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Patient Safety Alert

The Necessity of Peer Support

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At 10AM on a Tuesday morning you learn of an unexpected death of a patient in the operating room of your hospital. You know that your colleagues in health care quality will be notified and that a collaborative review of the care will be launched. You know that your hospital has a strong support program for the family members for that patient. Do you know if your staff will receive support?

Background

Clinicians may experience their own trauma in the aftermath of an adverse event. At the instigation of a sentinel event and its response, the AMC PSO convened representatives from its membership. The goal of the AMC PSO was to identify a systematic approach to supporting its hospital-based clinicians and staff in the wake of a traumatic event, whether that event be in the context of care delivery or a clinician or staff member's personal life.

Relevant literature shows that the experience of a medical error or adverse event may significantly impact the psychological well-being of clinicians.[1] When that impact is profound, it has been labelled the 'second victim' phenomenon, a term coined by Albert Wu in 2000.[1] Second victims are defined as health care providers who are involved in an unanticipated adverse event, medical error, or patient injury and "become victimized in the sense that the provider is traumatized by the event".

According to the AHRQ/PSNet's Patient Safety Primer, [1] "Second victims" may:

- Feel personally responsible for the unexpected patient outcome
- Feel as though they have failed the patient
- Second-guess their clinical skills
- Second-guess their knowledge base"[1]

Other characteristics of note[1] for second victims include the following:

- Each second victim's experience is unique
- Some events present a higher risk for inducing a second victim response
- Providers tend to 'worry' in a predictable pattern
- The entire team may be impacted by a clinical event
- Self-isolation is the first tendency of providers [and others] who have experiences a traumatic event[1]

In addition to the impact a traumatic event may have on a clinician's or staff member's psychological well-being, that impact can extend to the individual's ability to practice with a "reasonable mastery of the environment" and its required skills. This may introduce additional risks into high functioning patient safety environments.

The Institute for Healthcare Improvement (IHI) has expanded the "Triple Aim" to the quadruple aim for health care:

1. Improving the health of populations
2. Enhancing the care for individuals
3. Reducing the per capita cost of health care[2]
4. Improving the work life of health care providers, including clinicians and staff" [2]

This additional aim is viewed as essential to success in delivering on the initial three aims. Improving the work life of clinicians and staff is critical to creating a culture and environment that supports quality, safety, and efficiency, and it outlines a pathway to "conversation, dialog, and mutual understanding"[3] between clinicians and staff who are experiencing a problem.

We now recognize that the need for peer support extends beyond a particular clinician or staff member experiencing the 'second victim' phenomenon. A member, who shared data collected and aggregated from their peer support program, indicated that personal issues (e.g. co-worker death, divorce, or a death in the family)[9] are among the most frequently identified reasons for requesting peer support. This underscores the importance of considering the total experience, not only the work-related experience, of an individual clinician or staff member when designing and implementing systems to address IHI's fourth aim.

The panel of subject matter experts that the AMC PSO assembled reviewed literature on current peer support and event response strategies and systems. The panel included clinical leaders from anesthesiology, surgery, emergency medicine, and nursing, as well as leaders from quality, safety, and risk management. The AMC PSO also sought out expertise from beyond the domain of healthcare. A subject-matter expert from law enforcement joined the group to offer a law enforcement's perspective on implementing a peer support program for police officers who had experienced a traumatic event in the line of duty.

From a review of the literature[4] the group learned that in the aftermath of an event clinicians may proceed through various stages of response including:

1. **"Chaos and Accident Response"**
   Clinician experiences internal and external turmoil and may be in a state of shock in the midst of trying to both determine what happened and manage a patient who may be unstable or in crisis. Clinician is distracted and self-reflected, needs others to take over.

2. **Intrusive Reflections**
   Clinician experiences feelings of inadequacy, self-doubt, and loss of confidence. Clinician engages in continuous re-evaluation of the situation through "haunted re-enactments."

3. **Restoring Personal Integrity**
   Clinician seeks support from trusted persons, but may not know where to turn and may be fearful of how others will react. Unsupportive responses from colleagues can impair recovery, as they may intensify self-doubt and make it difficult for the clinician to move forward.

4. **Enduring the Inquisition**
   Clinician braces for the institutional investigation, wonders about the impact on his or her job, licensure, and the potential for litigation. Clinician may be reluctant to disclose information for fear of violating privacy regulations.

5. **Obtaining Emotional First Aid**
   Clinician feels uncertain about who is safe to confide in due to privacy concerns and not wanting to expose loved ones to pain. In the study, most clinicians felt unsupported or under-supported, partly due to ambiguity around whom to approach and what can be discussed.

6. **Moving On**
   Clinicians feel internal and external pressure to "move on," and in the study had three forms of doing so (1) *dropping out:* changing their role,

moving to a different practice setting, or leaving their profession, (2) *surviving:* “doing okay” after acknowledging mistake, but having a hard time forgiving self, finds it "impossible to let go, (3) *thriving:* making something good come out of the event.”[4]

The group was particularly mindful of clinicians’ reported uncertainty about with whom to discuss their experience. When explored via psychometric evaluation, clinicians report that “the most desired second victim support option was ‘a respected peer to discuss the details of what happened.’”[5]

Existing Frameworks for Peer Support

Additionally, peer support, as defined by the American Mental Wellness Association, “is a type of encouragement, advice, and emotional help provided by someone who has experienced the problems you are currently experiencing. [Peer supporters] have ‘been there, done that’ and can provide a unique perspective from someone who understands what [a clinician or staff member is] going through.”[13] A component of the group’s deliberations included a brief survey of the existing structures for peer support that were already implemented in various health care systems. The chief characteristics of any effective peer support program, as described by Wuthnow et al., are “(1) immediacy, (2) proximity, (3) expectancy, and (4) brevity.”[6] Of importance is that the intention of these programs is not to provide long-term psychological or behavioral support, but rather “(1) stabilization (i.e. cessation of escalating distress, (2) mitigation of acute signs and symptoms of distress, and (3) restoration of adaptive independent functioning, if possible, or facilitation of access to a higher level of care.”[6]

CRITICAL INCIDENT STRESS MANAGEMENT

The literature defines a “critical incident” as “any situation or event faced by emergency or public safety personnel (responders) or individuals that causes distressing, dramatic or profound change in their physical appearance or psychological functioning.” Stress resulting from an incident has been described as consisting of 4 major types of signs and symptoms: cognitive, physical, emotional or affective, and behavioral.[6]” The 7 core components of critical incident stress management are:

1. Pre-crisis preparation includes stress management education, stress resistance, and crisis mitigation training for both individuals and organizations.

2. Demobilization/informal briefings/staff advisement is performed at the scene, during the event, or after the event and may involve responders and other community support groups. For the worker actually involved in a protracted event, it may simply involve having a break or time out to refresh, recoup, and perhaps have nourishment.

3. Defusing is a 3-phase, structured small group discussion provided within 12 hours of an incident for purposes of assessment, providing information about critical incident stress (CIS) and resources identifying at-risk individuals, triaging, and acute symptom mitigation. This may promote resolution and minimize the need for additional critical incident stress management (CISM); sessions most often last 30 minutes or less.

4. Critical incident stress debriefing (CISD), utilizing the “Mitchell model,”[7] involves a structured group discussion consisting of 7 phases: introduction (including ground rules); facts as perceived by each individual, although participation is not mandatory; participants’ thoughts related to the event; participants’ reactions to the event; symptoms present; teaching about CIS, how to reduce distress, and resources; and re-entry. A CISD is usually provided 1 to 10 days after the incident and is designed to mitigate acute symptoms, assess the need for follow-up, and if possible provide a sense of post-crisis psychological closure. A CISD may last several hours, depending upon the event and the number of participants. Only individuals actually involved in the incident are permitted to participate. A qualified mental

health professional must be part of the debriefing team.

5. Facilitate one-on-one crisis intervention/counseling or psychological support throughout the full range of the crisis spectrum.
6. Family crisis intervention, as well as organizational consultation.
7. Follow-up and referral mechanisms for assessment and treatment, if necessary

PEER SUPPORT PROCESSES AMONG AMC PSO MEMBERS

During the group's deliberations, three of the AMC PSO's members described aspects of their current systems for peer support.

Example 1 – Decentralized Peer Support Program
One member described a program in which clinicians and staff nominated peers to serve as peer supporters. Once nominated by a peer, the peer supporters attended a training to learn the key components of the program. The training included role playing and information about additional resources within the medical center for added supports. Following the training the Peer Supporters wore self-identifying badges while working in their clinical service areas and a roster of the current peer supporters was released to the organization. Importantly, in this model an individual in search of peer support could approach a nominated peer support provider directly. The project manager for the Peer Support program tracked the number of peer support interactions as reported monthly by the peer supporters. This program also tracked the reasons for the peer support. No identifying information was collected related to the person supported. This program has the benefit of having peers immediately available for help in the clinical areas.

Example 2 – Centralized Office for Peer Support
A second member described a program in which the delivery of peer support was very similar to the program mentioned above, however, the route to gaining peer support was through a centralized office that fielded requests and assigned peer supporters to the person requesting support. This program has the benefit of deploying a more standardized method for peer support. This program also carefully identified and trained individuals who would provide peer support.

Example 3 – Application to be a Peer Supporter
A third organization articulated a program in which any employed clinician or staff person could apply for a role as a peer supporter and then be trained. This program had the benefit of ensuring that those selected for the role had expressed a direct interest in providing peer support.

All three examples included an intentional process for selection of peer supporters, along with training programs. The three crucial aspects of well-defined peer support program that designers and implementers should thoughtfully consider are:

1. Selection and training of peer supporters
2. Reporting structures and accountability for peer supporters
3. Data collection for peer program utilization and maintenance

Effective implementation of a peer support program requires broad awareness among all clinicians and employees within an institution. Additionally, several peer support programs are housed within a larger framework for responding to unexpected events.

Reasons for Seeking Peer Support

An essential component of an effective peer support program is that both the providers and the recipients of the support, know the appropriate reasons for seeking or providing assistance. The group considered the development of a list of event types that would *require* engagement with the peer support program. This list was thought to be important in order to reduce the stigma associated with seeking peer support by normalizing the

approach. Additionally the group considered and deliberated about a requirement that following certain events there is a mandatory process to relieve the clinician from duty and require peer support. Ultimately the group decided that while there should be an offer of peer support following these events, there should not be a hard rule about relieving someone from duty. Rather, the peer support process was described as a moment where the peer supporter checked in with the individual who had experienced a critical incident and then, if needed, facilitated access to additional supports and decision making about how best to proceed.

The group then achieved consensus on the following categories of events that should be considerations for setting a peer support intervention into action:

1. Unexpected death of a patient
2. Unexpected death/suicide of co-worker or co-worker's family member
3. Unexpected Cardiac Arrest/Resuscitation
4. Aggressive, disrespectful, physical workplace violence episode (verbal or physical)
5. Adverse or traumatic event where there is media attention
6. Personal life situation (i.e. divorce, malpractice)

The preceding list was based on examples from programs at other health care organizations, law enforcement,[8] and the feedback generated at AMC PSO deliberations. The list is intended to serve as a starting point for organizations as they customize programs to their own particular needs. When organizations adopt and customize this list they may consider which of these categories would merit a mandatory peer support conversation. For example, most members of the AMC PSO group thought that item 6 was not a topic for 'mandatory' conversation, nor was it necessarily a given that this would be a topic shared in the workplace. However, if a peer or co-worker became aware of a personal life situation, they could choose to check with in the individual. In contrast, item 1 might be identified as an event category that necessitates a check in, irrespective of an individual's vocalized desire for peer support.

Special Considerations

The group also deliberated on the relationship between a peer support program and the policies and procedures for an organization's investigation and formal response to an adverse event. Specifically, there should be policies and procedures for root cause analysis, the protection of that analysis under federal and state statutes for privilege and confidentiality, and response to, and litigation of, a malpractice claim. While the group felt that exploring an opportunity to include a peer support program under the confines of a procedure that meets state and federal standards for privilege and confidentiality would be worthwhile, it stressed that *objectives of a peer support program are mutually exclusive from those of an adverse event investigation*. A peer support program should be thought of as one of several interventions to be considered in response to an adverse event and that the focus for this is on the emotional well-being of those involved not the causal facts of the adverse event.

The following table summarizes one AMC PSO member's description of a peer supporter's specific role:

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WHAT A PEER SUPPORTER DOES	**WHAT A PEER SUPPORTER DOES *NOT* DO**
Normalizes feelings of peer	Participates in Quality Assurance, RCAs
Validates competence of peer	Offers disclosure coaching (there are other resources for this)
Assesses peer's need for resources	Deals with job performance issues
Directs peer to other resources as appropriate	Handles substance abuse coaching or violence prevention
Follows up with peer in the short term and long term to "check in"	Offers malpractice suit support (there are other resources for this)

Closing Remarks

The primary aim of health care organizations is to provide high quality health care to its patients and community. However, high quality health care is dependent upon clinicians and staff who are mentally and physically prepared to deliver it. Peer support is one mechanism for an organization to both communicate to its clinicians and staff that it cares about them and to ensure that there is a clear path for clinicians and staff to seek support in moments of profound emotional distress.

Final Recommendations

1. All programs should maintain some type of peer-support program.
2. The size and style of the program may vary depending on the size of the organization and the nature of the program, but all health care providers should have access to peer supporters.
3. All programs should generate a list of "must-meet" conditions that would mandate at least one meeting with a peer supporter. An example of such a list is included above.

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