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# Peer-to-Peer Emotional Support for Second Victims of Hospital Adverse Events

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## Abstract

**Problem:** Psychological impact of trauma on healthcare workers is profound, and if left unaddressed can debilitate its victims, depress morale, and undermine safety culture. When adverse events occur and focus is placed on providing care and support to patients and their families, the emotional support needs of healthcare workers must also be acknowledged.

**Context:** Frontline workers in the oncology unit of the medical center that is the setting for this project experience emotional distress as "second victims" of adverse patient events. Close relationships develop between providers and patients during long-term treatments. When unanticipated or adverse patient events there can be significant psychological impact on quality care at the bedside.

**Interventions:** Ten nurses or physicians from the oncology unit were recruited and trained to be peer-to-peer responders in the Team RISE program from Johns Hopkins.

**Measures:**. The outcome measure was to foster awareness of second victims of unanticipated events and provide immediate emotional support to frontline healthcare workers. Two process measures evaluated the change in awareness and support provided by a peer responder team trained in Team RISE curriculum from Johns Hopkins Hospital.

**Results:** Ten peer responders (100% of recruits) participated fully in the meetings and two-day training, and completed pre and post implementation surveys at 100%. Knowledge of the second victim phenomenon increased by 23% from 78% pre-survey to 96% post-survey. Pre-implementation only 65% of participants would reach out to a peer compared to 100% post-

implementation, a 54% increase. Willingness to engage a peer for support increased by 31%, from 60% before training to 91% after training.

**Conclusions:** This project displayed the effective implementation of a peer to peer support program in addressing second victim phenomenon from an organizational approach. A peer responder program fosters a greater awareness of second victims and provides support to frontline healthcare workers who experience trauma from adverse patient events.

***Key words***: second victim, trauma, resilience, emotional distress

# Peer-to-Peer Emotional Support for Second Victims of Hospital Adverse Events

## Section I: Introduction

Health care is a high-risk enterprise for patients and providers. Unanticipated events may lead to both physical and psychological trauma, with a negative impact on patients, healthcare providers, and the healthcare organization. Caregivers themselves may fail to recognize the negative impact of stressful events. The Patient Safety and Quality Improvement Act of 2005 (Public Law 109-41) was enacted in response to a growing concern about patient safety in the United States brought into sharp focus by the 1999 Institute of Medicine report, *To Err is Human: Building a Safer Health System* (Kohn et al. (1999). Medical errors have been shown to have profound psychological impacts on health care providers, jeopardizing their personal and professional selves and their ability to deliver high-quality patient care (White & Delacroix, 2020). A peer-to-peer support system for healthcare workers affected by trauma can enhance their ability to cope and improve self awareness. Both can be viewed as investments in organizational success as effective coping strategies and heightened self awareness promote safe practices and encourage meaningful engagement with patients and peers.

### Problem Description

Recent research has placed a spotlight on trauma within the healthcare setting. Trauma can result from medical errors, patient harm or death, or violence within the care environment. Historically, when adverse events occur, focus is placed on providing care and support to patients and their families. Yet, the psychological impact of trauma on healthcare workers is profound and can be debilitating if not addressed Wu (2000). Frontline healthcare workers who are involved in or witness adverse events as "second victims" of trauma, Evidence suggests that second victims who are unsupported may undermine an organization's safety culture (Quillivan

et al., 2016). According to Edrees et al. (2016), “organizations often fail to recognize the impact of adverse events on healthcare providers who suffer emotional distress as ‘second victims’ of the same incidents that harm patients” (p.1). Recognizing the need to support second victims of traumatic events, a team at Johns Hopkins Hospital developed a peer-to-peer support system, Resilience In Stressful Events, or RISE (Edrees et al., 2016). The Team RISE peer-based support system functions as psychological “first aid” for second victims according to Johns Hopkins medicine (2020). Team RISE has been shown to foster a sense of safety and trust among staff, provide a greater awareness of second victim phenomenon, provides structured organizational support for second victims, supports staff retention, and creates an environment of psychological safety (Edrees et al., 2016). Analysis of Team RISE program results over several years (Busch et al., 2020) have provided evidence that a peer-to-peer support system reduces physical and mental trauma rates secondary to multi factorial stressors, among them adverse patient safety events, hospital evacuations, infectious disease outbreaks such as the COVID-19 pandemic, and natural disasters.

The second victim phenomenon was largely unknown to the general public prior to the onset of the COVID-19 pandemic. The toll of the pandemic on frontline healthcare workers came into full view through news coverage and the co-workers, friends, and family members of frontline healthcare workers witnessing their exhaustion, anxiety, depression, and symptoms of post-traumatic stress. Second victims need fast, personal and confidential support within a comprehensive, easily accessible, stratified system and reinforcing clinician resilience, and thus their ability to function in the long term (Ettl et al., 2020). “It is safe to say that the panic period of the pandemic is passing but the healthcare profession will be scarred. Second victim

syndrome, or the emotional trauma for a healthcare provider following an adverse event, will come into play like never before" (Evans, 2020, para. 2).

The second victim toll on healthcare workers in the months following COVID-19 are projected to be immense, causing depression, anxiety, doubting ability to perform the job, leaving the profession, absenteeism, decreased work performance, or self harm (Evans, 2020). The medical center of the Northern California healthcare organization that is the setting for this quality improvement project did not have a system in place to support frontline healthcare staff who experience trauma in the course of providing care. The onset of the COVID-19 pandemic brought attention to the urgent need for a program to create a psychologically safe and supportive environment for the healthcare staff.

The Northern California medical center is currently engaged in the process to achieve Magnet® designation ("Achieve Magnet Status," n.d.). Magnet hospitals are designated by the American Nurses Credentialing Center (ANCC) as institutions where nurses are empowered to not only take the lead on patient care, but to be the drivers of institutional change and innovation. Structural empowerment, one of the accreditation assessment components, addresses organizational programs that enhance professional development and promote a positive image of nursing. Nurses who work in a psychologically safe environment are empowered to practice with a high level of professionalism and promote a positive image of nursing to patients, peers, and with healthcare professionals from other disciplines. Implementation of a Team RISE peer-to-peer support system, starting with a pilot program in the licensed, 25-bed oncology unit, will assist this medical center in achieving a high standard of enhanced professional development. Creating a psychologically safe environment and enhancing well-being will move the medical facility closer to its organizational goal of Magnet designation.

## Available Knowledge

### PICOT Question

For frontline healthcare workers in an oncology unit of a hospital (P), does peer responder training in the Team RISE second victim support program (I), compared to a hospital unit that does not off second victim support training (C) increase emotional support for second victims of adverse events (O) by July 1, 2021 (T)? An electronic search was conducted on January 30, 2021 in the PubMed, CINAHL, Cochrane, AHRQ, Joanna Briggs Institute, and EBSCO databases using the terms *secondary victim, resiliency in healthcare, psychological trauma*, and *peer-to-peer support systems*. Limitations were set to include English only and publication dates no earlier than 2008. The initial search returned 550 articles. Five articles were selected for inclusion in the review based on relevance to the PICOT question and quality of evidence as appraised with the Johns Hopkins Nursing Evidence-Based Practice (JHEBP) research evidence appraisal tool (Dang & Dearholt, 2018). See Appendix A for the Evaluation Table.

### Literature Review

A comprehensive review of literature was performed to evaluate the evidence on peer-to-peer support systems for frontline healthcare workers to address psychological trauma and secondary victim phenomena, with attention given to increased resiliency and improved retention as outcomes. Evidence from the studies reviewed is consistent in showing the need to support health care workers experiencing second victim trauma.

Connors et al. (2021) conducted a qualitative study for the implementation of Team RISE. In this study, surveys were distributed to 27 current RISE members, 19 (70%) who had been members for more than three years. The survey response rate was 100%. The results

showed that members found their duties to be meaningful (100%; n=27), personally satisfying (96%; n=26), and positively impactful (93%; n=25). Content analysis revealed positive perceptions of RISE volunteering and personal empowerment. Members indicated a personal affinity with RISE and gains in energy and enjoyment from their membership. Appraised with the JHEBP tool, this article is Level III C.

In a retrospective study, Busch et al. (2020) extracted hospital workplace violence data for 2009 through 2019 from three hospital-based second victim support systems, including the Johns Hopkins Team RISE peer-to-peer support program. The study indicated a growing need to support healthcare workers following events of workplace violence exposure in the current healthcare environment. The results of this study contributed to enhanced understanding of the psychological impact of workplace violence exposure on the healthcare workforce and the role that institution-based supportive structures can play. The authors recommend health care institutions take a holistic approach to workplace violence, including timely access to interventional peer support programs. This journal article is Level III B using the JHEBP appraisal tool.

Bruyneel (2019) conducted a cross-sectional study of secondary victim symptoms to evaluate the effects on healthcare providers following incidents in which harm to a patient had occurred. During this study 4369 Netherlands healthcare providers (1619 doctors and 2750 nurses) filled out surveys on symptoms resulting from patient safety incidents that had occurred in the prior six months and during their entire career. The results displayed that the three most-reported symptoms were doubts about one's ability, a feeling of being unable to provide quality care, and a feeling of being uncomfortable working in a team. In specific instances where permanent harm or death to a patient had occurred, these feelings were eightfold greater than

when no harm occurred and lasted longer than 6 months. This article is Level III A as rated with the JHEBP appraisal tool.

A qualitative research study of pediatric nurses was conducted by Kellog and Kleis (2020) to evaluate the impact of psychological trauma and second victim support. In this study a cross-sectional survey was sent out to 6,000 pediatric nurses across the United States. Of the 6,000 surveys, 350 (5.8%) were returned. Data was independently reviewed by the two researchers, then coded into keywords related to secondary victim, traumatic stress, or coping and grouped by composing themes. Six themes emerged from the survey. These themes are workplace stress, pressure to perform despite feeling unsupported, inability to separate traumatic experience from personal life, consumption of traumatic experiences, using positivity to cope. This study highlighted the need for further research into second victims and the impact on healthcare workers. A limitation of the Kellogg and Kleis (2020) study is that the data comes from one select specialty (pediatric nursing), while psychological trauma and secondary victim phenomena need to be evaluated in all areas of nursing. The authors indicated the need for further research to determine which experiences are most traumatic, evaluate negative side effects, and examine interventions that best reduce secondary traumatic stress in nursing. This journal article rates Level III C with the JHEBP appraisal tool.

Cabilan and Kynoch (2017) undertook a systematic review of literature on trauma experienced by nurses and the support given when adverse errors occurred. Nine qualitative studies published between 1994 and 2017 were included in the review. The studies were selected for relevance to the study objectives, and analyzed using the Joanna Briggs meta-aggregation approach. The narratives of 284 nurses generated 15 categories, which were then synthesized into four categories. The categories were adverse errors causing stress, lack of

support after error occurred, indecision on whether to disclose the error, and recovery process after an error occurred. The evidence given from this survey suggested the need for further evaluation and research on how best to support healthcare workers suffering from second victims. This article is rated Level III A using the JHEBP appraisal tool.

## Rationale

Dr. Jean Watson's Theory of Caring Science (2008) provides the theoretical framework of therapeutic interventions for implementing a peer-to-peer support system for second victim phenomenon in frontline healthcare workers. The Theory of Caring Science is based on creating transpersonal relationships through ten Caritas processes (Watson, 2008) The ten Caritas processes are (a) sustaining humanistic-altruistic values by practice of loving kindness, compassion, equanimity with self and others; (b) being authentically present, enabling faith/ hope/ belief system; honoring subjective inner, life-world of self/ others; (c) being sensitive to self and other by cultivation own spiritual practices; beyond ego-self to transpersonal presence; (d) developing and sustaining loving, trusting-caring relationships; (e) allowing for expression of positive and negative feelings; authentically listening to another person's story; (f) creatively problem-solving-solution seeking through caring process; full use of self and artistry of caring-healing practices via use all ways of knowing/being/ doing/ becoming; (g) engaging in transpersonal teaching-learning within context of caring relationships; staying within other's frame of reference-shift toward coaching model for expanded health/wellness; (h) creating healing environment at all levels; subtle environment at all levels; subtle environment for energetic authentic caring presence; (i) reverentially assisting with basic needs as sacred acts, touching mind/body/spirit of spirit of other; sustaining human dignity; and (j) opening to spiritual, mystery, unknowns-allowing for miracles. The framework for Jean Watson's Caring

Science suggests that those individually, collectively, and organizationally involved in patient care contribute to the wellness and caring of humanity in cases where it may be threatened (Watson, 2008). The second victim phenomenon for healthcare workers traumatized by adverse events presents such a case.

The Theory of Caring Science emphasizes the centrality of human caring within the nursing profession, with a focus on transpersonal relationships with healing potential for both the one who is caring and the one who is being cared for. The focus on healing in the Team RISE curriculum and program is consistent with the Theory of Caring Science. A peer-to-peer transpersonal relationship supports trust, expression of feelings, and learning moments that promote healing. Applying the Theory of Caring Science through a Team Rise intervention addresses psychological trauma and builds resiliency by providing a healing environment. A healing environment supports each provider's ability to find meaning in their work and connect to others in trusting relationships, in turn enhancing the quality of the care at the bedside.

## Specific Project Aim

The aim of this project was to recruit, educate, and train 10 peer-to-peer responders from the oncology unit in the Team RISE curriculum. Preparing 10 peer-to-peer responders was intended to create the foundation for implementation of the Team RISE support system to address the second victim phenomenon of frontline healthcare workers after an adverse event. The project aim was met July1, 2021. See appendix B for project timeline.

# Section III. Methods

## Context

The setting for this project is the oncology unit of a 340 licensed-bed hospital in a Northern California medical center. The oncology unit has 25 licensed beds and serves a

combination of oncology, telemetry, and medical surgical patients, although the most are oncology patients. The oncology unit's leadership consists of a nurse manager, seven assistant nurse managers, and a medical director. The oncology team is a multidisciplinary team that includes an hospital physician, oncologist, and primary oncology nurse for each oncology patient assignment per shift. The oncology care team works together to plan, implement, and provide education and complex treatment  to oncology patients from all over Northern California. The course of inpatient treatment involves repetitive cycles and may last from weeks to months, or even a year or more. Over the course of treatment, the oncology care team becomes emotionally connected to the patients. When a patient does not survive or there is an unexpected outcome, the care team may become emotionally distressed, thus "second victims" as defined by Edrees et al. (2016). Creating a safe culture for the healthcare team during stressful events, and aiding in their emotional well-being and psychological healing from trauma requires organizational support facilitated by leadership. This support, in turn, enables the team to deliver the high quality care they expect of themselves. In addition to enhanced quality of care Moran et al. (2020) showed that the Team RISE program reduced the rate of nursing time off and nursing turnover related to adverse incidents (Figure 1). See appendix C for cost benefit analysis.

The healthcare organization of which the oncology unit is a part has an employee assistance program but does not have a program in place to provide the immediate support needed after an adverse event has occurred.

**SWOT Analysis**

The organization's strengths, weaknesses, opportunities, and threats (SWOT) with respect to initiating a Team RISE peer-to-peer second victim support program were analyzed to inform the intervention and implementation process (Figure 2). A strength of the recruitment, selection, and training project is that this Northern California medical center has been working on increased awareness of second victims and recognizes the need to support frontline healthcare staff. Dialogue around increasing support to enhance the emotional well being of staff has taken place in leadership meetings and through educational webinars and other programs specifically designed to enhance wellness in all areas for employees. An additional strength is the opportunity to expand implementation to other units resulting from funding via a grant awarded to implement Team RISE in four of the organization's medical centers in Northern California. With increased funding facilitated by the regional leadership team and supported by local leadership, the implementation of this peer-to-peer support system is likely to see successful results similar to those of Johns Hopkins Hospital Team RISE programs. A potential weakness stems from the need to support the functional needs of the unit. There may be gaps in providing adequate staff to cover the oncology unit needs and simultaneously support the peer responders to attend meetings and training. A second potential weakness is the risk of internal conflict arising if Team RISE responders if they are unable to facilitate a RISE intervention due to inadequate staffing, or absence due to illness, leave, or vacation. Lack of response as expected

could tarnish perceptions of Team RISE responders in the oncology unit and diminish enthusiasm for the program among the RISE responders.

An opportunity lies in replicating the Team RISE program in other units in the hospital and across the wider healthcare organization. A threat stems directly from the workforce and the union that they belong to. The union has a strong influence on professional standards, clinical practices, and staffing to support structural needs, and has not expressed assurance that these will not be compromised by the responsibilities imposed on Team RISE responders.

Weaknesses were addressed before, during, and after recruitment and training of the 10 oncology Team RISE peer responders. Education and training for each peer responder is compensated by the medical center. However, some voluntary, uncompensated time, such as responding to a RISE alert, will also be necessary. The 10 peer responders understand and have committed to this. The voluntary portion of the program ensures that each peer responder will not be taken from the structural needs of the unit in order to respond to a RISE alert, but will respond at an appointed time off shift. These aspects of the RISE program were communicated to the union overseeing the healthcare staff to ensure clarity and maintain a positive relationship with the union. The union's oversight of the healthcare workforce at the medical center was taken into careful consideration in the design and implementation plan for this project to ensure its success. See Appendix D for SWOT analysis.

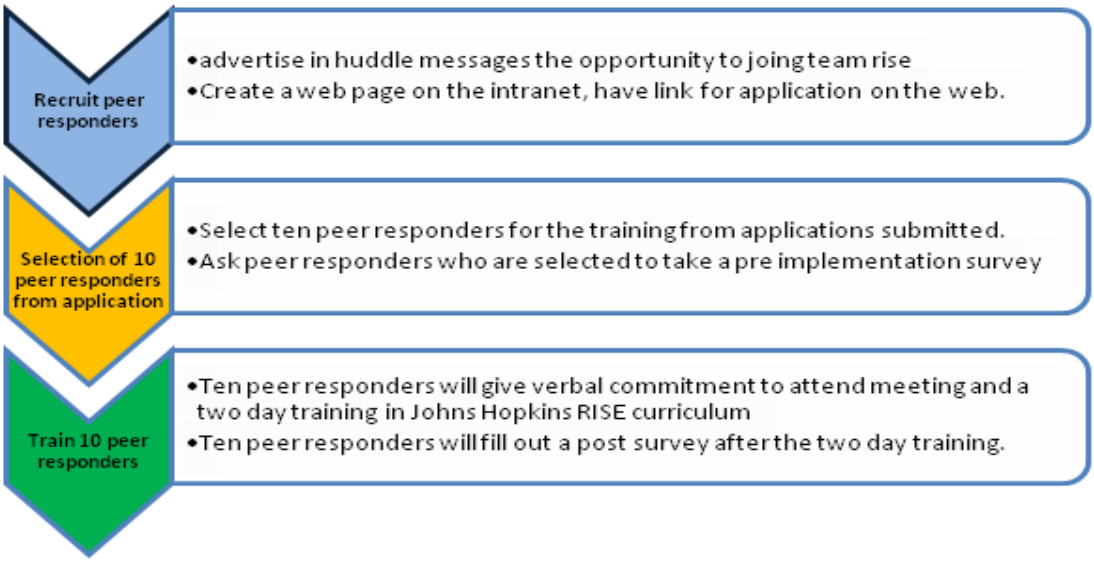
## Intervention

The purpose of this project was to take an organizational, sustainable approach to providing immediate emotional support to second victim frontline healthcare. Project implementation began by recruiting physicians and nurses from the oncology unit to participate in training and education as Team RISE peer responders. program. Recruitment was

accomplished through posted flyers, shift huddle messages, discussions with the oncology team during leadership meetings, and an intranet Web page with a link connected to an application. The application gathered basic information and included questions to gauge the presence of qualities needed in a peer responder: compassion, empathy, therapeutic communication, and a strong interest in supporting peers during stressful events. Completed applications went directly for review with oncology leadership. Ten successful applicants were notified and asked for their verbal commitment to attend biweekly meetings for 8 weeks preceding a two day training in the Johns Hopkins Team RISE curriculum (Figure 3).

**Figure 3**

*Team RISE Recruitment and Training Sequence*




Curriculum for Team RISE consisted of a didactic portion, strategies for responding to a peer intervention, simulation activities, role playing, and application of strategies/ techniques for recognizing and supporting individuals or teams that may be experiencing a trauma response or have become second victims of a work related events (see Appendix E for training outline). After the two-day training, biweekly meetings were held to evaluate gaps in the training content,

address questions or concerns, and provide additional support for their role as Team Rise peer responders. The biweekly meeting will provide valuable opportunities to discuss progression of RISE program, opportunity for improvement, and evolution of this program into additional units within this Northern California Medical Center.

## Study of the Intervention

The intervention was studied using pre and post implementation surveys created for the project and administered with Survey Monkey. The pre and post surveys assessed knowledge acquired, likelihood of using Team RISE, and perceived value of Team RISE to each peer responder as part of their individual professional practice. The pre-implementation survey evaluated (a) knowledge of the second victim phenomenon; (b) experience reaching out for support, and (c) helpfulness of outreach in coping with a stressful event or second victim. The pre-implementation data was shown to participants during a joint meeting to lay the foundation for a peer-to-peer responder program for second victim emotional support.

The ten peer responders attended biweekly meetings for 8 weeks prior to the two-day training course to review the purpose of the peer responder support system, questions about the role of the RISE responder, and give an opportunity to address apprehension or concerns that may arise before the two day training takes place. Following the two day training, a post survey was administered to evaluate (a) increased personal awareness of the second victim phenomenon; (b) individual confidence in reaching out to peers after an adverse event; (c) using the RISE program for themselves after an adverse event, and (d) the impact of RISE training on individual professional practice.

## Measures

Ten peer-to-peer responders from the oncology unit at this Northern California medical center were recruited and trained in the team RISE program by July 1st, 2021. The outcome measure for the implementation of the peer to peer response program was complete training for all ten peer responders at 100%. The team RISE training provided by Johns Hopkins curriculum fosters greater awareness of second victim phenomenon and provides organizational support with these ten peer responders to those involved in adverse patient events. Several primary and secondary drivers played a pivotal role in structuring recruitment and selection of peer responders assuring that the specific aim of this project was met (see Appendix E for Project Charter). Process measures were a pre- and post-implementation survey to evaluate likelihood of peer responders reaching out to a peer as a responder and the likelihood of them using the RISE peer support system for themselves following an adverse patient event. An increase from the pre-implementation survey to post implementation post survey showed a 31% increase in the likelihood of peer responders using the program if they are involved in an adverse event or experience the second victim phenomenon. The results from the outcome and process measures will be helpful in recruiting, selecting, and training Team RISE peer responders as the program expands to additional units within this medical center. See Appendix F for driver diagram in the project charter.

## Ethical Considerations

The implementation of a peer responder program within this Northern California medical center post COVID 19 pandemic proves to be both needed and fraught ethical considerations. . Post pandemic concerns with adequate staffing continue to be a pressing consideration within the functional needs of the Oncology unit. The staffing limitation is of concern in navigating balance

between adequate staffing for needs of the unit and added support for Team RISE training making implementation of a new program requiring staff buy-in and participation conflicting. Having ten peer responders committed to this training and then not having organizational support to remove them from the unit for training adds disappointment and lack of organizational support conflicting with the aim of this program. This lack of support has the ability to create mistrust between staff and the organization in supporting the emotional wellness of the peer responders and their peers.

Compassion fatigue of individuals within the healthcare staff continues to make the recruitment and selection process difficult, this conflicting ethical concern is high as staff and the team RISE peer responders are being asked to exert more work and commitment in the training and future implementation of this program. The organization is asking for more commitment from a healthcare workforce who are possibly in a current state of compassion fatigue and emotional distress with the inability to effectively commit to this program.

There is a potential for peer responders to practice outside the scope of the peer responder role in a complex RISE alert. The peer responder may feel obligated to offer assistance beyond the peer responder role, subjecting the individual and the organization to increased risk. To address this, the scope of practice and tools to address potential risk are clarified in the training. A second ethical consideration is ensuring confidentiality of patient health information. With the exception of "must report" situations, patient health information will be treated as confidential. Each peer responder is trained to guide away from the specific details of each case and redirect the focus to emotional support.

This project was reviewed and approved by the University of San Francisco School of Nursing and Health Professions faculty project chair Leisel Buchner and was determined to

qualify as an Evidence-Based Change of Practice Project. Institutional Review Board consideration and approval was not required. A signed statement of determination as a non-research project is presented in Appendix G.

## Section IV. Results

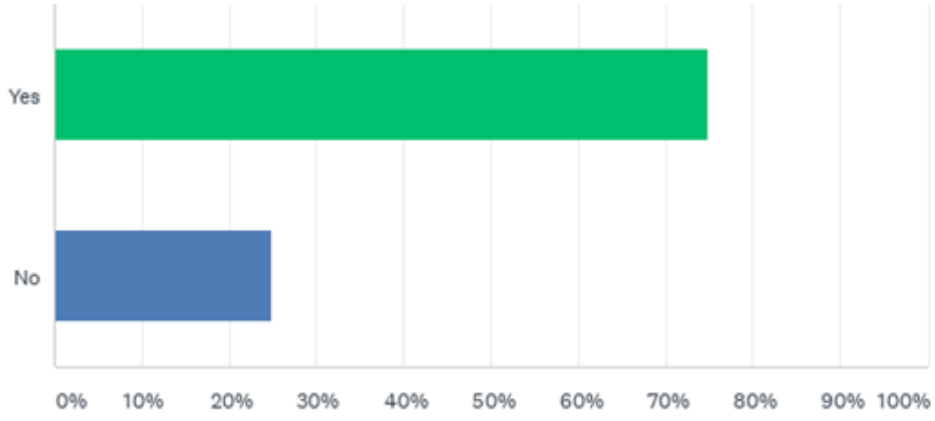
### Outcome Results

The outcome measure result for this intervention was 100% of peer responder recruits attending biweekly meetings, completing the training, and completing both the pre- and post-implementation surveys. The results of the post-implementation survey showed 100% of the peer responders (n=10) felt comfortable with reaching out to a peer who may have been a second victim of an adverse patient event. The peer responders on the post survey increased by 31% their likelihood of using the program for themselves.

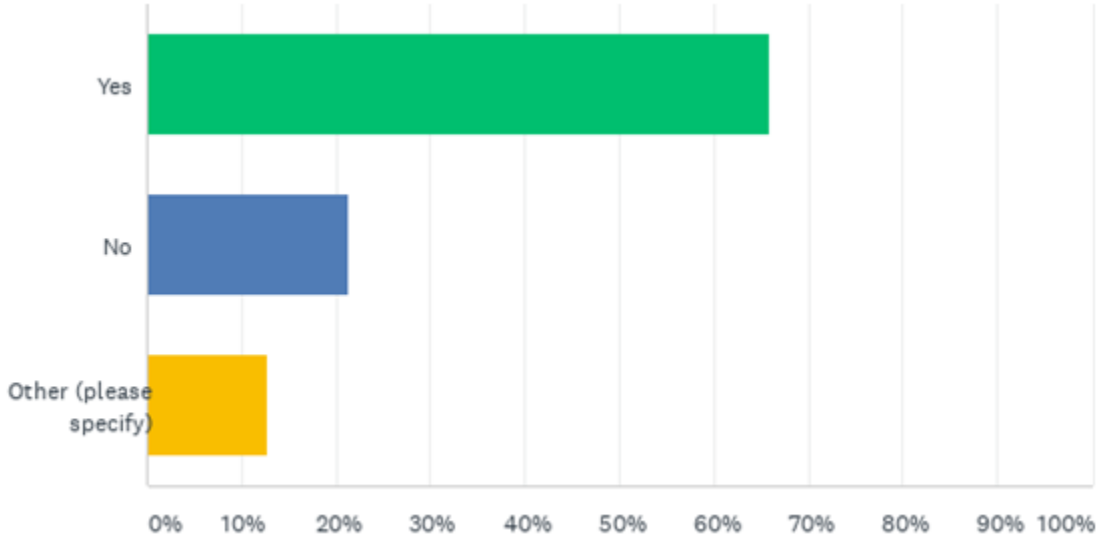
**Figure 3**

*Pre-Implementation Survey*

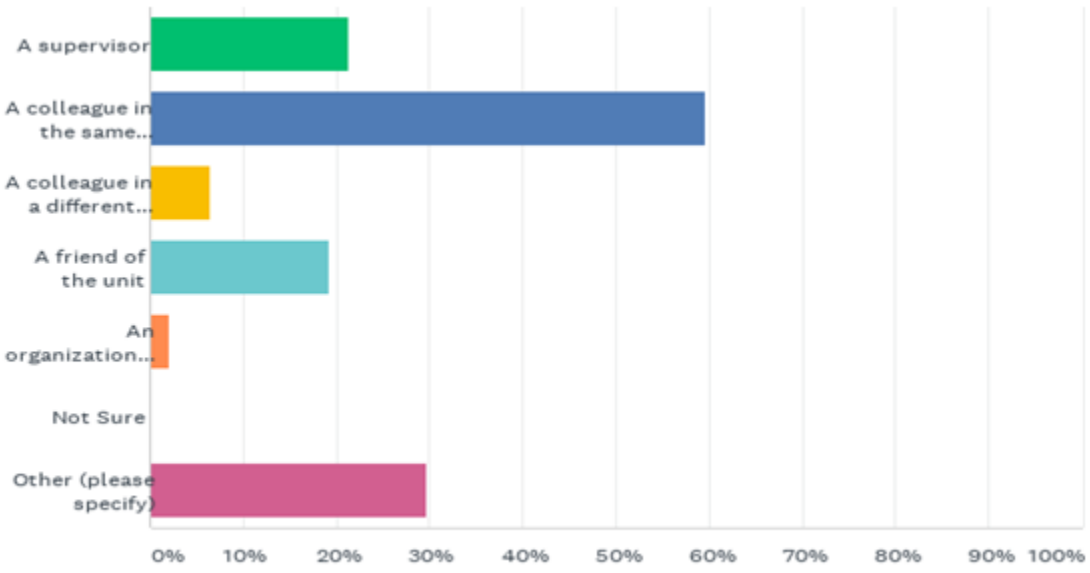
Question 1- Have you heard of the term "second victim" used to describe health care workers who have been emotionally affected by an unanticipated event?



Question 2- As a second victim, did you/ they reach out to speak to someone at work regarding this incident?




Question 3- Was this individual that you reach out to




Question 4- Did you find that speaking with this individual helped you cope with the situation?

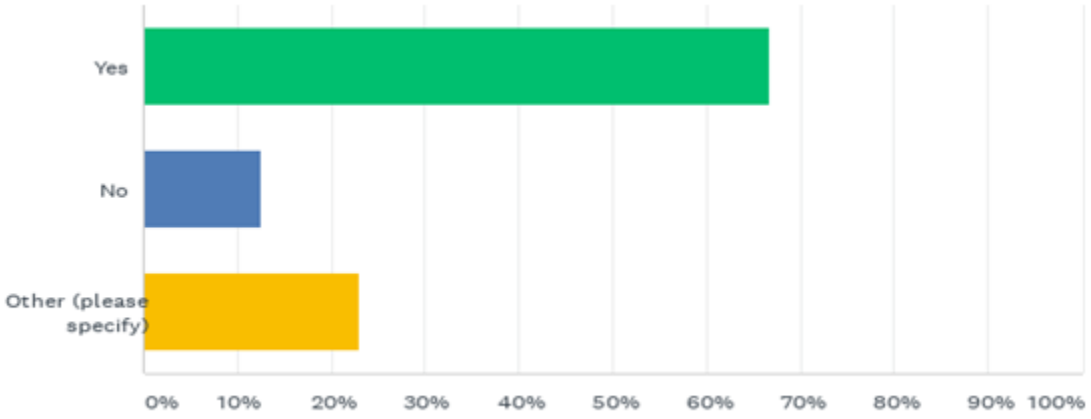
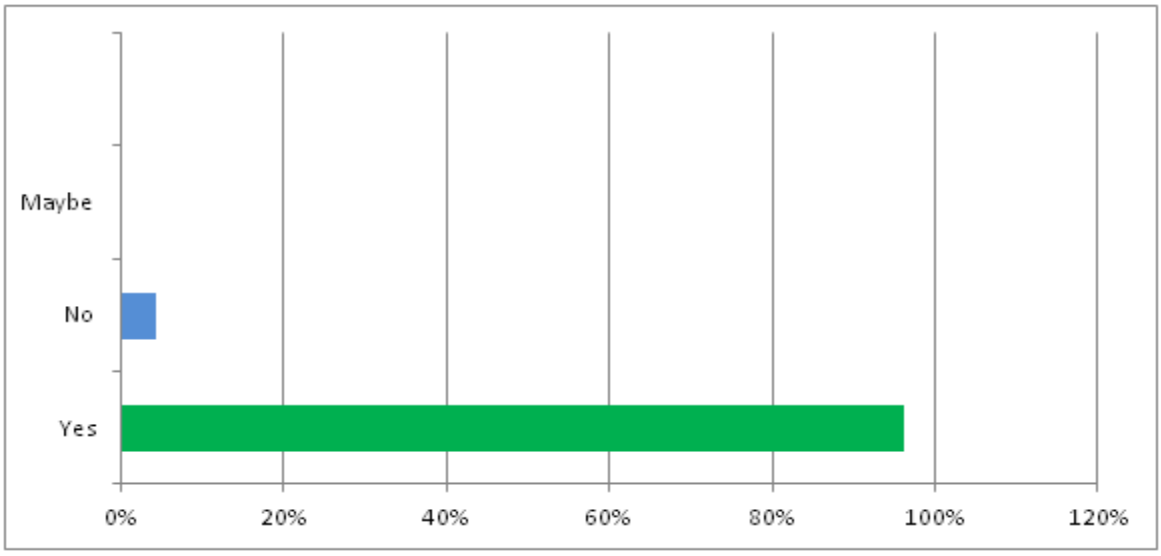


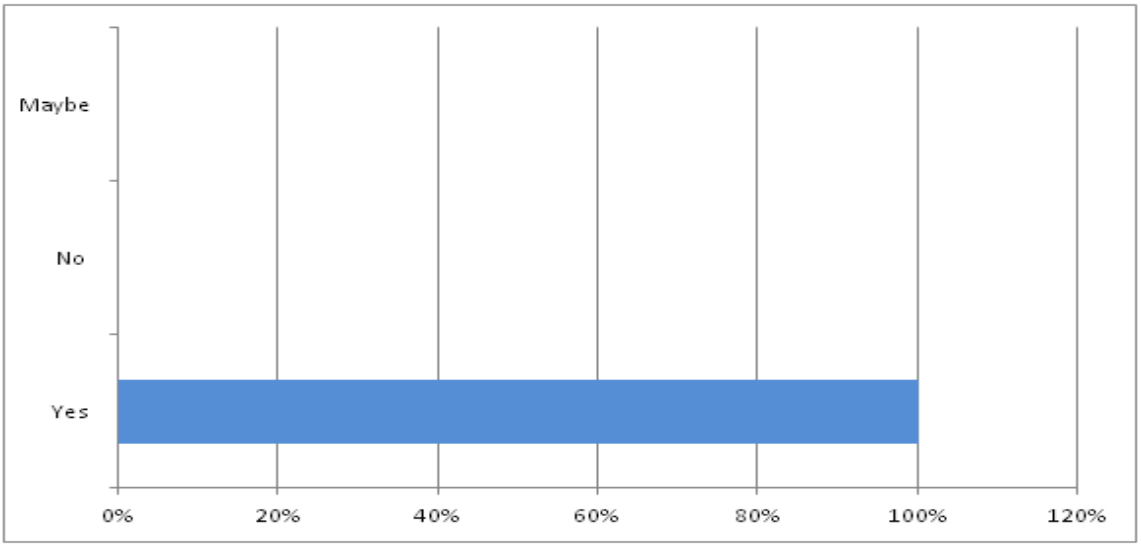

**Figure 4**

*Post-Implementation Survey*

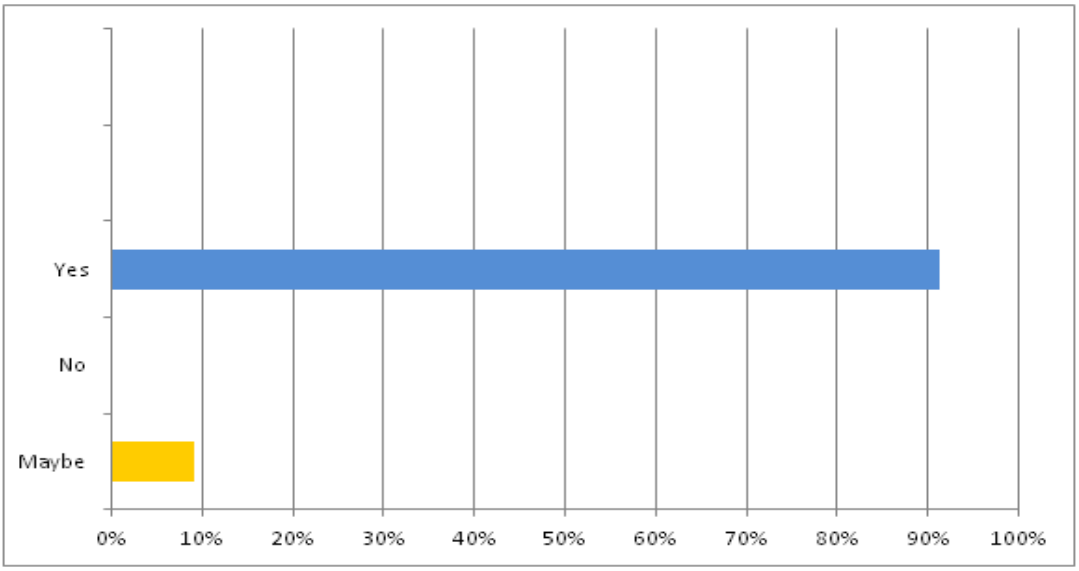
Question 1- Since becoming a peer responder, have you become more personally aware of second victim trauma as it relates to adverse events?



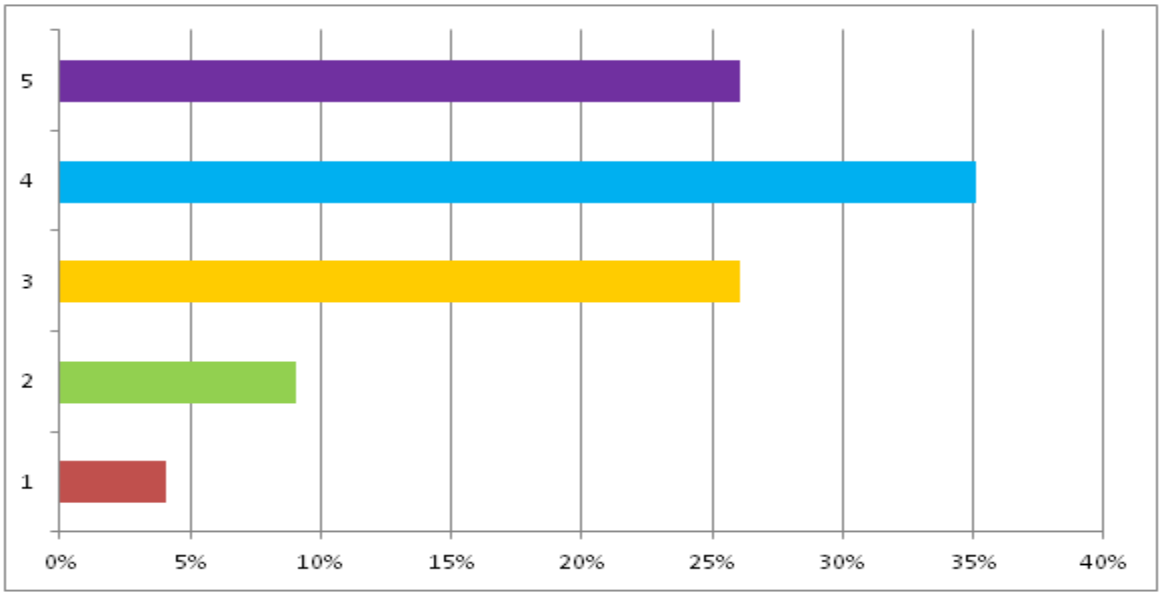

Question 2- Since joining team RISE do you feel more confident in reaching out to your peers after an adverse patient related event?




Question 3- Since joining team RISE do you feel you are more likely to utilize the RISE program for yourself after an unanticipated adverse patient event?




Question 4- On a scale of zero to five how much impact has the RISE training you attended had on your professional practice (five being the highest impact)?




The results of this project are intended for use to facilitate smooth implementation of the next phase of Team RISE in the oncology unit and inform future implementation in additional units in the Northern California medical center.

## Section V: Discussion

### Summary

The intervention of facilitating organizational support in implementation of a peer-to-peer responder team to address emotional support for second victims of this Northern California hospital was successful. The team RISE project successfully completed the first and second process measures of recruitment, selection, and training of 10 Team RISE responders, as measured by a 100% attendance and completion rate of training by all 10 peer responders. The balancing measures were analyzed in monitoring the turnover rate of selected peer responders with incomplete attendance of the meetings and training. The balancing measure was 0% turnover of the 10 selected peer responders. The pre and post implementation surveys showed significant increase in frontline healthcare workers were 31% more likely to utilize a peer

support system after implementation of RISE training and education. Providing organization support to frontline healthcare workers sets a foundation for immediate intervention of those affected by adverse events and begins the process for emotional support. Process for facilitation of implementing this program within a micro system was established as a foundation for future implementation in other units within this medical center. Continual process improvement will occur as post-project team RISE peer responders will continue to participate in biweekly meetings to debrief on implementation strategy, structure of the team RISE call, structured call process for responding to a RISE alert, discuss concerns with or successes of RISE responses, application of learned tools, and challenges that occur. This continued forum for discussion will allow for continued support of peer responders and additional recruitment and training to occur. Sustaining continued success of the project will require committed leadership support of peer responders in this program.

Providing immediate emotional support to those involved in adverse patient events has been displayed in this study to enhance individual support and professional practice with the peer responders. It is noted in the research primary support and prevention of long term negative effects related to second victim phenomenon starts with increased awareness and education. Organizational support for frontline healthcare workers in this facility has started to shift the environment to one of awareness, support, and a proactive approach to negative effects associated with the second victim phenomenon.

## Conclusion

The negative impact of frontline healthcare professionals' emotional distress on the quality and safety of patient care was highlighted in "To Err is Human," the groundbreaking Institute of Medicine report published in 1999. However, only recently has providing emotional

support to frontline healthcare workers been recognized as a priority need. The COVID-19 pandemic brought attention to an already stressed healthcare system and amplified the emotional distress endured by frontline providers in the course of caring for patients (IOM, 1999).

The future reach of this program is implementation of team RISE into all additional units within this medical center. This Team RISE implementation is anticipated to serve as a model for expanding recruitment, training, and implementation of Team RISE peer responder programs to all other units in the Northern California medical center.

## Section VI: References

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## Section VII: Appendices

### Appendix A

### Evaluation Tables

| Study | Design | Sample | Outcome/Feasibility | Evidence rating |
|---|---|---|---|---|
| Connors, C., Dukhannin, V., Norvell, M., Wu, A. (2021). Exploring volunteer retention and sustainability of second victim support program: *Journal of Healthcare Management/ American College of Healthcare Executives.* | the design for this study of current RISE members included a survey with quantitative and qualitative components. | 27 respondents, 19 had been members for 3 or more years | The RISE program at JHH, which relies on volunteer peer responders, has been sustained with little attrition for more than 7 years. Its experienced healthcare professionals are inspired by their work and its impact and by their colleagues. RISE members feel a personal affinity for the group and its work. RISE provides a source of professional and personal growth, empowerment, and resilience. Other peer support programs that use volunteers may benefit from these insights. | L III C |
| Bijay, A.Connors, C Isolde, M., Scott, S., Story, A., Wu, A. (2020). The role of institution-based peer support for health care workers emotionally affected by workplace violence: *The Joint Commission Journal of Quality and Patient* | A retrospective extraction and summary of the for YOU and RISE databases and the MU Health Care and JHH databases was performed tracking hospital | Between 2009 and 2019, forYOU documented 834 peer support interventions | This study indicates the growing need for health care workers' support in the aftermath of WPV exposure in today's healthcare environment. Health care institutions should take a holistic approach to WPV, including timely access to interventional peer support programs. A cost-benefit analysis suggested that RISE can reduce health care worker turnover, leading to institutional cost savings. Dukhanin et al. published preliminary evidence for the effectiveness of RISE in the pediatric setting. Merandi et al., replication of the | L III B |

| | | | | |
|---|---|---|---|---|
| *Safety.* | wide data on WPV. Two cases describe the experience of WPV victims. | | forYOU program, showed that the peer support improved health care workers emotional well being and led to decreased absenteeism. | |
| Kellogg, M.B., Kleis, A. E., (2020). Recalling stress and trauma in the work-place: A qualitative study of pediatric nurses. *Pediatric Nursing*, 46(1), 5-10**.** | Qualitative study: analysis of "open-ended" responses from cross-sectional surveys of pediatric nurses. | This study explored pediatric nurses from across the United States working in many different locations and sub-specialties. Sample size included the 350 responses from 6000 emails sent. | This study identifies six themes associated with secondary victim/ psychological trauma in pediatric nurses and the need for further research.<br>1) pressure to perform despite emotion<br>2) feeling unsupported<br>3) inability to separate traumatic experiences from personal life<br>4) consumption by traumatic experiences<br>5) using positivity to cope<br>6) the need for further research is needed to determine which experiences are most traumatic for pediatric nurses, negative effects of secondary traumatic stress for patients, and interventions that best reduce secondary traumatic stress in nursing.<br><br>Despite publications of several studies on this topic, findings from this analysis of nurses working in multiple pediatric specialties suggest that nurses need more support in their workplaces to deal with their stress. It is important that nurses recognize symptoms of secondary stress. Educational sessions on stress management and secondary trauma is an excellent first step to assist nurses in dealing with work related stressors (Meadors et al. 2009). | L III C |

| | | | | |
|---|---|---|---|---|
| Cabilan, C.J. Kynoch, K., (2017). Experiences of and support for nurses as second victims of adverse nursing errors: a qualitative review, *JBI Database of Systematic Reviews and Implementation Reports*. DOI: 10.11124/JBISRIR-2016-003254 | A systematic review which included qualitative studies, grounded theory, discourse analysis, and phenomenology | Sample size: included 9 qualitative studies including one review. The narratives of 284 nurses, including a structured search strategy was used to locate all unpublished qualitative studies, but was limited to the English language, and published between 1980-2017. | The review highlights the distressing experiences of nurses as second victims. The review recommends that this must be acknowledged as an expected response to adverse errors, therefore support for these nurses is paramount based on the studies included in this review. 1- Nurses must acknowledge the detrimental effects of adverse errors on nurses 2- Nurses must have access to a support person whom they trust, is well oriented to the healthcare system and understands the experience of second victims. 3-The treatment of nurses must be without judgment, blame and punitive action in order to facilitate disclosure and reconciliation. | L III A |
| Bruyneel, L., Coeckelberghs, Dutch Peer Support Collaborative Research | Descriptive study, Cross Sectional study | 4369 healthcare providers (1619 | The impact of PSI remains an underestimated problem. The higher the degree of harm, the longer the symptoms last. Future studies should evaluate how | L III A |

| | | | | |
|---|---|---|---|---|
| Group, E., Panella, M., Schouten, L., Seys, D., Vanhaecht, K., Zeeman, G., (2019). Duration of second victim symptoms in the aftermath of a patient safety incident and association with the level of patient harm: a cross-sectional study in the Netherlands, *British Medical Journal*. DOI: 10.1136/bmjopen-2019-029923 | | doctors and 2750 nurses) involved in a PSI (patient safety) incident at any time during their career. Setting: 32 Dutch hospitals in a peer support collaborative | these data can be integrated in evidence-based support systems | |

## Appendix B

## Project Timeline

| Implementation Step | 8 months | 5 1/2 months | 5 months | 5 weeks | 4 weeks | 3 weeks | 2 weeks | 1 week | Go live July 1st, 2021 |
|---|---|---|---|---|---|---|---|---|---|
| Submission of proposed plan for the Team RISE | | | | | | | | | |
| Approval of proposed plan by COO and CNE | | | | | | | | | |
| Connect with HR for approval | | | | | | | | | |
| Connect with Med/Legal for approval | | | | | | | | | |
| Obtain funding and approval from Regional KPMG, selected for Grant | | | | | | | | | |
| Create unified huddle message for recruiting, link on intranet, and flyers | | | | | | | | | |
| Conduct a Pre training survey | | | | | | | | | |
| Evaluate applicants and select 10 peer responders | | | | | | | | | |
| Two day training for the ten selected peer responders | | | | | | | | | |
| Conduct a Post training survey | | | | | | | | | |

## Appendix C

## Cost Benefit Analysis

The primary budget for startup for this Northern California medical center and continuation of the Team RISE program is time associated with employee salary. The 10% of staff needed for initial education and then time during shift to be available for a "care call" are the primary drivers of cost. Table 1 shows the initial training cost is estimated to be $51,040. Time (salary) allocated for leadership to meet for rollout planning would be covered with the general budget for continual improvement processes covered with the goal for Roseville's journey to Magnet status.

Table 1: Startup cost for KP Roseville L&D, ICU, Oncology

| Cost | Day 1 | Day 2 | Total |
|---|---|---|---|
| People (attendees for TEAM Rise training) | 6 Leadership (1 Team Leader, 5 Leaders) | 68 staff (38 L&D, 20 ICU, 10 Oncology) | 74 participants |
| Cost for training ($200/participant) | $1,200 | $13,600 | $14, 800 |
| 6 hours of class time | $3,600 (averaged at $100/hour) | $32,640 (averaged at $80/hour) | $36,240 |
| Grand total | | | $51,040 to train 74 participants |

Nominal cost associated with general use of resources could also be captured in the routine unit budget. No additional procurement of resources is necessary for Team RISE to be successful. Future cost associated with years 2 and on would factor in growth of the departments and retirement or other attrition of trained peer support. An estimated $1,100 would need to be allocated yearly to continue this program, shown in Table 2.

Table 2: Future Cost

| Cost | Day 2 training | Total |
|---|---|---|
| People | 4 new staff | |

| | | |
|---|---|---|
| Training ($200/participant) | $800 | |
| Class Time | $320 | $1,100/year |

Moran et al. showed that the Team RISE program reduced the rate of nursing time off and nursing turnover related to adverse incidents. The study demonstrated that for every $656.25 spent per nurse; the unit saved $22,576.05 per year, a net gain of $21,919.80 shown in Table 3. Budget impact analysis revealed in one study that a hospital could save over $1.8 million each year because of the Team RISE program (Moran et al., 2017). Even if the actual savings are more moderate than these estimates, the Team RISE module still appears financially feasible.

Table 3: Expected Results of the Base Case Cost-Benefit Analysis at Johns Hopkins in 2017

| Strategy | Cost | Net Monetary Benefit (NMB) |
|---|---|---|
| Rise not implemented | $81,196.45 | |
| Team Rise implemented | $58,620.40 | $22,576.05 |

*****(Moran et al., 2017)

Using the data reported for Johns Hopkins you can extrapolate that this Northern California medical center would have similar results. Even if the net monetary benefit was lower than at Johns Hopkins, there would still be a gain, not a loss of revenue.

## Appendix D

**Figure 2**

*SWOT Analysis*

# Appendix E

## Team RISE Training Agenda

### Caring for the Caregiver: Implementing RISE Agenda

**Registration and continental breakfast**

**Introduction**
The need for peer support, the RISE Implementation Road Map, and a quick pre-assessment of participants' knowledge

**Module 1: Define the Problem**

- Surveying your own organization to assess second victims' needs and build the case for a peer support program
- Ways to engage key stakeholders to align organizational goals with the RISE program

**Module 2: Design the Plan**

- Detailed process steps and timelines to help your team set realistic goals for program implementation

**Lunch**

**Module 3: Develop Your RISE Peer Responder Team**

- Approaches to recruit the right peer responders, support those responders, and promote sustainability among the team

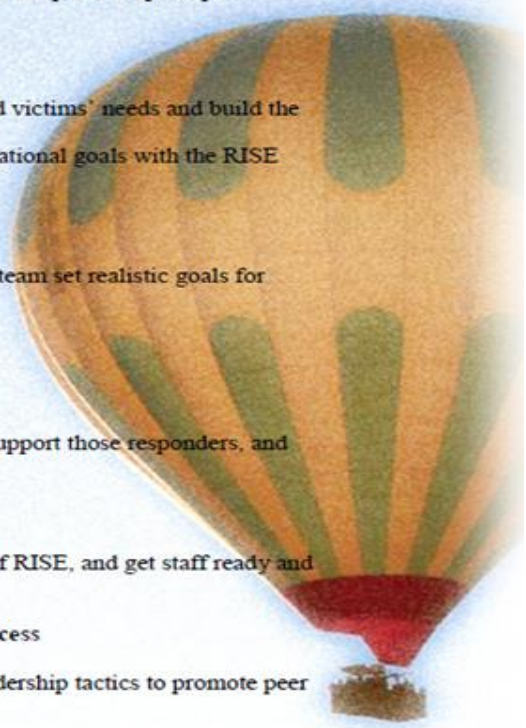
**Module 4: Roll Out RISE**

- Strategies and tactics to ensure a smooth rollout of RISE, and get staff ready and excited for this new service

**Module 5: Sustain Peer Responders and Measure Success**

- Data collection tools, marketing concepts and leadership tactics to promote peer responder retention and RISE service use

**Discussion and questions**



*Presented by*
*Maryland Patient Safety Center in collaboration with*
*The Johns Hopkins Hospital RISE Program*

Maryland Patient Safety Center | Johns Hopkins Medicine

# Caring for the Caregiver: Implementing RISE Agenda

**Registration and continental breakfast**

**Introduction**
The need for peer support, the RISE Implementation Road Map, and a quick pre-assessment of participants' knowledge

**Module 1: Define the Problem**

- Surveying your own organization to assess second victims' needs and build the case for a peer support program
- Ways to engage key stakeholders to align organizational goals with the RISE program

**Module 2: Design the Plan**

- Detailed process steps and timelines to help your team set realistic goals for program implementation

**Lunch**

**Module 3: Develop Your RISE Peer Responder Team**

- Approaches to recruit the right peer responders, support those responders, and promote sustainability among the team

**Module 4: Roll Out RISE**

- Strategies and tactics to ensure a smooth rollout of RISE, and get staff ready and excited for this new service

**Module 5: Sustain Peer Responders and Measure Success**

- Data collection tools, marketing concepts and leadership tactics to promote peer responder retention and RISE service use

**Discussion and questions**

*Presented by*
*Maryland Patient Safety Center in collaboration with*
*The Johns Hopkins Hospital RISE Program*

MARYLAND Patient Safety CENTER

JOHNS HOPKINS MEDICINE

# Appendix F

## Project Charter

Charter for Team RISE a Peer-to-Peer Support System at a Northern Medical Center

Jessica Van Leuven

University of San Francisco

## Table of Contents

## Charter for Team RISE a Peer-to-Peer Support System

## Team RISE (Resiliency In Stressful Events)

**Project Charter:**

Increase staff resiliency by effectively implementing the peer-to-peer support system team RISE.

**Global Aim:**

Foster a greater awareness of secondary victim and psychological trauma in frontline healthcare workers. Provide organizational support with team RISE for healthcare workers that suffer from secondary victim and psychological trauma as a result from a work related incident. Implementation of team RISE throughout the entire Northern California Medical Center by November 1st, 2021.

**Specific Aim:**

The implementation of a peer-to-peer support system starting with 10 trained peer-to-peer responders to pilot the RISE program in the 25 licensed bed oncology unit by July 1st, 2021.

**Background:**

Health care is a high-risk enterprise for both patients and providers. Unanticipated events may occur that often lead to both physical and psychological trauma. Trauma negatively impacts healthcare providers, patients, and the organization. Caregivers often fail to recognize the negative impact of stressful events. The Patient Safety and Quality Improvement Act of 2005 (Public Law 109-41), signed into law on July 29, 2005, was enacted in response to growing concern about patient safety in the United States and the Institute of Medicine's 1999 report, To

Err is Human: Building a Safer Health System (Agency for Healthcare Research and Quality [AHRQ], n.d.). Medical errors' can induce profound psychological impact in health care providers' that jeopardize their personal and professional selves and their ability to deliver high-quality patient care (White & Delacroix, 2020).

Providing a peer-to-peer support system for those affected by trauma can enhance their ability to cope, increase awareness, promote safer practices, engage meaningfully with patients, and become active participants in the success of the organization. This Northern California Medical Center does not currently have a system in place to support trauma and secondary victims in frontline staff. The RISE program is in conjunction with this Northern California Medical Centers path towards achieving Magnet accreditation. Magnet hospitals are certified by the American Nurses Credentialing Center (ANCC) as institutions where nurses are empowered to not only take the lead on patient care, but to be the drivers of institutional change and innovation. The implementation of a peer-to-peer support system starting with 10 trained peer-to-peer responders to pilot the RISE program in the 25 licensed bed oncology unit meets structural empowerment, one of five components in achieving Magnet recognition. A psychologically safe environment promotes empowerment within each individual to practice at a higher level of professionalism and safety. Implementation of team RISE will help move this Northern California Medical Center towards achieving the organizational goal of Magnet accreditation.

**Table 1**

*Sponsors*

| | |
|---|---|
| Senior Vice President-Area Manager | Kimberly Menzel |
| Chief Nurse Executive | Debbie Reitter |
| Maternal Child Healthcare Director | Marina Beck |

| | |
|---|---|
| Adult Services Healthcare Director | Daniel Moffit |

**Goals:**

The intention of this project is to provide organizational support for secondary victims in frontline healthcare workers in the oncology unit at this Northern California Medical Center.

X. Organize a core team for team RISE planning and implementation of objectives.
XI. Survey sent out to staff evaluating the need for organizational support for psychological distress in frontline healthcare workers.
XII. Identification of volunteer peer-to-peer responders.
XIII. Train peer-to-peer responders in caring for the caregiver
XIV. Promote awareness of team RISE through flyers, huddle messages, presenting at staff meetings, and Internal website.
XV. Pilot team RISE in Oncology unit starting July 1st, 2021

**Table 2**

*Measures*

| **Measure** | **Data Source** | **Target** | **Results** |
|---|---|---|---|
| Pre Survey filled out by each of the ten peer responders selected | Survey Monkey | 100% | 100% |
| **Process** | | | |
| Recruit team using flyers, huddle messages, and application process via an intranet link. | Intranet link, to collect applicant information | 100% | 100% |
| 10 peer-to-peer responders trained | 10 selected peer-to-peer responders to attend meetings and trainings on Microsoft Teams | 100% | 100% |
| # of peer responders trained by July | Johns Hopkins Team RISE two-day training, interactive approach via Microsoft Teams | 100%. | 100% |
| # of peer responders who would utilize a peer responder program if involved in adverse patient event. | pre vrs post implementations survey results | 85% | 91% |
| # of peer responders who feel comfortable reaching out to a | pre vrs post implementations survey | 85% | 100% |

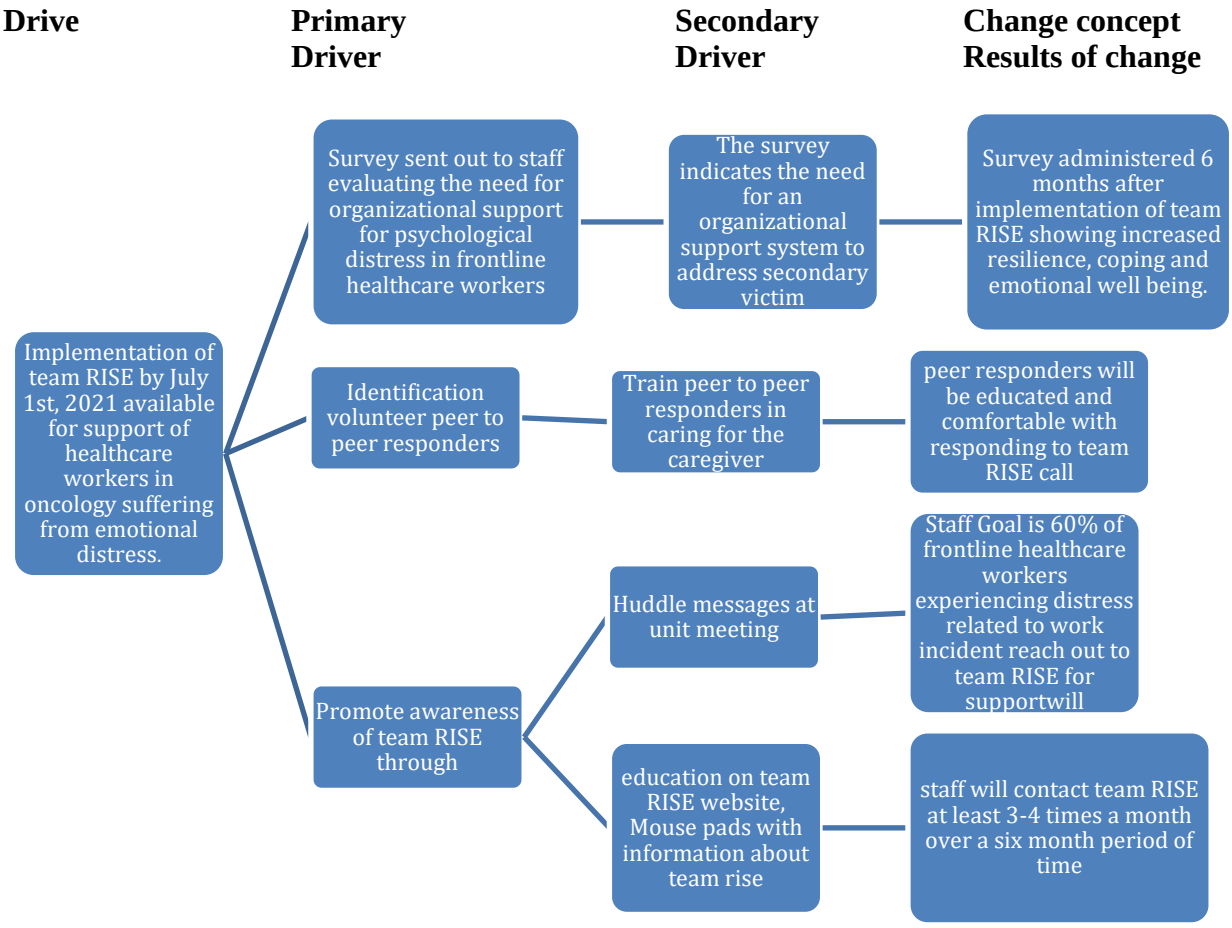
| | | | |
|---|---|---|---|
| peer after and adverse event | results | | |
| **Balance** | | | |
| The turnover rate of peer responders after training.<br><br>Staffing insufficiencies, creating increased burn out, compassion fatigue, lack of desire to commit to additional programs. | Rates of turnover for peer responders after initial training.<br><br>Difficulty in recruiting additional responders to maintain the program. | 15% or less of peer responders leave the program. | 0% |

**Table 3**

*Team*

| | |
|---|---|
| MD Project Lead | Dr. K. K. |
| RN Project Lead | J. V. Assistant Nurse Manager |
| Social Work Manager | E. M. |
| Peer to Peer Responder MD | Dr. S. M. |
| Peer to Peer Responder MD | Dr. A. C. |
| Peer to Peer Responder RN | S. H. |
| Peer to Peer Responder RN | R.Y. |
| Peer to Peer Responder RN | C.C. |
| Peer to Peer Responder RN | N. M. |
| Peer to Peer Responder RN | T. M. |

## Driver Diagram



**Measurement Strategy**

**Background (Global Aim):** Foster a greater awareness of secondary victim and psychological trauma in frontline healthcare workers. Provide organizational support for healthcare workers that suffer from secondary victim and psychological trauma as a result from a work related incident with team RISE. Implementation of team RISE within oncology unit by July 1st, 2021

**Population Criteria:** Frontline Healthcare workers in the oncology unit at this Northern California Medical Center approximately 150 staff.

**Data Collection Method:** Data will be obtained using a survey before implementation of team RISE training and two weeks prior to implementation of team RISE on July 1st, 2021.

**Table 4**

*Data Definitions*

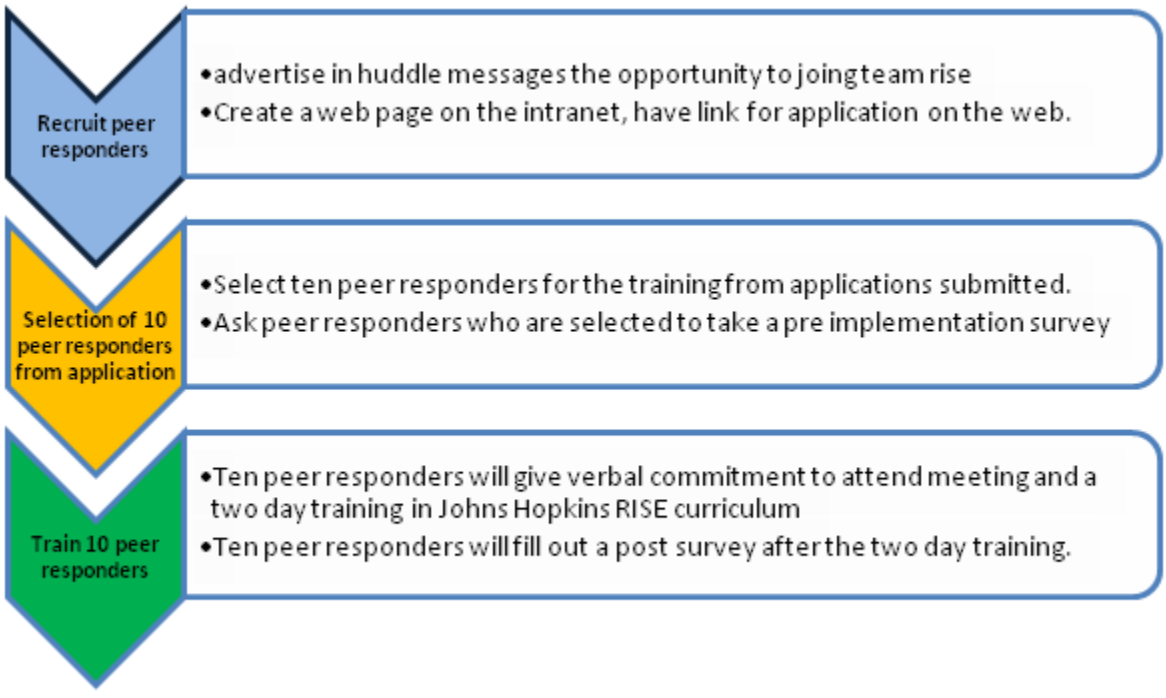
| Data Element | Definition |
|---|---|
| Caregiver | An employee in health care |
| Peer Responder (PR) | A person who provides a confidential resource for employees to discuss their response to stressful events. |
| Resilient Zone | When our bodies react and adapt to a situation, and we cope well with feelings that arise in order to maintain normal functioning |
| Second Victim | A health care provider who is involved with a patient related adverse event or medical error, and as a result experiences emotional and sometimes physical distress. |

**Table 5**

*Measure Descriptions*

| Measure | Measure Definition | Data Collection Source | Goal |
|---|---|---|---|
| Ten peer responders Trained by Johns Hopkins Team Rise two day Microsoft Teams training. | N= # of peers signed up for training D= # of peers who attend the training | Microsoft Teams interactive training. Attendance role | 100% total of 10 peers trained in the two-day peer responder course |
| Ten peer responders selected from initial applicants | N= #ten peer responders D= # total number of applicants | Intranet link, to collect applicants information | 10 peer responders selected |
| Speaking with a peer is beneficial for emotional support and coping in secondary victim or emotional distress related to workplace | N= # of individuals responding that peer support is helpful on preliminary survey D= # of individuals responding that peer support is helpful on post survey | Survey Monkey | Initial survey showed 60% of individuals surveyed stating peer support is helpful. Goal is for 80% of individuals on post survey to state peer support via team RISE is beneficial. An increase of 20% |

**Changes to test**



**CNL Competencies**

The clinical nurse leader (CNL) is a master's educated nurse prepared to practice across the continuum of care within any health care setting. The CNL has unique insight to the diverse challenges within the continually changing healthcare system of today. The goal of the CNL role is to return expert clinicians to the point of care to strengthen the nursing professions' contributions to improve the quality, safety, and outcomes of healthcare in the United States (Gilmartin, 2014).

The CNL is a risk anticipator for individuals delivering care, patients receiving care, and the systems that are set up to improve healthcare outcomes. The team RISE program is evidence based practice involving the CNL role as a risk anticipator to ensure safety for the individuals providing care and those receiving care. Research has shown psychological trauma within healthcare to have a negative impact upon frontline healthcare workers and their ability to perform safely.

A CNL is an outcome's manager that uses evidence for practice to determine appropriate application of interventions across diverse populations. In healthcare the focus of trauma was often placed on patients and their families. Historically, when adverse events occur, focus is placed on providing care and support to patients and their families. According to (Edrees et al., 2016), “organizations often fail to recognize the impact of adverse events on healthcare providers who suffer emotional distress as ‘second victims’ of the same incidents that harm patients” (Edrees et al., 2016, p. 1). Team RISE is an evidence based program created to support frontline health care workers suffering from emotional distress. Team RISE fosters a psychologically safe environment and provides organizational support for staff.

As a team manager the CNL is able to delegate within the healthcare team appropriate resources such as is with team RISE. This peer based support system organized by the CNL provides support using peers trained in team RISE. This CNL set up the organizational structure, facilitated the education, and fostered the availability of calling a team RISE alert 24 hours a day, seven days a week. This was accomplished by utilizing resources within the Microsystems team RISE is being implemented in.

Being competent as a risk anticipator, outcomes manager, and team manager empowered this CNL with the skill and knowledge needed to assess the Microsystems of oncology in this Northern California medical center. The assessment disclosed the need for organizational support of frontline healthcare workers suffering from emotional distress due to work related trauma. Further analysis of research was conducted with focus on secondary/ psychological trauma in healthcare workers. The evidence revealed the need for organizational support of frontline healthcare workers. The team RISE program is an evidence based support system set up by Johns Hopkins to support healthcare staff who may be suffering from emotional distress due to a work related event (Edrees et al., 2016).

## Appendix G

### CNL Project: Statement of Non-Research Determination Form

**Student Name: Jessica Van Leuven**

**Title of Project:**

Team RISE a Peer-to-Peer Support System

**Brief Description of Project:**

**A) Aim Statement:**

**Specific Aim:**

The implementation of a peer-to-peer support system starting with 10 trained peer-to-peer responders to pilot the RISE program in the 25 licensed bed Oncology unit by July 1st, 2021.

**Global Aim:**

Foster a greater awareness of secondary victim and psychological trauma in frontline healthcare workers. Provide organizational support with team RISE for healthcare workers that suffer from secondary victim and psychological trauma as a result from a work related incident. Implementation of team RISE throughout the entire Northern California Medical Center by November 1st, 2021.

**B) Description of Intervention:**

The organizational support of healthcare workers suffering from work related

emotional distress, trauma, and secondary victim by implementing a peer-to-peer support system designed by Johns Hopkins. This peer-to-peer support system is known as Team RISE (Resiliency, In, Stressful, Events). The RISE Peer responder basic training is designed specifically to train peers within the healthcare setting to respond to a peer in emotional distress. These responders will provide timely support to staff in response to stressful patient-related events at this Northern California Medical facility's inpatient oncology unit. RISE was developed as a support system for health care employees. It is essential to recognize that healthcare is a complex and often stressful profession filled with everyday events that impact the health and well being of health care workers. With Team RISE a core team of 10 peer responders will be trained in the Team RISE curriculum. The curriculum includes a didactic portion, strategies for responding, simulation activities, and application of strategies/ techniques specialized in recognizing and supporting individuals or teams that may be experiencing a trauma response or have become secondary victims. This team will provide 24hr coverage with an on call schedule in teams of two responders to cover per day. Initial survey showed 60% of individuals surveyed stating peer support is helpful. Goal is for 85% of individuals on post survey to state peer support via team RISE is beneficial.

**C) How will this intervention change practice?**

Providing a peer-to-peer support system for those affected by trauma can enhance their ability to cope, increase awareness, promote safer practices, engage meaningfully with patients, and become active participants in the success of the organization. A psychologically safe environment promotes empowerment within each individual to practice at a higher level of professionalism and safety.

**D) Outcome measurements:**

Post intervention debrief survey for each RISE alert response. Initial survey results displayed 60% of healthcare workers benefit from speaking with a peer. The post survey from team RISE peer-to-peer intervention will display an increase of 31% of healthcare workers within the Oncology department who experience emotional distress and access to team RISE intervention expressing an increase in coping and support from an organizational standpoint in this Northern California Medical Center.

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

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

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

Comments:

***EVIDENCE-BASED CHANGE OF PRACTICE PROJECT CHECKLIST ****

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

| **Project Title: Team RISE a peer-to-peer support system** | **YES** | **NO** |
|---|---|---|
| The aim of the project is to improve the process or delivery of care with established/ accepted standards, or to implement evidence-based change. There is no intention of using the data for research purposes. | **YES** | |
| The specific aim is to improve performance on a specific service or program and **is a part of usual care**. ALL participants will receive a standard of care. | **YES** | |
| The project is **NOT** designed to follow a research design, e.g., hypothesis testing or group comparison, randomization, control groups, prospective comparison groups, cross-sectional, case control). The project does **NOT** | **YES** | |

| | | |
|---|---|---|
| follow a protocol that overrides clinical decision-making. | | |
| The project involves implementation of established and tested quality standards and/or systematic monitoring, assessment or evaluation of the organization to ensure that existing quality standards are being met. The project does **NOT** develop paradigms or untested methods or new untested standards. | **YES** | |
| The project involves implementation of care practices and interventions that are consensus-based or evidence-based. The project does **NOT** seek to test an intervention that is beyond current science and experience. | **YES** | |
| The project is conducted by staff where the project will take place and involves staff who are working at an agency that has an agreement with USF SONHP. | **YES** | |
| The project has **NO** funding from federal agencies or research-focused organizations and is not receiving funding for implementation research. | **YES** | |
| The agency or clinical practice unit agrees that this is a project that will be implemented to improve the process or delivery of care, i.e., **not** a personal research project that is dependent upon the voluntary participation of colleagues, students and/ or patients. | **YES** | |
| If there is an intent to, or possibility of publishing your work, you and supervising faculty and the agency oversight committee are comfortable with the following statement in your methods section: *"This project was undertaken as an Evidence-based change of practice project at X hospital or agency and as such was not formally supervised by the Institutional Review Board."* | **YES** | |

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

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

**STUDENT NAME (Please print):**

**JESSICA VAN LEUVEN**

**Signature of Student:** **Jessica Van Leuven** **DATE 4/11/2021**

**SUPERVISING FACULTY MEMBER NAME (Please print):**

_____

**Signature of Supervising Faculty Member**

_____**DATE**_____