The second victim phenomenon occurs when healthcare providers experience emotional or physical distress as a result of traumatic clinical events. Few hospitals have formalized peer support programs for second victims to navigate the postevent experience and offload associated emotional labor. This article describes the implementation of a second victim peer support program in a large academic anesthesiology practice, with the goal of augmenting emotional support for anesthesia providers. Program activations were tracked in a shared mailbox. Following peer support, second victims completed an evaluation assessing support received; trained peer supporters completed 2 evaluations assessing their comfort level and peer support encounters. From July 2018 to June 2020, ninety-one program activations (179 affected individuals) were made. A total of 130 peer support encounters were documented. Trained peer supporters were able to provide helpful support to affected colleagues nearly all (98.8%) of the time. Nearly 97% of second victims (25 of 31 evaluation respondents) reported the support as extremely or very beneficial, and 96.8% would recommend the program to colleagues. A second victim peer support program was successfully deployed in a large anesthesia department. This program was effective at a departmental level, fostering providers’ well-being.

The term second victim is defined as “a healthcare professional (HCP) involved in an unanticipated adverse patient event, medical error, and/or patient-related injury who becomes victimized in the sense that the provider is traumatized by the event.”1 In these situations, it is common for HCPs to experience guilt, shame, anxiety, fear of judgment by colleagues, reliving of the event, self-doubt, isolation, and/or hypervigilance.2-4 Some HCPs are so traumatized by an event that they become depressed, severely anxious, or burnt out; leave their chosen career; or consider suicide.1-10 Although some institutions have formal support systems available, such as an employee assistance program (EAP), to help HCPs work through the emotional implications, they are often underutilized.11-14 In January 2018, the Joint Commission issued an advisory on supporting second victims, highlighting the need for a proactive approach.15

Anesthesia providers are exposed to perioperative adverse events that can lead to major emotional impact, such as medical errors, intraoperative awareness, perioperative visual loss, stroke, intraoperative cardiac arrest, or patient death.3-7 Other situations can also create emotional stress, including ethically challenging cases, multiple difficult events over a short time, any situation close to a provider’s personal story, death or trauma to a colleague, cases involving victims of abuse, and cases involving a near-miss.2,16 Survey findings reveal that 60% to 85% of anesthesia providers have a history of being involved in an adverse event that affected them emotionally or physically at some time during their training or careers.3-5,7,17 Most second victims turn to informal support from peers, family, or friends; few seek formal support through institutional offerings.3-5,7 Some anesthesia providers feel as though available support systems are inadequate, whereas others are not aware of supportive resources after experiencing a stressful or traumatic event.4,5,17 The most desired form of support after involvement in traumatic events is talking with peers.1,3,5,14,17-21 Peer support offers the advantages of immediacy and shared experiences, both crucial to normalizing the postevent response.

In our anesthesiology practice at Mayo Clinic in Rochester, Minnesota, the need for a second victim peer support program became apparent after a department-wide survey (unpublished written data, 2016) revealed that perioperative adverse events were experienced by 240 (68%) of 353 providers, with 219 (62%) reporting compromised well-being. The most frequent symptoms experienced included reliving the event (78%), guilt (72%), anxiety (71%), professional self-doubt (56%),
depression (54%), and sleeplessness (54%). The most desired type of postevent support was talking with anesthesia colleagues (90%). Two hundred twenty-nine (65%) did not feel adequate support was available after adverse events. The revelation that more than half of the survey respondents had experienced adverse events, coupled with the lack of a formalized support program in the department, resulted in the prioritization of the development of a second victim peer support program for anesthesia professionals. The purpose of this article is to describe the implementation and evaluation of a formalized peer support program for second victims in an anesthesia department at a large academic institution.

**Methods**

**Setting.** A second victim peer support program was developed and implemented in the Department of Anesthesiology at a large academic institution in the Midwest. The department has 632 individuals: 195 anesthesiologists, 300 Certified Registered Nurse Anesthetists (CRNAs), 59 residents, 6 fellows, and 72 Student Registered Nurse Anesthetists (SRNAs). The medical center consists of 3 campuses, including 2 hospitals and 1 outpatient surgery center. The anesthesia department has multiple divisions, including Cardiac, Critical Care, Multispecialty, Neurosurgery, Pain Medicine, Pediatrics, Obstetrics, Orthopedics, Outpatient Procedural Center, and the Preoperative Examination Clinic.

**Model of Peer Support.** The Healing Emotional Lives of Peers (HELP) program was developed over 3 years (Figure 1) and modeled after reputable second victim peer support programs. The HELP Program comprises an escalating 3-tiered system of support, most closely resembling the Scott Three-Tiered Interventional Model of Second Victim Support.

1. **Tier 1** consists of psychological first aid by colleagues at the local level where the event occurred. Tier 2 adds assistance by trained peer supporters (TPSs)—anesthesia providers who have completed specialized training. Tier 3 layers on the use of institutional resources beyond peer support, including the EAP, chaplaincy, and patient safety (Figure 2).

**Trained Peer Supporter Education and Training.** A critical component of the HELP program is the pool of TPSs used in tier 2 activations. To develop a robust pool (target goal, 5%-10% of the department) of TPSs representing all shifts and professional roles, the authors undertook a recruitment campaign. All members of the anesthesia department were invited to become TPSs, with an emphasis on the importance of possessing qualities such as emotional intelligence, respect, trustworthiness, and ability to communicate with and actively listen to others. Department leaders were strongly encouraged to attend, as their awareness and understanding of the second victim phenomenon was critical to their ability to serve as advocates for the HELP Program. Educational credits were granted for workshop attendance.

A 4-hour training workshop was developed (Table 1) and conducted. Workshop content was based on recommendations from existing literature, reputable second victim peer support programs, and information from the 8-hour “Second Victim Train the Trainer” workshop sponsored by the University of Missouri Health’s for YOU Program and the Center for Patient Safety in St Louis, Missouri. On workshop completion, participants completed a course evaluation, including an inquiry of interest in serving as a TPS for the HELP Program, respecting that not all individuals may see themselves as a formal TPS after attending the workshop.
HELP Program Activation and Peer Support Process. When a stressful or traumatic clinical event occurs, the initial goal is for members in the clinical area to acknowledge that the event has occurred and recognize that involved colleagues may be affected (tier 1 support). Immediately following the event, colleagues in tier 1 offer psychological first aid to those involved in the event. Simultaneously, a formal activation is submitted on the HELP Program’s intranet website to initiate one-on-one support from a TPS (tier 2 support). Information submitted with HELP activation includes the name of the colleague or colleagues who may benefit from peer support, date of event, clinical division in which the event occurred, a brief description of the event, and name of the submitting individual. The activation form is then routed to a dedicated electronic mailbox shared only by members of the HELP Leadership Team, composed of 4 CRNAs and 5 physician anesthesiologists. These individuals demonstrated a passion for the subject matter; are trustworthy, respected members of the department; and volunteered to commit to help with logistical considerations, triaging new activations, and matching these activations to TPSs. It was important to have both CRNA and physician anesthesiologists represented.

Activations can be made by anyone who was either directly involved in or aware of a stressful or traumatic event. Emphasis is placed on being proactive in making activations for peer support, rather than waiting for colleagues to manifest emotional distress; this is dependent on providers having an awareness of the second victim phenomenon, high-risk clinical events, and supportive resources available. To increase awareness in tier 1 encompassing all anesthesia professionals, the authors presented information at departmental grand rounds, divisional meetings, and other institutional educational offerings in addition to frequent updates on the HELP Program in quarterly departmental newsletters.

Members of the HELP Leadership Team rotate the responsibility of monitoring the mailbox for new activations and reaching out to a TPS to initiate tier 2 support. When possible, the affected colleague is matched to a TPS in the same division for enhanced outreach based on geographic proximity and shared experiences. The HELP Leadership Team member contacts the selected TPS to see if he or she is available to reach out to an affected colleague. Once availability is confirmed, activation details and evaluation links are emailed to the TPS. The TPS invites the affected colleague to voluntarily engage in a supportive conversation within 24 to 72 hours. If accepted, a meeting is scheduled between the TPS and the affected colleague. If staffing allows, relief may be provided to allow meetings to occur during the workday. Otherwise, the TPS and the affected colleague arrange to meet at a time and place conducive to their personal schedules after hours. After the initial encounter or if the invitation is declined, the TPS obtains permission to follow up with the affected colleague within 1 week (Figure 3). These options are offered in recognition of the fact that some affected colleagues need time to process the event and related emotional labor before talking with others, whereas others may not desire talking to a peer at all.

During the tier 2 supportive interactions, TPSs follow a 4-step approach (Introduction, Exploration, Normalization, and Follow-up), which focuses on working through the emotional impact of the event instead of discussing specific event details. The TPSs actively listen, validate and normalize feelings, and provide contact information for tier 3 resources. It is voluntary for affected colleagues to use tier 3 resources above and beyond peer support. Confidentiality is maintained and no notes are taken.

Program Monitoring and Metrics. After providing...
peer support, TPSs complete an evaluation documenting the supportive encounter (Figure 4) and a self-assessment (Figure 5) within 1 week. The affected colleague is also invited to complete an evaluation of the support received (Figure 6). These electronic evaluations were adapted with permission from the University of Missouri Health’s for YOU Program. Metrics are only gathered from the tier 2 encounters for 2 reasons: (1) capturing information from tier 1 interactions, which are “in the moment” and more casual would be challenging and (2) tier 3 support is voluntary, and inquiring about additional support that affected colleagues seek is exceedingly invasive.

• Data Analysis (Evaluation of Metrics). Our institutional review board waived the need for full review as the project was deemed to be quality improvement. Quantitative data collected from activation, encounter, self-assessment, and evaluation forms were summarized using standard descriptive statistics, including counts with percentages for categorical variables. Qualitative responses were analyzed by identification of themes. Responses were collected and analyzed using software (Qualtrics).

Results

• Educational Workshops and Trained Peer Supporters. Fifty-seven anesthesia providers (female, 46; 80%) attended the TPS educational workshops. Participants included 40 (70%) CRNAs, 13 (22%) physician anesthesiologists, and 4 (7%) anesthesia residents. Forty-nine (86%) of 57 participants (7.8% of department) indicated interest in serving as a HELP Program TPS following participation in the workshop.

<table>
<thead>
<tr>
<th>Topic of Interest</th>
<th>Learning Method</th>
</tr>
</thead>
</table>
| Defining the Second Victim Phenomenon | Lecture  
Video Analysis:  
CRNA’s Story: When Caring Hurts  
Video Analysis:  
Anesthesiologist’s Story: Suffering in Silence  
Round table discussion |
| Predictable Recovery Trajectory of Second Victims | Video Analysis:  
CRNA 3 Years Later |
| Peer Support Interventions | Video Analysis:  
Perspective from an Anesthesia Trainee as a Second Victim  
Video Analysis:  
Peer Support 1 and 2  
Round table discussion |
| Skill Building | Role Playing:  
Peer Support Using 4 Step Approach  
1 person role play second victim  
1 person role play Trained Peer Supporter |
| The HELP (Healing Emotional Lives of Peers) Program | Lecture  
Round table discussion |
| Conclusion | |
| Complete Post-Workshop Evaluation | |

Table 1. Second Victim Workshop Training Program Schedule
HELP Program Activations for Peer Support. From July 2018 through June 2020, a total of 91 electronic activations were submitted through the HELP Program website for 179 perioperative team members. Most activations (89/91; 97.8%) were made by colleagues, but 2 were self-referrals. Activations were submitted by 50 CRNAs (54.9%), 19 physician anesthesiologists (20.1%), 15 surgical charge nurses (16.5%), and 7 SRNAs (7.7%). The most common events leading to HELP activation were intraoperative patient demise, cardiac arrest, and pediatric care (Table 2).

Although 179 HCPs’ names were submitted via HELP activation for tier 2 support, only 130 (72.6%) encounter forms were completed. Eight providers (6.2%) declined the invitation for peer support. Of the 122 supportive encounters, personnel receiving peer support included 64 CRNAs (52.5%), 14 physician anesthesiologists (11.5%), 14 registered nurses (11.5%), 12 SRNAs (9.8%), 8 certified surgical technicians (6.6%), 7 residents and fellows (5.7%), and 3 other professionals (2.5%). The average length of tier 2 supportive encounters was 19 minutes (range, 2-240 minutes).

**HELP Program Activations for Peer Support**

**HELP Encounter Request**
Anesthesiology and Perioperative Medicine

**Encounter Information (Completed by the Trained Peer Supporter)**

- **Request Type**: New, Declined Peer Support
- **Second Victim’s Professional Role**: CRNA, MD, Resident/Fellow, SRNA, Other
- **Length of Interaction (minutes)**: Open text box
- **Risk Factors of Event**: Drop-down menu of high risk clinical events*
- **Comments**: Open text box

*High risk clinical events: pediatric case, patient that reminds staff of their family, patient known to staff members, community high profile, multiple patients with bad outcomes, long-term patient, palliative care, first death under their watch, unexpected patient demise, organ donation, young adult patient, death of staff member or spouse, victim of violence, litigation, other

**Figure 3.** Overall Process of HELP Program’s Tier 2 Level of Peer Support

**Figure 4.** Encounter Form Completed by the Trained Peer Supporter After Inviting an Affected Colleague to Engage in a Supportive Conversation

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**Evaluations of Peer Support.** Of the 122 documented
tier 2 peer support encounters, 85 (69.7%) TPS self-assessments were completed (Table 3). Strategies that worked well for TPSs included active listening, meeting in a private setting, normalizing, and reassuring. Seven TPSs (8.2%) indicated feeling uncomfortable during the encounter for various reasons, including shedding tears,

**Figure 5. Self-Assessment Completed by a Trained Peer Supporter after Facilitating a Supportive Conversation with an Affected Colleague**

**Figure 6. Evaluation Form Completed by an Affected Colleague Who Received Peer Support from the HELP Program**
not knowing what to say, staying focused on the emotional impact vs talking about event details, and fear of people talking negatively about the affected colleague.

Thirty-one (25.4%) evaluations from affected colleagues were received (Table 4). Twenty-five of the 31 affected colleagues (80.0%) rated the support received as “extremely” or “very beneficial”, and 28 (90.3%) were “extremely” or “very satisfied” with their experience.

Discussion

This report describes the implementation and evaluation of a second victim peer support program in the anesthesia department of a large academic medical center. Many factors contributed to the successful implementation of this program. These factors included key stakeholder buy-in, departmental engagement, dedicated time for workshop participation, a committed leadership team, and adaptation of an effective model of support and program monitoring tools from an existing reputable program, in addition to the lessons learned from similar programs throughout the country to develop and execute the program.1,13,17,19,22,23,28-30 Through efforts of the HELP Program, departmental recognition of second victims and outreaches for colleagues involved in high-risk clinical events have steadily increased over time. Having approximately 10% of the department serve as TPSs may have facilitated heightened surveillance and timely outreach to affected providers.19 Having TPS representation from CRNAs, physician anesthesiologists, trainees, and all clinical divisions/specialties, as well as from both men and women, has been instrumental in allowing for rapid deployment and individualization of emotional support. The strategy of matching a TPS who works in close geographical proximity to the affected colleague was used to facilitate face-to-face encounters within 24 to 72 hours of the event.

Reaching out to affected colleagues to aid with emotional coping has resulted in a major and important shift in culture, enhancing psychological safety. Awareness of the HELP Program has spread throughout the periopera-

<table>
<thead>
<tr>
<th>Clinical event</th>
<th>Activations (N=91)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intraoperative Patient Demise</td>
<td>42</td>
</tr>
<tr>
<td>Pediatric patient</td>
<td>23</td>
</tr>
<tr>
<td>Intraoperative Cardiac Arrest</td>
<td>14</td>
</tr>
<tr>
<td>First death in the Operating Room</td>
<td>8</td>
</tr>
<tr>
<td>Multiple difficult events over short period of time</td>
<td>8</td>
</tr>
<tr>
<td>Prolonged resuscitation</td>
<td>6</td>
</tr>
<tr>
<td>Medication or System Error</td>
<td>5</td>
</tr>
<tr>
<td>Patient Known to Staff</td>
<td>4</td>
</tr>
<tr>
<td>Organ donation case</td>
<td>4</td>
</tr>
<tr>
<td>Violent Patient and/or Staff</td>
<td>4</td>
</tr>
<tr>
<td>Unanticipated difficult airway</td>
<td>3</td>
</tr>
<tr>
<td>Patient Situation Closely Resembles Someone in Personal Life</td>
<td>2</td>
</tr>
<tr>
<td>Intraoperative Awareness</td>
<td>2</td>
</tr>
</tbody>
</table>

*Each activation may be associated with more than one clinical event

Table 2. Summary of HELP Program Activations

<table>
<thead>
<tr>
<th>Question</th>
<th>Total (N=85)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did you feel you were able to provide helpful support?</td>
<td></td>
</tr>
<tr>
<td>Agreed</td>
<td>84 (98.8%)</td>
</tr>
<tr>
<td>Disagreed</td>
<td>1 (1.2%)</td>
</tr>
<tr>
<td>I am comfortable with my knowledge and skill as a TPS.</td>
<td></td>
</tr>
<tr>
<td>Agreed</td>
<td>80 (94.1%)</td>
</tr>
<tr>
<td>Disagreed</td>
<td>5 (5.9%)</td>
</tr>
<tr>
<td>I need additional training and experience as a TPS.</td>
<td></td>
</tr>
<tr>
<td>Agreed</td>
<td>19 (22.4%)</td>
</tr>
<tr>
<td>Disagreed</td>
<td>66 (77.6%)</td>
</tr>
<tr>
<td>I felt satisfied with how the peer support encounter turned out.</td>
<td></td>
</tr>
<tr>
<td>Agreed</td>
<td>81 (95.3%)</td>
</tr>
<tr>
<td>Disagreed</td>
<td>4 (4.7%)</td>
</tr>
</tbody>
</table>

Table 3. Summary of Trained Peer Supporters’ Self-Assessments
tive practice, resulting in activations being initiated by a variety of providers, including associates in surgical services that did not receive HELP Program training. This illustrates the prevalence and impact of stressful perioperative events on all team members. Only 2 self-referrals were requested for emotional support, but the team anticipates that additional self-referrals will be made in the future as awareness of the program and comfort with asking for support increase.

The success of the program depends on various factors, most notably an assurance of complete confidentiality on the parts of both TPSs and affected colleagues. Barriers to requesting peer support may include a fear of lack of confidentiality, as well as both the risk of exposure to legal implications and a fear of disciplinary actions. Our institution’s anesthesia department does not belong to a federally designated Patient Safety Organization, which allows for federal-level confidentiality protection for second victim conversations through the Patient Safety and Quality Improvement Act of 2005. To mitigate any fears of legal consequences, TPSs are instructed to maintain strict confidentiality, not to take notes during encounters, focus on the emotional implications of the event, and complete evaluations in a de-identified manner by omitting use of names, dates, and specific event details.

Although most clinical events that triggered activations centered on intraoperative patient demise, cardiac arrest, and events involving pediatric patients, other uncommon events such as unplanned difficult airway, violent patients, organ donation, and intraoperative awareness prompted activation. Unsurprisingly, the cardiac, trauma, and pediatric anesthesia divisions had the highest number of activations, which has led to concern of burnout among TPSs in these high-risk clinical areas. Recruiting additional TPSs in these divisions has been advantageous to facilitate peer support and to mitigate any potential burnout.

Nearly all TPSs believed they were able to provide helpful support to affected colleagues, likely reflecting that personalized social contact and feeling valued by others facilitates recovery from difficult clinical situations. The TPSs indicated that active listening, validating, normalizing, following the 4-step key principles, finding a private location, and focusing on the emotional impact rather than on event details were effective strategies during supportive interactions. Qualitative comments indicated the importance of maintaining engagement with all TPSs via regular meetings for ongoing educational needs and touchpoints; however, in-person quarterly meetings were not well attended by TPSs. The HELP Program is currently assessing different avenues to maintain engagement such as virtual meeting platforms.

Unfortunately, only about one-fourth of affected colleagues who received peer support completed an evaluation on the support received. Of those that did respond, more than 90% indicated that it was “extremely” or “very beneficial” and that they were “extremely” or “very satisfied” with the interaction. All but one affected colleague indicated that they would recommend the HELP Program to colleagues in need, indicating that the peer support received may have helped with the postevent recovery by normalizing and offloading associated emotional labor.

### Table 4. Summary of Affected Colleagues’ Perception of Support

<table>
<thead>
<tr>
<th></th>
<th>Total (N=31)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>How beneficial was the support you received from the HELP Program?</strong></td>
<td></td>
</tr>
<tr>
<td>Extremely beneficial</td>
<td>16 (51.6%)</td>
</tr>
<tr>
<td>Very beneficial</td>
<td>9 (29.0%)</td>
</tr>
<tr>
<td>Moderately beneficial</td>
<td>5 (16.1%)</td>
</tr>
<tr>
<td>Slightly beneficial</td>
<td>1 (3.2%)</td>
</tr>
<tr>
<td><strong>How distressing was the event that led you to the HELP Program?</strong></td>
<td></td>
</tr>
<tr>
<td>Extremely distressing</td>
<td>3 (9.6%)</td>
</tr>
<tr>
<td>Very distressing</td>
<td>16 (51.6%)</td>
</tr>
<tr>
<td>Moderately distressing</td>
<td>9 (29.0%)</td>
</tr>
<tr>
<td>Slightly distressing</td>
<td>3 (9.7%)</td>
</tr>
<tr>
<td><strong>How satisfied were you with your experience with the HELP Program?</strong></td>
<td></td>
</tr>
<tr>
<td>Extremely satisfied</td>
<td>19 (61.3%)</td>
</tr>
<tr>
<td>Very satisfied</td>
<td>9 (29.0%)</td>
</tr>
<tr>
<td>Moderately satisfied</td>
<td>2 (6.4%)</td>
</tr>
<tr>
<td>Slightly satisfied</td>
<td>1 (3.2%)</td>
</tr>
<tr>
<td><strong>Would you recommend the HELP Program to a colleague?</strong></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>30 (96.8%)</td>
</tr>
<tr>
<td>No</td>
<td>1 (3.2%)</td>
</tr>
</tbody>
</table>
In response to the current coronavirus disease 2019 (COVID-19) pandemic, the HELP Program has expanded into high-risk clinical areas, such as Intensive Care Units, Emergency Departments, the hospital Internal Medicine Department, and COVID-19-specific units. In recent months, the program also expanded throughout the entire health system enterprise, another clear indication of the success of the program in the anesthesia department. To facilitate the rapid expansion of the program, the 4-hour in-person workshop was converted to an interactive virtual platform and has been conducted 20 times from April 2020 to December 2020. More than 600 enterprise employees attended these workshops, with approximately 70% indicating interest in serving as a TPS.

An enterprise-wide HELP Program website was created, and a web-based collaborative platform (SharePoint, Microsoft Corp) now serves as the main hub for communication and documentation. To help with administrative oversight, the HELP Program secured an operational home in Enterprise Well-being.

Several challenges and limitations were encountered during the HELP Program implementation in the anesthesia department. Our goal has always been to match affected colleagues with TPSs who work in the same specialty area to increase timeliness and sharing of similar experiences; however, the heterogeneity of provider schedules made matching TPSs with affected colleagues difficult. Another challenge relates to the process of initiation of activations early on in the program implementation. Initially, tier 2 activations were primarily made after affected colleagues displayed emotional distress. In the early days of the program, anesthesia providers who were present to offer tier 1 support felt the need to get affected colleagues’ permission to refer them for tier 2 support. When asked about the need for referral, most affected colleagues stated that they were fine and did not need to talk to a peer. After further education and enhanced awareness, most activations are made in a proactive manner for all staff involved in a potentially emotionally traumatizing event, which allows for provision of earlier support to a larger group of colleagues. In addition, referral of colleagues involved in cases discussed at morbidity and mortality conferences is also occurring.

Another limitation of the program is the difficulty in capturing each encounter and thus documenting all metrics. Because completion of the peer support encounters and self-assessments is voluntary for TPSs, several peer supportive interactions may have occurred but not have been captured. Because only one-fourth of the affected colleagues who received peer support completed an evaluation, it is possible that reporting bias may be present; perhaps only the affected colleagues who were satisfied with the peer support they received completed the evaluation. To mitigate this potential of bias and increase compliance in completing evaluations and capturing metrics, TPSs now receive a formatted email with direct links to the evaluations any time they commit to offer tier 2 support to an affected colleague. The TPSs also send the affected colleague an email follow-up, which includes a link to the evaluation of support they received. Another challenge is the lack of dedicated administrative support to meet the demand for the HELP Program, particularly as utilization and implementation in other hospital departments and throughout the enterprise increases.

Despite these challenges, the HELP Program has successfully provided peer support to a large number of anesthesia professionals over the first 2 years of the program’s inception. The HELP Program is now a resource for surgical colleagues, the institution’s Children’s Center, the Department of Obstetrics and Gynecology, and 6 affiliated satellite hospitals in the region. Adding these clinical specialties provided opportunities for 6 additional training sessions, increased the number of TPSs to 200, and nearly doubled the number of total activations.

Implementing a system of support for second victims may look different depending on the size, location, resources, and culture of the individual department or institution. We hope this article provides a guide to implement peer supportive strategies at the departmental level to mitigate the isolation and emotional volatility that is too often experienced after involvement in stressful or traumatic clinical events.

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DISCLOSURES

Robyn Finney, DNAP, CRNA, has declared no financial relationships with any commercial entity related to the content of this article. Adam Jacob, MD, has declared no financial relationships with any commercial entity related to the content of this article. Julie Johnson, DNP, CRNA, has declared no financial relationships with any commercial entity related to the content of this article. Hayley Messner, DNP, CRNA, has declared no financial relationships with any commercial entity related to the content of this article. Bridget Pulos, MD, has declared no financial relationships with any commercial entity related to the content of this article. Hans Svigum, MD, has declared no financial relationships with any commercial entity related to the content of this article. The authors did not discuss off-label use within the article. Disclosure statements are available for review upon request.

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