Health Care

The Second Victim Experience: Train-the-Trainer Workshop

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New Jersey Hospital Association

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Today's Objectives

1. Describe the 'second victim' phenomenon and high risk clinical events.
2. Describe the evidence based process used to design and deploy the forYOU team at University of Missouri Healthcare.
3. Describe the six stages of second victim recovery.
4. Understand components of the Scott Three tier model of support to design a plan to support personnel.
5. Review key steps to implementing peer support team training.

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Today's Health Care: The Facts

44,000-98,000 deaths/year in U.S. due to preventable adverse events (Kohn et. al, 2000).

Revised estimates at least 210,000 (and possibly more like 400,000) die in U.S due to preventable harm (James, 2013).

With revised estimates: At least 4 clinicians/patient = 840,000 to 1.6 million clinicians impacted

Could this represent the next healthcare crisis?

Kohn, LT, Corrigan, JM, & Donaldson, MS. (2000). *To err is human: building a safer health system.* Washington, D.C.:National Academy of Sciences Press.

James, J.T. (2013). A new, evidence-based estimate of patient harms associated with hospital care. *Journal of Patient Safety, 9(3), 122-128.*

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History of the PROBLEM

Adverse event reviews – individuals at the ‘sharp end’ noted to be experiencing ‘predictable’ behaviors post event

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Review of the Literature

Medical error: the second victim

Albert Wu, MD

The doctor who makes the mistake needs help too

When I was a house officer another resident failed to identify the electrocardiographic signs of the pericardial tamponade that would rush the patient to the operating room late that night. The news spread rapidly, the case tried repeatedly before an incredulous jury of peers, who returned a summary judgment of incompetence. I was dismayed by the lack of sympathy and wondered secretly if I could

improvements that could decrease errors. Many errors are built into existing routines and devices, setting up the unwitting physician and patient for disaster. And, although patients are the first and obvious victims of medical mistakes, doctors are wounded by the same errors: they are the second victims.

Virtually every practitioner knows the sickening realisation of making a bad mistake. You feel singled

"Virtually every practitioner knows the sickening realization of making a bad mistake. You feel singled out and exposed…..You agonize about what to do…… Later, the event replays itself over and over in your mind"

images of illness have in fact created an expectation of perfection. Patients, who have an understandable need to consider their doctors infallible, have colluded with doctors to deny the existence of error. Hospitals react to

failure to do so earlier and, if you haven't told them, wondering if they know.[1–3]

Sadly, the kind of unconditional sympathy and support that are really needed are rarely forthcoming.

Wu, A. (2000). Medical error: the second victim. The doctor who makes the mistake needs help too. *British Medical Journal*, *320*, 726-727.

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Safety Culture Survey

Agency for Health Care Research and Quality (AHRQ)
www.ahrq.gov

Patient Safety Culture Survey

2 Questions –

1) **Within the past year, did a patient safety event cause you to experience anxiety, depression, or wondering if you were able to continue to do your job?"**

2) **Did you receive support from anyone within our health care system?**

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Second Victim Task Force

Project Leads – Patient Safety and Risk Management

Team Members

- Case Manager
- Chaplain
- Chief Medical Officer
- Clinical Educator
- EAP
- Employee Wellness
- Health Psychologist
- House Manager/Supervisor
- Nursing Department Managers
- Quality Improvement Specialist
- Researcher - Nursing
- Respiratory Care Manager
- Social Service
- Staff Nurses

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Second Victim Defined…..

"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."

Scott, S. D., Hirschinger, L. E., Cox, K. R., McCoig, M. M., Brandt, J., & Hall, L. W. (2009). The natural history of recovery for the healthcare provider second victim after adverse patient events. Journal of Quality and Safety in Health Care, 18, 325-330.

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What is a Second Victim?

A Qualitative Research Project is Initiated……

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Qualitative Research Overview

Participants = 31

Females 58%

Average Years of Experience

- MD 7.7
- RN 15.3
- Other 17.7

Average Time Since Event = 14 months

- Range – 4 weeks to 44 months

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High Risk Scenarios

- Patient ‘connects’ staff member to family
- Pediatric cases
- Medical errors
- Failure to rescue cases
- First death experience
- Unexpected patient demise

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Commonly Reported Symptoms

- Extreme Fatigue
- Sleep Disturbances
- Rapid Heart Rate
- Increased Blood Pressure
- Muscle Tension
- Rapid Breathing
- Frustration
- Decreased Job Satisfaction
- Difficulty Concentrating
- Flashbacks
- Loss of Confidence
- Grief / Remorse

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“ I will never forget this experience……This patient will always be with me – I think about her often…… Because of this, I am a better clinician! ”

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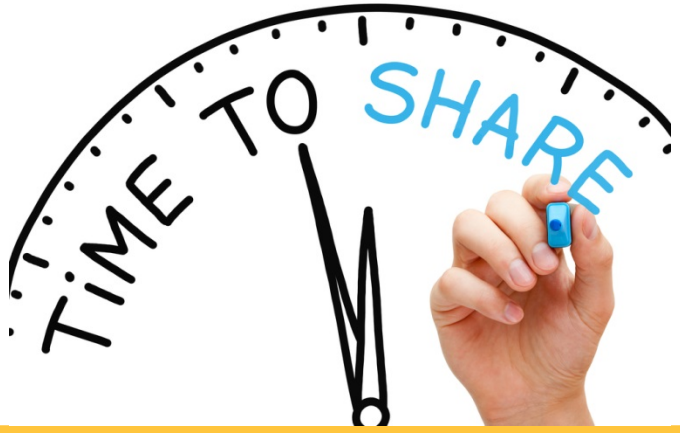
SMALL GROUP EXERCISE

Share a clinical experience when you were personally distressed by an unanticipated patient outcome **OR** describe an event that created distress in a professional colleague.



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Report out

- Describe one of your compelling stories…
- Include:
  - De-identified patient overview
  - What happened?
  - What kind of reactions were identified?
  - What feelings/emotions were expressed?

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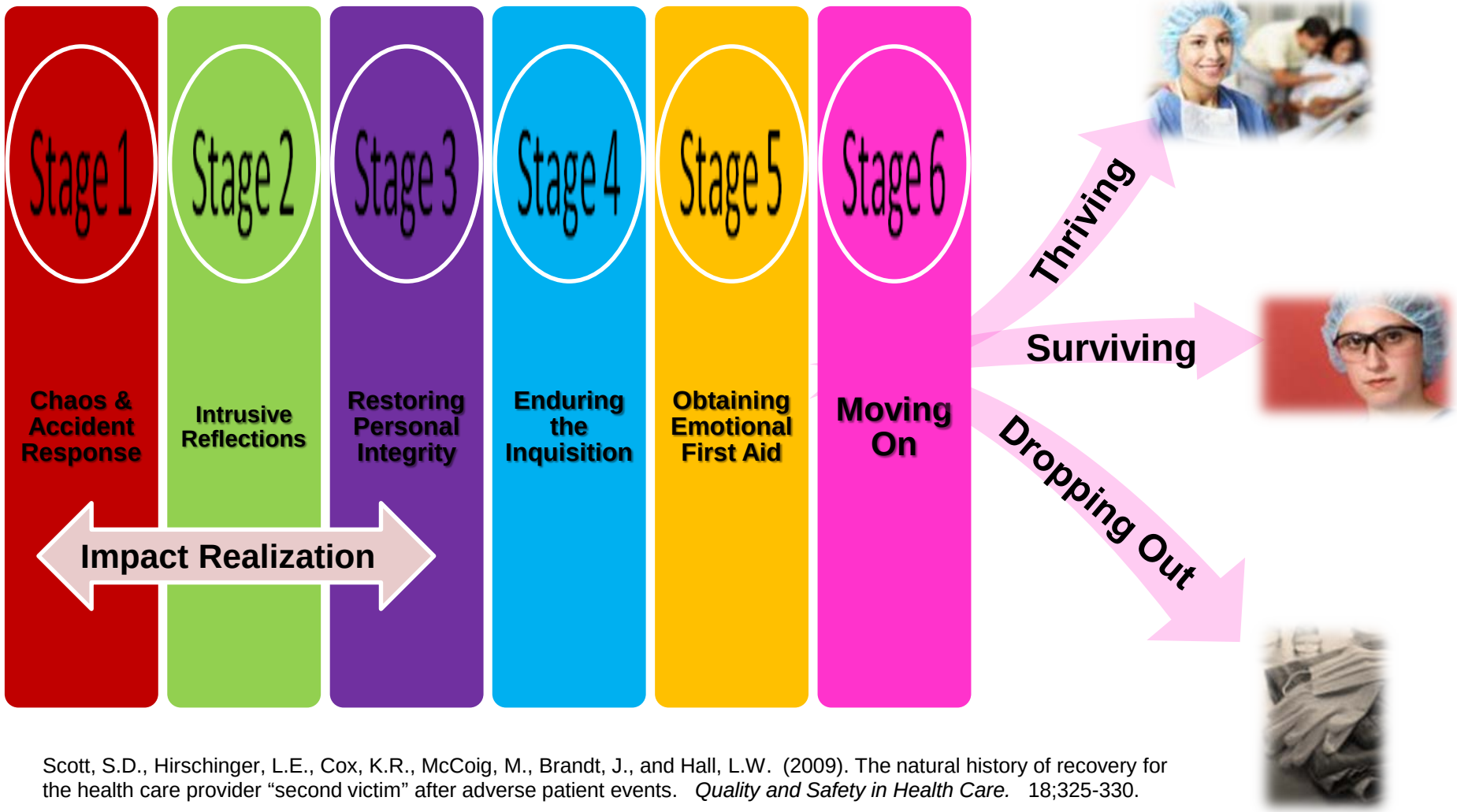
Second Victim Recovery Trajectory



Scott, S.D., Hirschinger, L.E., Cox, K.R., McCoig, M., Brandt, J., and Hall, L.W. (2009). The natural history of recovery for the health care provider "second victim" after adverse patient events. *Quality and Safety in Health Care.* 18;325-330.

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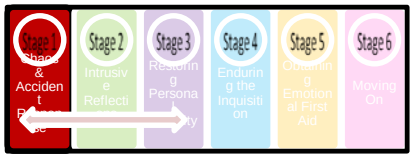
Chaos and Accident Response

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



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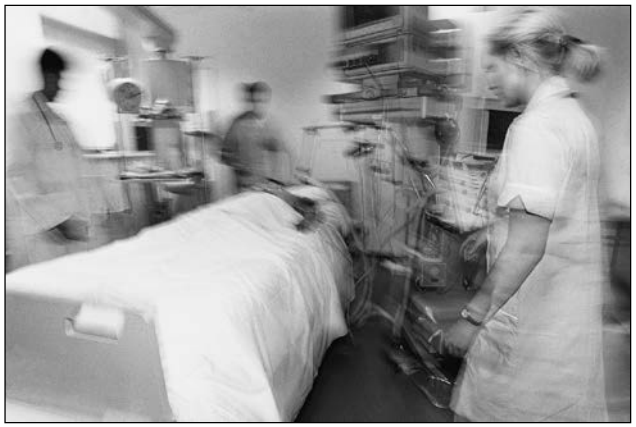
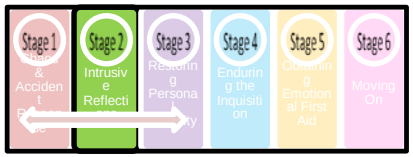
Intrusive Reflections



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



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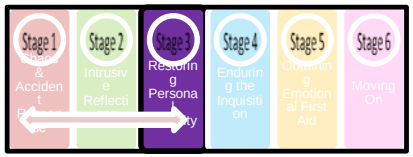
Restoring Personal Integrity



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



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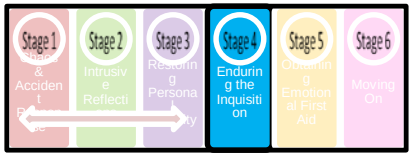
Enduring the Inquisition

“I didn’t know what to do or who to talk to professionally or legally.”

“Clearly, I know we needed to keep that quiet - it might have been helpful to be able to talk to someone else but I couldn’t do that.”



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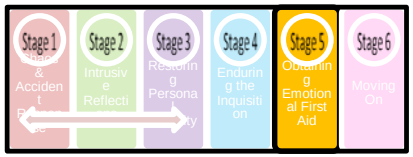
Obtaining Emotional First Aid

“There was nobody I could tell, not even my husband. All I could say is I’ve had a really horrible day.”



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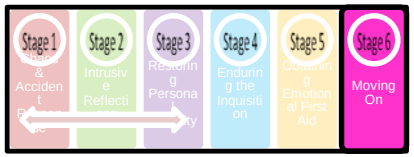
Moving On….Thriving

“I was questioning myself over and over again…but then I thought … I’ve just had this experience in my life where I had to encounter this tragedy but it made me a better person. It really did, and it gave me insight.”



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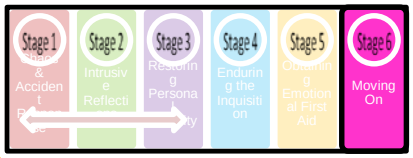
Moving On….Surviving

“I figured out how to cope and how to say yes, I made a mistake. And that mistake caused a bad patient outcome but I haven’t figured out how to forgive myself for that or forget it. It’s impossible to let go.”



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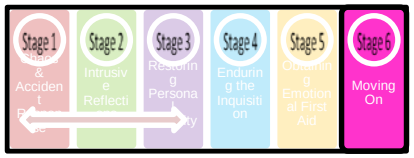
Moving On….Dropping Out

“A fresh start was good for me.”

“I actually ended up moving to a different floor. My new supervisor who oriented me expressed confidence and belief in me and helped me re-grow my own sense of confidence and self belief.”



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Kim Hiatt, RN
March 8, 1961 – April 3, 2011

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Insights Into Dropping-Out

- Vast majority in-patient care (77%)
- 70% related to permanent harm/death of patient
- 50% were direct care providers
- ~58% assumed roles with less or equal risk to similar exposure
- 1/3 of participants reported significant decrease in joy and meaning of work post event.
- Major influencers to change role: 1) Inadequate social support and 2) Effects of emotional labor

Rodriquez, J. & Scott, S.D. (2017). Dropping out and starting over: The impact of adverse events on clinicians. *Joint Commission Journal on Quality and Patient Safety.* 44:137-145. DOI: 10.1016/j.jcjq.2017.08.008.

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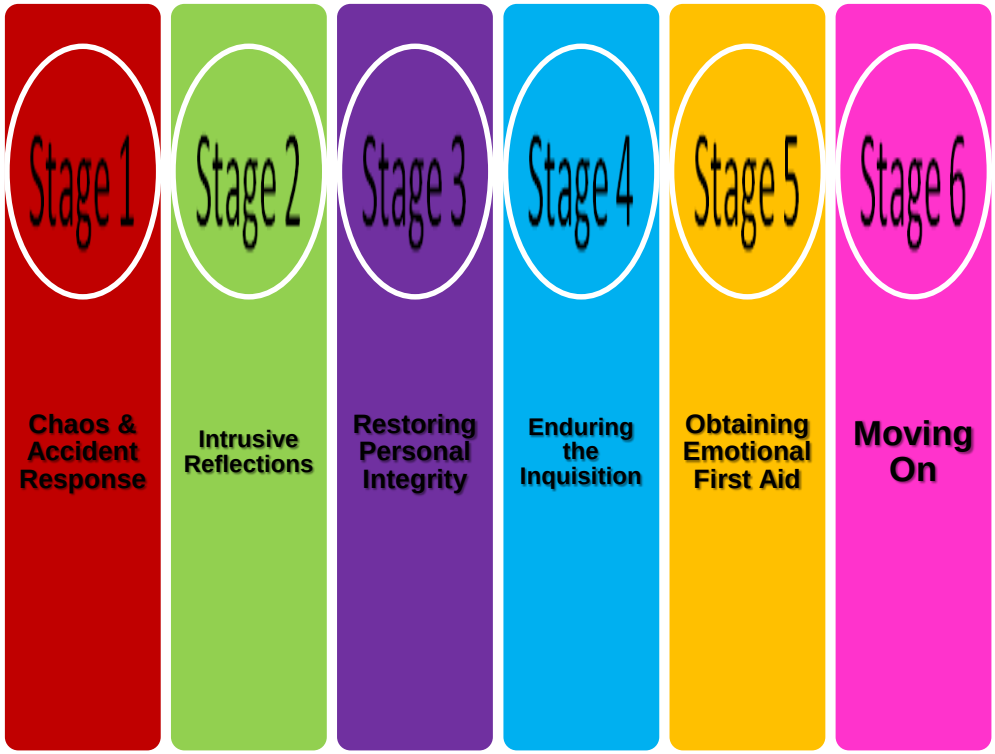
Tripping or Triggering



Reliving the ‘initial’ event when an external stimulus, such as a similar clinical situation, is presented.

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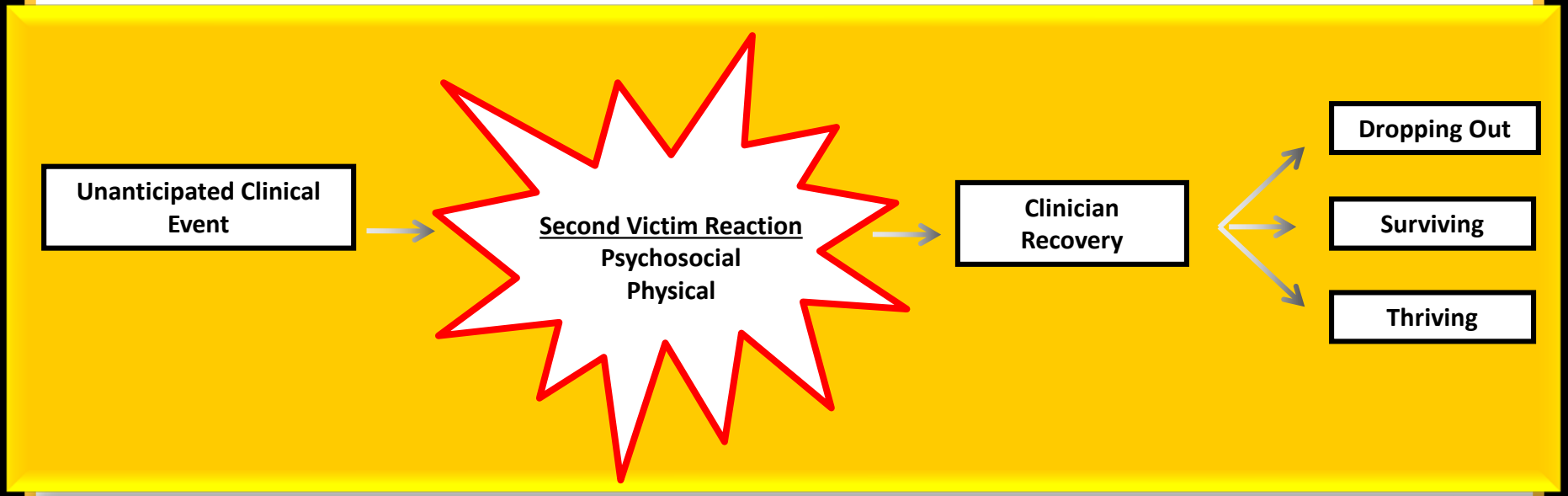
Second Victim Conceptual Model



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A Second Victim Case Study

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The Second Victim Experience: Train-the-Trainer Workshop

Skill Building – Offering Clinician Support

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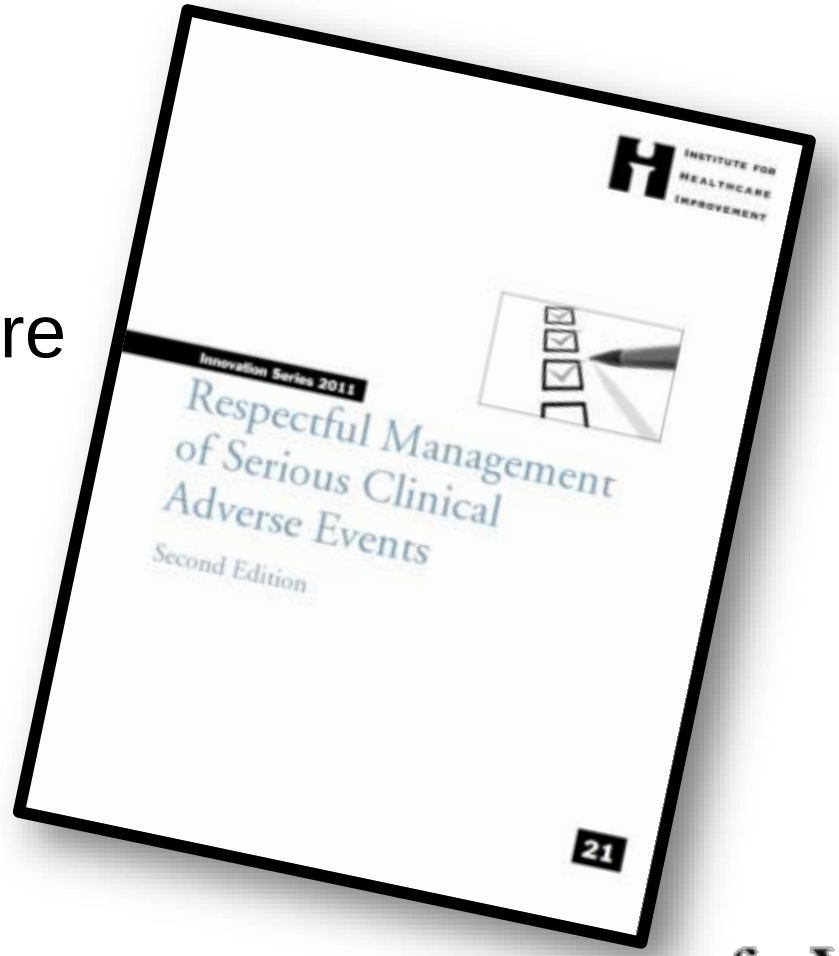
Guidelines for Clinician Care

Institute for Health Care Improvement



http://www.ihi.org/knowledge/Pages/IHIWhitePapers/RespectfulManagementSeriousClinicalAEsWhitePaper.aspx

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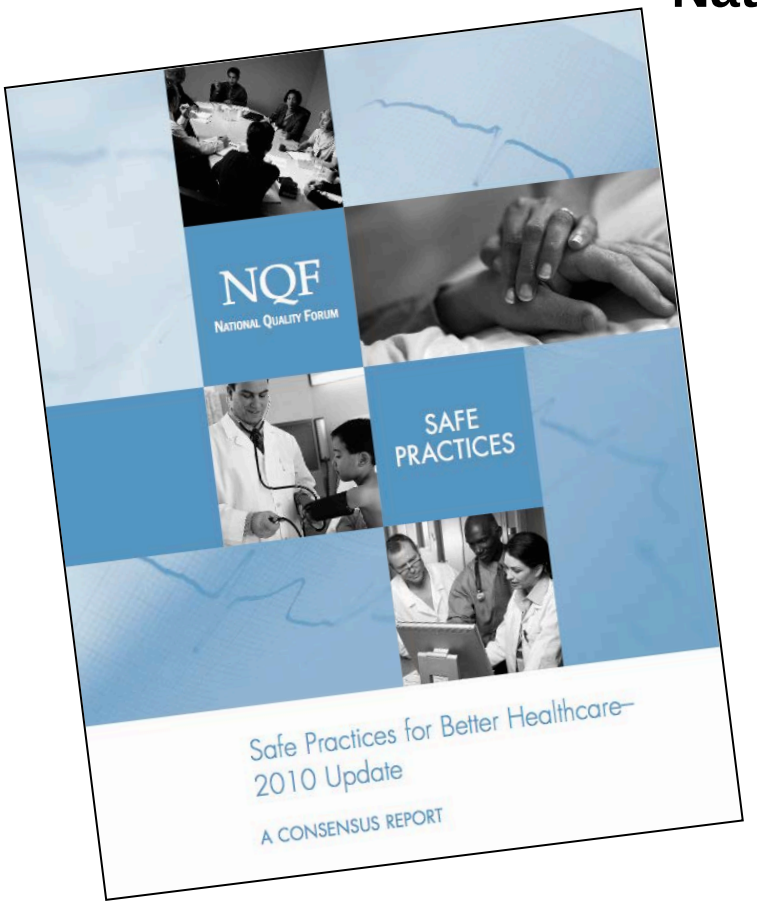
Guidelines for Clinician Care (continued)



National Quality Forum – Safe Practice 8: Care for the Caregiver

Provide care to the caregivers (clinical providers, staff, and administrators) involved in serious preventable harm to patients, through systems that also foster transparency and performance improvement that may reduce future harmful events.

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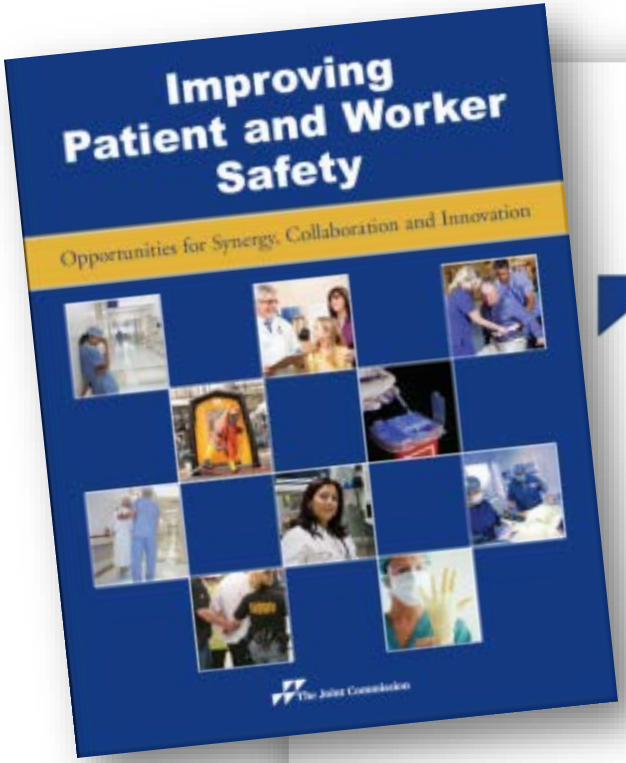
Guidelines - Regulatory



The Joint Commission

LD.04.04.05 – EP 9

The leaders make support systems available for staff who have been involved in an adverse of sentinel event.

http://www.jointcommission.org/improving_Patient_Worker_Safety/

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Clinician Support

No two clinicians have the same support needs!

Awareness is the first intervention –

Proactively plan & educate regarding institutional response plan

Fear of the unknown (next steps) is profound

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Barriers to Receiving Support

Stigma associated with reaching out for help

Organizational patient safety culture

High acuity areas have little time to integrate what has happened

Fear of loss of professional integrity

Fear of loss of licensure

Fear a compromise of collegial relationships because of event

Fear of future legal woes - HIPAA, confidentiality Implications

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Second Victim Interventions

Second victims want to feel...

Appreciated Valued

Respected Understood

Last but not least….Remain a trusted member of the team!

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forYOU Team Objectives….

- **Minimize the human toll** when unanticipated adverse events occur.
- **Provide a ‘safe zone’** for faculty and staff to receive support to mitigate the impact of an adverse event.
- an internal rapid response infrastructure of **‘emotional first aid’** for clinicians and personnel following an adverse event.

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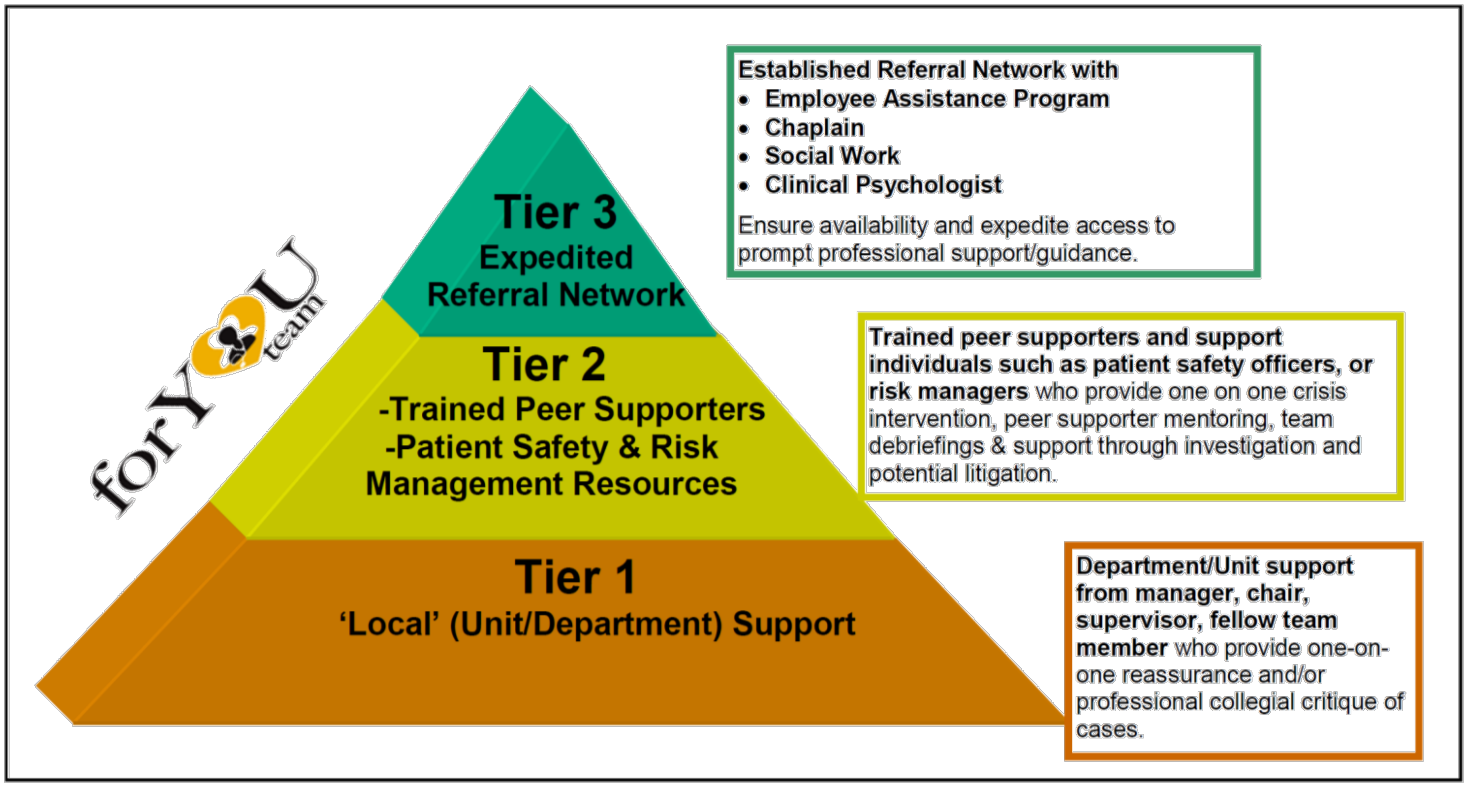
Support Strategies Interventions

The Scott Three-Tiered Interventional Model of Second Victim Support



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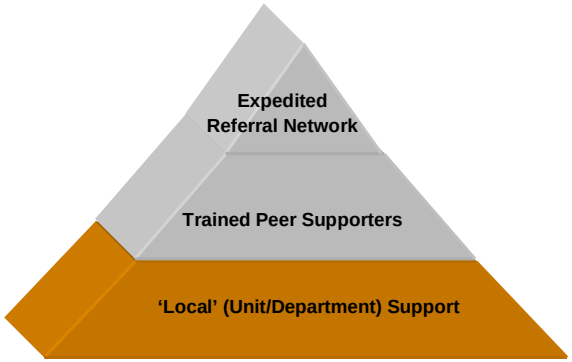
First Tier – ‘Local’ support

Five Key Actions – Department Leaders

- Connect with clinical staff involved
- Reaffirm confidence in staff
- Consider calling in flex staff
- Notify staff of next steps – keep them informed
- Check on them regularly



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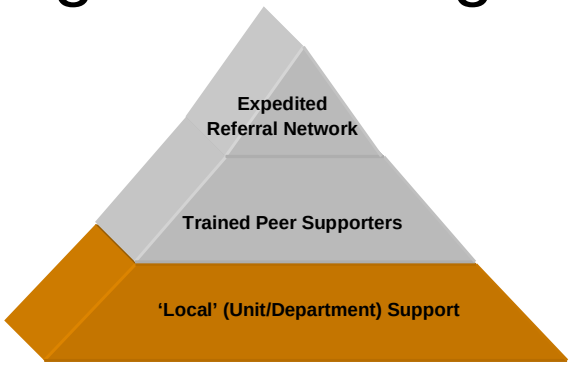
First Tier – ‘Local’ support

Key Actions – Colleagues/Peers

- Be ‘there’ for your co-worker.
- Practice active listening skills and offer support as you deem appropriate.
- Don’t ask about specific details of the event…. Instead, focus on how your colleague is feeling.



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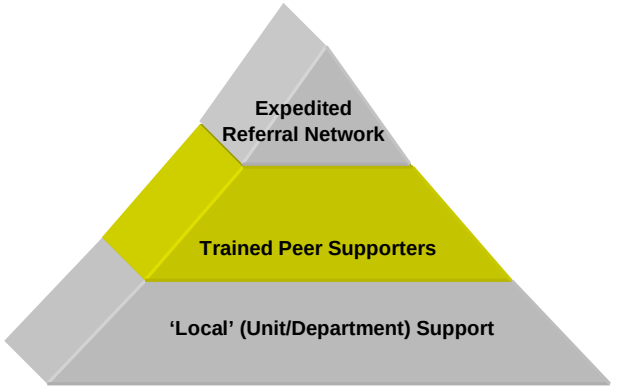
Second Victim Interventions

Second Tier Interventional Strategy

ForYOU Peer Support Team, Patient Safety Representatives, and Risk Management

- **One on one peer support**
- **Team De-Briefings**



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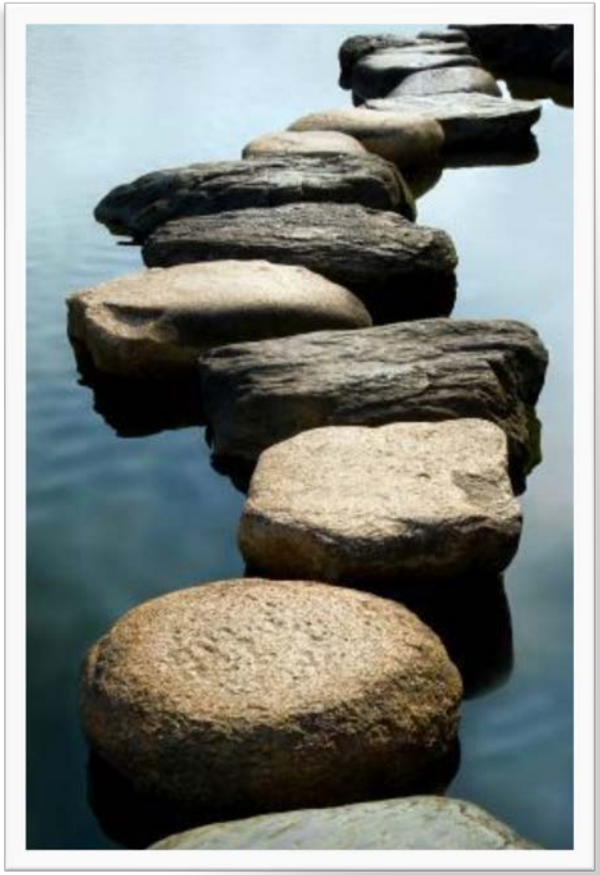
The Supportive Interaction

1. Introduction
2. Exploration
3. Information
4. Follow-up



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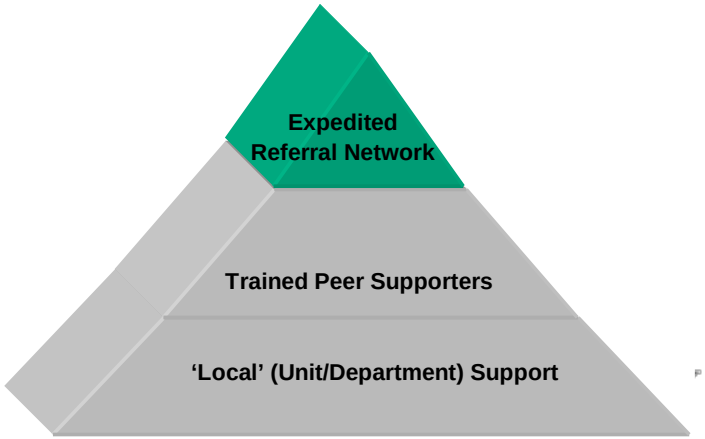
Second Victim Interventions

Third Tier Interventional Strategy

Expedited Referral to Experts = Clinical Psychologists, Chaplains, Employee Assistance Program (EAP), Social Workers, Holistic Nurse or Personal Counselor.



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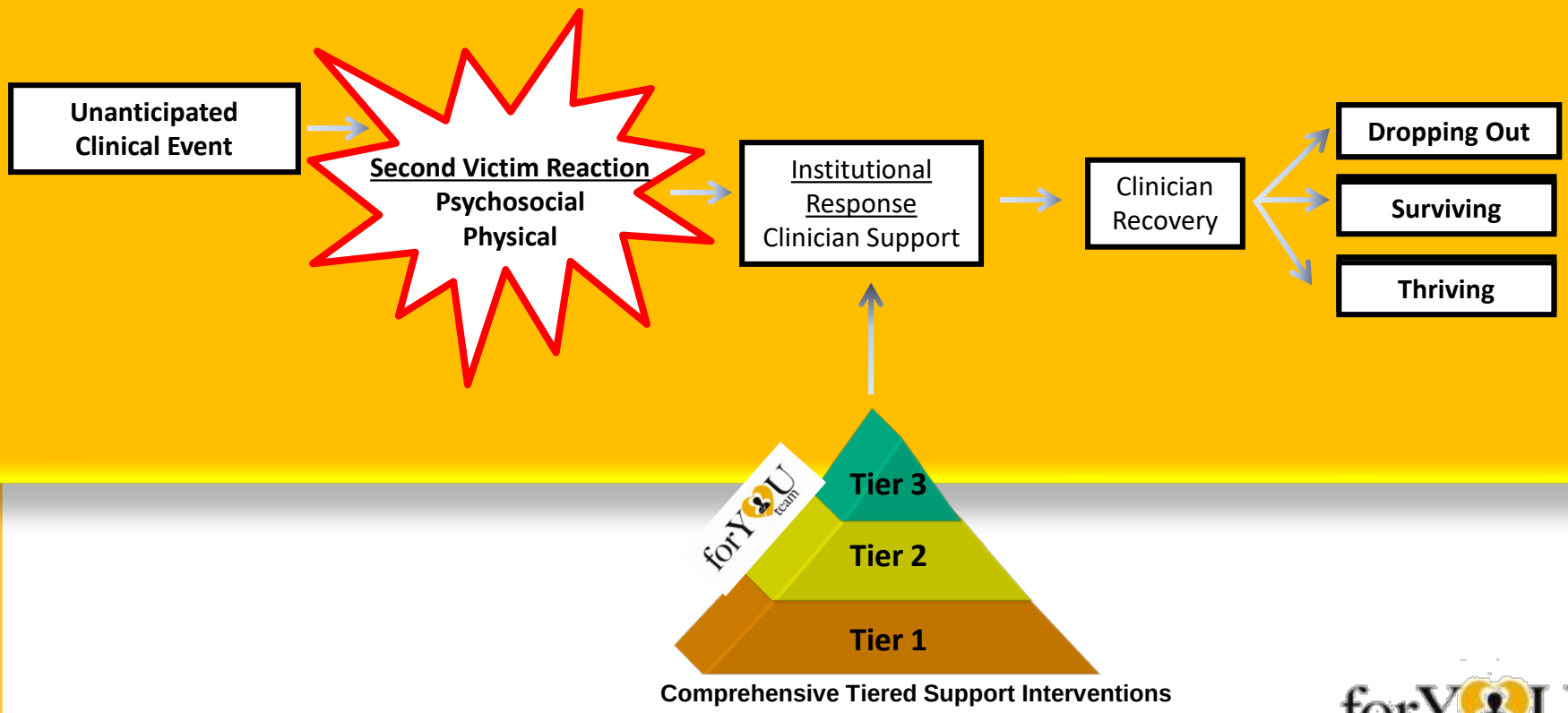
Second Victim Intervention Model



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Traumatic Stress Reaction

“Any event which has sufficient emotional power to overwhelm a person’s ability to cope.”

- Jeffery T. Mitchell, Ph.D.

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Reactions to Stress

Are affected by…

- **Exposure to stressor**
- **Perception of the event**
- **Experience**
- **Personal coping skills**
- **Concurrent stressors**

~Reactions are individual ~

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The Art of Listening
Points to Ponder

- We listen at 125-250 words per minute
  We think at 1000-3000 words per minute

- 75% of the time we are distracted, preoccupied or forgetful

- 20% of the time, we remember what we hear

- Less than 2% of people have had formal education with listening

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Tips for Enhancing Non-Verbal Communication

- Make eye contact.
- Be relaxed and open with your posture. Smile genuinely. Calm voice.
- Sit squarely facing the person. Do not sit behind a desk. Sit at eye level.
- Use good body language—nod your head and lean forward.
- Make the individual feel that you have time.
- Try not to write during this time

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Open-ended Questions

- Questioning in a supportive way
- Ask How and What → Not Yes or No

Example:

- What other experiences/feelings did you have?
- How did that work for you?
- Tell me more about…

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Being Quiet

- Giving the other time to think as well as talk

Example:

Silence is okay, but may be uncomfortable

Watch for when appropriate to break the silence

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Personal Stories

- Sharing relevant personal information

Example:

- I had a similar experience...
- I've been through something like that...
- That happened to me once too...

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Active Listening is NOT:

- Counseling
- Solving another person's problems
- Telling another person what to do
- Interrogating or questioning another person
- Judging another person
- Imposing one's own beliefs on another person
- Providing inaccurate information

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How to provide peer support
Emotional First Aid

- Don't try to fix it!
- Purposefully talk through the experience
- Listen to the story
- Help put incident in perspective
- Conversation used as a "band-aid"

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Benefits of a Clinician Support Network

Staff have a way to **get their needs meet** after going through a traumatic event

Helps reduce the harmful effects of stress

Provides some normalization and helps the individual gett back to their routine after a traumatic event

Promotes the continuation of productive careers while building healthy stress management behaviors

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The Second Victim Experience: Train-the-Trainer Workshop

Lessons Learned from 8 Years of Clinician Support

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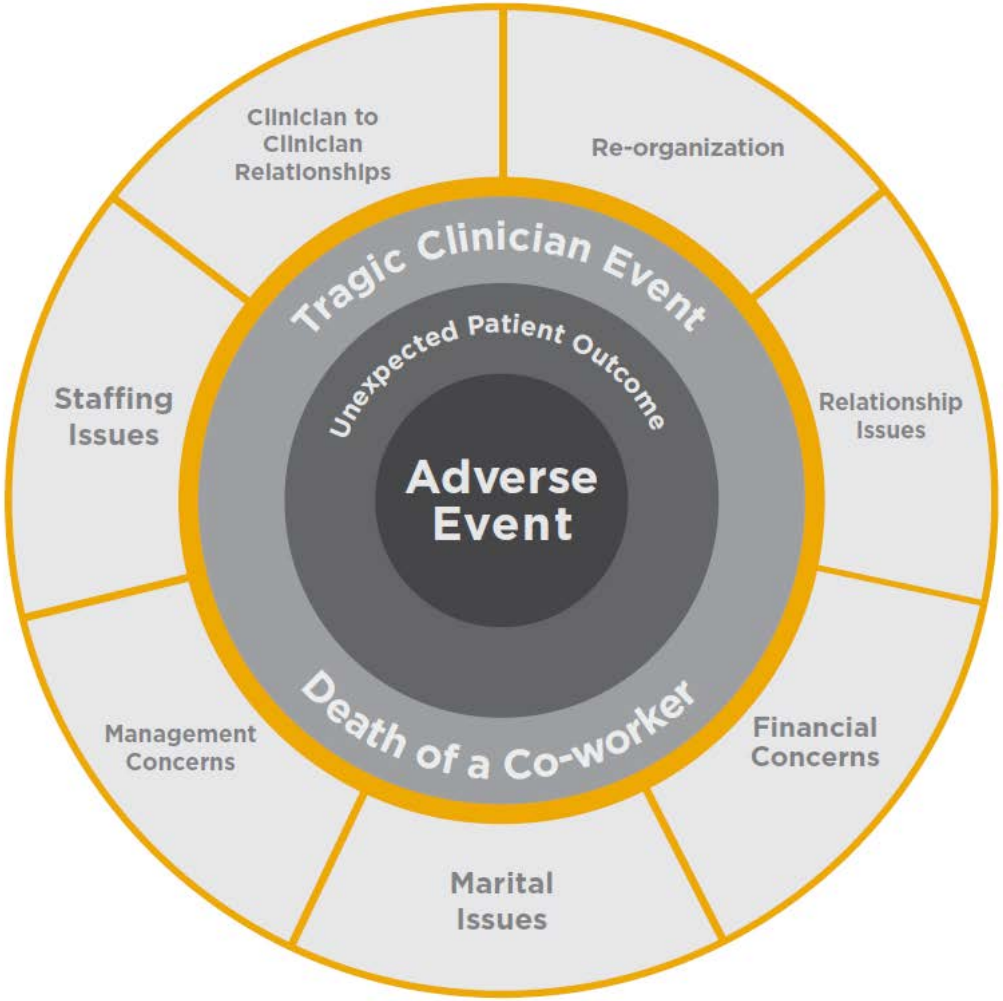
Scope of Service



forYOU team INTERACTIONS

Peer Supporter:

Activation: ☐ New ☐ Mentoring (No direct support provided) **Length of Interaction:**

Professional Type: ☐ MD/DO ☐ RN/LPN ☐ Respiratory Therapy ☐ Pharmacist ☐ EMT-P/EMT ☐ Other

Event Type: ☐ Unanticipated Patient Outcome ☐ Adverse Event (Medical Error) ☐ Personal/Professional Crisis ☐ Other

Event Outcome	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	☐ Pediatric case (21 years & younger)
	☐ Long term patient	☐ Unexpected patient demise
	☐ Medical error	☐ Young adult patients
	☐ Multiple patients with poor outcomes	☐ Other
	☐ Organ donation	

Referrals	Additional Information
☐ No Referral Made	
☐ Chaplain	
☐ Clinical health Psychologist	
☐ Employee Assistance Program (EAP)	**Comments:**
☐ Personal Counselor	
☐ Risk Management/Patient Safety Team	

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

Referrals	Additional Information
☐ Not Needed	
☐ Chaplain	
☐ Clinical Health Psychologist	
☐ Employee Assistance Program (EAP)	**Comments:**
☐ Personal Counselor	
☐ Risk Management	

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forYOU Team Activations

04/01/2009 – 3/31/18

One on One Encounters = 606

Group Briefings = 133 (n=1082)

Leadership Mentoring = 64

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Reasons for Activations

Unexpected Patient Outcomes- 51%

Tragic Clinician Event - 35%

(Staff related 'personal' crisis)

- ***Death of a staff member/family member***
- ***Serious illness of staff member***
- ***Litigation Stress***

Medical Errors- 14%

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Safety Culture Survey

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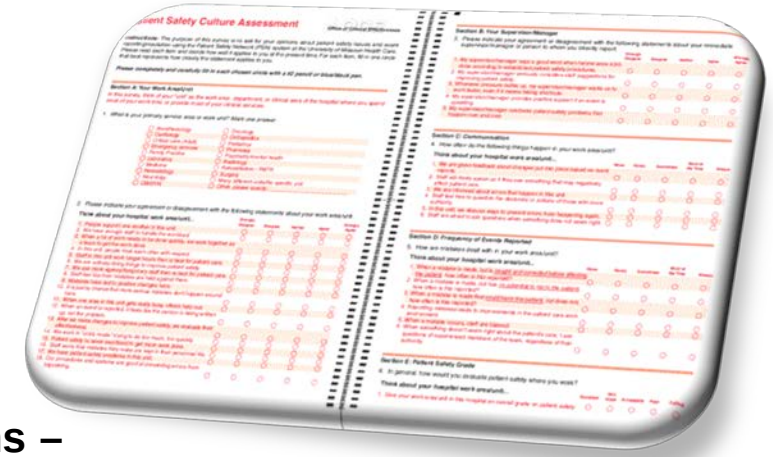

2 Questions –

1) **Within the past year, did a patient safety event cause you to experience anxiety, depression, or wondering if you were able to continue to do your job?"**

2) **Did you receive support from anyone within our health care system?**

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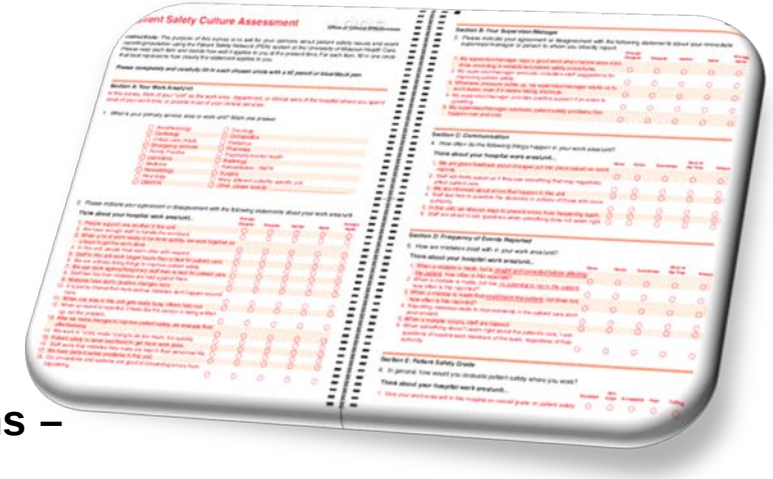
Agency for Health Care Research and Quality (AHRQ)

www.ahrq.gov



3 populations:

1) Non second victim
2) Second victim with support
3) Second victim without support

2 Questions –

1) **Within the past year, did a patient safety event cause you to experience anxiety, depression, or wondering if you were able to continue to do your job?"**

2) **Did you receive support from anyone within our health care system?**

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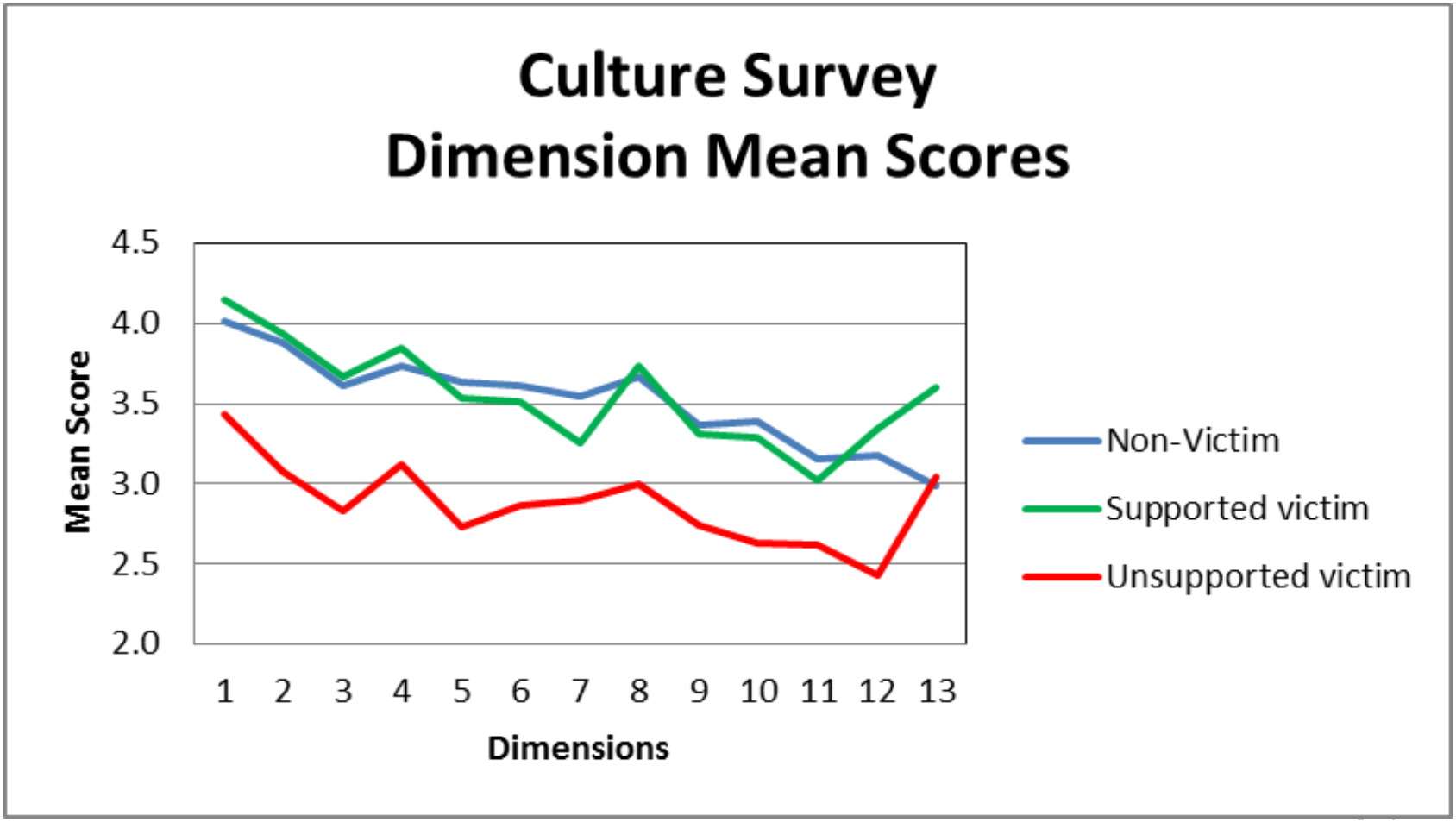
Results



Scott, S.D. (2015). Second victim support: Implications for patient safety attitudes and perceptions. *Patient Safety & Quality Healthcare.* 12(5), 26-31.

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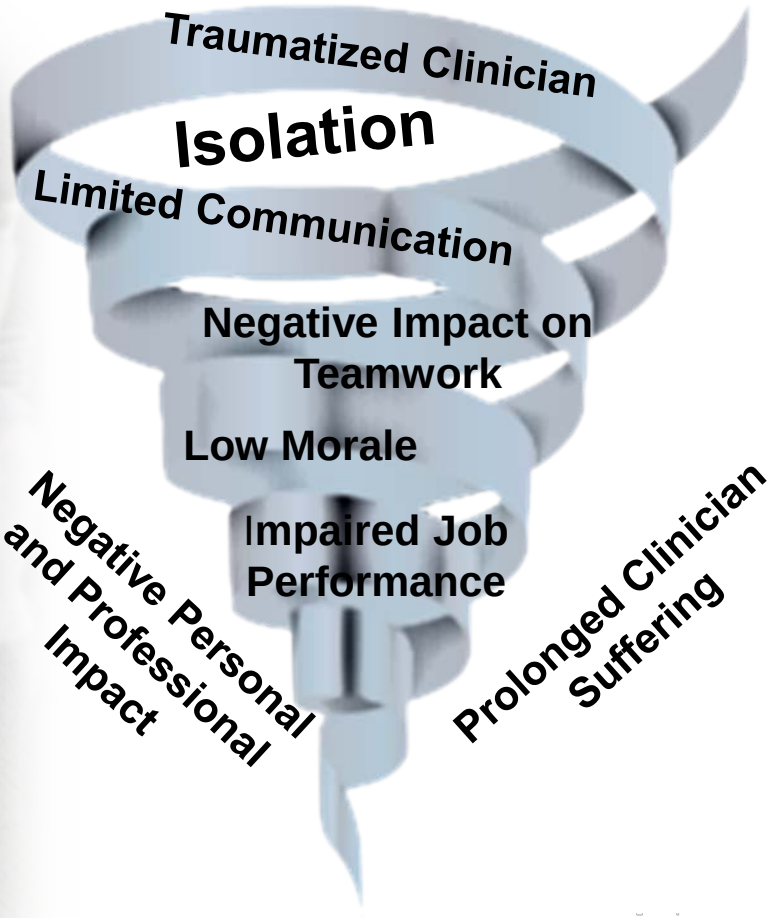
The Aftermath of No Support



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The Second Victim Experience: Train-the-Trainer Workshop

Active Caring – Skill Practice

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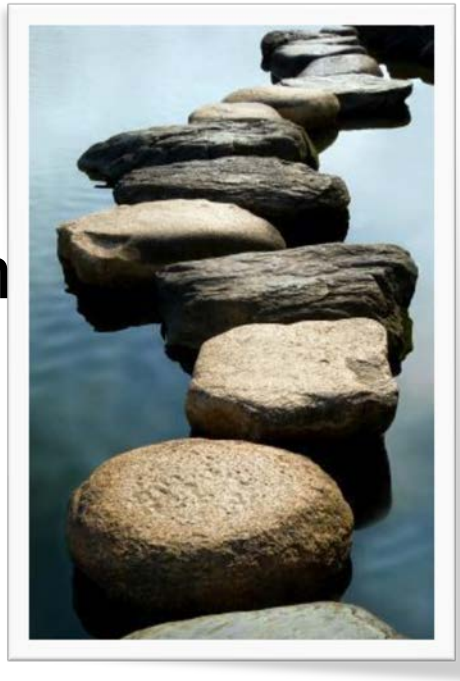
Walking Through the Interaction

1. Introduction
2. Exploration
3. Information
4. Follow-up



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Introduction

Initiate the conversation

Introduce yourself as a peer supporter

Explain the goal of the peer support team

- *How are you doing with this all of this?*
- *What do you need?*
- *I am here if you want to talk now.*

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Exploration

Allow time for the expression of emotions…

What are their thoughts…
What are their reactions…
What are their symptoms…

- *How are you feeling?*
- *What part are you having problems with right now?*
- *Are you having any unusual or disruptive thoughts?*
- *How are things going for you?*

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Information "Normalizing"

Provide information

- Discuss destructive behaviors
- Discuss normal reactions to unusual situations

- *You need to know that you are not the first person in health care to experience these feelings…*
- *This might take some time…*
- *I'm sorry that you are going through this…*
- *What are you doing to take care of yourself?*

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Follow up

Is an additional visit needed?

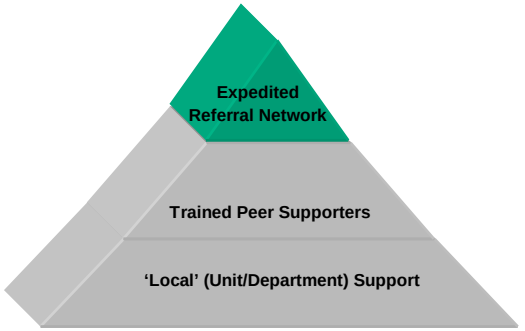
- Provide pamphlets
- Touch base as needed (1 day- 2 wks)

Referral to additional resources

- Patient Safety
- Risk Management
- Department Leaders

Additional assistance

- Contact team leader



I'm available to talk anytime….
Here's how to reach me…..
Here are some additional resources.
Would you like me to connect you with anyone else?

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Communication Advice

- Focus on the person and their experience
- Engage in active listening
- Reflect back what you hear the person say
- Maintain good (non-verbal) body language
- Keep good eye contact
- Validate from your perspective as a peer who has also experienced an unanticipated clinical event

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Words of Caution

- Know your limits
- Know your own issues
- Debriefing of the debriefer is essential

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Tier 2

Emotional Group Support

Facilitated discussion

- Thoughts
- Reactions
- Symptoms

Educate

- Provide pamphlets
- Additional resources

Additional follow up, if required

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Special Considerations

Emotional Group Debriefing

Trained facilitators must facilitate

'Lifeguards' = Peer Team Members

Observer during debrief

Additional follow-up

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The Second Victim Experience: Train-the-Trainer Workshop

Designing a Support Team – Special Considerations

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1. Internal Patient Safety Culture Preparedness/Leadership Readiness

Identify executive champions

Determine location of clinician support command

Adverse safety event investigation process clearly delineated

Reporting culture

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2. Identify Natural Second Victim Supporters

Identify key individuals who routinely assist others

Formalize the role of project team lead

Identify executive champion(s)

Form advisory group to assist with team design and deployment

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‘Natural’ Supporters

- Chaplains
- Clinical Health Psychologist
- Social Workers
- Employee Assistance Programs
- Employee Wellness Specialists
- Health Care Staff
- Holistic Nurse
- Palliative Care Staff
- Patient Safety Staff
- Risk Management Staff

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3. Establish Team Infrastructure

Define team structure

Determine mechanism for providing support

Define activation guidelines for support (individual/teams)

Develop a proposed budget

Develop an executive business plan

Seek administrative approval for proposed team structure

Develop operational plans for response team

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What Should Support Look Like?

Confidential

24/7 availability

Voluntary clinician participation

‘Fast track’ referral to support/guidance

Types of support offered

Who can fulfill role of support

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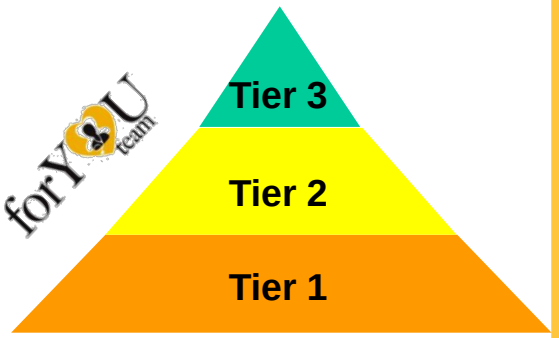
Types of Support Models

- ✓ Peer Support Teams
- ✓ Individuals – Risk Manager, Patient Safety, Various Administrators & Medical Leaders
- ✓ Local Managers
- ✓ Employee Health or Wellness Centers
- ✓ EAP referrals



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Team Recruitment

- ❑ Identify high risk areas
- ❑ Identify high risk clinical events
- ❑ Identify high risk teams
- ❑ Approach managers of the above areas to recruit peer supporters
- ❑ Identified staff to complete team application
- ❑ Welcome letter to new members with training date/time
- ❑ Create an organizational chart

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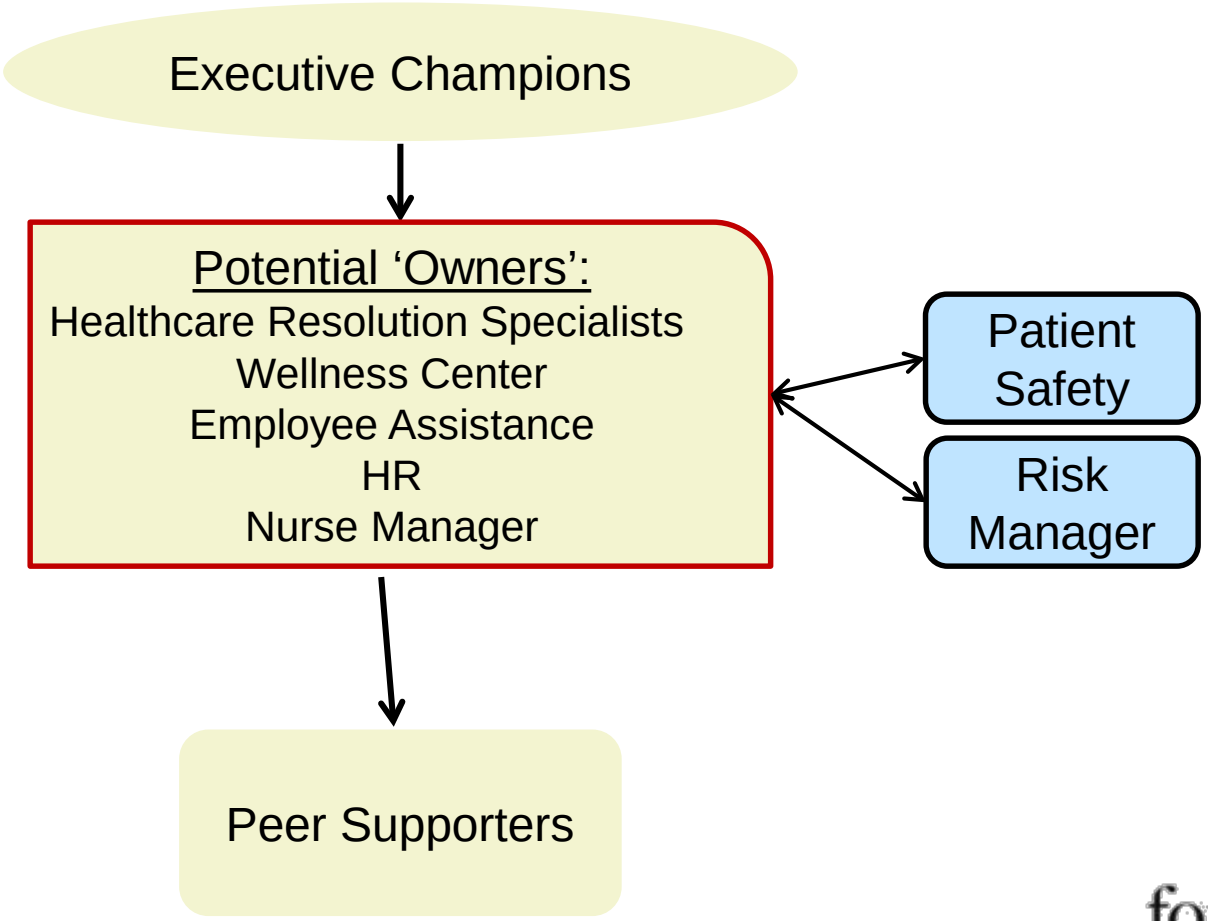
Potential Team Structures



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Develop Team Policies/Procedures

Peer supporter application

Peer supporter agreement

Activation algorithm

Institutional post event support policy

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APPLICATION
forYOU Team Membership

Individuals interested in pursuing membership in the forYOU Team will be asked to complete this application for review by the Membership/Team Structure Committee.

I. **Personal Information**

Name _____

Address _____

City _____ State _____ Zip Code _____

Phone (Home/Cell)_____ Phone (Work) _____

II. **Education Information**
Highest degree of education received _____

Degree received _____ Year_____

III. **Employment Information**

Current unit/department _____Current title _____

Primary shift worked _____ Clinical experience (years) _____

IV. **Clinical experience**
What experience do you have in providing any of the following? (Include specific information about those experiences that are applicable to you)

a. Individual Counseling/Coaching
b. Small group work
c. Stress Management
d. Training or education in other areas (please specify areas)

_____

_____

How did you hear about the forYOU Team?

_____

_____

Why would you like to become a member of the forYOU Team?

_____

_____

Comments or additional information you would like us to know about you to aid in the forYOU Team selection process.

_____

_____

I would like to be considered for the role of forYOU team peer supporter.

Applicant's Signature _____ *Date* _____

I endorse this applicants request to join the forYOU team.

Manager Signature _____ *Date* _____

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Agreement of Understanding

forYOU

Team Membership

I, _____, agree to serve as a **forYOU Team** for a minimum of one year. I agree to the following commitments:

1. Attend mandatory forYOU Team initial training session as scheduled.
2. Participate in forYOU team interventions, meetings and education presentations (estimated at 3-5 hours) per quarter.
3. Attend a minimum of 50% of monthly forYOU team meetings per year.
4. Complete report for each encounter in a timely manner.
5. Maintain strict confidentiality regarding delivery of crisis support services, including topics discussed and personnel involved. Refrain from taking personal notes regarding case specific information. Any breech in confidentiality will result in immediate removal of the individual from the team.
6. Abide by the established team protocols and operational guidelines.
7. Provide at least a four week notice to the forYOU team facility lead in voluntary separation situations.

I have read and understand these commitments and agree to serve as a member of the forYOU Team for a one-year period.

_____

forYOU Team Applicant (Signature) **(Date)**

The forYOU Team Coordinator and Facility Lead(s) agree to the following commitments to team members:

1. Provide the initial/formal forYOU Team training for new members.
2. Provide ongoing educational support.
3. Offer support to team members after forYOU team activation as necessary.
4. Regularly evaluate team operations and membership.
5. Arrange 24 hour/7days a week access via text pager.

_____

Team Facility Lead (Signature) **(Date)**

_____

Team Coordinator (Signature) **(Date)**

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4. Develop Internal Marketing Campaign

Develop second victim awareness strategy

Identify high risk clinical areas within your facility

Identify high risk clinical teams

Embed second victim surveillance strategies into clinical routines

Develop an informational brochure

Identify various meetings to introduce the second victim concept

Develop ‘just in time’ resources for contacting the second victim team

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The In It Together Program

Peer Support For You (PSFU)

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2gether

COPE (Caregivers Overcoming Pressure Events)

Healing Healers

HOPE Helping Our Peers Endure

Grace Unit

Peer Alliance Support Team (PAST)

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RISE (Resilience in Stressful Events)

Commit to Care

Hands to Hold

YouMatter™

Shoulders to Shoulders

Support for Second Affected Victims for Emotional Stability (SSAVES)

HOPE (Healing Outcomes from Pressure Events)

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5. Establish Training Program for Second Victim Supporters

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Training Goal

The second victim course should be designed to prepare an individual to serve as a content expert on the second victim phenomenon and capable of providing peer support to a colleague as indicated.

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Initial Training Planning

- Develop a timeline
- Create an agenda
  - Introductions
  - Executive story
- Identify presenters
- Set due date- presentations & handouts
- Determine all equipment needed
  - Laptop, speakers, pointer, flip-charts, markers
- Determine breaks
- Determine lunch/refreshment/ beverage arrangements
- Secure and select a classroom

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Training Agenda

4-5 Hours

Course Curriculum

- Welcome/Introductions/Course Overview
- A Personal Second Victim Story
- Second Victim Overview
- Skill Building
- Caring in Action – Simulation
- Next Steps

Objectives:

1. Discuss the “second victim” phenomenon.
2. Describe the various stages of second victim recovery.
3. Recognize high risk clinical events, which could expose clinicians to the second victim phenomenon.
4. Summarize various interventional strategies to support clinicians experiencing the second victim phenomenon.

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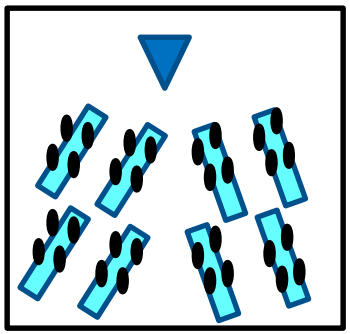
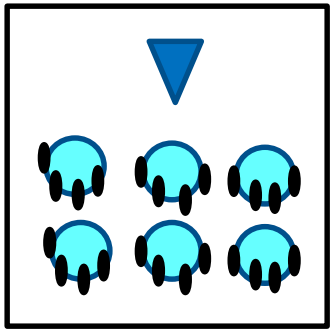
Room Requirements

- ❑ Limit training to 40 individuals
- ❑ Classroom set up
  - ❑ Round tables, use classroom style if not available
  - ❑ 4 individuals at a table (no >6)
- ❑ Arrange for relevant equipment
  - ❑ Laptop, speakers, pointer, flip-charts, markers
  - ❑ KLEENEX
- ❑ PowerPoint presentations downloaded
  - ❑ Backup copy of PowerPoint
- ❑ Handouts
- ❑ Class evaluation form
- ❑ Attendance sheet
- ❑ Lifeguards assigned





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6. Ensure Team Effectiveness

Develop an encounter form to capture general information

Establish a dashboard overview of general team performance

Develop an evaluation tool to assess team effectiveness

Develop a team member satisfaction tool

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INTERACTIONS

Peer Supporter:

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Activation: ☐ New ☐ Mentoring (No direct support provided) **Date of Interaction:** **Length of Interaction:**

Professional Type: ☐ MD/DO ☐ RN/LPN ☐ Respiratory Therapy ☐ Pharmacist ☐ EMT-P/EMT ☐ Other

Event Type: ☐ **Unanticipated Patient Outcome** ☐ **Adverse Event (Medical Error)** ☐ **Personal/Professional Crisis** ☐ **Other**

Event Outcome	**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	☐ Pediatric case (21 years & younger)
	☐ Long term patient	☐ Unexpected patient demise
	☐ Medical error	☐ Young adult patients
	☐ Multiple patients with poor outcomes	☐ Other
	☐ Organ donation	

Referrals	**Peer Reflections (No Specific Case Detail)**
☐ 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 Reflections (No Specific Case Detail)**	
☐ Not Needed		
☐ Chaplain		
☐ Clinical Health Psychologist		
☐ Employee Assistance Program (EAP)		
☐ Personal Counselor		
☐ Risk Management		

☐ Follow-Up **#2**	**Date of Interaction:**	**Length of Interaction:**
Referrals	**Peer Reflections (No Specific Case Detail)**	
☐ Not Needed		
☐ Chaplain		
☐ Clinical Health Psychologist		
☐ Employee Assistance Program (EAP)		
☐ Personal Counselor		
☐ Risk Management		

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forYOU Team Impact – Peer Supporter

"I have been a peer supporter on the ForYOU team for over seven years and it has been one of the more gratifying parts of my job at MU Health Care. It truly brings joy to my every day work when I can help a suffering colleague. What an incredible experience to not only care for our patients but also for our 'own'. Thank you for the opportunity!" forYOU Team Peer Supporter

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Support Evaluation Form

How did we do?

If you've received support from the forYOU Team, please fill out this form. Your comments will be used in a confidential manner to improve the services we provide.

1. I am a:

- ☐ Nurse
- ☐ Physician
- ☐ Pharmacist
- ☐ Respiratory therapist
- ☐ Social Worker
- ☐ Other _____

2. The peer support I received from forYOU was:

- ☐ Extremely beneficial
- ☐ Very beneficial
- ☐ Moderately beneficial
- ☐ Slightly beneficial
- ☐ Not at all beneficial

1. How distressing was this event?

- ☐ Extremely distressing
- ☐ Very distressing
- ☐ Moderately distressing
- ☐ Slightly distressing
- ☐ Not at all distressing

3. How satisfied were you with the experience?

- ☐ Extremely satisfied
- ☐ Very satisfied
- ☐ Moderately satisfied
- ☐ Slightly satisfied
- ☐ Not at all satisfied

4. I would recommend the forYOU service to a colleague:

☐ Yes ☐ NO, Please explain why not _____

_____

_____

5. How can we improve our team? _____

_____

_____

_____

Thank you!

Thank you for taking the time to provide us feedback on the forYOU Team. To submit this survey, please send it via campus mail to:

Office of Clinical Effectiveness
DC 103.40

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Team Meeting Agenda – 3 sections

Spreading the word

-What opportunities can we find in our system?
-Grand rounds, wellness fair, caring rounds, etc.

Encounter discussions

--What Went Well? What to Do Differently with Next Encounter?
Tracking key factors
-Tracking follow up
-Second victim follow up

Educational offering

-Grief and Bereavement
-Moral Distress
-Introduction to Stress Management Model
-General Stress Management
-Active Listening
-Caring for the Caregiver
-Self care

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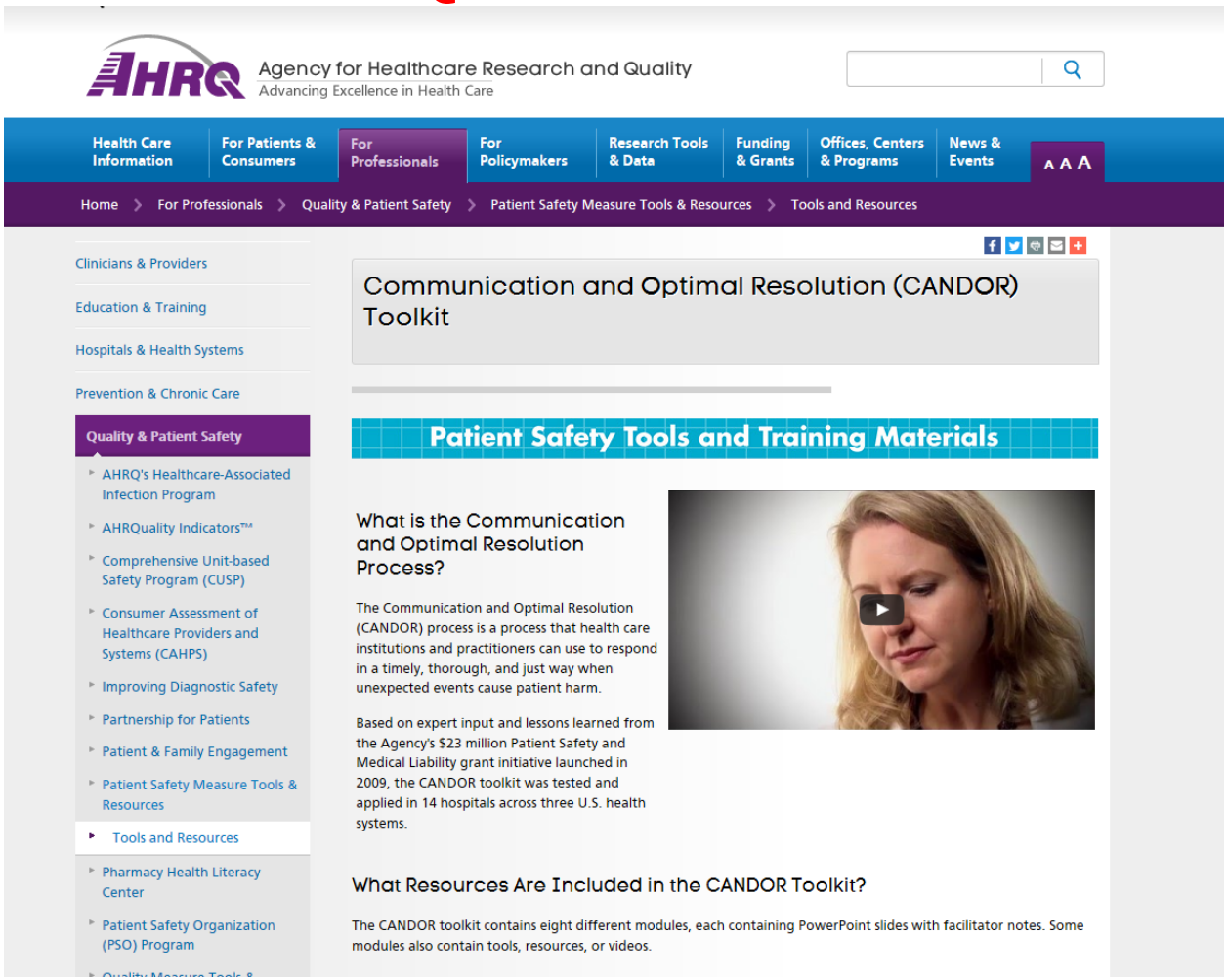
AHRQ – CANDOR Tool



http://www.ahrq/gov/professionals/qulaity-patient-safety/patient-safety-resources/resources/candor

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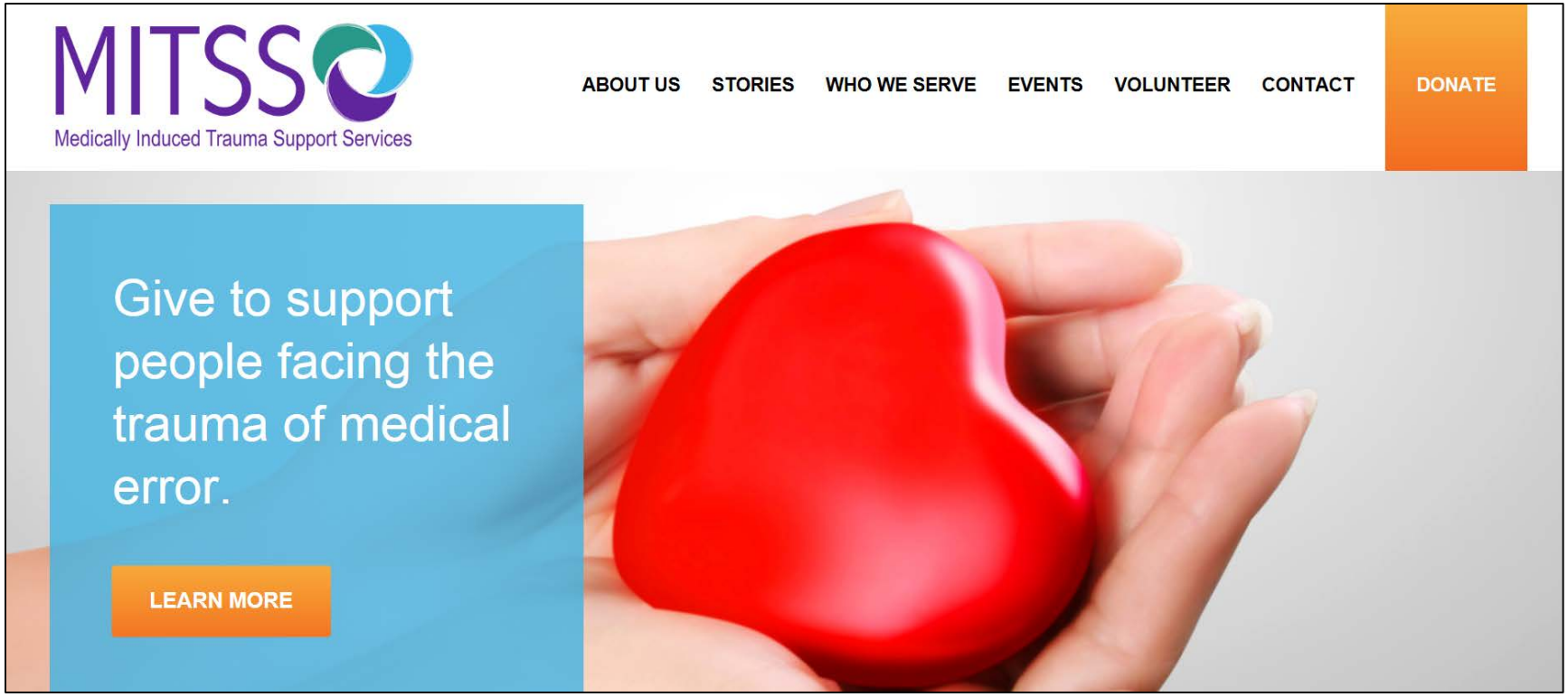
www.mitss.org



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