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The purpose of this study was to describe hospital nurses' experiences with organizational support following an adverse event (AE). Additionally, this study explored the organization's support programs' usefulness and availability.

AEs occur often in medical procedures and at all levels of the healthcare system. AEs are predictors of quality care and patient safety. While the exact number of AEs experienced by nurses annually remains unknown, it is suggested that all clinicians will experience at least one AE in their professional career. While research has placed great focus on AEs related to nursing through increasing patient safety by cultivating healthcare systems' protocols and procedures, many times caring for the nurse following an AE is overlooked, leaving the nurse to experience professional and personal suffering.

A thorough review of the literature identified the importance of providing support to nurses following an AE. However, research is lacking on the nurses' experiences in regards to organizational support. Twelve hospital staff nurses who had experienced an AE participated in this qualitative descriptive study. Data were collected via in-depth, semi-structured, audiotaped interviews and analyzed using thematic analysis.

Two themes with six subthemes emerged from data analysis. Theme 1 was "Weighing up internal and external resources" and consisted of four subthemes: (a) Types of support, (b) Desired support, (c) Barriers to receiving support, and (d) Availability of support. Theme 2 was, "Thoughts, feelings, and actions" and consisted of two subthemes: (a) Actions taken in the aftermath, and (b) Emotional state in the aftermath.

Findings from the study have implications for nursing practice and research. Nurse managers and the organization play a dire role in providing support to nurses following an AE. Immediate actions that nurse managers should offer to nurses following an AE are unit-specific peer support, unlimited free counseling support, and the offer of time off.

SECOND VICTIM SUPPORT: NURSES' PERSPECTIVES OF
ORGANIZATIONAL SUPPORT

by

Misty Britt Stone

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Approved by

Committee Chair

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APPROVAL PAGE

This dissertation, written by Misty Britt Stone, has been approved by the following committee of the Faculty of The Graduate School at The University of North Carolina at Greensboro.

Committee Chair

Susan Letvak

Committee Members

Cynthia Bacon

W. Richard Cowling III

Celia Hooper

Date of Acceptance by Committee

Date of Final Oral Examination

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PREFACE

The format of this dissertation follows the manuscript option for the School of Nursing at the University of North Carolina at Greensboro and is organized into five chapters. Chapters I, II, and III are the Introduction, Integrative Literature Review, and Methods sections of the study, respectively. Chapters II and IV are manuscripts submitted for publication review written in the publication style of the target journal, and also include their own reference page and appendix.

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CHAPTER I

INTRODUCTION

An error-free healthcare environment is one that is non-existent, and when one makes an error, the work environment is not one that is favorable or forgiving of the individual. In the mid-1980s articles began being published that showcased personal stories from healthcare professionals relaying intense feelings of incompetence and feelings of guilt after being involved in a medical error. While one thinks of a nurse as having strong emotional defenses, being involved in an AE can “shake even the most resilient nurse” (Scott, 2014, p. 1). Dr. Albert Wu (2000) was the first to suggest that physicians experience this type of emotional response and coined the term for these individuals as ‘second victims.’ To expand on this, the first victim is the patient and/or family, the second victim is the clinician (Wu, 2000), and the third victim is the organization (Mira et al., 2017). Scott et al. (2009) define the term second victim as “healthcare 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” (p. 32). Often, these individuals feel they are personally responsible for the error while many feel they have failed the patient, leaving them “second-guessing their clinical skills and knowledge base” (Scott et al., 2009, p.

326). Second victims have reported reliving and fixating on the event for years later and some even decades later.

Denham (2007) acknowledges that the second victim is not limited to only physicians, but nurses and any healthcare worker can and do become second victims. As a second victim, the individual is faced with a lack of sympathy from colleagues, is blamed for the error, and is considered incompetent by others. When faced with such situations, the second victim undergoes emotional and professional injury, “and is left to grapple with feelings of guilt and inadequacy without assistance” (Jones & Treiber, 2012, p. 286).

The intense emotional response experienced by second victims are precursors to what is known as the second victim phenomenon and without emotional support this does not readily resolve. While nearly half of healthcare workers at some point in their career will experience the second victim phenomenon (Seys et al., 2013), many times these individuals suffer in silence (Grissinger, 2014; Hirschinger, Scott, & Hahn-Cover, 2015; Scott et al., 2009).

Wu et al. (2017) note that the prevalence of healthcare providers impacted emotionally by AEs is high. In a study by De Wit, Marks, Natterman, and Wu (2013), the researchers reported that 60% of healthcare providers “reported involvement in an adverse event, of which 66 percent experienced anxiety, depression, or a concern about their ability to perform their job as a result of the experience” (p. 852). The study also estimated the occurrence of the second victim phenomenon to be as high as 43.3% in

which 40.8% of the participants (healthcare providers) described a moderately severe, harmful impact and 2.5% reported a severe impact on their lives (De Wit et al., 2013). Research studies exploring the impact of AEs on clinicians have identified negative feelings experienced by these individuals such as shame, guilt, doubt, denial, and distortion of reality (Mira et al., 2017; Rodriguez & Scott, 2017; Wu & Stecklberg, 2012; Wu et al., 2017). Positive feelings have also been described, but less frequently (Harrison et al., 2015). For instance, healthcare workers have described feelings of empowerment to assert safety concerns after an AE and that their interactions with coworkers and/or patients improved if they “felt well supported, valued, or trusted” (Harrison et al., 2015, p. 29) by the healthcare organization.

Being involved in an AE can be stressful and traumatic for clinicians, causing them substantial distress (Kable, Kelly, & Adams, 2018; Scott, 2011; Seys et al., 2013; Wu, 2000). The effects experienced by the healthcare worker can be so devastating that the individual never recovers. Research shows that when one experiences the second victim phenomenon they have “reduced professional confidence, reduced job satisfaction, and thoughts of leaving the healthcare profession altogether” (Burlison, Scott, Browne, Thompson, & Huffman, 2017, p. 1). Without appropriate organizational support, it has been found that clinicians can experience emotions similar to those seen in post-traumatic stress disorder-like symptoms, while some healthcare workers commit suicide and/or have suicidal ideations (Wu et al., 2017). Research notes that committing another medical error after experiencing the second victim phenomenon increases, therefore jeopardizing

the safety of patients (Burlison et al., 2017). There is growing evidence suggesting that second victims need emotional support in the aftermath of an error; however, most clinicians do not receive such support. Therefore, healthcare organizations have an ethical obligation to provide emotional support to clinicians to help lessen the suffering of the second victim and to ensure patient safety.

Defining Adverse Events

In reviewing the literature, there is neither a standard definition for AEs in healthcare, nor is there a gold standard for measuring and reporting of AEs (Rafter et al., 2015). Table 1.1 provides the various definitions used in nursing research for AEs.

Table 1.1

Definitions of Adverse Event

Definition	Author(s) and citation(s)
An injury that was caused by medical management (rather than the underlying disease) and that prolonged the hospitalization, produced a disability at the time of discharge, or both	Brennan et al. (1991), p. 370
An unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment), that requires additional monitoring, treatment, or hospitalization, or that results in death	Classen et al. (2011), p. 583; Institute for Healthcare Improvement (2006), p. 2
An error resulting in some degree of patient harm (i.e., wrong site surgery, harmful drug overdose)	Harrison et al. (2015), p. 28

Table 1

Cont.

Definition	Author(s) and citation(s)
An unintended injury or complication which results in disability, death, or prolonged hospital stay and is caused by health care management	Kable et al. (2018), p. 238
Unintended injuries or complications resulting in death, disability, or prolonged hospital stays that arise from health care management	Kang, Kim, and Lee (2014), p. 1
An untoward incident, therapeutic misadventure, iatrogenic injury, or other occurrences of harm or potential harm directly associated with care or services provided	Martin, Reneau, and Jarosz (2018), p. 9
An event, preventable or nonpreventable, that caused harm to a patient as a result of medical care. This includes never events; hospital-acquired conditions; events that required life-sustaining intervention; and events that caused prolonged hospital stays, permanent harm, or death	U.S. Department of Health and Human Services (n.d.), p. 1

To add to the ambiguity of defining an AE, the Agency of Healthcare Research and Quality (2018) provide the following subcategories for AEs.

- Preventable adverse events: those that occurred due to error or failure to apply an accepted strategy for prevention;
- Ameliorable adverse events: events that, while not preventable, could have been less harmful if care had been different;
- Adverse events due to negligence: those that occurred due to care that falls below the standards expected of clinicians in the community. (para. 9)

Kagan and Barnoy (2013) point out in their writing that “the definitions are various and diverse” (p. 272) for AEs. The AE definition that is used in this current study is from the U.S. Department of Health and Human Services (n.d.), which states,

an event, preventable or nonpreventable, that caused harm to a patient as a result of medical care. This includes never events; hospital-acquired conditions; events that required life-sustaining intervention; and events that caused prolonged hospital stays, permanent harm, or death. (p. 1)

Background and Significance

AEs occur in almost all medical procedures and at all levels of the healthcare system (Duarte, Stipp, da Silva, & de Oliveira, 2015; Hodak, Kolacko, & Luetic, 2017). Such events are predictors of quality care and patient safety. The most common AEs in nursing are “related to patient falls, administration of drugs, bedsores, insufficient hand hygiene and hospital infections” (Hodak et al., 2017, p. 10). While the exact number of AEs experienced by nurses yearly is unknown, a recent study of 1,790 nurses from across the United States found 49.7% had experienced some sort of medical error in the past 5 years (Melnik et al., 2018).

Research studies dating back to the 1950s began reporting on AEs. However, it was not until the early 1990s with the publication of the results of the Harvard Medical Practice Study in 1991 that people started to become interested in AEs (Brennan et al., 1991; World Health Organization, 2002). Research studies have placed great focus on AEs related to nursing through increasing safety by improving organizational protocols and procedures (Scott, 2011). While this is important, many times caring for the nurse

after an AE is overlooked, leaving the nurse to experience professional and personal anguish (Scott, 2011). However, research in the last few years has begun to emerge on the care and support of the nurse following an AE and/or medical error.

While nearly half of healthcare professionals at some point in their career will experience what is known as the second victim phenomenon (Seys et al., 2013), many times these individuals suffer in silence (Grissinger, 2014; Hirschinger et al., 2015; Scott et al., 2009). Research studies indicate the need for healthcare organizations to develop support programs for nurses after experiencing an AE (Chan, Khong, & Wang, 2017; Edrees et al., 2016; Grissinger, 2014; Joint Commission, 2018; Pratt & Jachna, 2015; Scott et al., 2009), as it is critical for the psychosocial and physical recovery of the nurse (Dekker, 2013). When organizational support is lacking, second victims express an inability to move forward (Scott et al., 2009). Despite this, research organizations infrequently provide such care and support for nurses following an AE (Grissinger, 2014; Pratt & Jachna 2015; Ullström, Andreen, Hansson, Ovretveit, & Brommels, 2014). A small number of studies have made various suggestions for support programs and interventions that can be utilized in healthcare organizations when caring for second victims (Burlison et al., 2017; Edrees et al., 2016; Joint Commission, 2018; Scott et al., 2010). However, as Wu and Stecklberg (2012) note, there is no standard procedure for supporting second victims.

Research studies provide limited descriptions of organizational support programs for nurses following an AE. Furthermore, while researchers propose the various kinds of

support programs or interventions healthcare organizations should implement, how beneficial the programs are remains less studied.

Purpose of the Study

The purpose of this study was to describe hospital nurses' experiences with organizational support after having an AE. A secondary purpose was to explore such programs' usefulness and availability.

Theoretical Framework

Frameworks are described as the map used for a study, providing a rationale for the development of research questions or hypotheses and for keeping the researcher focused on the purpose of the study (Green, 2014). The conceptual model by Schiess et al. (2018) assisted the researcher in framing her thoughts and organizing ways in which the data are presented. The conceptual model's theoretical underpinnings come from Lazarus's model of stress and Antonovsky's "sense of coherence" (Schiess et al., 2018, p. 15). In Lazarus's Theory of Stress, he states that "psychological stress refers to a particular kind of relationship between person and environment. The stress relationship is one in which demands tax or exceed the person's resources" (Lazarus, 1990, p. 3). Antonovsky (1993) suggests that one's health is a movement on a continuum of ease and disease. He notes that the sense of coherence is seen in one's ability to understand the whole situation, along with the capability to use/access the resources available (Antonovsky, 1993). This capability is in combination with one's ability to assess and comprehend the situation in which they find themselves and to find meaning in order to

move in a health-promoting direction (Antonovsky, 1993). From these underpinnings and through a qualitative metasynthesis approach, the Transactional Second Victim Experience conceptual model was developed by Schiess et al. (2018).

Transactional Second Victim Conceptual Model

While previous research studies have defined and discussed the second victim experience, the Transactional Second Victim Experience model (Figure 1.1) is the only conceptual model published on the second victim phenomenon. The full model uses the concepts of appraising the situation, weighing up internal and external resources, restoring integrity, and continuing professional life. The researcher used a partial model focusing on that of weighing up internal and external resources.

The researcher used the partial model because the other parts/constructs of the model focus on describing the second victim experience/phenomenon; however, while this is valuable information, this was neither this study's purpose, nor does this align with this study's method. The purpose of this study was to describe hospital nurses' experiences with organizational support after having an AE with a secondary purpose to explore such programs' usefulness and availability. Therefore, the partial model in the Transactional Second Victim Experience utilizing weighing up internal and external resources was used to frame the study's research questions and analysis.

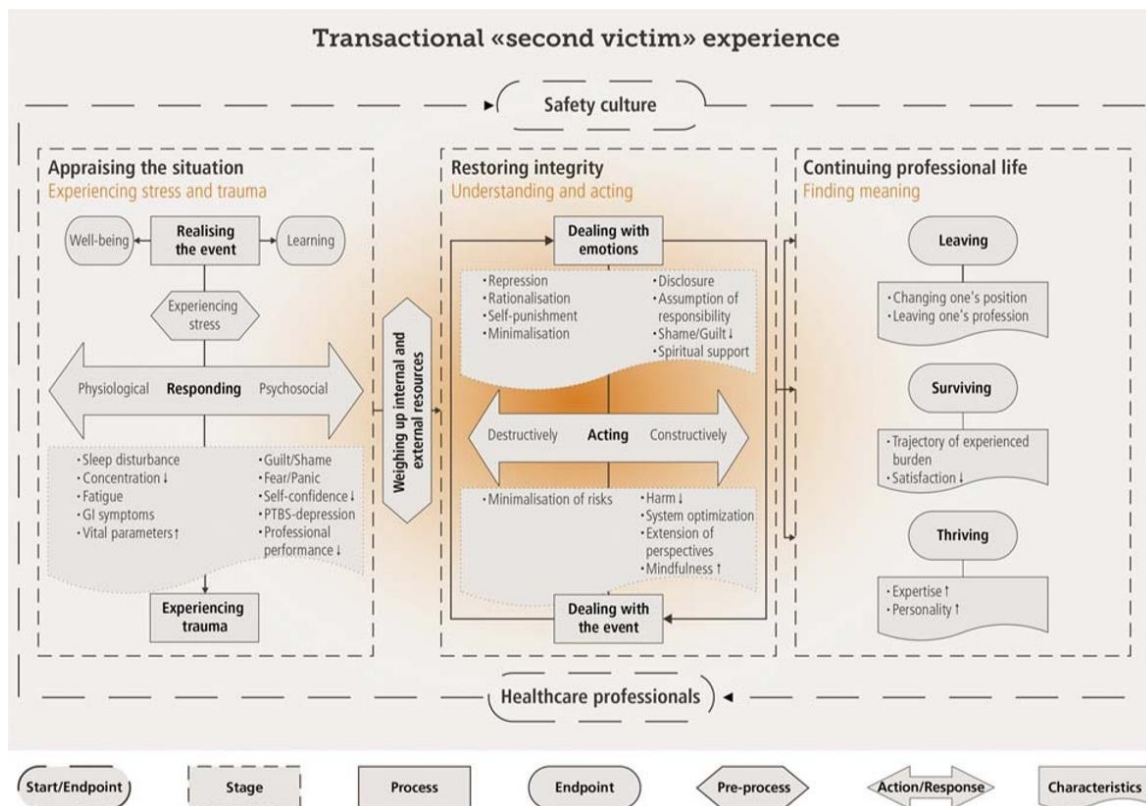


Figure 1.1. Conceptual Model. From “A Transactional ‘Second-victim’ Model-experiences of Affected Healthcare Professionals in Acute-somatic Inpatient Settings: A Qualitative Metasynthesis,” by C. Schiess, D. Scheappach, R. Schewendimann, K. Vanhaecht, M. Burgsraller, and B. Senn, 2018, *Journal of Patient Safety*, Epub Ahead of Print, p. 14. Copyright 2019 by Wolters Kluwer Health, Inc. Reprinted with Permission.

Understanding the internal and external resources that best assist the nurse in moving past the AE is the foundation of providing such support. Internal resources will be the support or interventions that the healthcare organization offers to the nurse following the AE. These are supports that are located inside the healthcare organization, for example, peers, group debriefings, and one-on-one debriefings. The external resources are those that the healthcare organization cannot offer the nurse due to a lack of

resources, not having a formal support program, lack of employee trust, and other various reasons (Dukhanin et al., 2018; Joint Commission, 2018). The healthcare organization refers and assists the nurse in locating outside persons and support programs or the person seeks out their own resources outside of the organization, such as someone in whom they can confide. These external resources may be mental health counseling, crisis intervention, and/or confiding in family and friends. Therefore, research questions were framed around the internal and external resources so as to provide a better understanding of the types of support the nurse utilizes following an AE as well as the supports that work best. This information provided a clearer understanding of effective support programs for these second victims.

Definitions

Adverse event—"An event, preventable or nonpreventable, that caused harm to a patient as a result of medical care" (U.S. Department of Health and Human Services, n.d. p. 1).

Nurse—An individual who has completed a program of nursing education and is licensed to practice nursing. A nurse is prepared and authorized:

(1) to engage in the general scope of nursing practice, including the promotion of health, prevention of illness, and care of physically ill, mentally ill, and disabled people of all ages and in all health care and other community settings; (2) to carry out health care teaching; (3) to participate fully as a member of the health care team; (4) to supervise and train nursing and health care auxiliaries; and (5) to be involved in research. (International Council of Nurses, 2019, para. 4)

Second victim—“Healthcare 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 et al., 2009 p. 32).

Support system—An individual that provides practical, social, and emotional support for others who share similar experiences (Peers for Progress, 2010).

Assumptions

The study had the following assumptions: AEs regularly occur to nurses employed in inpatient settings and these nurses will honestly report their experiences with support programs after having had an AE.

Summary

It is imperative to the nurse’s psychological health that healthcare organizations effectively support second victims following an AE. In order for healthcare organizations to provide appropriate support, research is needed to understand what types of support are currently being offered to nurses in addition to nurses’ experiences with those supports. Obtaining nurses’ unique perspectives can assist healthcare organizations in strategically developing effective support programs.

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CHAPTER II

MANUSCRIPT ONE: INTEGRATIVE LITERATURE REVIEW—SECOND VICTIM SUPPORT PROGRAMS FOR HEALTHCARE ORGANIZATIONS

Abstract

Introduction: Second victims require the support of the healthcare organization following an adverse patient event. Managers and leaders of healthcare organizations have an ethical responsibility to provide such support.

Methods: The purpose of this integrative literature review using Whittemore and Knafl's (2005) methodology was to quantify, evaluate, and describe research publications in the United States from 2009 to 2019 with regard to second victim support programs in healthcare organizations.

Results: After the utilization of Boolean operators, 11 articles were identified from ProQuest, PubMed, Cumulative Index of Nursing and Allied Health Literature, Google Scholar, Medline, Electronic Journals, and reference lists. Following an adverse patient event, respondents wanted immediate support from the healthcare organization and their supervisors, with additional 24 hours a day, 7 days a week peer support, and knowing how much information could be disclosed and with whom they could disclose.

Respondents suggested having time off to process the event and having a procedure for staff to follow after experiencing an adverse patient event would be helpful. The second victim support program most often cited in the literature was the forYOU peer support

program made up of trained peer supporters who respond to the second victim within 12 hours or less following the event, utilizing one-on-one debriefings and group debriefings.

Conclusion: While research suggests healthcare organizations need support programs to assist second victims in coping in the aftermath of an adverse patient event, it remains unclear if the majority of healthcare organizations offer such support. This literature review assists organizations in better understanding the types of support that are offered (i.e., peer supporters, group debriefings, and/or one-on-one peer support) as well as suggestions for those organizations who are in the planning phases of a support program.

Introduction

Although it was undefined and unnamed, the second victim concept was first introduced in 1954 when two surgeons shared their unexpected operating room catastrophes along with the emotional impacts that followed their experience (Johnson & Kirby, 1954). For reasons that are unclear, the second victim phenomenon is not commonly recognized in healthcare organizations today (Daniels & McCorkle, 2016).

The second victim can be any healthcare worker who has been involved in an adverse patient event. Specifically, second victims have been defined by Scott et al. (2009), stating, “second victims are healthcare 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” (p. 326).

One study found the occurrence of the second victim phenomenon to be as high as 43.3% in which 40.8% of the participants (healthcare providers) “described a moderately

severe harmful impact and 2.5 percent reported a severe impact on their lives” (De Wit, Marks, Natterman, & Wu, 2013 p. 852). Sixty percent of these healthcare providers “reported involvement in an adverse event, of which 66 percent experienced anxiety, depression, or a concern about their ability to perform the job as a result of the experience” (De Wit et al., 2013 p. 852). When one experiences the second victim phenomenon one has “reduced professional confidence, reduced job satisfaction, and thoughts of leaving the healthcare profession altogether” (Burlison, Quillican, Scott, Johnson, & Hoffman, 2016, p. 1). Second victims have reported reliving and fixating on the adverse patient event for years to even decades later. Burlison et al. (2016) suggest that committing another error after one experiences the second victim phenomenon increases, consequently putting the patient’s safety at risk.

Second victims are left feeling personally responsible for the outcome of the patient and the majority experience feelings of failure and second-guessing “their clinical skills and knowledge base” (Scott et al., 2009, p. 326). Research studies and the Joint Commission (2018) indicate the need for hospital organizations to develop support programs for clinicians following an adverse patient event (Chan, Khong, & Wang, 2017; Edrees et al., 2016; Grissinger, 2014; Pratt & Jachna, 2015; Scott et al., 2009), as it is critical for the psychosocial and physical recovery of the clinician following an adverse patient event (Dekker, 2013). A conclusion drawn from a study by Scott et al. (2009) claimed that when organizational support lacks, second victims express an inability to move forward. In recognizing the seriousness this phenomenon has on the individual and

its impact on patient care, an advisory was issued by Joint Commission in January 2018.

The advisory aims to provide healthcare organizations with recommendations and resources for supporting second victims. It is not known if one particular type of support program for second victims is a one-size-fits-all approach. Furthermore, it is unknown if nurses require a different type of support in comparison to other healthcare workers.

What is known is that support is needed for second victims. Burlison et al. (2016) suggest that mitigating the impact adverse patient events cause is the responsibility of managers and leaders in the healthcare organization.

The purpose of this integrative literature review is to describe types of support suggested/used and what is being done by healthcare organizations to support second victims. This review is of importance in understanding the types of support being offered and/or provided to best assist second victims in coping with the event in order to return to their daily lives. Another importance of this review is in the dissemination of evidence-based support strategies in the hope that hospital organizations will implement such.

Methods

Whittemore and Knafl's (2005) integrative review methodology was utilized to explore support for second victims. The method allowed a combination of diverse methodologies incorporating the following stages: (a) identification of the problem, (b) literature search, (c) evaluation of data, (d) analyzing data, and lastly (e) presenting the findings.

The review entailed a comprehensive literature search using databases of Cumulative Index of Nursing and Allied Health Literature (CINAHL), PubMed, Google Scholar, Medline, ProQuest, and Electronic Journals, as well as reference lists from studies. The search terms included in the integrative review were “second victim in nursing,” “second victim in physicians,” “second victims,” “second victim support,” “second victim phenomena,” “second victim interventions,” “second victim effects,” “clinician support,” “institutional support,” “adverse events,” “supporting nurses,” “institutional emotional support,” and “second victim in healthcare.”

Several hundred articles were found. Therefore, the search then utilized Boolean operators (Roberts & Hyatt, 2019) and included the keywords “second victims AND support,” “second victims AND support programs,” “second victims AND support groups,” “second victims AND services,” “nurses, AND second victim AND organizational support,” “second victims AND systems,” and “clinicians AND support.” To present the current state of the science, and in following Whittemore and Knafl’s (2005) methodology for Step 3 of the review process, the search was limited to research and/or evidence-based studies that were published in English between 2009 and 2019. The year of 2009 was chosen as the starting point since this was when the second victim phenomenon was first defined, therefore providing a true representation of the term and the support needed.

For inclusion in this review, literature had to be research that was based on primary sources (Roberts & Hyatt, 2019), conducted in the United States (U.S.) since

2009, published in English, and focused on types of support for second victims in healthcare. Literature was excluded if it was not written in English, if it was outside of the U.S., if it was published prior to 2009, and if it did not focus on healthcare workers. Limiting the literature search to the U.S. provides a more practical approach for healthcare organizations considering to implement established support programs when taking into account the similarities of the infrastructure of U.S. healthcare organizations, possibly making support programs easier to replicate and implement. Another reason for limiting the search to the U.S. was to understand to what extent healthcare organizations in the U.S. are supporting nurses. It is also not known if nurses within the U.S. require the same support as those outside the U.S. Non-research literature such as commentaries, letters, expert opinion, and review articles were also excluded from the search as these are non-scholarly and lack rigor (Roberts & Hyatt, 2019). A total of 36 titles of articles, abstracts, dissertations, and theses underwent review for relevance. This step eliminated several articles and a full-text review of the remaining articles further narrowed the literature. The following literature was excluded: two articles validating a second victim support tool, three literature review articles, one article on second victim rights, six articles that were commentaries, one abstract for a poster presentation, one article on barriers and facilitators of support, two articles exploring coping strategies of second victims, one article on perceived level of support, two editorials, two articles on the psychological effects of adverse patient events, and four articles that were conducted outside of the U.S. A full-text review of the remaining articles further narrowed the

literature. Eleven articles were identified for review in two areas—implementation of support services/programs in hospital settings and types of support suggested. A literature map suggested by Creswell and Creswell (2018) is presented in Figure 2.1 (see Appendix A) and outlines the selection process. In Whittemore and Knafl's (2005) methodology, Step 4 suggests evaluating and rank-ordering studies by methodological and theoretical order; however, this step was omitted due to the limited number of studies found. Lastly, following Step 5 of Whittemore and Knafl's (2005) methodology, study findings were analyzed and organized by general focus area and a review of the literature is presented in the succeeding section.

Results

Of the 11 identified studies displayed in Table 2.1 (see Appendix A), two areas were identified: development and implementation of support programs in hospital settings (8), and types of support for second victims (3). Two studies were qualitative, one study was quantitative, six studies used mixed methods, and two were intervention studies. Sample sizes ranged from 4 to 575 healthcare workers (i.e., physicians, nurses, midlevel providers, risk managers, and others), with three studies not reporting a sample size, and one study approximating a sample size. Four of the studies developed a second victim support program, three studies only described support programs and support needed, two studies evaluated support programs with one of those using a longitudinal design, one study implemented a support program, and one study made an effort to implement a program. Two of the 11 studies were specific to nurses only.

Discussion

This integrative literature review demonstrates that second victims need support and that some organizations are providing successful support programs while others are still considering or have no intentions of developing such programs for reasons not provided in the literature. For organizations considering starting a second victim support program, this review provides them with insight as to what the healthcare worker would like in a support program, the availability of such programs, and programs that already exist, such as the forYOU program, which will give organizations a starting point during the development and implementation phases. While it is unclear if all healthcare workers require a one-size-fits-all support program and which programs are more effective than others, what does remain evident is some type of support should be provided to second victims, which is better than no support at all. From the integrative literature review, an argument can be made that few hospitals have developed and implemented their own second victim support program; hence, the extent of support programs in hospital organizations is limited. Two studies were specific to nurses; however, nurses were often the highest utilizers of the support programs in the studies that were multidisciplinary.

Suggested Support for Second Victims

Three studies made suggestions for support needed for healthcare workers following an adverse patient event (Edrees, 2014; Scott et al., 2009; White et al., 2015). Using a qualitative approach, Scott et al. (2009) developed a 6-stage recovery trajectory for second victims. Stage 5 of the trajectory is that of “Obtaining emotional first aid” (p.

328), where participants noted they would like to have a safe person in whom they could confide. Participants also proposed for organizations to have in place a formal support program and procedures following an adverse patient event. Overall, Scott et al. (2009) suggested having supervisors and peers trained in providing immediate support to those needing it. According to the authors, an organization's first step should be awareness and developing an awareness campaign which "promotes open dialogue about the definition and prevalence of second victims" (Scott et al., 2009, p. 330), as it is imperative to understand such in order to develop, mitigate, and sustain second victim support programs.

In a dissertation by Edrees (2014), the author explored types of support offered to second victims in 38 hospitals located in Maryland. Of the 43 participants, all but one reported that their hospital offered Employee Assistant Personnel (EAP) services to staff. From open-ended interviews, the majority of the participants reported wanting 24 hours a day, 7 days a week peer support availability, having time to reflect on the event, having time off after the event, and having support from executive leadership or their direct supervisor. Nearly 70% of the hospitals surveyed did not offer a support program while 13.2% were developing such and 15.8% had a support program in place. Six of the 38 hospitals surveyed had support programs in place utilizing individual and group support with peer supporters that were multidisciplinary. However, there lacks a discussion on what the programs entail, how the programs were and can be implemented, and how effective the programs are, making replication of the programs extremely difficult.

To understand the perceptions from risk managers about the characteristics of provider support programs, White et al. (2015) conducted a qualitative study with 575 members of the American Society for Healthcare Risk Management representing 423 healthcare organizations. Of the respondents, 73.6% reported their organization had some type of emotional support program with 7.3% reporting their organization has plans of initiating a support program. Four participants noted their organization previously had a support program; however, it had been discontinued. In 42 of the healthcare organizations that were planning to develop support programs, 76.2% noted they would likely train individuals and more likely to base the program's design on an already developed model, citing the Medically Induced Trauma Support Services program and the forYOU program. Healthcare organizations planning to provide support services reported they were more likely to provide support utilizing peers and support groups in comparison to the healthcare organizations that had an existing support program. The authors further "recommended steps for leaders to improve existing second victim support services" (White et al., 2015 p. 37). These steps are (a) assess the structure, utilization, and efficacy of local support programs; (b) raise an awareness; (c) develop a plan to close gaps with recommended services; and (d) "create additional tiers of service for those who do not recover with peer support or who endure litigation" (White et al., p. 37), which is similar to the three-tier model developed in Scott et al.'s (2009) forYOU program.

Support Programs Provided by Healthcare Organizations

Three of the studies discussed implementation of support programs in healthcare organizations; however, the majority of the studies did not go into details on how these programs were implemented, making them difficult for other organizations to replicate. The first publication of an implemented second victim support program was developed by Scott et al. (2010) at the University of Missouri Health System referred to as the forYOU program. forYOU utilizes a three-tiered model that provides confidential peer-to-peer support for individuals following a stressful event to address the unique needs of the clinician (Hirschinger, Scott, & Hahn-Cover, 2015). Originally, 80 peer supporters were trained in supporting the individual in the acute stages of emotional trauma (Scott et al., 2010); however, since the program's expansion, there are now 137 peer supporters (Hirschinger et al., 2015). Following the involvement in an adverse event, Scott et al. (2010) suggest immediate activation of a second victim rapid response team with the forYOU team placing an emphasis on immediate availability. The overall goal of the forYOU program is to ensure that the healthcare worker does not go home to suffer alone, assisting them to move past the event returning to their pre-event performance and to ultimately thrive in their profession (Hirschinger et al., 2015; Scott et al., 2010).

After 5 years of the forYOU program being implemented throughout the University of Missouri Health System, Hirschinger et al. (2015) conducted a longitudinal study evaluating the program. During the first 5 years of the forYOU program being implemented 1,075 clinicians were documented as receiving either group debriefings or

one-on-one peer support. Tiers were used to determine the type of support needed for the individual. For Tier 1 criteria, 62% of mentoring was offered to nursing leaders accounting for the highest group. Those meeting Tier 2 criteria accounted for a total of 1,028 clinicians supported to include group debriefings and one-on-one caring moments, with 53% of those supported being either registered nurses or licensed practical nurses. While Tiers 1 and 2 addressed the majority of clinicians' needs, 9.7% required professional referrals as part of Tier 3 criteria. Due to the success of the forYOU program employees began using the program for other things that were not related to adverse patient events causing the program to limit its scope, keeping the focus on second victims.

A replication of the forYOU program was undertaken by Merandi et al. (2017) in collaboration with the University of Missouri Health System. forYOU was replicated in a free-standing pediatric academic healthcare organization located in Columbus, Ohio. A multidisciplinary steering committee was developed and assigned to implement the "second victim program that was institution wide, peer-based, support system" (Merandi et al., 2017, p. 2); giving the name YOU Matter. Piloting began with the hospital's pharmacy staff and showed to be successful; therefore, YOU Matter was then implemented in the emergency department with various departments following until being implemented in all departments in 2014 to include being "spread out to all urgent cares, outpatient primary care clinics, and ambulatory specialty clinics" (Merandi et al., 2017, p. 2.). This is the first published study addressing implementation in outpatient

settings. The authors note that training and implementation of the YOU Matter program followed that of the forYOU program by Scott et al. (2010), which enabled the program to be operational within 6 months. The YOU Matter program also uses the three-tier model developed by Scott et al. (2010). What is different about the YOU Matter program is the use of electronic documentation that was added later due to the program's growth. This is contrary to the forYOU program by Scott et al. (2009) and the program discussed by Lane et al. (2018), as these authors note no documentation being utilized. The documentation system's primary purpose is to quantify the frequency and types of encounters with second victims (Merandi et al., 2017). YOU Matter was implemented in 2013 and since has over 300 trained peer supporters, 232 peer encounters, 21 documented group encounters, and 30 leaders identified with nurses being the majority of the trained peer supporters at 44% (Merandi et al., 2017). Nurses were most documented to use YOU Matter at 75 of the 232 encounters, similar to the study findings by Hirschinger et al. (2015). While Merandi et al. (2017) did not discuss explicitly how the program was implemented, it can be implied that it followed the implementation process of the forYOU program by Scott et al. (2010), hence being a replication study. It would be ideal if the authors discussed how the YOU Matter program was implemented in the outpatient settings so this could be replicated, as this is different from the forYOU program by Scott et al. (2010) and is the first published study on providing such support in this setting.

Edrees et al. (2016) describe how the Resilience in Stressful Events (RISE) peer support program was developed at Johns Hopkins Hospital by leaders in patient safety,

risk management, and clinical departments. RISE provides timely psychological first aid and emotional support within 12 hours of the clinician experiencing an adverse patient event. The RISE program offers 24 hours per day, seven days a week support in a peer-to-peer or a group format dependent upon the request of the healthcare worker. The support groups are made up of trained peer responders. Sixty-three percent of the peer responders are nurses and 50% are colleagues from the Department of Pediatrics (Edrees et al., 2016) and expanded to all departments/units in 2012 (Dukhanin et al., 2018). In implementing the RISE program, an awareness campaign was launched using websites for advertisement, promotional videos, screen savers on work computer screens, and presentations conducted to clinic unit staff, as well as recruitment of unit-level champions. Edrees et al. (2016) explain in detail each phase of the process for developing and implementing the RISE peer support program. Phase I was the development of the RISE leadership team and developing a mission for the program. Six members made up this multidisciplinary team that designed a work plan, procedures to providing support, identified additional team members, and determined training and additional resources. The RISE peer responders were formed in 2011. Phase II involved recruitment and training of the RISE peer responders. In the original peer responder group, nurses represented the majority at 63%. During this phase, it was mandated that peer responders attend a 6-hour psychological first aid training to properly address emotional distress on a monthly basis to include lectures, story-telling, role play, and group discussions. Phase III launched and piloted the RISE program in the Department of Pediatrics, a 205-bed area at

Johns Hopkins Children's Center. Phase IV was the hospital-wide expansion of RISE, which occurred 7 months after the pilot in the Department of Pediatrics. During this phase, a two-tiered anonymous call system was designed in which two peer responders were on call at all times, allowing one to assist the other if needed. Additionally, should the first peer responder be a coworker on the same unit as the caller, the call is passed off to the second responder, which is contrary to the design of the forYOU and YOU Matter programs. A limitation of the RISE program was employees were not made fully aware of the program despite the efforts made in Phase IV, prior to implementation; therefore, the program was not utilized as frequently (Edrees et al., 2016).

Since the implementation of the RISE program at Johns Hopkins Hospital, Dukhanin et al. (2018) conducted a study to evaluate the program's implementation and effectiveness in the Department of Pediatrics using anonymous pre- and post-surveys. Quantitative analysis and content analysis of open-ended questions were conducted. Approximately 900 individuals were sent a 4-year follow-up survey; however, the response rate was low and estimated at 23.3%. The majority of the responses came from nurses at 49%. Responders were 93% likely to recommend the RISE support program. Content analysis identified barriers to utilizing the program such as overcoming blame culture and the need to promote the initiative. The need for more staff time to handle adverse events in utilizing the RISE program was reported by respondents, echoing recommendations from respondents in White et al.'s (2015) study. The most desired aspects of the RISE program were a non-judgmental approach, 24 hours, 7 days a week

access, and the commitment to follow up. While 20 respondents addressed specific experiences with the RISE program, the majority characterized the program as being useful and worthwhile with a few expressing doubts about the program (Dukhanin et al., 2018).

One study developed a curriculum for certified registered nurse anesthetists (CRNA) through a literature review and utilization of a panel of five experts who had experience with second victims (Daniels & McCorkle, 2016). The expert panel included one Ph.D. prepared registered nurse, two medical doctors, one Ph.D. prepared CRNA, and one Ph.D. prepared psychologist. The authors recommended adding educational content into CRNA programs to help with understanding the second victim phenomenon as well as how to cope, and how to support second victims. While the researchers note that there is a need for educational programs on second victims, there was no discussion on what exactly the curriculum would entail, what information would be included in the teaching, which semester the education would fit best in—in the CRNA program, or how to best implement such curricula.

One study developed a clinician peer support program at two large teaching hospitals affiliated with Washington University School of Medicine in St. Louis, Missouri. The program's name was not disclosed, being referred to as a clinician peer support program. The program provides support to *only* physicians, residents, fellows, physician assistants, nurse practitioners, and CRNAs following an adverse patient event (Lane et al., 2018). Peer supporters initially received a 2-hour live training. Three training

sessions occurred with feedback received from trainees after each session in order to make modifications to the trainings. In the final training session trainees were taught about the emotional and functional impact an adverse patient has on clinicians and education on warning signs and known risk factors signifying that clinicians may need additional support from internal and/or external resources. Simulations were used in training where a peer supporter had an opportunity to act in the peer supporter role and in the supported clinician role. Additionally, a one-hour presentation focusing on the second victim phenomenon was presented during grand rounds, faculty and staff meetings, and other departmental meetings (Lane et al., 2018). At the end of the training sessions, 36 peer supporters from a variety of departments made up the peer supporter pool. After 6 months the peer support team expanded to include midlevel providers. Changes were later made to the program in that the program began to proactively contact all physicians and midlevel providers after being involved in a serious error or adverse event. It is worthy to note that peer supporters are not assigned to peers in the same field or who hold a supervisory position to the peer supporter which is different from what Dukhanin et al. (2018) suggest in the RISE program and what Scott et al. (2010) use in the forYOU program. It should be noted that nurses and other front-line healthcare workers were neither part of the peer supporter pool, nor were they eligible to receive peer support from the program. The authors do not speak to why nurses and other healthcare workers were excluded from receiving and/or providing peer support. This could be due to some

literature suggesting that physicians and midlevel providers require different support than nurses; however, research studies are lacking in this area.

As a Capstone project, one study attempted to implement a support program called Helping Others Process the Event (HOPE) in a 247-bed community hospital in the rural Piedmont of North Carolina. Lee (2014) does not discuss what the program's support entails and without successfully locating this program in published literature, HOPE remains unclear. In an attempt to implement HOPE, Lee (2014) began with assessing the organization's internal and external support resources and the hospital's core values. An assessment of the organization's internal culture of safety, the staff's awareness of adverse events, and responses of clinicians and staff, along with establishing a multidisciplinary advisory group were completed. It was discovered the organization did not offer formal support to employees. With a focus on nurses who had been involved in an adverse event in the last 12 months, Lee (2014) surveyed 68 nurses to assess resources for formal and informal emotional support. Due to a low response rate of four nurses, the organization decided not to develop or implement HOPE but suggested postponing the project with revisions made to the survey and plans to distribute it to all hospital employees. However, Lee (2014) notes there was no ongoing communication with the hospital which contributed to a "lack of trust, poor attitudes, and low morale" (p. 31) causing the implementation of the HOPE program to be unsuccessful.

Implications

Organizational support is of utmost importance for second victims in assisting the individual to cope effectively, hence increasing the likelihood of the individual being able to return to their normal clinical duties while contributing to preventative strategies for adverse patient events (Kable et al., 2018). Effective and sustainable organizational support can help to ensure that nurses and other healthcare workers never have to experience the second victim phenomenon alone. The Joint Commission (2018) provides recommendations when designing support strategies for second victims such as instilling a just culture, offering immediate peer-to-peer support, and engaging all team members in the debriefing process.

Conclusion

Research studies provide limited descriptions of organizational peer support programs for second victims following an adverse patient event. There are limited evaluations of the feasibility, implementation, and effectiveness of second victim support programs. Research has amplified the understanding of the second victim phenomenon and its effects on nurses; however, much research is still warranted in order to develop a full understanding of the phenomenon and to develop effective and sustainable support programs. While the majority of studies have surveyed participants using a multidisciplinary approach, it continues to remain unclear as to what types of support are needed specifically for nurses. Additional studies are needed to better understand the

nurse's emotional and psychological needs following an adverse patient event in order to strategically develop second victim support programs.

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Appendix A

Table and Figure

Table 2.1

Summary of Reviewed Studies

No. Author(s), Year	Design	Population	Intervention/Purpose	Results
1 Daniels, R. G., & McCorkle, R., 2016	Intervention study Theory used: Second Victim Phenomenon (although not explicitly stated)	N = Panel of 5 experts (1) Ph.D. prepared nurse (1) Ph.D. prepared psychologist (1) Ph.D. prepared CRNA (2) Medical Doctors	To develop a second victim curriculum for Nurse Anesthetists using a systematic literature review and an expert panel comprised of RNs, CRNAs, and psychologists.	The second victim curriculum can be used to educate CRNAs about second victims and to acknowledge and address the second victim phenomenon among new graduate and student nurse anesthetists, to offer standards for an evidence- based curriculum in developing educational offerings on the second victim phenomena, to promote a better understanding of peer and support protocols for second victims and to function as part of the required content in nurse anesthesia training curriculums.
2 Dukhanin, V., Edrees, H. H., Connors, C. A., Kang, E., Norvell,	Mixed methods Theory used: none mentioned	N = approximated response rate at 23.3% Nurses, physicians, managers, and others	To evaluate the effectiveness of the Resilience in Stressful Events (RISE) support program.	Responders were 93% likely to recommend the RISE support program to others. Content analysis identified barriers such as overcoming

No. Author(s), Year	Design	Population	Intervention/Purpose	Results
M., & Wu. A. W., 2018				blame culture, need to promote the initiative, and need for more staff time to handle adverse events in utilizing the RISE program.
3 Edrees, H., 2014	Mixed methods Conceptual Framework used: The Malcolm Bridge Health Care Criteria for Performance Excellence Conceptual Framework	N = 43 Organizational leaders representing 38 hospitals	To gain the perceptions of patient safety leaders on the concept of supporting second victims and on developing second victim support programs.	Approximately 18% of Maryland hospitals had a second victim support program with details of the structure, accessibility, and outcomes of those programs provided.
4 Edrees, H., Connors, C., Paine, L., Norvell, M., Taylor, H., & Wu, A., 2016	Mixed methods Theory used: none mentioned	N/A	To describe the development of the RISE program and to evaluate its initial feasibility and subsequent implementation.	Peer responders reported that the encounters were successful in 88% of the cases and 83.3% reported meeting the caller's needs. The majority of the calls were from nurses.
5 Hirschinger, L. E., Scott, S. D., & Hahn-Cover, K., 2015	Quantitative Theory and Conceptual Model used: Theory of Transpersonal Caring and the Critical Incident Stress Management Conceptual Model	N = 100 nurses	To examine the emotional support structure, the forYOU support program that was implemented at Missouri Health Care (MUHC).	The study took place over a 5-year period and during that time the forYOU team members documented emotional support in the form of mentoring, group debriefings, and one-on-one support for 1,075 clinicians at MUHC. Sixty-two percent of mentoring was offered to nursing leaders. For one-on-one caring moments, 53%

No. Author(s), Year	Design	Population	Intervention/Purpose	Results
				were registered nurses or licensed practical nurses.
6 Lane, M. A., Newman, B. M., Taylor, M. Z., O'Neill, M., Ghetti, C., Woltman, R., & Waterman, A. D., 2018	Intervention study Theory used: none mentioned	N = 36 peer supporters (physicians and midlevel providers)	To describe the process in training peers for the implementation of a second victim support program in a teaching hospital. The program was developed with the support of Washington University's School of Medicine (WUSM) and WUSM's Faculty Practice Plan.	One-hundred and sixty-five individuals were referred to the peer support program with 17 declining follow-up and 16 requiring referral to higher level support. Only physicians and midlevel providers could access/use the program.
7 Lee, S., 2014	Mixed methods Theory used – Watson's Theory of Human Caring	N = 4 Nurses	To implement the Helping Others Process the Event (HOPE) program, a second victim support team, to identify the effects of adverse events on the nurse's professional identity and desire to remain in the nursing profession.	Due to a lack of response rate from nurses (N = 4) on the initial survey the hospital decided to postpone implementation of the HOPE program however no other communications occurred with stakeholders and community persons. Also noted were a lack of trust, poor attitudes, and low morale as limitations to implementing the HOPE program.
8 Merandi, J., Liao, N., Lew, D., Morvay, S., Stewart, B., Catt, C., & Scott, S. D., 2017	Mixed methods Theory used: Second Victim Phenomenon (not explicitly stated)	N/A	To describe the implementation, management, and sustainment of the YOU Matter support program replicated from the Missouri Health Care's Model.	At 32%, RNs and LPNs, represented the highest number of those who utilized the program with nurses having 72 of 232 encounters. Demographically nursing represented 44% or peer supporters for the YOU

No. Author(s), Year	Design	Population	Intervention/Purpose	Results
				Matter program. Staff reported improvements in their emotional state and improvement in return-to-work metrics.
9 Scott, S. D., Hirschinger, L. E., Cox, K. R., McCoig, M., Brandt, J., & Hall, L. W., 2009	Qualitative Theory used: Second Victim Phenomenon	N = 31 (11) Registered nurses, (10) physicians, and (10) others	To understand the second victim phenomenon through interviews with second victims.	Suggested programs that can be developed to successfully screen at-risk professionals immediately after an adverse event, and types of support that can be used to expedite recovery and lessen adverse career outcomes for second victims in healthcare organizations.
10 Scott, S. D., Hirschinger, L. E., Cox, K. R., McCoig, M., Hahn-Cover, K., Epperly, K. M., Phillips, E. C., & Hall, L. W., 2010	Mixed methods Theory used: none discussed	N/A	To describe the deployment of a rapid response system (RRS) for second victims in a healthcare organization.	Approximated that 67 encounters occurred using RRS. Did not specify which disciplines these individuals made up.
11 White et al. (2015)	Qualitative Theory used: none discussed	N = 575 Registered nurses and physicians	To describe the perceptions of risk managers in regards to characteristics of support programs for clinicians.	Of the participants, 73.6% reported their organization has some type of support programs to provide emotional support to clinicians following a patient adverse event with the other 7.3% reporting their organizations had plans of initiating support programs. Four participants noted that their healthcare organization previously had a support

No. Author(s), Year	Design	Population	Intervention/Purpose	Results
				program that was discontinued.

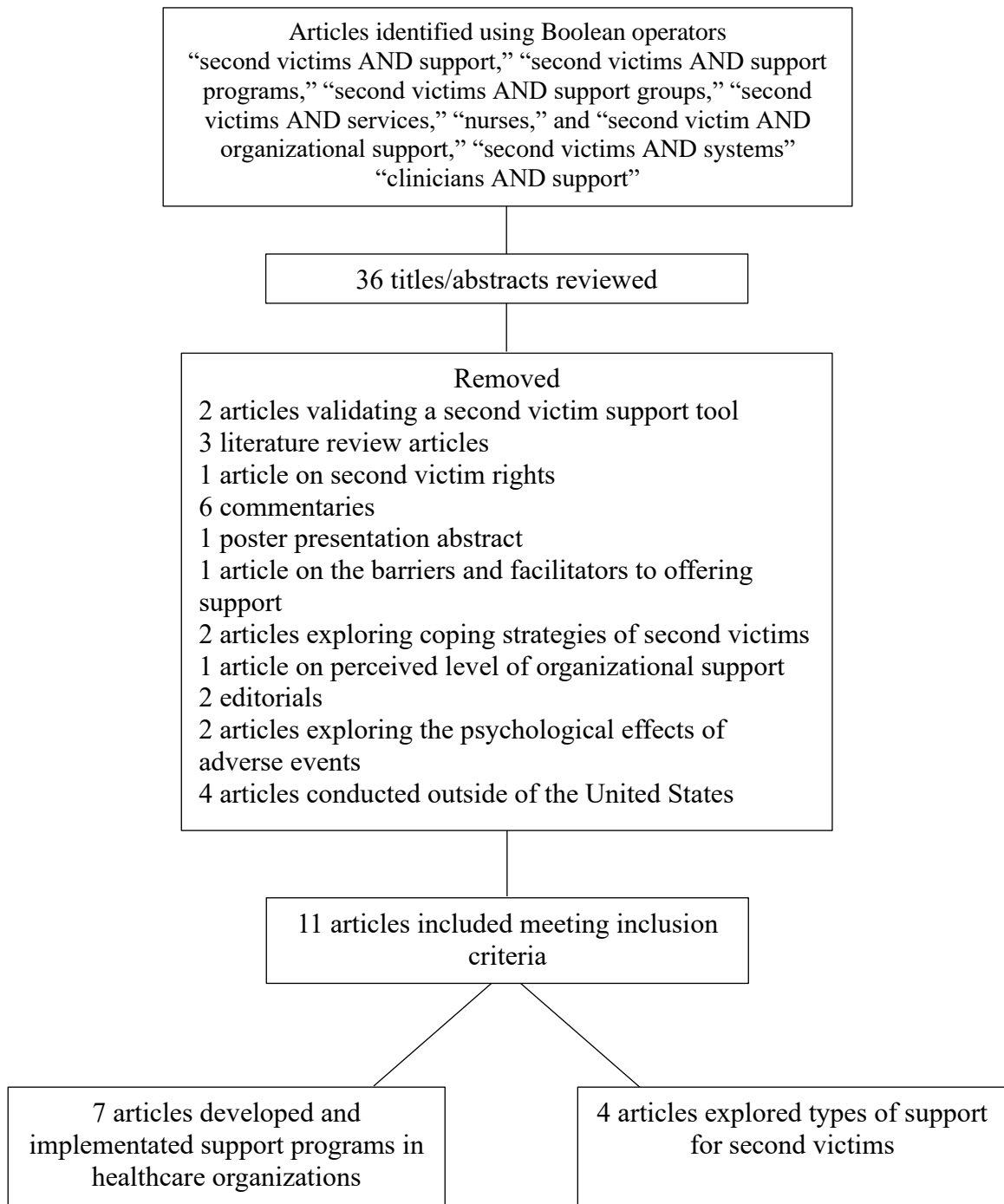


Figure 2.1. Literature Map of the Search Process.

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I acknowledge I am the sole author of this manuscript. (Misty Stone MSN, RN – Ph.D.
Student)

CHAPTER III

METHODS

A review of the literature identified the importance of support programs for healthcare professionals following an AE; however, there is very little information available on nurses' experiences of such programs. By increasing understanding of hospital nurses' experiences of the effectiveness and availability of such programs, healthcare organizations will be better able to develop and/or improve existing support programs. This qualitative descriptive research study arose from the researcher's inquiry into nurses' experiences following an AE, gaps in research identified in the literature, and pilot study findings (see Appendix A) conducted by this researcher (Stone, 2019).

Research Questions

The following research questions guided the study:

1. What is the hospital staff nurses' experiences with organizational support following an AE?
2. What are the nurses' perceptions of the perceived availability and the usefulness of organizational support following an AE?

Design

Qualitative Approach

Several studies have been conducted over the last decade including qualitative and quantitative methodologies to better understand the second victim experience and to develop support programs for second victims. Researchers have been able to identify symptoms that are experienced by second victims and the types of support that second victims prefer (Hirschinger, Scott, & Hahn-Cover, 2015; Scott et al., 2009). While quantitative research has developed a survey tool that can be used to evaluate the experience of the second victim as well as the adequacy of support resources offered in organizations (Burlison, Scott, Browne, Thompson, & Hoffman, 2017), there continues to remain an unclear understanding of this.

A qualitative descriptive approach was used for data collection and analysis as described by Sandelowski in her 2000 and 2009 writings. In Sandelowski's (2009) writing she notes that this method cannot be described as any one method developed solely by one person. This design was chosen over phenomenology as qualitative descriptive aims to describe participants' experiences while not attempting to explain or interpret the phenomenon (Sandelowski, 2000). This approach provided the researcher with an opportunity to reflect and to provide a "straight description" of the participants' experiences with organizational support in assisting the researcher in describing and clarifying those experiences (Sandelowski, 2009, p. 334). The qualitative descriptive method encompasses a combination of sampling, data collection, and analysis that is

consistent with qualitative research. These procedures are notorious for shedding light on “the who, what, and where of events” (Sandelowski, 2000, p. 339) through one’s experience as one describes it. A qualitative descriptive design allowed the researcher to produce findings that were data-near while using some degree of interpretation, as “no description is free of interpretation” (Sandelowski, 2000, p. 335).

Sample and Sampling Method

The sample in this study was derived from hospital staff nurses in southeastern North Carolina. The study’s inclusion criteria were: (a) a licensed registered nurse, (b) ability to speak and read English, (c) have experienced an AE in the last 10 years in an acute care setting in the U.S., (d) is older than 18 years of age, and (e) received either formal or informal organizational support following an AE. Exclusion criteria were (a) inability to read and speak English, (b) no involvement in an AE in the last 10 years in the U.S., (c) younger than 18 years of age, or (d) did not receive any form of organizational support following an AE. Inclusion criteria for experiencing an AE in the last 10 years was chosen so the researcher could gather the most current information on support provided by healthcare organizations as well as the participants being able to remember specifics about their experiences following an AE.

Recruitment of participants occurred using purposive sampling and snowball sampling. Snowball sampling is a purposive sampling technique that uses one participant to locate another participant which is used when participants are difficult to reach due to their experience (Streubert & Carpenter, 2011). An Institutional Review Board (IRB)

approved flyer (see Appendix E) was used for recruitment through posting on social media (Facebook & Instagram) with individuals being able to like, share, and tag others in the post. Individuals interested in participating in the study contacted the researcher via Facebook private message, phone or email (provided on the IRB approved flyer). The researcher explained the study to the potential participant as well as reviewed inclusion criteria. For those participants who met the inclusion criteria, a one-on-one interview was scheduled in a private and confidential place of the participants' choosing or via telephone. In utilizing snowball sampling, at the end of each interview, the researcher asked the participant if he/she knew someone who would speak with the researcher about their experience with organizational support following an AE. At that point, the researcher provided her contact information so the participant could share with another potential participant.

The sample size was determined when the researcher reached data saturation, meaning the researcher was no longer hearing anything new from the participants' experiences (Haber, 2010). Polit and Beck (2014) note that qualitative interview studies typically consist of 10 participants, but this number varies and in general ranges anywhere from five to 25 participants. In reviewing other qualitative descriptive studies using nurses in exploring organizational support the sample sizes ranged from 10 to 120 (Joesten, Cipparrone, Okuno-Jones, & DuBose, 2015; Kable, Kelly, & Adams, 2018). Data saturation for this study was met with 12 participants.

Data Collection Procedure

Prior to beginning the interview questions the researcher again explained the research study and read the consent form (see Appendix B) to the participant with a copy of the consent given to the participant. A semi-structured interview script (see Appendix D) was used for data collection with the researcher being the instrument. Additional interview questions were used during the interview serving as prompts to stimulate further comments and/or to clarify participants' meanings. One-on-one interviews were conducted either face-to-face or via telephone. Interviews were digitally audiotaped and on average lasted approximately 45 to 50 minutes.

Setting the tone for the interview was an essential part of the data collection process. The researcher provided a relaxed atmosphere to encourage the participant to share their firsthand experiences. After setting the tone for the interview, the demographic data sheet (see Appendix C) was completed to assist the researcher in describing the participants by years of nursing experience, type of nursing degree, race/ethnicity, and gender. Once this was completed the interview began. The Transactional Second Victim Experience conceptual model (Schiess et al., 2018), specifically the construct of weighing up internal and external resources, was used as a guide in developing the interview questions. Interview questions that were asked of all participants included:

Q1. First, can you begin by describing what it is like to be a nurse following an adverse event in an inpatient setting?

- Q2. Can you tell me about the support you received from the healthcare organization and what it entailed?
- Q3. Were you given time off from your nursing duties following the event, and if so, how much time was given?
- Q4. Following the adverse event (days, months, maybe years later) did the organization continue to support you, and if so, describe this support?
- Q5: What other types of support or services would you have liked to received or been offered that you were not?
- Q6. To what extent would you recommend the support you received to other peers/coworkers?
- Q7. Please share with me how the organization involved you in the process that analyzed the event?
- Q8. Did you leave or did you stay in the same department/unit/job role following the event?
- Q9. Is there anything else that you would like to tell me that would help me to understand the experiences you had with organizational support following an adverse event?

Two participants became emotional during their interviews. They were asked if they needed a break or needed to stop the interview altogether. Both participants declined this; however, a short break was provided and the interview resumed when prompted by the participant. Participants were free to omit any interview questions they did not want

to answer; however, this did not occur. Participants were each given a \$25.00 gift card at the completion of the interview. For the interviews that were conducted via phone a digital gift card was emailed to them.

Protection of Human Subjects

IRB approval was first obtained. Interviews were conducted in a private location of the participants' choosing and confidentiality of participants was stressed. Interviews were audiotaped using a digital recorder, then digitally transcribed. Once transcribing was complete the researcher then double-checked the transcripts for accuracy and de-identified. Any names used in the interviews were replaced by a blank line. For example, if the participant verbalized the name of a specific hospital, the name was replaced by "_____ (hospital)." Following verification of accurate transcription by the researcher and the dissertation committee chair, audiotaped files were then destroyed. A master list associating the participants name with their pseudonyms was kept in a password protected file on the researcher's home computer, which was also password protected at the home screen. All word documents were password protected. Documents were stored in box.uncg.edu which were only accessible by the researcher and the researcher's dissertation committee chair. De-identified transcripts were stored in password-protected files stored on the researcher's password-protected home computer and in box.uncg.edu. Data collection was concurrent with data analysis.

Data Analysis

Following digital transcription, the researcher replayed and listened to each recorded interview for validation of correct transcription. This also allowed the researcher to become immersed in the data. Field notes were kept for each interview allowing the researcher to reflect on key areas and as reminders to further explore certain thoughts or feelings by the participant that needed further exploration. A decision-making audit trail was maintained throughout data analysis.

Data analysis took place during and following data collection over a 3-week time span. The use of Microsoft Word and Microsoft Excel facilitated the organization of data and coding. Data collection and analysis continued simultaneously until data saturation was attained after the 12th participant was interviewed (Streubert & Carpenter, 2011).

Thematic Analysis

Data analysis followed the procedural steps of thematic analysis from Braun and Clark's (2013) staging of coding and analysis. This approach assisted the researcher in interpreting and making sense of the experiences shared by the participants. Reading and re-reading of the transcripts began the data analysis phase to allow the researcher to become immersed in the data. The next step was organizing the data in a meaningful and systemic way that gave rise to codes which reduced data into smaller chunks of meanings as suggested by Braun and Clark (2013). Not every piece of text was coded, only those pieces that were pertinent to or captured something interesting in relation to the research questions. In developing codes, open coding was used so the researcher could develop

and revise codes during the course of the analysis process. A detailed codebook was maintained using a Microsoft Excel spreadsheet. Throughout this process, discussions occurred with another researcher. Once coding was finalized, 67 codes resulted with each one being defined. From the codes, categories were then developed and defined using a Microsoft Excel spreadsheet. From this point, preliminary themes emerged. In finalizing themes, collaboration with another researcher occurred with two themes and six subthemes emerging from the data.

Limitations

The psychological trauma that many times is associated with being involved in an AE may have deterred participants from coming forth and sharing their experience. For recruitment and sampling, there was potential for self-selection bias due to the strategies used to reach this specific population of individuals. There is potential for recall bias which can be seen with self-reporting. Participants were able to vividly describe their experiences and the previous events; however, it is unknown to the researcher if participants left out certain details. Furthermore, the accuracy of memory could have been influenced by other events and experiences. Additionally, the study's participants were from one geographical area in the U.S. so results may not be generalizable.

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CHAPTER IV

MANUSCRIPT TWO: HOSPITAL STAFF NURSES' EXPERIENCES WITH ORGANIZATIONAL SUPPORT

Abstract

Objective: The purpose of this study was to describe hospital nurses' experiences with organizational support after being involved in an adverse event (AE).

Background: The majority of hospital staff nurses will experience or be involved in an AE. Literature supports the need for support following an AE to mitigate the effects of experiencing such events.

Methods: A qualitative descriptive approach was used for data collection and analysis.

Results: Findings suggest that nurses want to feel valued, have a role in analyzing the AE to prevent identical events, and to be supported by the overall organization immediately after the event and in the months following.

Conclusion: To help lessen the suffering of the nurse following an AE, healthcare organizations have an ethical obligation to provide emotional support to the nurse and to ensure patient safety.

Adverse events (AEs) happen in a majority of medical procedures and at all levels of the healthcare system (Duarte, Stipp, da Silva, & de Oliveira, 2015; Hodak, Kolačko, & Luetić, 2017). AEs are predictors of quality care and patient safety. Common AEs experienced in nursing are “related to patient falls, administration of drugs, bedsores,

insufficient hand hygiene and hospital infections” (Hodak et al., p. 10). While the exact number of AEs experienced by nurses annually remains unknown, a study by Melnyk et al. (2017) suggested of 1,790 nurses surveyed from across the United States, 49.7% had experienced some sort of medical error over the last five years.

While research studies in the 1950s first began reporting on AEs, it was not until the early 1990s with the publication of the Harvard Medical Practice Study that individuals became interested in AEs (Brennan et al., 1991; World Health Organization [WHO], 2002). Research studies have placed great focus on AEs related to nursing through increasing patient safety by cultivating healthcare systems’ protocols and procedures (Scott, 2001). While this is important, many times caring for the nurse following an AE is disregarded, leaving the nurse to experience professional and personal anguish (Scott, 2001).

A thorough review of the literature identified the importance of providing support to nurses after an AE experience. However, information available on nurses’ experiences in regards to such support is limited. By increasing understanding of hospital nurses’ experiences with organizational support, healthcare organizations and nurse leaders will be better able to develop and/or improve existing support services.

Background

Involvement in an AE can be taxing and traumatic for clinicians, causing them significant distress (Kable, Kelley, & Adams, 2018; Scott, 2001; Seys et al., 2013). The effects experienced by the clinician can be so devastating that the clinician never moves

past the event. To assist nurses in moving past these events, organizational support may be offered and provided formally or informally. Formal support is support that is offered to all hospital employees and many times follows procedures and protocols. Examples of formal support is support provided by the Employee Assistance Program (EAP), mental health counseling, and/or peers who are specially trained in providing emotional support. Informal support may only be offered to certain hospital employees on a certain unit or department and/or is offered casually through peer discussions. Examples of informal support would be casual peer support (peers not trained in providing emotional support), support from mentors, and/or unit specific debriefings.

Research indicates that when post AE support is lacking from the healthcare organization, clinicians can experience symptoms similar to those seen in post-traumatic stress disorder, including suicidal ideations and suicide (Wu et al., 2017). Without adequate support, the likelihood of being involved in another AE increases, jeopardizing the safety of patients (Burlison, Scott, Browne, Thompson, & Hoffman, 2017). Unfortunately, research suggests that most clinicians do not receive needed support. Research studies provide limited descriptions of organizational support programs, especially specific to nurses following an AE. Furthermore, while researchers propose the various kinds of support programs or interventions healthcare organizations should offer, no studies were identified that explored the nurses' perceptions and experiences with organizational support following an AE. Thus, the purpose of this study was to better

understand hospital nurses' experiences with organizational support after experiencing an AE.

Methods

The study employed a qualitative descriptive design. The research questions were:

1. What are hospital staff nurses' experiences with organizational support following an AE?
2. What are the nurses' perceptions of the perceived availability and usefulness of organizational support following an AE?

For this study, an AE was defined as

an event, preventable or non-preventable, that caused harm to a patient as a result of medical care. This includes never events; hospital-acquired conditions; events that required life-sustaining intervention; and events that caused prolonged hospital stays, permanent harm, or death. (U.S. Department of Health and Human Services, 2012, p. 1)

Participants

Through purposive and snowball sampling, 12 participants met the inclusion criteria of (a) being a licensed registered nurse, (b) being able to speak and read English, (c) had experienced an AE in the last 10 years in an acute care setting in the U.S., (d) was older than 18 years of age, and (e) received informal or formal support following an AE. One participant identified as male (8.3%) and 11 identified as female (91.6%). For ethical/racial identity, five (41.6%) were African American, five (41.6%) were Caucasian, one (8.3%) was Latino, and one (8.3%) was Native American. Three (25%) participants

had an Associate's Degree in Nursing, five (41.6%) had a Bachelor of Science in Nursing, and four (33.3%) had a Master's in Nursing. Years of nursing experience ranged from 2 to 28 years ($M [SD]$, 15 [18.3]). The participants' AE experiences ranged from the most current one being in the last year and the oldest one being experienced in the last 8 years. All of the participants represented different hospital organizations.

Data Collection

An Institutional Review Board (IRB) approved flyer was used for recruitment with the researcher posting the flyer on social media (Facebook & Instagram) with the capability of others being able to share, like, tag, and comment on the post. Individuals who were interested in being part of the study contacted the researcher via email (two participants), private message via Facebook (five participants), and text messages to the researcher's cell phone (nine participants). Snowball sampling was incorporated at the end of each interview by asking the participants if they would contact another potential participant and provide the researcher's contact information. The Transactional Second Victim Experience conceptual model by Schiess et al. (2018), specifically the construct of weighing up internal and external resources, was used as a guide in developing a core set of interview questions. Additional questions were used during the interview to serve as prompts to stimulate further comments and/or to clarify meanings. One-on-one, semi-structured audio-recorded interviews were conducted. On average, interviews lasted approximately 45–50 minutes. Data saturation was achieved.

Data Analysis

Thematic analysis following Braun and Clark's (2013) staging of coding was used. Reading and re-reading of the transcripts began the data analysis phase. The next step was organizing the data in a meaningful and systemic way that gave rise to codes which reduced data into smaller chunks of meanings. Not every piece of text was coded, only those pieces that were pertinent to or captured something interesting in relation to the research questions. In developing codes, open coding was used so the researcher could develop and revise codes during the course of the analysis process. Throughout this process, discussions occurred with another researcher. From the codes, categories were then developed and defined within a Microsoft Excel spreadsheet. From this point, preliminary themes emerged. In finalizing themes, collaboration with another researcher occurred with two themes and six subthemes emerging from the data.

Findings

A visual framework of the themes and subthemes are represented in the thematic map (see Appendix A). The thematic map shows the theme *Weighing up Internal and External Resources* as being a precursor to the theme *Thoughts, Feelings, and Actions*. The map also signifies that subthemes *Barriers to Receiving Support* and *Availability of Support* are correlated with each other.

Theme 1—Weighing Up Internal and External Resources

The theme *Weighing Up Internal and External Resources* includes four subthemes: Types of Support, Desired Support, Barriers to Receiving Support, and the

Availability of Support. Barriers to Receiving Support and the Availability of Support were found to be correlated from the participants' experiences in that barriers contribute significantly to support availability.

Subtheme—Barriers to receiving support. This subtheme emerged from participants' experiences with the types of barriers that impeded their abilities to access support. Several of the participants noted how they were "unsure of how to access support services" or what kinds of support services were offered by the hospital organization. Two participants discussed how their organization offers EAP services, but both participants talked about a barrier to using this service. The EAP service provides the employee with "six free sessions." However, one of the participants noted, "I don't want to use them [free sessions] all up," whereas another participant stated, "if you continue, you know, to go to the sessions [EAP], then they'll charge you like a fee for them." Both participants noted due to the cost of EAP services they were reluctant to use this support service. The two participants noted they were "saving up the free sessions" in case they experience some sort of severe event and then would need to use the free sessions offered.

Another barrier to support received was attributed to the work environment. Participants noted that because of their "job duties" it was "difficult to find the time to access support." Duties of the job included "documenting about the adverse event" and continuing with the remainder of their patient assignments. Additionally, more than half of the participants noted they waited before reaching out for support to see if someone

from nursing leadership would seek them out first to offer support; however, this rarely happened.

Subtheme—Availability of support. One interview question focused on how available support was from the organization. A few of the participants responded saying that they were “unsure of how available support is from the organization.” This was especially noted as responses from those participants who worked night and weekend shifts. “It [support] tends to happen during the week more so than on the weekend.” All 12 of the participants noted they would appreciate support being offered immediately or very soon after the AE. One participant stated, “I’ve had a few times where it’s [support] occurred within maybe two weeks, but several times where it’s been a month, two months later, maybe more than that.” Another participant noted that the availability of support had a lapse in time to the point that “I really had almost forgotten about the event.” However, not all participant responses were negative. Some of the participants noted the support from the organization and nurse managers was very available: “there was always someone, even if not in the hospital one of those persons [mental health tech and/or on-call provider] were on call and could come debrief if needed.”

Subtheme—Types of support. Participants shared their experiences with various types of support that they received from the hospital organization either formally or informally. Formal supports mentioned were EAP, code lavender, chaplain services, counseling services, and coaching and counseling. Informal supports within the organization described by participants were casual peer support discussions and unit-

specific debriefings. Informal supports received outside of the organization were supports provided by the participant's family members and mentors such as a "past nursing professor."

While most of the types of support above are self-explanatory, code lavender was a support service with which the researcher was not familiar. According to the participant, code lavender is either

at the leader's discretion or anybody really on the floor, can initiate it and . . . they [unit staff] just say we need a code lavender . . . the leaders will just bring the bags out and they gave it to everyone on the floor whether they were working with that patient that day or not because most likely we've all come in contact with them.

The participant noted inside these bags are items such as essential oils, tissues, and a pamphlet with some encouraging words. When the researcher asked the participant how these items helped him move past or cope with the AE, he stated that

it is not really the items, it's really just the thought that, you know, my leaders [nursing leaders/ management] are concerned about my wellbeing even though, you know, we're there for the patients . . . it reassures us that we have back up, we have support if we need it.

Subtheme—Desired support. While participants discussed the types of support they received, either formally or informally, they were also asked about desired types of support they would have liked to receive. Participants talked about how they wanted closure of the event in the form of follow-up from nursing leadership in regards to meetings leadership attended about the AE, meetings in which "I was not allowed to

attend those meetings. I guess they are more for leadership.” Participants also noted they would have liked to have received support from nursing leadership and the overall organization earlier as this would have been extremely beneficial in “moving past the event.” Some of the accounts of what the participants desire in support are as follows:

I think sooner [support] would have helped, yes. While it [the event] was still fresh.

Someone to approach me after the event versus me approaching them for support.

. . . sometimes you need somebody that's a little bit unbiased.

. . . a debriefing immediately following an adverse event.

More than half of the participants talked about how they would have liked to have been included in the processes that examined the event and provided with the opportunity to give their insights as to how identical events could be prevented.

Theme 2—Thoughts, Feelings, and Actions

Themes 1 and 2 have a direct correlation with one another. As participants gave their accounts of their experiences with organizational support it became apparent that once the participants weighed up their internal and external resources (Theme 1), this had substantial effects on their thoughts, how they felt, and lastly the actions they took in the aftermath of the AE. The two subthemes that emerged were Emotional State in the Aftermath and Actions Taken in the Aftermath.

Subtheme—Emotional state in the aftermath. Participants were asked about what it was like to be a nurse after being involved in an AE. Several noted “it is scary”

and “it is lonely.” One participant talked about how she “felt left out” due to not being included in leadership meetings that discussed the AE. Reliving the event was mentioned by several participants. One participant stated, “I have found myself waking up at night and thinking about the event.” While others questioned their actions and skills, “Sometimes it makes you wonder, could I have caught something earlier or did I neglect to assess something or did I not listen to my patient well enough?” Feelings experienced by the participants in the aftermath of the AE ranged from feeling responsible, to confused, to feeling used.

Subtheme—Actions taken in the aftermath. Some of the participants talked about how they waited after the AE to hear what actions needed to be taken next. One participant stated, “I felt like I needed to protect myself by writing down a narrative account of what happened in case I needed to testify or explain myself later.” Other participants talked about how they felt like they were just “waiting for closure” due to the lengthy investigations that occurred after the AE, while other participants took steps to ensure their own “self-care.” Several of the participants talked about how they completed a Root Cause Analysis (RCA) following the event; however, many of the participants misunderstood this as support offered by the organization. One of the participants noted how they were relieved of their job duties for an hour or so following the AE. The participant talked about how this allowed her time to “decompress.” Others discussed how they continued on with their “job duties” and one stated, “We cried in our car.” One participant shared how she began looking for a new job after feeling blamed and ridiculed

by her nurse manager who “only cared about how he looked” after the AE. One participant stated, “I resigned from the organization the next day” following her AE experience. Another participant talked about how she “literally broke down in the middle of the unit”; she went on to say, “I didn’t come back [to work] for about a week and a half. Everybody thought I quit, but I didn’t, I just had to call out and tell them I couldn’t, (pause) I couldn’t come back for a while.”

Discussion

While some of the participants felt they received the support they needed, others felt that more support could have been provided or at least offered by their manager and the overall organization. Immediate support from and follow-up by nurse managers were the most frequent desires from all of the participants as they believed this signified being valued and cared for. It was surprising that more than half of the participants felt that completing a RCA was a type of support offered by the organization, when in fact it is one of the procedures taken to uncover the problems that caused the AE and not so much providing support to the nurse.

In exploring the participants’ opinions of being offered or provided with time off following an AE, each participant thought this was something that should be offered to every nurse following an AE. One participant strongly believed this should be offered and added, “Not even with just an AE but any kind of event that causes an emotional response by the nurse.” While some noted they may not take the time off because they would feel

they were “putting their team in a bind,” all of the participants agreed that at least being offered this opportunity would be appreciated.

While research is conflicting on the use of trained peer supporters that are unit specific, in this study, every participant discussed how they would prefer a unit-specific trained peer supporter versus one that was not unit specific. This would be someone to whom they could relate and someone that would understand the unit’s structure and processes. Participants noted they would be less likely to use a trained peer supporter if it was not one that was unit-specific.

Conclusion

Nurse managers and the organization play a critical role in providing support to nurses following an AE. The barriers of providing support vary among organizations; however, it is still an ethical duty of the organization and nurse managers to ensure support is provided—and provided without delay. Immediate actions that nurse managers should offer to their nurses following an AE are peer unit-specific support, unlimited free counseling support, and the offer of time off.

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Appendix A

Thematic Map of Themes and Subthemes

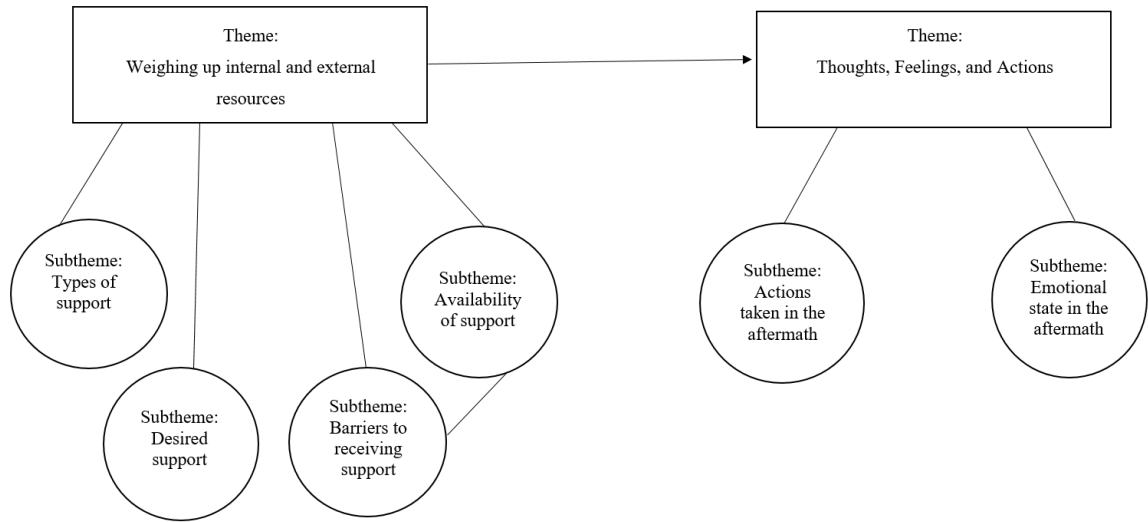


Figure 4.1. Thematic Map of Themes and Subthemes.

CHAPTER V

DISCUSSION

Introduction

The purpose of this study was to describe hospital nurses' experiences with organizational support following an adverse event (AE). A secondary purpose was to explore such programs' usefulness and availability. Participants consisted of 12 registered nurses whose experiences with organizational support represented Southeastern North Carolina. The experiences of the participants were captured through one-on-one, semi-structured interviews. As discussed in the previous chapter, two themes and six subthemes emerged from the participants' narratives. Theme 1 was, *Weighing up internal and external resources* and consisted of four subthemes: (a) *Types of support*, (b) *Desired support*, (c) *Barriers to receiving support*, and (d) *Availability of support*. Theme 2 was, *Thoughts, feelings, and actions* and consisted of two subthemes: (a) *Actions taken in the aftermath*, and (b) *Emotional state in the aftermath*. This chapter explores the meaning of the themes and the participants' experiences in relation to the chosen conceptual model and past research. Implications for nursing practice, nursing research, and future recommendations for research are discussed. Lastly, the studies limitations are presented.

Themes

Weighing Up Internal and External Resources

The first theme, *Weighing up internal and external resources*, described the initial phase the participants took in the immediate aftermath of the AE. It was apparent from the participants' experiences that after evaluating the situation they began to weigh up internal and external resources, which led them to utilize personal resources and seek out support from those they trusted either inside or outside of the healthcare organization. While participants wanted to talk to someone about their feelings and share their side of the story about the AE, many were cautious in doing so. Participants described internal resources, being those found inside the organization, as well as resources that were located external to the organization such as confiding in family members and outside mentors. This theme is consistent with Schiess et al.'s (2018) Transactional Second Victim Experience conceptual model's concept of weighing up internal and external resources. Weighing up resources allowed participants to share their unique experiences of internal and external support that generated the four subthemes for Theme 1.

Types of support. Participants discussed several types of support—formal and informal, and external and internal. Internal supports ranged from unit-specific peers, to manager support, to debriefing sessions, to EAP services, as well as a Code Lavender. One participant talked about a special room located on the unit where staff could go to decompress and be alone for a few minutes to gather themselves and their thoughts. This support was offered by the healthcare organization and was available for all hospital

employees. Literature provides this type of support as an example of creating a supportive and safe environment for staff following a traumatic event (Joesten, Cipparrone, Okuno-Jones, & DuBose, 2015; Joint Commission, 2018; Scott et al., 2009).

EAP services were mentioned by all of the participants as a type of support offered by the healthcare organization; however, of the 12 participants, only one noted using this service. Research is controversial in using EAP services noting this type of support is not adequate in supporting the nurse in the aftermath of an AE. However, the one participant who did use this service noted it was beneficial and not just for work-related issues but also for personal issues, and she had used the service for both.

Code Lavender, an internal support that was unit-specific, was described by one participant. This type of support is not discussed in the current literature and was unknown to this researcher. While this type of support was noted to be beneficial to only one participant, it provides evidence that conversations do not always have to occur surrounding the event, but instead a gesture of caring, such as with Code Lavender, could be extremely beneficial with coping in the aftermath of an event.

Peer support was used most frequently by the participants. Specifically, participants elaborated about how they confided to unit-specific peers to reassure them that they had performed the correct nursing interventions and that no one person was at fault. Conversations with their peers were informal and occurred on an as-needed basis, many times at the nurse's station. Since research is controversial in regards to using unit-specific peers for emotional support, one of the interview questions specifically asked the

participants what they thought about this issue. All 12 participants noted unit-specific peers was their preference as these peers would better understand the unit and the procedures of the unit, unlike a peer who was from another unit. All participants verbalized that if peer support was offered by the organization using trained peer supporters who were not unit-specific, they would most likely never consider using this support. This is a new finding that adds to the current body of literature.

While several of the participants agreed their unit manager was supportive in the weeks to months following the AE, some had conflicting experiences with this. Participants talked about how this type of support was beneficial to the entire unit when provided, but a lack of unit manager support was a huge downfall for the unit and its cohesiveness among the unit's staff. Many of the participants who did not receive adequate support from their unit managers reiterated that this was not always because the manager did not want to support them, but rather it was due to the manager being preoccupied with his/her leadership responsibilities that were placed on them by the healthcare organization.

Debriefings were another form of internal support that was utilized by some of the participants. This is a type of 'caring moment' that Hirschinger, Scott, and Hahn-Cover (2015) presented in their study titled "Clinician Support: Five Lessons Learned." However, in a study by Gazoni, Amato, Malik, and Durieux (2012), the researchers argued that debriefing the persons involved following the AE has not been proven to help and may actually make posttraumatic-like symptoms worse. The Joint Commission

(2018) recommends conducting debriefings that include all team members who were involved in the AE. Participants described unit-specific debriefings that included various individuals being in attendance for these. One participant expressed her appreciation with mental health counselors, her manager, the hospital's Chief Nursing Officer, the critical care intensivist, and the Chaplain being involved in the debriefing she attended. None of the debriefings discussed were alike in regards to how they were conducted, when and where they took place, or the specific persons in attendance, yet the debriefings were beneficial as participants described how these provided a safe environment where they could share their feelings and thoughts while never feeling blamed for the event.

Chaplin services were used by some of the participants. Those who utilized this service talked about how they had a good working relationship with the Chaplin and therefore felt comfortable and trusted this individual. Two of the participants discussed a Chaplin was always on call during the night and weekend shifts but if it was a Chaplin they did not know they refrained from using the Chaplin support service. This finding is one that is new and adds to the current body of literature.

For external supports, one participant talked about how she confided in her aunt who was a retired nurse while another participant talked about discussing the events with her immediate family. The participant who provided her experience with confiding in her family noted her main reasons for doing such was because they had no knowledge of healthcare. Therefore, they were unbiased and nonjudgmental, which aligns with findings in a study by Joesten et al. (2015); however, this study included nurses as well as other

disciplines. Research notes that more often than not healthcare professionals will seek support from their family or close friends about their event versus coworkers (Joesten et al., 2015; Schiess et al., 2018). The participant who relied on her aunt for support noted her reason for this was because she had been a long-time nurse; therefore, she trusted her and knew she had her best interest in mind. Lastly, one participant talked about how she relied on a past nursing instructor with whom she had a personal relationship and whom she trusted.

Desired support. Participants shared the types of support they would have liked to have received following their AE. While a few of the participants noted they felt they received the support they needed, they still had suggestions for other types of support that would have been beneficial. For instance, immediate support was most desired from all of the participants, which aligns with the Joint Commission's (2018) recommendations as well as other studies' findings (Edrees et al., 2016; Scott et al., 2010); however, these studies surveyed individuals from various healthcare disciplines. Support persons approaching the nurse versus the nurse seeking out support was desired by all of the participants. Some of the participants described what Scott et al. (2009) discuss as a rapid response support team for the nurse, which is when a trained peer offering support approaches a nurse who experienced the AE within 12 hours.

All of the participants except one desired to be included in the leadership meetings that occurred following the AE. The participants felt this would give them an opportunity to not only give their point of view about the AE but also would give them

the satisfaction in being included in the process that explored the AE. Closure of the event was also noted as being a huge reason for wanting to be involved in the process that explored the event. The one participant who did not desire to be included in the leadership meetings noted it was due to her being committed to other personal and work-related obligations already; being too busy.

All of the participants desired follow-up from their nurse manager in the weeks following the AE. This finding is similar to that of Edrees et al. (2016), Dukhanin et al. (2018), and Kable, Kelly, and Adams (2018). Participants in this study talked about how follow-up would aid in the closure of the event as well as them just knowing what the end results of the event were. Participants went on to note that follow-up should occur within a few weeks following the AE so they did not have to continue to relive the event and could move past it. All of the participants talked about never knowing even years later what the results of their events were in regards to if they were seen to be at fault or not, with one participant left to wonder if the patient survived or not.

Lastly, every participant desired being supported in an unbiased way. Having someone they could trust who would not have a biased opinion was someone they all desired for support. This would allow them to open up and feel as though they could approach this person and walk away from the conversation feeling a sense of acceptance even if they had made a mistake, whether it was one that was big or small. Research notes this is what is known as a safety culture. A just culture is a blame-free work environment where staff feel they can report AEs without fear of being reprimanded or

punished (Agency for Healthcare Research and Quality, 2018). In the study by Dukhanin et al. (2018) these findings were extremely similar in that participants wanted support that was unbiased and non-judgmental.

Barriers to receiving support. Participants talked about how they were aware of the different types of support that the organization offered. However, the most frequent barrier to receiving support was participants not knowing how to go about accessing the support or whom to call if they needed support, which aligns with similar findings from a study by Scott et al. (2009). Participants knew there were EAP services available, but they were unsure who to contact or what the procedure was in order to receive such support. Other participants discussed how they were cautious to use EAP services because of confidentiality issues and the possibility of repercussions or retaliation from their nurse manager. Another barrier to receiving EAP services was a discussion shared by two of the participants who explained that after so many EAP sessions they would then have to pay out of pocket for this service. Therefore, they were reluctant to use this service or at least postpone using it until they severely needed it.

Another frequent barrier to receiving support was not having the time to do such. The examples given from the participants were having to document about the AE, completing RCAs, and having other patients they had to care for. Sadly, participants talked about how they came to realize that they were there to care for their patients and their own needs were less important because AEs “are part of the job,” as stated by more than half of the participants.

Availability of support. Several of the participants noted that supports such as debriefings and manager support many times were delayed. This time lapse caused the participants to relive the AE. One participant talked about how it had been so long after the event when her manager did approach her that she had almost forgotten about the event. Peers were always available to provide support, whereas managers were not as available, mainly due to their leadership duties and not being visible on the unit as often as were peers. In regards to unit-specific debriefings, participants noted it was difficult to get all of the staff together in a timely manner to conduct the debriefings; therefore, this type of support was delayed. Chaplin services were always available for those organizations that provided this service. There was always a Chaplin on call 24 hours a day, 7 days a week. EAP services for some organizations was only available Monday through Friday during normal working hours with a two of the organizations having a 24-hour 1-800 number staff could utilize.

Thoughts, Feelings, and Actions

The theme *Thoughts, feelings, and actions* reflect those thoughts, feelings, and actions of the participants in the aftermath of the AE. The emergence of this theme was one that was unanticipated but is one that is strongly supported by the participants' descriptions in the aftermath of the AE. The participants' thoughts, feelings, and actions heavily depended upon the type of support they received and the experiences that went along with those supports. This theme supports the final stage of Scott et al.'s (2009) Recovery Trajectory. In this final stage of the trajectory, nurses decide if they will change

professional roles, leave the nursing profession, survive so they can at least perform at the expected performance level, or thrive, turning the experience into something good.

Emotional state in the aftermath. In exploring what it was like to be a nurse following an AE, participants' responses varied; however, all 12 participants noted it was scary. The continual thinking about and reliving the event and the actions they took during the AE was something that each participant vividly discussed. The majority of the participants said they found themselves asking when another event was going to happen. Questioning nursing skills and their nursing judgment was mentioned by two of the participants.

Several factors influenced the emotional state of the participant such as support received from peers and the organization, the relationship the participant had with the patient, and past clinical experiences and AEs. These findings were similar to ones found in a study by Scott et al. (2009) and Harrison et al. (2015). Nurses tend to become emotionally attached to patients after caring for them for an extended period of time. One participant talked about how she and other staff cried in their cars on their way home that day, while another participant provided meticulous details about uncontrollably weeping in the nurses' station following the AE.

Actions taken in the aftermath. Participants' actions varied in the aftermath and were dependent upon the support they received from their peers and/or the organization. One participant talked about how she felt she needed to protect herself immediately

following the AE so she took the time to write down her side of the story and the events that occurred along with the interventions she took and the things she said.

Two of the participants shared how they quit their job with one quitting the day following the AE and the other quitting within a few weeks of the AE. However, the participant who waited to quit her job shared that this was only because she was waiting to get another job before leaving her old one. A few of the participants said they considered leaving but did not because they liked the staff with whom they worked. Two participants reported they never considered leaving because of an AE because these events are just part of the job. Lastly, one participant who did not quit her job talked about how she was not mentally or emotionally able to go to work the days following the AE so she had no choice but to call in sick for the next week.

One of the participants attended the patient's funeral services. He talked about how this helped him with the closure of what had occurred. He noted that the patient's family wanted him to attend the funeral services; while he had never done this before, he did it this once and had no regrets. This type of action following an AE has not been presented in the literature.

Implications for Theory

Schiess et al.'s (2018) Transactional Second Victim Experience conceptual model was used to guide the researcher in formulating research questions as an integrated way of exploring organizational support following an AE. While the conceptual model assists one to better understand the experience one endures following an error, the researcher

specifically examined the concept of weighing up internal and external resources. This concept was chosen by the researcher to better understand the aspects of what this concept entails as these are not explicit in the Transactional Second Victim Experience model. Therefore, research questions were written with this concept being the guide. In return, this approach allowed the researcher to better understand the relationship between internal and external resources as well as provide examples of these and determine which ones were often used by the nurse following an AE.

Weighing up internal resources included unit-specific peer support, EAP services, Chaplin services, mental health technicians, Code Lavender, and unit-specific debriefings. Weighing up external resources included mentors located outside of the hospital and confiding in family. Participants were careful in ‘weighing up’ the resources that were most beneficial to them.

Schiess et al’s. (2018) model is one that is new to research and is presented only in one publication to date. Therefore, the concept of weighing up internal and external resources is one that is new, and to this researcher’s knowledge, this is the first study to apply the model even more specifically with nurses as the sole participants. The concept of weighing up internal and external resources was beneficial in data collection and analysis providing the researcher with a better understanding of these resources, their attributes, and the consequences.

Implications for Nursing Practice

While it can be argued that some support is better than no support, nurse managers and organizations should strive to provide the nurse with the types of support that are most beneficial in assisting them to move past the event. Support that is immediately available with a clear process of how to activate this support is of utmost importance for nurses. Organizations that currently have a support program in place should invest time in reevaluating their program through surveying nurses who have utilized the program. This would give the organization's leadership a better understanding of how beneficial, useful, and accessible their current program is so changes can be made, if warranted. For organizations that do not currently have a support program for nurses, these organizations should make this an immediate priority as this study and other studies demonstrate that nurses need and desire such support. In developing a support program, organizations should use best practices, many of which have been presented in Chapter II of this document. Another important step is getting nurse buy-in and allowing nurses to be part of implementing the support program. Surveying nurses to best understand the support they most desire would be an excellent first step to take in developing a support program as no one better knows the kinds of support they need or desire than nurses themselves. As mentioned earlier, support is most likely not a one-size-fits-all.

In regard to the implications of offering nurses time off following the event, organizations should consider this idea. While staffing shortages exist in many hospital

organizations throughout the United States, the idea of optional time off may seem to add to the shortage; however, in reality, it could decrease nurse call-outs while increasing nurse retention, nurse satisfaction, and patient safety. Most likely not all nurses will take the time off, but as noted in the study's findings, nurses would like to have this opportunity should he/she need it. To make this an option for all nurses, the organization should consider having a clearly written policy on this issue.

Implications for Nursing Research

Research studies provide limited descriptions of organizational support programs. In reviewing these studies there has been little documentation of the steps that were taken during the development and implementation of the support program. Furthermore, there are limited evaluations of the feasibility, implementation, and effectiveness of the developed programs. While researchers propose the various kinds of support programs organizations should offer, little research is available to provide evidence that such programs benefit second victims and the extent of the benefits. However, the benefits of support programs can be measured using the Second Victim Experience and Support Tool (SVEST). The SVEST instrument's psychometric properties were validated by Burlison, Scott, Browne, Thompson, and Hoffman (2017) and can be used by healthcare organizations when implementing and tracking the performance of support services.

A cross-country exploration of support programs has not been conducted. It is evident from research that AEs occur nationwide; therefore, it is essential to understand what is happening cross-country in order for researchers and healthcare organizations to

share ideas, experiences, and best practices to provide support that is beneficial for nurses.

While there has been research conducted that focuses on the healthcare professional's job-related effects after experiencing an AE, little research has been done that examines the effects on the nurse's personal life. Also, less studied is the exploration of the fact that the more harmful the AE, the more distress that is placed on the nurse.

Lastly, several research studies have been conducted recommending organizations to develop and implement support programs; however, to this author's knowledge, this study and one other study by Joesten et al. (2015) are the only studies that provide evidence of the usefulness of support programs. To this researcher's knowledge, this study is the only one that has solely surveyed nurses using a qualitative approach; Joesten et al. (2015) used a quantitative approach and the tool utilized lacked psychometric validation. Replicating this qualitative study would allow for more generalizability to assist healthcare organizations in determining how to best support nurses following an AE.

Study Limitations and Assumptions

There were limitations to this study. Since this study was conducted in Southeastern North Carolina, findings may not reflect the experiences of other nurses in other geographical areas of the United States. For recruitment and sampling, there was the potential for self-selection bias due to the strategies used to reach this specific population of individuals. There is potential for recall bias which can be seen with self-

reporting. Participants vividly described their experiences with organizational support; however, it is unknown to the researcher if participants left out certain details.

Additionally, the accuracy of memory could have been influenced by other AEs and experiences. Lastly, while there was representation from various races/ethnicities and education levels, the study consisted of only one male; therefore, the study's findings may not be as generalizable to male nurses.

The study had one assumption in that AEs regularly occur to nurses employed in inpatient settings and these nurses would honestly report their experiences with support programs following an AE. Participants' statements confirmed that AEs regularly occur as they believed these were part of the job. It is this researcher's belief that the experiences shared were accurate accounts of the participants' discrete experiences with organizational support.

Conclusion

This qualitative descriptive study provided a beginning understanding of the experience of the nurse with organizational support following an AE. Two themes with six subthemes were generated from analysis of the participants' transcripts. To this researcher's knowledge, these findings are the first that present solely the nurse's perspectives. Implications for nursing practice and research as well as recommendations for future nursing research were discussed.

While this study produced findings similar to those in past studies, new findings were revealed such as the benefits and usefulness of organizational support, support

desired by nurses, and the opportunity for time off from nursing duties following an AE. Additionally, this study was unique in that the participants represented exclusively the nursing profession, whereas the majority of other studies included various healthcare professionals.

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APPENDIX A

PUBLISHED MANUSCRIPT: CLINICAL NURSES' EXPERIENCES WITH SENTINEL EVENTS

The following manuscript was published in *Nursing Management*:

Stone, M. (2019). Clinical nurses' experiences with sentinel events. *Nursing Management*, 50(11), 38–42. doi:10.1097/01.NUMA.0000602808.65184.b7

Abstract

Purpose: To develop an understanding of hospital staff nurses' experiences with sentinel events. **Design:** A qualitative descriptive phenomenological approach was used. **Methods:** Semi-structured interviews were conducted. **Findings:** Data analysis revealed two overall themes. **Conclusion:** Following a sentinel event emotional support is lacking from nurse managers.

Introduction

Little is known about nurses' perceptions of sentinel events (SE) and/or the changes needed in the work environment to best support nurses following such events. The Joint Commission defines a sentinel event as an unexpected occurrence involving death and/or serious physical and/or psychological injury to a patient.¹ While data about SE numbers are accessible, little information is known about nurses' perceptions of these events. Therefore, the purpose of this article is to describe nurses' experiences with SEs in hospital settings to include Intensive Care Units (ICU), medical/surgical, long-term care, psychiatric, and Alzheimer's units.

For the years 2005-2017, the Joint Commission reported 67% of all SEs occurred in a hospital setting.¹ SEs for the years 2005-2017 claimed the lives of 5,826 patients with an overall total of 11,189 patients impacted in some way.¹ While patients and families are dramatically affected after a SE, so is the nurse who was involved in the event. In the days following such an event, the needs of the nurse are overlooked during this very difficult and traumatic time, leaving them to suffer in silence.²

Design and Methods

For this pilot study, a qualitative descriptive phenomenological approach was used for data collection and analysis in order to capture the lived human experience of registered nurses who had experienced a SE. Hospital staff nurses were recruited for this pilot study in light of the fact that many of these events occur in the hospital setting according to Joint Commission's statistics.¹ Participants were recruited using purposive sampling through social media (i.e., Facebook). Participation was voluntary with consent obtained from each participant. IRB approval for the study was obtained prior to recruitment.

One-on-one semi-structured interviews were conducted in a private place of the participants choosing. After obtaining basic demographic information (i.e. age, gender, years of nursing experience), open-ended questions were asked to gather information regarding the SE that occurred, the nurse's feelings about the event, the work environment before and after the event, and the type(s) of support provided to the nurse following the event. Probing questions focused on what happened before, during, and

after the sentinel event, the nurses' perceptions of why the event occurred, and if the event could have been prevented.

Data Collection and Analysis

The researcher audio recorded interviews and later transcribed them verbatim. Names of the participants were changed to pseudonyms. The researcher used bracketing to put aside the information previously learned about the phenomenon in order to examine the data collected. The researcher recorded field notes in order to document participant emotions, responses, and the environmental context in order to get a thick description of the participant's story. For an audit trail, the researcher kept a personal journal, this also ensured rigor. Interviews were conducted in a private setting of the participant's choosing that was free of distractions and ensured confidentiality. Data analysis followed Munhall's conceptual model of phenomenology that explored the uniqueness and the human experience of each participant.³ The researcher spent significant time dwelling with the data until the essence and themes of the participants' experiences were identified. Dwelling with the data included listening to the audio recorded interviews numerous times and comparing field notes with the audio recordings which allowed the researcher to become fully immersed in the data in order to acquire an understanding of the participants' experiences while making sense of these accounts. Through extraction of participants' significant statements that pertained directly to the phenomenon of interest, the researcher was able to formulate meanings. The researcher then categorized the formulated meanings into common themes.

While the researcher conducted the coding of data independently, these were then reviewed for accuracy by another researcher where discussions took place to ensure the themes and relationships were presented accurately. This process continued until a consensus was reached. This process established credibility and dependability of the data analysis process.⁴

Participants and Their Sentinel Event Experiences

Five registered nurses, each from different hospital organizations, shared their SE experience with the researcher. Of the five participants, four held leadership type positions (i.e., charge nurse and/or nurse supervisor) when the SE occurred so they gave their experience from that perspective. One participant shared two stories in which she was the direct care nurse during the time of the SE occurrence. While this number of participants is small it should be noted that each participant shared two to three different SE experiences except for one participant who shared one experience. This gave the researcher a total of eight SE experiences. One participant worked in the ICU, one in psychiatry, one on an Alzheimer's unit, and two participants worked on medical/surgical units. Years of nursing experience for the participants at the time of the SEs ranged from one to 30 years.

Inclusion criteria included being a nurse who was involved (directly or indirectly) with a SE in a hospital setting in the United States and being able to read and write English. Exclusion criteria included being unable to read or write English and never being involved in a SE in a hospital setting in the United States.

The SEs described included: a young patient who became paralyzed, a patient who jumped from the second story window of a psychiatry unit, a patient who escaped a psychiatry unit and was found on a post-partum unit, a patient who was found with her head and neck trapped in a hospital bed's side rails, a patient on an Alzheimer's unit who escaped the unit and was lost in the woods, a patient who was misdiagnosed and subsequently died, a renal patient that received four times the dose of an ordered medication, and a non-verbal patient whose care was being overseen by hospital residents.

Results

Two main themes were identified from the participants' experiences of being involved in a SE: (a) Failures of the work environment, and (b) When emotions, feelings, and behaviors affect practice and personal life.

Failures of the Work Environment

For the theme 'Failures of the work environment,' the participants noted the work environment was not a welcoming one and the nurses' problems were the nurses' problems to be dealt with. The participants' descriptions of the work environment just prior to the occurrence of the SEs are presented below.

. . . it was the same kind of day, we were always busy . . . We were actually licensed for 20 patients and often ran a census of 22-25. (Megan, charge nurse)

And there was the environment. It wasn't a good one to just go in and sit down and talk to people . . . (Mabel, charge nurse)

. . . we were all new nurses . . . the charge nurse had her full load of patients . . . we were short-staffed that day . . . my problems were my problems. (Penelope, staff nurse)

Sometimes the elevator door would just open. We had been telling people that the elevator door was not doing what it was supposed to and they argued with us until the end of the world. Our nurse manager and even the head leadership people wouldn't listen, they just didn't believe us. (Megan, charge nurse)

During the interview, participants shared their perceptions as to why the SEs occurred. Selected participants' descriptions are presented below:

Honestly, I think she probably wasn't mentored good enough because this wasn't the first time a mistake had happened but this was the first time a mistake of this caliber had happened. (Mabel, charge nurse)

. . . I don't think the resident listened to his nurse [me] . . . the doctor was leaving the floor while we were rounding with the residents . . . I went running after him and I said my patient, he's going to die. He said trust me they [the residents] got this and I believed him . . . as far as they [the residents and provider] knew they were going to let my patient die but they hadn't told me. (Penelope, staff nurse)

. . . I felt like I wasn't being listened to by the provider or my nurse manager . . . I stayed after work that night . . . I charted a whole note about every time I had talked to the resident and what I had said. The next day a co-worker called me to tell me that he [the patient] had died during the night. (Penelope, staff nurse)

When Emotions, Feelings, and Behaviors Affect Practice and Personal Life

Each participant described how they continue to relive the event even years later. For the theme 'When emotions, feelings, and behaviors affect practice and personal life,' several of the participants noted they were afraid another mistake was going to occur again. Due to such fears, one of the participants considered changing hospital units where another participant voluntarily stepped down as the unit's charge nurse. Another

participant shared how one nurse that was directly involved in the SE left nursing after 20 years of being in the profession. Some of the participant's descriptions related to the impact SEs had and continue to have on their personal and professional life are presented below.

she [the staff nurse] was visibly distraught. The nurse was so distraught, that she couldn't even participate in the code . . . She actually went home and she called out sick for the next several days . . . she actually ended up transferring out of the ICU within 3 months. (Mabel, charge nurse)

After the sentinel event that nurse was very timid. She was terrified almost like she was afraid that she was going to make another mistake. (Mabel, charge nurse)

After a sentinel event experience, you are constantly holding yourself accountable. (Vicky, shift supervisor)

I actually went and shadowed in another department at the hospital. (Penelope, staff nurse)

Every day when I would clock in, I would ask myself when is it going to happen again? Did I do the right thing? Every day! (Vicky, shift supervisor)

. . . I resigned from my unit supervisor position. (Aubrey, shift supervisor)

She [the staff nurse] called out sick several days after all that happened. She never returned to the unit and she ended up leaving nursing altogether. She wasn't even old enough to retire. (Mabel, charge nurse)

She didn't want to be at the nurse's station with that physician. Every time that physician came in, she [the staff nurse] would go to the breakroom, or she would step in her patient's room. She avoids that physician even to this day. (Mabel, charge nurse)

Discussion

Participants described how the SE experience caused them significant distress, even comparing it to post-traumatic stress as has been discussed in current literature. Two of the participants described how they felt as though they were reliving the event due to the lengthy investigation process that was conducted by risk management and nursing leadership in the weeks and months following the SE. One participant stated, “I understand they [risk management and nurse managers] needed to do their investigation, but I needed help, too. I needed help in understanding what happened, and I needed someone to listen to me and to hear what I was feeling. But that never happened” (Penelope, staff nurse). All of the participants noted how they would have liked nothing more than support from nurse managers following the SE.

The participants’ recollections of the events were precise and vivid, recalling the smallest of details such as the time of day the event occurred, the patient-to-nurse staffing ratio, and some could recall the patient’s room number. The participants shared feelings ranging from guilt, anger, and embarrassment following the SEs. One participant noted that after the SE her confidence was shattered. The participant went on to state that “Not only did I lose my confidence, but I lost my identity as a nurse” because of how she was treated in the days following the SE.

Being involved in an event such as a SE can be stressful and traumatic for nurses, causing them substantial distress. While research studies show that peer and organizational support are needed following events such as a SE,⁵ surprisingly each of the

participants talked about how this was not provided or ever offered to them or their colleagues. When organizational support lacks following traumatic events such as SEs, literature suggests that nurses can experience emotions similar to those seen in post-traumatic stress disorder symptoms.⁶ Hence, it is important to ensure nurses receive emotional support from nurse managers, their peers, and the overall organization in order to move past the event and to thrive in the nursing profession.⁷ Literature suggests this support should come in the form of peer support programs;¹ however, a gap in the literature remains with the argument of emotional support being a one-size-fits-all approach or not. Studies have made various suggestions for emotional and peer support strategies that can be used in organizations.^{1,5,8,9}

Implications for Nursing Management

When developing and ultimately sustaining any form of support strategies, nurse managers and the overall organization must be supportive of such. Nurse managers need to have an active role in supporting the nurse following a SE, and in the months to come, as caring for the caregiver should be the nurse manager's priority. In a world that currently faces a shortage of nurses, nurse managers and healthcare organizations must develop and sustain support programs for nurses following a SE as not to add to this shortage.

Limitations and Recommendations for Future Research

This pilot study included a small number of participants. The small sample size could be due to the psychological trauma that many times is associated with being

involved in a SE. The sample size may limit the transferability of the study's findings. Additionally, for recruitment and sampling, there is the potential for self-selection bias due to the strategies that were used to reach this specific population of individuals. Regarding potential recall bias, it was noted that due to the profound effects the SEs had on the participants, they were each able to vividly discuss their experiences. More research is needed to explore organizational barriers and facilitators for developing and sustaining support programs for nurses following a SE.

Purpose of Pilot Study: To develop an understanding of nurse perceptions with sentinel events.

Hospital Units Included in Pilot: ICU, Medical/Surgical, Long-term Care, Psychiatric and Alzheimer's units; Specific organizational names cannot be shared but each participant was from a different hospital organization located in the United States.

Time Frame of Interviews: May 2018 through June 2018

Participants: Registered nurses; 1 RN with an Associates in Nursing; 4 RNs with a Masters in Nurse Education; Years of nursing experience at the time of the SE ranged from 1-30 years

Collection tool: Semi-structured interview guide

Sample Size: Five registered nurses

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APPENDIX B

CONSENT FORM

IRB Consent Form

Project Title: Hospital staff nurses' experiences with organizational support

Principal Investigator: Misty Stone, MSN, RN

Faculty Advisor: Dr. Susan Letvak, PhD, RN

What is this all about?

I am asking you to participate in this research study because I want to gain your experience of organizational support following an adverse event. This research project will only take about one hour and will involve you answering interview questions. The interview will be one-on-one in a private setting of your choosing. Your participation in this research project is voluntary.

Will this negatively affect me?

No, other than the time you spend on this project there are no known or foreseeable risks involved with this study.

What do I get out of this research project?

You and/or society will or might not have direct benefits; however, you may find it helpful to talk about your experience. It is the researcher's hope that the information gained from this study may benefit other nurses in the future as well as healthcare organizations in developing support programs.

Will I get paid for participating?

You will be paid with a \$25.00 MasterCard gift card if you complete the interview entirely.

What are the potential risks for participating in the research project?

There is a rare < 1% chance that you will experience emotional distress/stress when participating in this study. I will pause the interview should you experience distress. I will allow short breaks, and I will listen in a nonjudgmental manner. The below contact information is provided for additional support for mental health resources should you experience emotional distress/stress requiring follow up. Mental Health Services-CenterPoint Human Services Access:1-888-581-9988 (24 hours a day 7 days a week).

What about my confidentiality?

We will do everything possible to make sure that your information is kept confidential. All information obtained in this study is strictly confidential unless disclosure is required by law. We will make every effort to keep your information confidential. All data will be stored in a locked file cabinet in the PI's locked academic office. All computer data files will be stored in UNCG

Box and only shared with the dissertation chair. You will be identified by a pseudonym, not your real name, and other identifiable data will be altered in any written or verbal presentation of this study. At the conclusion of the study, data will be kept for five years. After five years, computer data will be erased and paper documents will be shredded and discarded appropriately. Once the recordings are digitally transcribed and checked for accuracy the audio recordings will be erased from the digital tape recorder.

Because your voice will be potentially identifiable by anyone who hears the recording, your confidentiality for things you say on the recording cannot be guaranteed, although the researcher will try to limit access to the recording as described in this section. A digital tape recorder will be used to record the one-on-one semi-structured interview. All recordings will be deleted from the digital recorder after data are transcribed into written text and checked for accuracy. Data will not be stored and will not be used in future research projects.

What if I do not want to be in this research study?

You do not have to be part of this project. This project is voluntary and it is up to you to decide to participate in this research project. If you agree to participate at any time in this project you may stop participating without penalty. You will waive the acceptance of the \$25.00 gift card.

What if I have questions?

You can ask Misty Stone, PhD student in Nursing, who may be reached at 910-258-6548 (misty.stone@uncp.edu) or Dr. Susan Letvak, Professor of Nursing at UNC-Greensboro, who may be reached at 336-256-1024 (saletvak@uncg.edu) anything about the study. If you have concerns about how you have been treated in this study call the Office of Research Integrity Director at 1-855-251-2351.

APPENDIX C
DEMOGRAPHIC SHEET

Demographic Data Sheet

Pseudonym Name: _____ **Date:** _____

Contact Phone Number: _____

Gender (circle one):

1. Female 2. Male

Ethnic/Racial Identity (circle)

1. Native American 2. Latino 3. Caucasian 4. African American 5. Asian/Pacific
6. Other _____

Circle one: 1. Registered Nurse 2. Licensed Practical Nurse

Education (circle highest degree completed)

1. Certificate (Licensed Practical Nurse)
2. Associate of Arts/Science
3. Baccalaureate of Arts/Science
4. Master's
5. Clinical or Practice Doctorate
6. Research Doctorate

Nursing Experience in Years (fill in the blank) _____ years

APPENDIX D

INTERVIEW SCRIPT

Interview Script

This interview is being conducted with _____ (pseudonym name). Today's date is _____ and the time is _____.

Thank you for taking the time to meet with me today. The purpose of this study is to understand your experience with organizational support following an adverse event. An adverse event is defined by the U.S. Department of Health and Human Services as "an event, preventable or non-preventable, that caused harm to a patient as a result of medical care. This includes never events; hospital-acquired conditions; events that required life-sustaining intervention; and events that caused prolonged hospital stays, permanent harm, or death." Developing an understanding of nurses' experiences following an adverse event can assist nurse leaders to better support nurses who experience these events. I do ask that organization, patient, and staff names are not shared. There are no right or wrong answers for the questions that I will be asking you. If it is okay, I would like to begin the interview at this time. As you are answering the questions feel free to add any other information about your experiences as well.

During the interview, I will tape recording our discussion, and I will also be making a few notes on paper just to keep my thoughts organized and keep myself on track. If at any time you want to tell me something that you do not want recorded feel free to turn the tape recorder off (demonstrate how to turn the recorder off).

Do you have any questions? Okay. Well, you are ready, let's begin. I would like to begin with asking you some basic information by completing a demographic data sheet. If there is a question you do not want to answer just say "skip question." How many years have you practiced nursing? What is your age? What is your gender? What is your race/ethnicity? What is your highest level of education? Are you a registered nurse or licensed practical nurse?

Grand tour question: Tell me about a time you received support from a healthcare organization following an adverse event.

- 1- First can you begin by describing what it is like to be a nurse following an adverse event in an inpatient setting?
- 2- Can you tell me about the support you received from the healthcare organization and what it entailed following an adverse patient event you experienced?
 - How did you access the support?
 - How available was the support?
 - What individuals provided the support (i.e., Peers, EAP, nursing leaders, etc.)?
 - Are the persons providing the support trained, are they peers, do they work on the same unit as the person needing the support?
 - Was the support formal or informal support?
 - What services did you have access to and what services did you actually use?
- 3- Were you given time off from your nursing duties following the event, and if so, how much time was given?
 - If so, how long were you given off?
 - Did you have to request the time off or was this voluntarily offered to you?
 - If you were not offered time off would you have liked to have been?
- 4- Following the adverse event (days, months, maybe years later) did the organization continue to support you, and if so, describe this support?
- 5- To what extent would you recommend the support you received to other peers/coworkers?
 - Can you describe to me why you feel this way?

- From your experience what were the strengths of the support you received?
 - What were the weaknesses of the support you received?
 - Describe how beneficial or not the support was that you received in moving past the event?
- 6- Please share with me how the organization involved you in the process that analyzed the event?
- What opportunities were you given to contribute your insights into preventing an identical adverse event?
- 7- Did you leave or did you stay in the same department/unit/job role following the event?
- What were the contributors to this
- 8- You have shared a lot of information with me today and I thank you. As you think back over our conversation, is there anything else that you would like to tell me that would help me to understand the experiences you had with organizational support following an adverse event?

This concludes the interview session. Thank you again for your time and for sharing your experience with me. If I may ask, can you think of someone that has been involved in an adverse event and may meet the study's criteria and would be willing to speak with me?

APPENDIX E
RECRUITMENT FLYER

Nurses Needed for Research Study!

Have you felt emotionally traumatized following an adverse patient event? An adverse patient event is defined as an event, preventable or nonpreventable, that caused harm to a patient as a result of medical care.

The purpose of this study is to understand nurses' experiences with organizational support following an adverse patient experience.

YOU may qualify for this study if you are a registered nurse or licensed practical nurse, 18 years of age or older, & received organizational support following an adverse patient event.



Study participation includes a 1-hour in-person interview at a place most convenient to the participant.

For more information please call
Misty Stone, PhD student in Nursing @ **910-258-6548**
or email misty.stone@uncp.edu
Under the direction of Dr. Susan Letvak, Professor of
Nursing at UNC-Greensboro (saletvak@uncg.edu or
336-256-1024)

Flyer revision date: 7/10/2019



APPENDIX F

PERMISSION TO USE FIGURE

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Licensed Content Author	Cornel Schiess, David Schwappach, René Schwendimann, et al
Licensed Content Date	Jul 23, 2019
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Type of Use	Dissertation/Thesis
Requestor type	Individual
STM publisher name	
Portion	Figures/table/illustration
Number of figures/tables/illustrations	1
Figures/tables/illustrations used	Figure 3
Author of this Wolters Kluwer article	No
Title of your thesis / dissertation	Second Victim Support: Nurses' Perspectives of Organizational Support
Expected completion date	Dec 2019
Estimated size(pages)	180
	Dr. Misty Stone 1135 Sadie Drive
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