventable adverse events should be observed for signs of emotional exhaustion and depersonalization -Institutions should implement the NQF standards for disclosure	
Miller, Scott, Beck, 2019. Second victims and mindfullness: A systematic review	None	Systematic review	N=15 studies	-Second victim phenomenon -Effectiveness of mindfulness-based interventions	RAMSeS was used in this systematic literature review. The Melnyk Hierarchy of Evidence for Intervention Studies was utilized	Conceptual analysis	-An absence of a diagnostic tool for second victims -Clinician deficit on awareness of institutional practices/protocols to guide institutional support, console colleagues, or generalized support for second victims	<u>Strengths:</u> -Adds research to the topic of "second victims" where research is limited <u>Limitations:</u> None <u>*Critical Appraisal Tool & Score</u>: Johns Hopkins *Research Evidence*

							-Common symptoms of second victims include anger, guilt, emotional distress, stress, burnout, anxiety, and shattered confidence -Two types of coping for second victims include atypical coping and constructive coping -Atypical coping includes avoidance, discounting, hypervigilance, and obsessive behaviors -Constructive coping included prevention of	*Appraisal Tool*: IIIA

							future errors and improving professional competence	
Scott, Hirschinger, Cox, McCoig, Hahn-Cover, Epperly, Phillips, Hall, 2010. Caring for our own: Deploying a systemic second victim rapid response team	None	Qualitative study	N=31 healthcare professionals	-Second Victim Rapid Response System -The suffering experience -Development of specific healing interventions	-Second Victim Experience survey used to estimate the size, scope, and requirements to deploy an effective support network -Survey to quantify frequency and nature of the second victim experience and to identify an effective institutional support response	-Simple counts and proportions for demographic items and categorical variables -Iteratively reviewed narrative responses submitted for desired support strategies	-Large portion of healthcare workforce suffering in relative silence -Need to design and deploy a support infrastructure -Support initiative should be established and disseminated widely throughout institutions -Need for a visible institutional commitment from medical and executive leadership	<u>Strengths:</u> -Adds research to the topic of "second victims" where research is limited <u>Limitations:</u> None <u>*Critical Appraisal Tool & Score</u>: Johns Hopkins *Research Evidence Appraisal Tool*: IIA
Seys et al., 2012. Health care professionals as second victims after adverse events: A	None	Systematic review	N = 41 studies	-Definitions of second victim in health care literature -Prevalence of second victims	RAMSeS was used in this systematic literature review. No commonly used tool found	Conceptual analysis	-Three descriptions and one definition of second victim found	<u>Strengths:</u> -Adequate sample size (N=41) -Systematic approach and reproducible method

systematic review				-Impact of the error on the second victim -Coping Strategies used by second victims			-Prevalence of second victims within the healthcare system is estimated in three studies and varies from 10.4% to 43.3% with one finding of over approximately 30% -Feelings of guilt, anger, frustration, psychological distress, and fear are the most common physical and psychosocial symptoms in a second victim following an adverse event -Reactions of a second victim are influenced by the outcome of the error and the RNs degree of personal responsibility	<u>Limitations:</u> -Included studies did not use the same type of adverse event and the same definition or description of second victim <u>*Critical Appraisal Tool & Score</u>: Johns Hopkins *Research Evidence Appraisal Tool*: IIIA

							for the adverse event -Female second victims tend to report more distress than male counterparts	

Dearholt, S. L., & Dang, D. (2018). *Johns Hopkins nursing evidence-based practice: Model and guidelines* (3rd ed.). Indianapolis, IN: Sigma Theta Tau International

Appendix C

Evidence Synthesis Table: Second Victim Studies

Studies	Design	Sample	Findings
A Burlison et al, 2017	Mixed-methods study	N=281 participants	➢ Prevalence of the second victim ➢ Symptoms of the second victim ➢ Impact & Implications of the second victim ➢ Strategies to prevent the second victim phenomenon
B Cabilan & Kynoch, 2017.	Systematic Review	N= 9 studies	➢ Prevalence of the second victim ➢ Symptoms of the second victim ➢ Impact & Implications of the second victim ➢ Strategies to prevent the second victim phenomenon
C Edrees et al., 2016.	Mixed-methods study	1) # prefer a multidisciplinary peer group to offer support: N=95 2) # prefer nurse manager support: N=21 3) # prefer pastoral care: N=18	➢ Impact & Implications of the second victim ➢ Strategies to prevent the second victim phenomenon

		4) # prefer individual or group support: N=97 5) # prefer access to support soon after event: N=17 6) # prefer access to support a few hours after event: N=34 7) # prefer access to support a couple days after event: N=66 8) # prefer access a week after event: N=11	
D Lewis, Baernholdt, Yan, & Guterbock, 2015.	Cross-sectional survey design	N=218 participants	➢ Prevalence of the second victim ➢ Symptoms of the second victim ➢ Impact & Implications of the second victim
E Miller, Scott, Beck, 2019	Systematic review	N=15 studies	➢ An absence of a diagnostic tool for second victims ➢ Clinician deficit on awareness of institutional practices/protocols to guide institutional support,

			console colleagues, or generalized support for second victims ➢ Common symptoms of second victims include anger, guilt, emotional distress, stress, burnout, anxiety, and shattered confidence ➢ Two types of coping for second victims include atypical coping and constructive coping ➢ Atypical coping includes avoidance, discounting, hypervigilance, and obsessive behaviors ➢ Constructive coping included prevention of future errors and improving professional competence
F Scott et al., 2010	Qualitative study	N=31 healthcare professionals	➢ Large portion of healthcare workforce suffering in relative silence ➢ Need to design and deploy a support infrastructure ➢ Support initiative should be established and disseminated widely throughout institutions ➢ Need for a visible institutional commitment

			from medical and executive leadership
G Seys et al., 2012	Systematic review	N = 41 studies	➢ Prevalence of the second victim ➢ Symptoms of the second victim ➢ Impact & Implications of the second victim ➢ Strategies to prevent the second victim phenomenon

Appendix D

The Caritas Coach Education Program

The Caritas Coach Education Program (CCEP) is a 6-month education program developed and led by Dr. Jean Watson and the faculty of the Watson Caring Science Institute. CCEP is recognized by the Commission on Accreditation as an American Nurses Credentialing Center Nursing Skills Competency Program. This program prepares nurses and other healthcare professionals to become Caritas Coaches. The Caritas Coach is a knowledgeable, experienced, reflective healthcare professional, who is prepared and committed to personally and professionally practice and model intelligent heart-centered approaches to health care by translating and sustaining the ethic, philosophy, theory and practice of the Science of Human Caring into our systems and society (Watson Caring Science Institute, 2013).

Through this program of innovative teaching-learning methodologies, self-reflection, authentic dialogue, 'teachings' and wisdom tradition are explored to prepare the future Caritas Coach to bring these teachings and methodologies out into the world to transform self and systems. Through the personal journeys of Caritas Coach students in learning these heart-centered methodologies and practices that make up Dr. Watson's philosophy and science of caring, Caritas Coaches are able to change and improve our systems and society (Watson Caring Science Institute, 2013).

Appendix E

DNP Statement of Non-Research Determination Form

Student Name: Shanda N. Whittle MSN, RN, CNL, Caritas Coach

Title of Project: The Second Victim Phenomenon: Using Caring Science to Heal Our Healers

Brief Description of Project:

A) Aim Statement: Does a program, led by a DNP Student/Caritas Coach and based on caring science, that supports healthcare professionals following an adverse event, reduce the second victim phenomenon in healthcare professionals over a six-month period?

B) Description of Intervention: Development of a caritas peer support program, that will be based on the findings of Burlison, et al. (2017), Scott, et al., (2010), and Merandi, et al., (2017). The intervention will consist of applying caring science (Watson, 2012) and the Scott (2010) three-tiered intervention model to circumvent the second victim phenomenon in healthcare professionals. This intervention will be implemented in eight phases:

1) Assess the organizations culture and support for healthcare professionals who may become victims of the second victim phenomenon utilizing the Medically Induced Trauma Support Services Organizational Assessment Tool for Clinician Support (Appendix A) (Medically Induced Trauma Support Services, 2010).
2) Develop a caritas peer support program committee
3) Formalize the definition of an adverse and/or traumatic clinical event for which the peer support program will be activated and update the *event type* section of the Caritas Peer Support Program Encounter Form to identify this
4) Identify key individuals in the organization for potential peer support persons and program champions
5) Establish the infrastructure for the program and team including:
    a) Defining the team structure

b) Determine methodology and activation guidelines for providing peer support following an adverse and/or traumatic clinical event
c) Develop a preliminary budget and business plan for the program
d) Develop operation plans and timeline for deployment of the peer support program
e) Develop a policy and guideline on supporting healthcare professionals following an adverse and/or traumatic event.
f) Recruit team members to be part of the Caritas Peer Support Program committee, department team members, peer support persons, and peer support champions

6) Develop an internal marketing campaign to raise awareness of the second victim phenomenon and of caring science strategies to prevent this phenomenon.
    a) Develop a second victim awareness strategy
    b) Develop an informational brochure with material on the second victim phenomenon and of caring science strategies to prevent this phenomenon
    c) Identify organization-wide and department specific meetings to share information on the peer support program
7) Establish a training program for peer support persons by:
    a) Identifying and developing internal resources and reference tools
    b) Design caritas peer support training
    c) Develop a plan to address ongoing continuing education and an ongoing plan to evaluate educational needs
8) Ensure team and program effectiveness
    a) Develop an encounter form to be utilized by peer support persons following an adverse and/or traumatic event
    b) Develop a schedule for regular meetings of the caritas peer support program committee
    c) Share progress of the caritas peer support program during organization-wide and department specific meetings

C) How will this intervention change practice? This intervention will help support a culture of safety, the hospital's nursing model of relationship-based care, and will add

to the growing body of evidence on programs to decrease the second victim phenomenon (Merandi et al., 2017).

D) Outcome measurements:

I. Second Victim Experience Survey: a 10-item survey developed by Scott (2010) that consists of four basic demographic questions, three "yes/no" questions to quantify knowledge of the term *second victim*, prior experience as a second victim, recent personal experience with event-related emotional anguish, institutional support received, and an opened ended question for the individual to recommend supportive interventions that he or she believes would promote healing. See Appendix B

II. Track organizational data pre and post intervention including:

A. Tracking of tier 2 and 3 events using the Scott Three Tier Interventional Model of Second Victim Support. See Appendix C.

B. Tracking of event specific data using the anonymous Caritas Peer Support Program Encounter Form (see Appendix D) as follows:

1) Number of events per month
2) Tracking of types of events and reasons for deployment of the Caritas peer support team
3) Tracking of number of event briefings
4) Tracking of types of clinical staff receiving support
5) Tracking of number Caritas peer support team encounters with staff during and following events

To qualify as an Evidence-based Change in Practice Project, rather than a Research Project, the criteria outlined in federal guidelines will be used:
(http://answers.hhs.gov/ohrp/categories/1569)

X This project meets the guidelines for an Evidence-based Change in Practice Project as outlined in the Project Checklist (attached). Student may proceed with implementation.

☐This project involves research with human subjects and must be submitted for IRB approval before project activity can commence.

Comments:

EVIDENCE-BASED CHANGE OF PRACTICE PROJECT CHECKLIST *

Instructions: Answer YES or NO to each of the following statements:

Project Title:	**YES**	**NO**
The aim of the project is to improve the process or delivery of care with established/ accepted standards, or to implement evidence-based change. There is no intention of using the data for research purposes.	**X**	
The specific aim is to improve performance on a specific service or program and **is a part of usual care**. ALL participants will receive standard of care.	**X**	
The project is **NOT** designed to follow a research design, e.g., hypothesis testing or group comparison, randomization, control groups, prospective comparison groups, cross-sectional, case control). The project does **NOT** follow a protocol that overrides clinical decision-making.	**X**	
The project involves implementation of established and tested quality standards and/or systematic monitoring, assessment or evaluation of the organization to ensure that existing quality standards are being met. The project does **NOT** develop paradigms or untested methods or new untested standards.	**X**	
The project involves implementation of care practices and interventions that are consensus-based or evidence-based. The project does **NOT** seek to test an intervention that is beyond current science and experience.	**X**	
The project is conducted by staff where the project will take place and involves staff who are working at an agency that has an agreement with USF SONHP.	**X**	
The project has **NO** funding from federal agencies or research-focused organizations and is not receiving funding for implementation research.	**X**	
The agency or clinical practice unit agrees that this is a project that will be implemented to improve the process or delivery of care, i.e., **not** a personal research project that is dependent upon the voluntary participation of colleagues, students and/ or patients.	**X**	
If there is an intent to, or possibility of publishing your work, you and supervising faculty and the agency oversight committee are comfortable with the following statement in your methods section: *"This project was undertaken as an Evidence-based change of practice project at X hospital or agency and as such was not formally supervised by the Institutional Review Board."*	**X**	

ANSWER KEY: If the answer to **ALL** of these items is yes, the project can be considered an Evidence-based activity that does NOT meet the definition of research. **IRB review is not required. Keep a copy of this checklist in your files.** If the answer to ANY of these questions is **NO**, you must submit for IRB approval.

*Adapted with permission of Elizabeth L. Hohmann, MD, Director and Chair, Partners Human Research Committee, Partners Health System, Boston, MA.

STUDENT NAME (Please print): Shanda N. Whittle

Signature of Student: *Shanda N. Whittle* **DATE:** November 6, 2018

SUPERVISING FACULTY MEMBER (CHAIR) NAME (Please print): Robin Buccheri, PhD, RN, FAAN

Signature of Supervising Faculty Member (Chair): *Robin Buccheri* **DATE:** November 7, 2018

Appendix F

GANTT Chart

	Fall 2018	Spring 2019	Summer 2019	Fall 2019	Spring 2020
Assess the organizational culture and support systems for clinicians	Completed				
Develop education for and recruit the peer support persons		Completed			
Formalize the definition of an adverse and/or traumatic clinical event for program		Completed			
Develop a Caritas Peer Support Program committee			Completed		
Identify key individuals in organization for peer support persons and program champions			Completed		
Establish the infrastructure for the program and committee team			Completed		
Develop an internal marketing campaign to raise awareness of SVP and Caring science			Completed		
Establish a training program for peer support persons			Completed		
Implement project			Completed		
Ensure team and program effectiveness through regular unit and committee meetings and sharing progress organization-wide				Completed	
DNP student will oversee and support program					Completed

Appendix G

Work Breakdown Structure for Caritas Peer Support Program

WBS Level 1:	**WBS Level 2:**	**WBS Level 3:**
1. Caritas Peer Support Program	**1. Caritas Peer Support Program** **1.1 Development of team** **1.2 Development of a Caritas Peer Support Program Committee** **1.3 Development of education** **1.4 Development of guidelines and procedure for deploying the Caritas Peer Support System** **1.5 Update of organizations Employee Assistance Program Policy and Procedure**	**1. Caritas Peer Support Program** **1.1 Development of team** **1.1.1 Chief Nursing Officer** **1.1.2 Director & managers** **1.1.3 PNPC*** **1.1.4 House managers** **1.2 Development of a Caritas Peer Support Program Committee** **1.2.1 Nurse leaders** **1.2.2 Department nurses** **1.2.3 Other health care professionals** **1.2.4 House managers** **1.3 Development of Education** **1.3.1 Training of department teams** **1.3.2 Training of peer support persons** **1.3.3 Training of unit champions** **1.4 Development of guidelines and procedure for deploying the Caritas Peer Support Program** **1.4.1 Chief Nursing Officer** **1.4.2 Nurse leaders** **1.4.3 Department teams**

		1.4.4 Caritas Peer Support Program committee **1.5 Update organizations Employee Assistance Program policy and procedure** **1.5.1 Chief Nursing Officer** **1.5.2 Human Resources** **1.5.3 Nurse leaders** **1.5.4 Department teams** **1.5.5 Caritas Peer Support Program committee**

***PNPC (Professional Nurse Practice Council)**

Appendix H

Project Communication Plan

The main goal of the Caritas Peer Support Program is to provide support for hospital clinicians who are a part of an adverse traumatic clinical event. In order for this program to be successful there must be a sustainable communication plan.

Key Stakeholders:

1. Senior leadership
2. House nursing supervisors
3. Directors and managers
4. Assistant nurse managers
5. Clinical employees
6. Human resource leadership

Communication Goals:

1. Timely communication of a traumatic clinical event to the Caritas Coach or designated member of the Caritas peer support team
2. Timely communication of steps taken by the Caritas peer support team to the department director, unit manager and director of patient safety
3. Timely follow-up with the second victim by the Caritas Coach or designated member of the Caritas peer support team.

Caritas Peer Support Program Contact List:

This list will consist of Caritas Peer Response committee members and the ways in which to reach them.

Team Member Name	Work Number	Cell Number	Email Address

Caritas Peer Support Program Event Log:

This log will remain confidential among Caritas Peer Support Committee members and will communicate and track events in which the program was activated.

Unit	Date	Event Code (Do not identify patient)	*Event Outcomes Code	Clinician Code (Do not use employee name)	Date of Initial Meeting with Clinician	Name of CPSP Member Meeting with Clinician	Referrals Made	Date of Follow up Meeting with Clinician

Event Outcomes Codes: 1-No Harm; 2-Harm; 3-Death

Appendix I

Letter of Support from Agency

Medical Center

[redacted]

AMERICA'S 50 Best HOSPITALS 2019 healthgrades

April 10, 2019

To Whom It May Concern:

This is a letter of support for Shanda Whittle to implement her DNP Comprehensive Project, Reducing the Second Victim Phenomenon: Healing Our Healers With Caritas Coaching at [redacted]

We give her permission to use the name of our organization in her DNP Comprehensive Project Paper and in future presentations and publications.

Sincerely,

[redacted]

Chief Nursing Officer

[redacted]

Appendix J

Stakeholder Analysis

DEFENDERS: KEEP SATISFIED **PATIENTS** **(High power and high influence)**	**LATENTS: CONSISTENT AND CONTINUOUS COACHING** **CLINICAL/PATIENT CARE TEAM** **(High power and low interest)**
APATHETICS: MONITOR AND SUPPORT **PROJECT TEAM (SECOND VICTIM COMMITTEE, DEPARTMENT TEAMS & CHAMPIONS)** **(High power and moderate interest)**	**PROMOTERS: COMMUNICATE OFTEN AND KEEP INFORMED** **HOSPITAL, DEPARTMENT & UNIT LEADERS** **(High power and high interest)**

Appendix K

Caritas Support for Healthcare Professionals Training Manual

TRAINING OBJECTIVES

- Define the second victim phenomenon
- Discuss Caritas as a means to heal our healthcare professionals
- Discuss peer support definitions and basics
- Discuss the Caritas Support for Healthcare Professionals process

THE SECOND VICTIM PHENOMENON DEFINITION (1)

- DEFINITION: Second victims are health care providers who are involved in an unanticipated adverse patient event, in a medical error and/or a patient-related injury and become victimized in the sense that the provider is traumatized by the event. Frequently, these individuals feel personally responsible for the patient outcome. Many feel as though they have failed the patient, second-guessing their clinical skills and knowledge base.

HIGH RISK SCENARIOS THAT CAN EVOKE A SECOND VICTIM RESPONSE (2)

- Patient who "connects" to a health care professional's own family
- Unanticipated clinical event involving a pediatric patient
- Unexpected patient death
- Preventable harm to patient
- Multiple patients with bad outcomes within a short period of time within one clinical area
- Long-term care relationship with patient death
- Clinician experiencing his or her first patient death
- Failure to detect patient deterioration in timely manner
- Death in a young adult patient
- Notification of pending litigation plans
- Community high-profile patient or event
- Health care professional who experienced needle stick exposure with high risk patient

- Death of a staff member or spouse of a staff member

SECOND VICTIM STATISTICS (3)

- 400 physician deaths by suicide annually
- 39% of physicians experience depression
- 24% of ICU nurses test positive for post-traumatic stress disorder
- 23-31% of nurses experience emotional exhaustion

SECOND VICTIM IMPACT (4,5)

High risk scenarios and the second victim response may lead to feelings of:

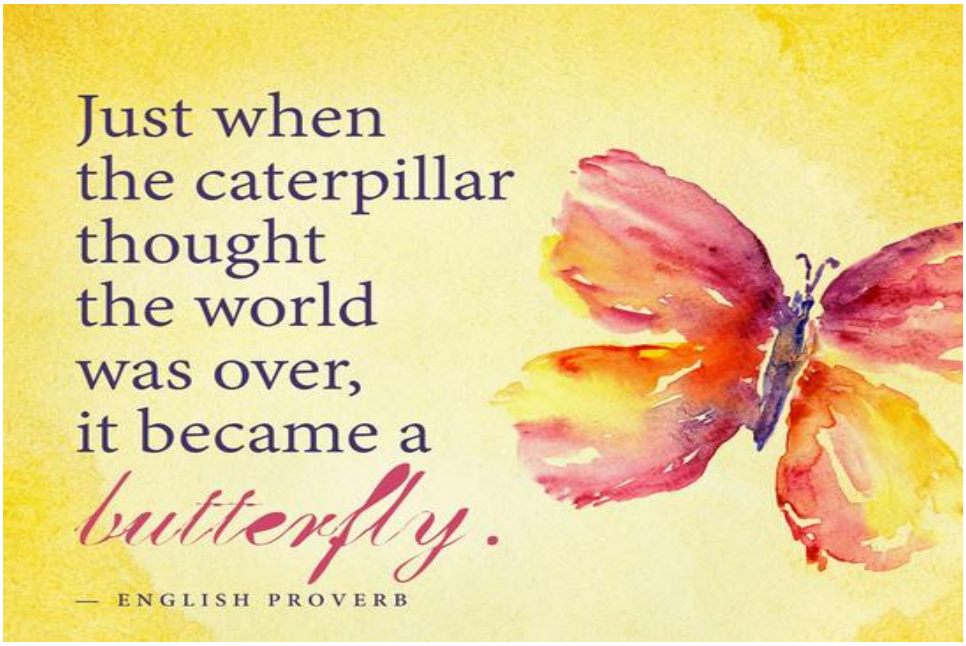
- Guilt
- Incompetence
- Self-doubt
- Humiliation
- Embarrassment
- Self-blame
- Frustration
- Loss of confidence
- Detachment
- Burnout
- Symptoms of depersonalization
- Anger
- Psychological distress
- Fear

This can lead to:

- Burnout
- Turnover of healthcare professionals
- Lower patient satisfaction

HEALING IS POSSIBLE

Healing and recovery are possible through Caritas infused peer support following a second victim event



PEER SUPPORT DEFINITION (6)

- DEFINITION: Peer support, within the health care system, is the giving of emotional, appraisal, and informational assistance by an identified person who possesses knowledge of a specific behavior or stressor and similar characteristics as the person being supported.

PEER SUPPORT HELPS TO MOVE FROM SURVIVING TO THRIVING (7)

It is possible to thrive following a second victim event. To do this, the Caritas team will:

- Provide one-on-one peer support
- Provide the clinician with a “safe place” to express their thoughts and reactions to enhance coping
- Offer caring, healing support and Caritas “first aid” to clinicians who have been involved in a second victim event
- Provide the clinician with tools and resources to enhance healing

- Ensure the clinician that the information they share will remain strictly confidential

PEER SUPPORT BASICS (7)

Peer support is:

- Voluntary (never force an individual to accept support)
- Non-judgmental (Acknowledge the other persons feelings/emotions without judging them and avoiding sarcasm)
- Being respectful of the other persons feelings/emotions. Hold each other in high regard and treat each other with kindness and dignity
- Reciprocal. Build a relationship with the other to aid in opening and awakening to the process of giving and receiving support
- Empathic and compassionate. Listen to the other with an open mind and heart putting yourself in their place

FIVE CARITAS RIGHTS OF THE SECOND VICTIM (8,9)

Using an adaptation of Denham's TRUST model of the five rights of the second victim and Watson's Caritas Processes@, each individual will be provided with a safe and confidential space to allow for:

- **Treatment that is just:** Engaging in genuine teaching-learning experiences that attend to unity of being and meaning while attempting to stay within the second victim's frame of reference. Through this process, the Caritas responder promotes knowledge, growth, empowerment, and healing in the second victim.
- **Respect:** Practicing loving-kindness and equanimity within the context of caring consciousness. Through this process, respect for the second victim is embraced by the Caritas responder, which honors the human dignity of the second victim.
- **Understanding and Compassion:** Allowing for expression of positive and negative feelings and listening authentically to the second victim's story. Through this process, a caring relationship is co-created between the Caritas responder and the second victim, which opens and awakens the second victim to the possibilities of spiritual growth and healing.
- **Supportive Care:** Creating a healing environment at all levels; a subtle environment for energetic, authentic caring practices to assist in healing the second victim. Through this process, the Caritas responder is able to create space for the second victim to participate in the caring-healing process.

- **Transparency and the Opportunity to Contribute:** Developing and sustaining a loving, trusting, and caring relationship with the second victim. Through this process, the Caritas responder is able to develop a helping-trusting and caring relationship with the second victim that provides the opportunity to learn and make changes within the system while also promoting healing.

A CALL FOR HELP (9)

Dr. Jean Watson notes that as healthcare and nursing mature and evolve, we are uniting with over 20 million nurses and midwives on the planet and more than 7 billion people-all crying out for healing in some way, to be embraced with love and knowledgeable human caring connections.

HEALING THROUGH CARITAS (9,10,11)

The meaning of *Caritas* comes from the Latin word meaning to cherish, to appreciate, to give special, if not loving, attention to.
Core concepts of Watson's Caring theory used for Caritas infused peer support:

- A relational caring for self and others based on a moral/ethical/philosophical foundation of love and values
- Caring occasions/caring moment: Heart-centered encounters with another person
- Transpersonal caring relationships (going beyond ego to higher "spiritual" caring created by "Caring Moments")
- Reflective/meditative approach (increasing consciousness and presence to the humanism of self and other)
- Caring is inclusive, circular, and expansive: Caring for self, caring for each other, caring for patients/clients/families, caring for the environment/nature and the universe

GUIDE TO THE TRANSPERSONAL CARING MOMENT

INTRODUCTION:

- Introduce yourself as a member of the Caritas Peer Support Team and explain the role of the team.
- Provide a brief description of the second victim experience.
- Provide a brief description of Caritas in nursing and healthcare.

MANIFESTING INTENTION: Create, hold and express thoughts, images, feelings, beliefs, desires, will and actions that promote healing:

- Move to a quiet environment where you can give the clinician your full attention and protect their human dignity.
- Be authentically "present" in a way that reaches out to the clinician by listening without interrupting them. In essence, connect with them.
- Allow the clinician to tell their story about the event including how it made them feel and how it has impacted their overall well-being
- Avoid judging or criticizing the clinician about the event
- Offer loving, caring support to the clinician
- Offer Caritas First Aid

APPRECIATING PATTERN: Value the clinician, confirm their worth, and enter into a relationship with them to confirm their worth and uniqueness to the organization and their profession:

- We are all connected in one form or another. Our stories and experiences connect us into a whole. Share your story about a similar event, if you have one, as a means of healing for the clinician
- Provide caring-healing education to the clinician about the normal physical and emotional responses following a second victim event

ATTUNING TO DYNAMIC FLOW & EXPERIENCING THE INFINITE: Let the clinician lead the way. During this process, there is a sensing of where to place focus and emphasis, what to say, and how to move and transition within the transpersonal caring moment.

- Allow for therapeutic periods of silence to allow the clinician to gather their thoughts
- Avoid humor or sarcasm and allow the clinician to end or transition the discussion as they wish
- Provide the clinician with a reflective caritas exercise they can practice in the future to assist in their healing
- Provide the clinician with the guide on caritas infused stress management techniques

FOLLOW-UP & INVITING CREATIVE EMERGENCE: Nurture the transformation and growth of the clinician following the event. Support them on their journey of healing and nurture their renewal and growth.

- Arrange a follow-up meeting with the clinician approximately one week following the first meeting
- Refer the clinician to other professional services if they request or appear to need continuing support

PROCESS OF CARITAS SUPPORT FOR HEALTHCARE PROFESSIONALS

- Healthcare professionals can make a self-referral or supervisors/employers can contact Caritas Renewal and Wellness at any time for support by calling 561-221-1739
- A trained Caritas responder will meet with clinicians involved in a serious adverse clinical event or personal/professional crisis to offer support
- The Caritas responder will provide Caritas "first aid" through use of:
    1. Five Caritas rights of the second victim
    2. The *Guide to the Transpersonal Caring Moment*
    3. A Caritas Renewal kit
- The Caritas responder will offer information about further resources if it is mutually determined that more comprehensive help is needed
- The Caritas responder will follow-up with the clinician as mutually determined

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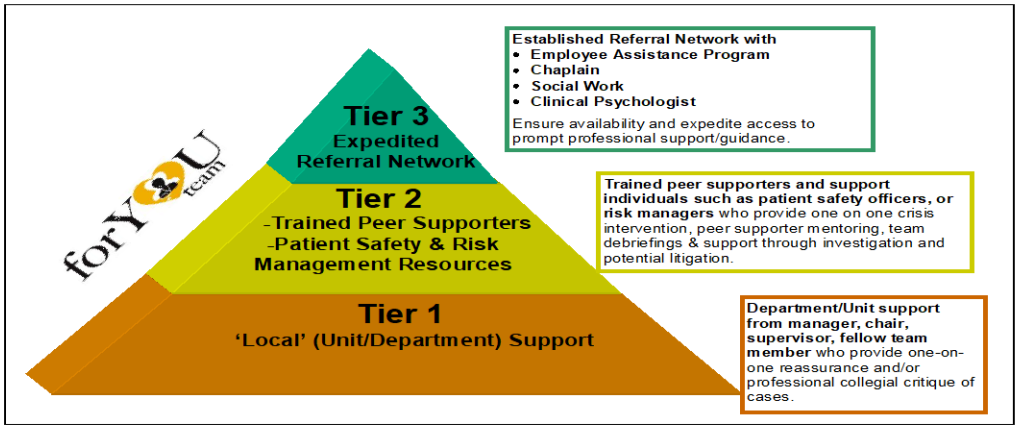
Appendix L

Scott Three-Tier Interventional Model of Second Victim Support

University of Missouri Health System

forYOU team

The Scott Three-Tiered Interventional Model of Second Victim Support



Appendix M

Guide to the Transpersonal Caring Moment

Guide to the Transpersonal Caring Moment

INTRODUCTION:

- Introduce yourself as a member of the Caritas Peer Support Team and explain the role of the team.
- Provide a brief description of the second victim experience.
- Provide a brief description of Caritas in nursing and healthcare.

MANIFESTING INTENTION: Create, hold and express thoughts, images, feelings, beliefs, desires, will and actions that promote healing:

- Move to a quiet environment where you can give the clinician your full attention and protect their human dignity.
- Be authentically "present" in a way that reaches out to the clinician by listening without interrupting them. In essence, connect with them.
- Allow the clinician to tell their story about the event including how it made them feel and how it has impacted their overall well-being
- Avoid judging or criticizing the clinician about the event
- Offer loving, caring support to the clinician
- Offer Caritas First Aid

APPRECIATING PATTERN: Value the clinician, confirm their worth, and enter into a relationship with them to confirm their worth and uniqueness to the organization and their profession:

- We are all connected in one form or another. Our stories and experiences connect us into a whole. Share your story about a similar event, if you have one, as a means of healing for the clinician
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FOLLOW-UP & INVITING CREATIVE EMERGENCE: Nurture the transformation and growth of the clinician following the event. Support them on their journey of healing and nurture their renewal and growth.

- Arrange a follow-up meeting with the clinician approximately one week following the first meeting
- Refer the clinician to other professional services if they request or appear to need continuing support

Cowling, W.R., Smith, M.C., & Watson, J. (2008) The power of wholeness, consciousness, and caring: A dialogue on nursing science, art, and healing. *Advances in Nursing Science*, 31(1), E41-E51. doi: 10.1097/01.ANS.0000311535.11683.d1

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Appendix N

Caritas Peer Support Program Encounter Form

Peer Supporter: _____

Activation:	**Date of Interaction:**	**Length of Interaction:**
☐ New ☐ Mentoring (No direct support provided)		
Professional Type:		
Event Type: ☐ Unanticipated Patient Outcome ☐ Unexpected patient death ☐ Adverse Event ☐ Personal/Professional Crisis ☐ Other unanticipated patient safety event		

Event Outcomes	**Risk Factors**	
☐ No Harm	☐ Community high profile	☐ Palliative care
☐ Temporary Harm	☐ Death of a staff member or their spouse	☐ Patient known to staff members
☐ Permanent Harm	☐ Failure to rescue	☐ Patient that reminds staff of their family
☐ Death	☐ First death under their "watch"	☐ Patient victim of violence
☐ Other	☐ Litigation	☐ Patient 21 years of age or under
	☐ Long term patient	☐ Unexpected patient demise
	☐ Medical error	☐ Young adult patient
	☐ Multiple patients with poor outcomes	☐ Other
	☐ Organ donation	
	☐	

Referrals	**Peer Reflection (No Specific Case Details)**
☐ No Referral Made	
☐ Chaplain	
☐ Clinical health Psychologist	
☐ Employee Assistance Program (EAP)	
☐ Personal Counselor	
☐ Risk Management/Patient Safety Team	

☐ Follow-Up #1	Date of Interaction:	Length of Interaction:

Referrals	**Peer Reflection (No Specific Case Details)**
☐ Not Needed	
☐ Chaplain	
☐ Clinical health Psychologist	

☐ Employee Assistance Program (EAP)		
☐ Personal Counselor		
☐ Risk Management/Patient Safety Team		
☐ Follow-Up #2	Date of Interaction:	Length of Interaction:
Referrals		**Peer Reflection (No Specific Case Details)**
☐ Not Needed		
☐ Chaplain		
☐ Clinical health Psychologist		
☐ Employee Assistance Program (EAP)		
☐ Personal Counselor		
☐ Risk Management/Patient Safety Team		

This interaction tool was revised utilizing the tool developed by Scott et al., 2010 and with the permission of Dr. Scott and the University of Missouri Health Care's forYOU team. Information contained in this document is privileged and confidential and may not be shared with other individuals

Appendix O

Caritas Peer Support Program Budget

Program Expenses			
Salaries/Wages			
	Per Hour	Hours Per Event including follow-up	Cost Per Event
Second Victim Employee	$40	2	$80
Caritas Coach/Peer Support Person	$40	2	$80
Total for Cost of Salaries/Wages			$160
Capital Costs/Caritas Renewal Bags			
Organza bag			$1.15/bag
Four Yogi Calming or Stress Relieving Tea Bags			$2.27/four tea bags
Small Tea-Light Aromatherapy Candle			$3.92/candle
Small Bottle of Essential Aromatherapy Oil			$2.80/bottle
Watson Caring Science Institute Pen			$1.46/pen
Small Personal Journal			$0.56/journal
Dr. Jean Watson's Touchstone Card			$0.74/card
Total for cost of Caritas Renewal Bag			$12.90
Start-Up Capital Costs/Hardware/Equipment			
None			$0.00
Operational Costs/Electricity/Heat/Water			
None: Included in operational cost of hospital			$0.00
Total Project Expenses Per Event			$172.76

The National Academy of Medicine (2018a) recognizes burnout among health care professionals as a threat to safe, high-quality care citing medical errors and medical malpractice suits being linked to burnout. They also note the cost of nurse turnover being roughly $82,000 - $88,000 per nurse and costs to replace one physician as roughly $1 million. These costs alone, not including the cost of the actual medical error, justify the cost of roughly $172.76 per Caritas Peer Support event.

Appendix P

Caritas Peer Support Program Pro-Forma

Pro-Forma Income Statement for Caritas Peer Support Program						
		Q1	Q2	Q3	Q4	YR 1
Caritas Peer Support	Estimated number of Caritas Peer Support events	65	65	65	65	260
	Second Victim Employee Salary	($2,600)	($2,600)	($2,600)	($2,600)	($10,400)
	Caritas Coach/Peer Support Person Salary	($2,600)	($2,600)	($2,600)	($2,600)	($10,400)
	Caritas Renewal Bags	($1,548)	($1,548)	($1,548)	($1,548)	($6,192)
RN Turnover	Estimated number of RN turnovers prevented	1	1	1	1	4
	RN turnover cost savings	$233,600	$233,600	$233,600	$233,600	$934,400
Totals	Operating Costs	($6,748)	($6,748)	($6,748)	($6,748)	($26,992)
	RN turnover cost savings	$233,600	$233,600	$233,600	$233,600	$934,400
	Total Cost Savings	$226,852	$226,852	$226,852	$226,852	$907,408
	EBITA	$226,852	$226,852	$226,852	$226,852	$907,408

Appendix Q

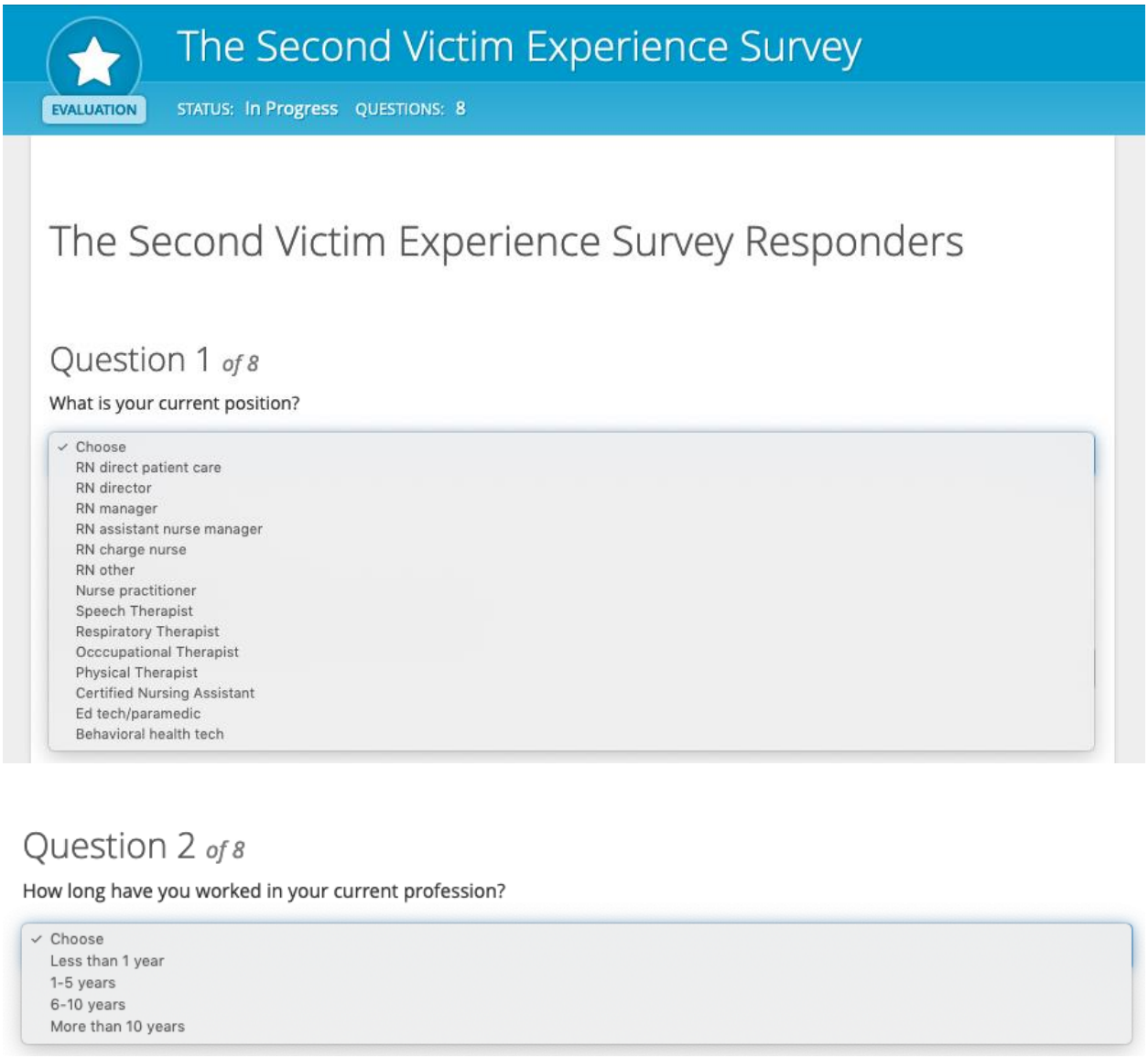
SWOT Analysis for a Caritas Peer Support Program

Strengths	**Weaknesses**
➢ Supports healthcare professionals following adverse traumatic clinical events ➢ Supports healthcare professional retention ➢ Supports safety of care for patients ➢ Supports patient satisfaction ➢ Supports staff satisfaction	➢ No current policy or procedure on supporting employees following an adverse traumatic clinical event aside from an Employee Assistance Program that does not have a focus on trauma informed care of the clinician ➢ No formal system to care for healthcare professionals following an adverse traumatic clinical event ➢ No formal hospital education on the effects of adverse traumatic clinical events on healthcare professionals
Opportunities	**Threats**
➢ Tools and resources DNP student has learned through her certification as a Caritas Coach which are being utilized for project ➢ Connection with Dr. Susan Scott who founded the first nationally recognized program to support clinicians following an adverse event and got her permission to revise and utilize her tools from the Missouri University forYOU program ➢ Increased awareness in healthcare and within the National Academy of Medicine on the importance of identifying and caring for our healthcare professionals ➢ New soon to be published consensus study report by the	➢ Transition in organization's administrative nursing leadership ➢ Busy and chaotic environment that may be a barrier to unit nurses volunteering time to be part of the Caritas Peer Support Program team ➢ Lack of awareness of the second victim by many in the organization and many seeing burnout and compassion fatigue as a normal part of their profession ➢ Foresee difficulty in getting employee buy-in on the importance of the Caritas Peer Support program

National Academy of Medicine on clinician burnout	

Appendix R

Revised Second Victim Phenomenon Survey on Organization Platform and Results



Question 3 *of 8*

How long have you been employed with Delray Medical Center?

- Choose
- ✓ Less than 1 year
- 1-5 years
- 6-10 years
- More than 10 years

Question 4 *of 8*

Have you heard the term *second victim* used to describe healthcare team members who have been emotionally traumatized by an unanticipated clinical event/outcome?

- ○ True
- ○ False

Question 5 *of 8*

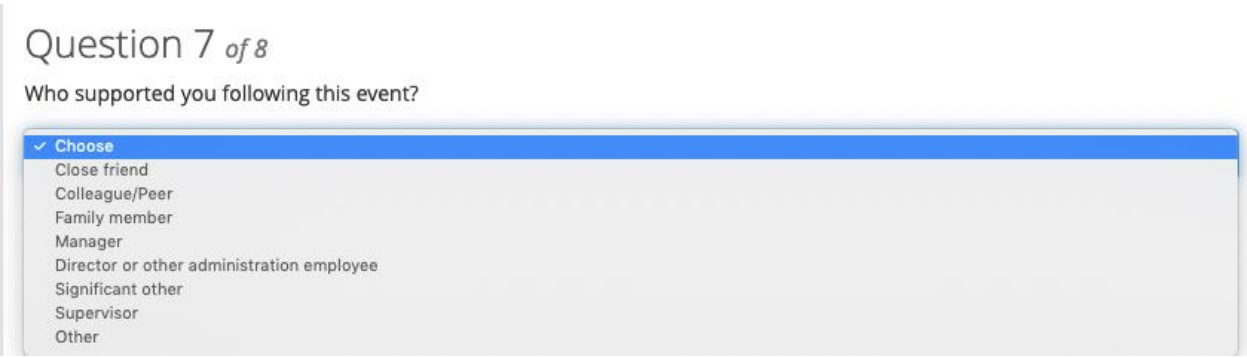
In the past 12 months, were there any clinical events that caused personal problems such as anxiety, depression, or concern about your ability to perform your job? (If yes, proceed to #6; if no, proceed to #8).

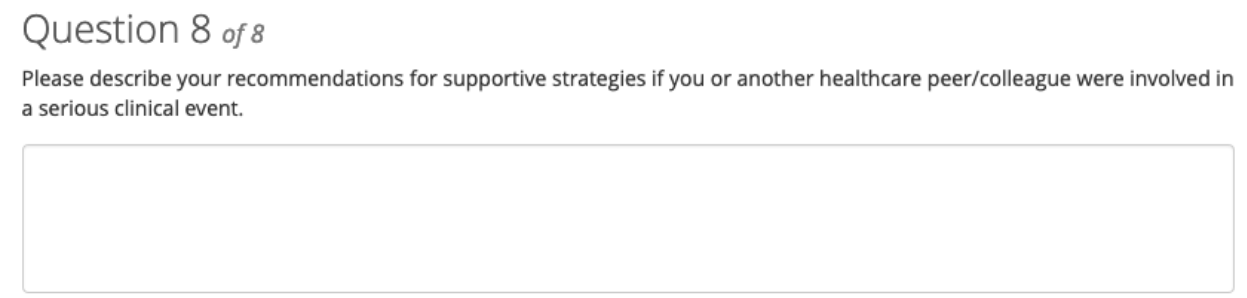
- ✓ Choose
- Yes
- No
- Rather not say

Question 6 *of 8*

Did you receive support from anyone within the Delray Medical Center system?

- ✓ Choose
- Yes
- No
- Rather not say
- I did not ask for support





Second Victim Experience Survey Results

Survey sent to1,035 DMC clinicians which included:

1. All RNs including directors, managers, and ANMs
2. Nurse practitioners
3. Speech therapists
4. Respiratory therapists
5. Certified nursing assistants
6. Emergency department technicians and paramedics
7. Behavioral health technicians

Received responses from 611 clinicians which equaled 59.03% and included:

1. 253 Direct care RNs
2. 6 RN directors
3. 17 RN managers
4. 52 RN ANMs
5. 13 Charge nurses
6. 112 “Other” RNs
7. 15 Nurse practitioners
8. 10 Speech therapists
9. 2 Respiratory therapists
10. 16 Occupational therapists
11. 28 Physical therapists

12. 59 Certified nursing assistants
13. 6 Emergency department techs or paramedics
14. 22 Behavioral health technicians

Survey Results:

1. How Long Have You Worked in Your Current Profession?
Less than 1 year = 13.1% of responses (n=80) 1-5 years = 35.19% of responses (n=215) 6-10 years = 14.73% of responses (n=90) More than 10 years = 37% of responses (n=226)
2. How Long Have You Been Employed by the Organization?
Less than 1 year = 18.49% (n=113) 1-5 years = 40.43% (n=247) 6-10 years = 14.73% (n=90) More than 10 years = 26.35% (n=161)
3. Have you heard the term *second victim* used to describe healthcare team members who have been emotionally traumatized by an unanticipated clinical event/outcome?
Yes = 46.64% (n=285) No = 53.36% (n=326)
4. In the past 12 months, were there any clinical events that caused personal problems such as anxiety, depression, or concern about your ability to perform your job?
Yes = 12.93% (n=79) No = 81.67% (n=499) Rather not say = 5.40% (n=33)
5. Did you receive support from anyone within the organization?
Yes = 8.35% (n=51) No = 40.75% (n=249) I did not ask for support = 40.92% (n=250) Rather not say = 9.98% (n=61)
6. Who supported you following this event?
Close friend = 6.06% (n=37) Colleague/Peer = 10.97% (n=67)

Family member = 6.55% (n=40)
Manager = 2.29% (n=14)
Director or other administrative employee = 0.82% (n=5)
Significant other = 4.42% (n=27)
Supervisor = 1.31% (n=8)
Other = 67.60% (n=413)

7.Please describe your recommendations for supportive strategies if you or another health care peer/colleague were involved in a serious clinical event.

Of the 611 respondents, 340 (55.65%) had no recommendations for this question. For the other respondents, their responses were broken down into the following categories:

1. Employee Assistance Program or EAP/Time off = 13 recommendations or 2.13%
2. Personal or organization provided psychologist/therapist/counseling = 56 recommendations or 9.17%
3. Peer or some other type of support system = 19.80% (n=121)
4. Gave opinion or advice for peers & leaders = 10.97% (n=67)
5. Request awareness of support = 0.65% (n=4)
6. Gave an experience = 0.98% (n=6)
7. Gave response that did not fall under any of these categories = 0.65% (n=4)

Appendix S

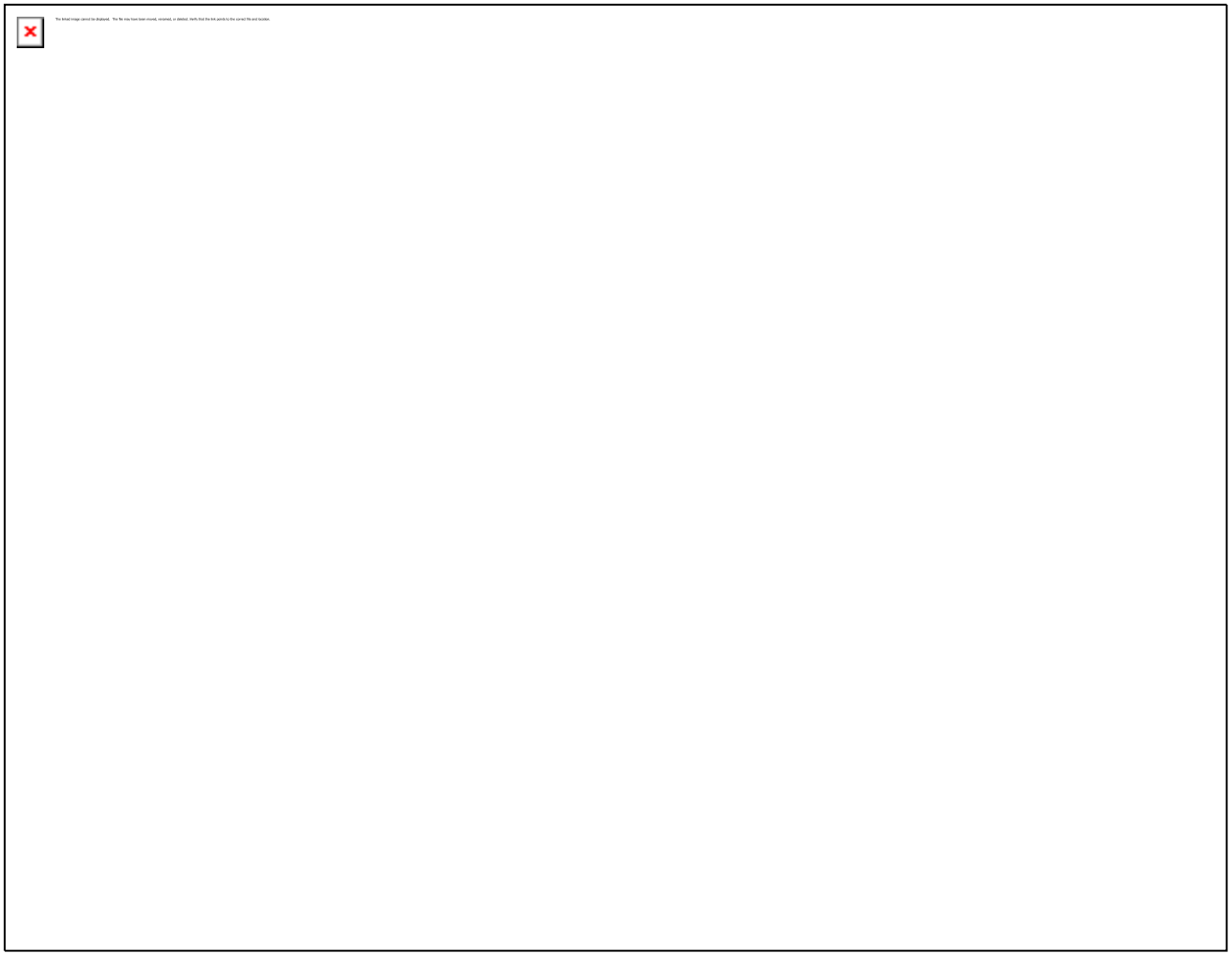
Caritas Peer Support Program Return on Investment and Predictive Financial Benefits of Program

Quarterly Predicted Investment Quarterly expenses is a prediction calculated based on data gathered in 3-month implementation period (August, September, & October 2019), which included 59 encounters (2 encounters were groups) and 117 Caritas Renewal Bags. This included 2 meetings per event of @ 30 minutes each at up to $40/hr for the second victim clinician and the Caritas Coach or peer responder			
Second Victim Employee	Caritas Coach/Peer Support Person	Caritas Renewal Bag	Net quarterly Expense
$40/hr for 0.5 hr. or less per event	$40/hr for 0.5 hr. or less per event	$12.90 per clinician involved in an event	
$2,360.00	$2,360.00	$1,510.00	$6,230.00
Predicted Investment Without Implementation Year 1, 2, & 3 predictions based on status quo with no Caritas Peer Support Program			
Year 1 (2020)	Year 2 (2021)	Year 2 (2022)	3 Year Total
$0	$0	$0	$0
Predicted Investment With Implementation Implementation year 1, 2 & 3 are predictions made based on having roughly the same number of peer support events as the 3-month implementation period of August, September, & October 2019 and utilizing the Caritas Peer Support Program to support the clinician			
Year 1 (2020)	Year 2 (2021)	Year 3 (2022)	3 Year Total
$9,440.00	$9,440.00	$6,040.00	$24,920.00
3 Year Cost Without Implementation	3 Year Cost With Implementation	Net Change in Revenue	
$0.00	$74,760.00	-$74,760.00	
This predicts an investment of $74,760 by the organization over three years if it had the same number of events and encounters as the quarterly period of August, September, and October of 2019. Culture would change and we could move closer to embracing our goal of Relationship-Based Care for our patients and employees as the program progressed. This in turn would be a catalyst for reducing the Second Victim Phenomenon and RN turnover.			
Quarterly Expected Profit			

Cost of RN turnover in the project organization was unable to be obtained so 2016 data from the National Healthcare Retention and RN Staffing Report was used (NSI Nursing Solutions Inc., 2016). This data showed one RN turnover to cost $233,600.00.			
Predicted Profit Without Implementation Without implementation year 1 is based on evidence that 17.5% of nurses will work in a hospital for only 1 year before leaving (University of New Mexico, 2016). Based on an estimate of 10 new RN hires per quarter for 12 months, year 1 would see roughly 7 RN turnovers. Without implementation year 2 is based on evidence that 33.5% of nurses will resign after 2 years on the job (University of New Mexico, 2016). Based on an estimate of 10 new RN hires per quarter for 12 months, year 2 would see roughly 13 RN turnovers. Without implementation year 3 is based on evidence that 43% of nurses will resign within 3 years on the job (University of New Mexico, 2016). Based on an estimate of 10 new RN hires per quarter for 12 months, year 3 would see roughly 17 RN turnovers			
Year 1 (2020)	Year 2 (2021)	Year 3 (2022)	3 Year Total
7 RN Turnovers	13 RN Turnovers	17 RN Turnovers	37
$1,635,200.00	$3,036,800.00	$3,971,200.00	$8,643,200.00
Predicted Profit With Implementation Implementation period year 1, 2, & 3 predicts preventing 3 RN turnovers in year 1, 9 RN turnovers in year 2, and 13 RN turnovers in year 3 respectively.			
Year 1 (2020)	Year 2 (2021)	Year 3 (2022)	3 Year Total
3 RN turnovers	9 RN turnovers	13 RN turnovers	
$700,800.00	$2,102,400.00	$3,036,800.00	$5,840,000.00
3 Year Profit Without Implementation	3 Year Profit With Implementation	Net Change in Revenue	
$8,643,200.00	$5,840,000.00	$2,803,200.00	
This predicts a profit of $2,803,200 to the organization over three years if we reduce the progression of RN turnovers as evident in the evidence. The caritas Peer Support Program has the potential to improve employee satisfaction, and reduce burnout and fatigue, all of which reduce the second victim phenomenon and RN turnover.			
ROI Calculation			
3 Year Predicted Profit	3 Year Predicted Investment	3 Year Predicted Profit Minus 3 Year Predicted Investment	
$2,803,200	$74,760.00	$2,728,440.00	

Appendix T

Caritas Peer Support Program Educational Brochure




Caritas Peer Support Program
Definitions
Caritas in nursing and healthcare:
The practice of bringing caring, love, and heart-centered human to human practices back into our life and work worlds.
Second Victim:
A second victim is a health care provider involved in an unanticipated adverse patient event, in a medical error and/or patient related injury and becomes victimized in the sense that the provider is traumatized by the event. Frequently, these individuals feel personally responsible for the patient outcome and many may feel as though they have failed the patient, second guessing their clinical skills and knowledge base.
Events which can evoke a second victim response:
*Unanticipated patient outcome
*Unexpected patient death
*Serious adverse event
*Personal/professional crisis
*Other unanticipated patient safety event
Caritas Peer Support Program
Clinical Implications:
*Alarming rates of burnout among healthcare professional across the board
*400 physician deaths by suicide annually
*24% of ICU nurses test positive for post-traumatic stress disorder
*39% of physicians suffer from depression
*23 to 31% of primary care nurses suffer from emotional exhaution
Physical Second Victim Symptoms:
*Insomnia
*Poor concentration
*Eating disturbances
*Headache
*Fatigue
*Nausea/vomiting
*Diarrhea
*Rapid heart rate
*Rapid breathing
*Muscle tension
Psychological Second Victim Symptoms:
*Isolation
*Frustration
*Fear
*Uncomfortable returning to work
*Anger and irritability
*Depression
*Extreme sadness
*Self doubt
*Flashbacks
*Feeling numb
Help is only a call away
For help, contact the Caritas Peer Support Team
561-221-1739
Proof

Appendix U

Chief Wellness Officer Job Description

JOB DESCRITION: CLINICIAN WELLNESS OFFICER

TITLE: Clinician Wellness Officer

CLASSIFICATION: Exempt

POSITION SUMMARY: The clinician wellness officer is responsible for the planning, development, implementation and monitoring of hospital-wide clinician wellness initiatives to reduce the second victim phenomenon. Symptoms of SVP include insomnia, fatigue, emotional outbursts, guilt, fear, anxiety, depression, thought of suicide, and reduced job satisfaction – all of which impairs clinical judgement and impacts patient safety (Joint Commission Quick Safety, 2018; Cabilan & Kynoch, 2017). One such initiative would be as the leader of the Caritas Peer Support Program. This is a program based on caring science and led by a Caritas Coach to reduce the risk of clinical staff developing the second victim phenomenon following an adverse traumatic clinical event.

POLICY: When an adverse clinical event occurs, the patient, his or her family, and the health care professional are affected and the patient becomes the priority for the healthcare organization. The healthcare professional can become emotionally traumatized by the event

which can lead to physiological and psychological health concerns that can last for months or years (Joint Commission Quick Safety, 2018). Because of this serious risk to healthcare professionals, the Joint Commission requires that there be defined mechanisms for support of staff who have been involved in an adverse and/or sentinel event as part of the healthcare organization's patient safety program (Hill-Davis, 2011). Joint Commission standard LD.04.04.05 notes that health care workers involved in adverse and/or sentinel events are themselves victims of the event and require support through organizational employee support programs (Joint Commission, 2018; Joint Commission, 2018a).

SCOPE: Hospital-wide

RESPONSIBLE TO: The Clinician Wellness Officer reports to the Director of Risk Management, Patient Safety Officer, Chief Operating Officer, and Chief Nursing Officer of the organization

POSITION QUALIFICATIONS:

1. Bachelor's degree in health-related field from an accredited institution (required)
2. Master's degree or doctoral degree in health-related leadership field from an accredited institution (preferred)
3. Minimum of five years of experience working with executive leaders and bedside employees
4. Knowledge of health and well-being practices and policies
5. Ability to work independently with excellent clinical and relational judgement and decision-making capabilities
6. Well-developed communication and interpersonal skills

7. Experience developing and implementing evidence-based performance improvement plans and projects within complex healthcare systems
8. Experience implementing and analyzing project assessment tools within complex healthcare systems
9. Experience working with interdisciplinary professionals, leaders and team members

ESSENTIAL JOB DUTIES AND RESPONSIBILITIES:

1. Facilitates a culture of physical, intellectual, and emotional wellness for organization clinical employees
2. Develops and implements a comprehensive employee wellness program for the organization
3. Develops and manages the employee wellness program budget
4. Works collegially and productively with Human Resources department, department directors, clinical managers, assistant nurse managers, clinical employees, and hospital stakeholders
5. Instills a just culture to facilitate learning from system defects and communicates lessons learned
6. Collaborates with the patient safety/risk management department to ensure all team members are engaged in the debriefing process and lessons learned from the event analysis are shared
7. Provides guidance on how employees can support each other during and following an adverse clinical event

8. Understands culture and diversity in devising and implementing plans for programs and employee participation
9. Collaborates with Human Resources in promoting the hospitals wellness program and Employee Assistance Program
10. Maintains metrics regarding programs, clinician feedback, outcomes and participation and strives for quality and growth in wellness programming for employees
11. Ensures confidentiality of patients, patient families, and healthcare professionals in compliance with HIPAA standards and other relevant regulations
12. Contributes to a work environment that encourages knowledge of, respect for, and development of skills to promote and support a culture of safety and wellness
13. Remains competent and up-to-date through self-directed professional education, development of professional relationships with colleagues, attending professional seminars and trainings relevant to position, and completing training and/or course work required by the organization
14. Contributes to the overall success of the employee wellness program by performing all other duties as assigned
15. Contributes to the success of the risk management/patient safety department by performing all other duties as assigned

POSITION PHYSICAL REQUIREMENTS: Must be able to sit, stand, walk, squat, bend, reach, twist and climb stairs. Must be able to lift up to 50 pounds, carry up to 24 pounds, push or pull up to 500 pounds on wheeled beds or stretchers. May have occasional exposure to fumes, blood, body fluids, bloodborne pathogens, infectious agents, and biohazardous agents. This

position requires contact with patients, patient family members and/or friends, and hospital employees.

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Appendix V

Link to Caritas Renewal and Wellness for Healthcare Professionals Inc. Website

https://www.caritasrenewalandwellness.org/?fbclid=IwAR3vgSyXi7bx-HCwPzaH-gX9nTRZVE147SP6XzjaschQ4NgWu2FCkGgJS_k