The Joint Commission Journal on Quality and Patient Safety 2024; 50:673–677

BONE Break: A Hot Debrief Tool to Reduce Second Victim Syndrome for Nurses

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The pandemic has intensified clinicians' workloads, leading to an increased incidence of adverse events and subsequent second victim syndrome, with almost half of health care clinicians experiencing its symptoms. However, following a literature review, no tools were found that addressed second victim syndrome in nurses. To address these issues and the gap in the literature, the authors developed the BONE Break hot debriefing tool. BONE Break is designed to be facilitated by charge nurses or other unit leaders as a means of offering peer support to other nurses who went through an adverse event. During its initial implementation, BONE Break was employed in 43 of 46 events adverse events (93.5%), and 41 of 43 sessions (95.3%) were deemed helpful. The research team has continued to gain stakeholder buy-in and implement BONE Break across multiple sites. Future work will determine BONE Break's efficacy in enhancing long-term nursing retention and reducing second victim symptoms.

Despite current efforts to increase patient safety, adverse events continue to occur. These experiences can be traumatic for the clinicians involved, resulting in second victim syndrome. *Second victim syndrome* refers to the negative impact (that is, victimization) a health professional feels following an adverse medical event.[1] This can include psychological, cognitive, and physical reactions,[2,3] which may lead to loss of work productivity, loss of personal and professional confidence, and, at times, the decision to leave the profession or role associated with the trauma.[4,5] Those suffering from second victim syndrome tend to blame themselves for the adverse event, seeing it as a personal failing rather than a systemic issue.[6,7] Prior research has found that up to 43% of clinicians have experienced second victim syndrome, and about half of these indicate it has had a moderately severe to severe impact on their lives.[8,9] In nurses, specifically, a subjective lack of support from their colleagues during adverse events has been reported to lead to feelings of isolation, judgment, and alienation.[10]

In 2018 The Joint Commission urged health care organizations to develop a strategy and/or program to support second victims immediately following an adverse event. This interest has been amplified as the COVID-19 pandemic increased clinician workload, leading to more adverse events.[11] Many second victim programs use a designated team of peer responders that provide support to providers following an adverse event.[12–15] Other systems lean on the employee assistance program to provide this support.[16] However, few programs have used work units for peer-to-peer support along with structured debriefing tools.

Structured hot debriefing tools have been used in emergency departments, children's hospitals, and other clinical settings with notable success.[17] *Hot debriefings* are those done immediately after the event and capitalize on minimized recall bias and the ability to immediately address urgent issues.[18] A recent systematic review found 21 articles each covering a different debriefing tool designed to be used following unsimulated clinical events.[19] Although many of these tools were used for hot debriefing, none focused solely on nurses. In addition, many of the tools identified elements of psychological safety and a focus on well-being and emotions, but this was not the main object of the tool. In fact, to the best of our knowledge, there are no hot debriefing tools focused on decreasing the development of second victim symptoms. Therefore, we developed a structured hot debriefing tool specifically designed for use by a team of nurses in the same unit following an adverse event, with a focus on immediate peer-to-peer support and emotional first aid to mitigate potential symptoms of second victim syndrome.

TOOL DEVELOPMENT AND DESCRIPTION

Right before the COVID-19 pandemic began, a new orthopedic trauma unit was created at our hospital. Many of the nurses on this unit were young and at the beginning of their careers. Unit leadership started to notice that adverse patient events were having a strong effect on these nurses. As these struggles increased with the onset of COVID-19, we started to look for tools that could be used to help preserve the psychological well-being of our staff.

We conducted a literature search to see if there were any existing tools that met our needs. However, we did not find any that focused directly on second victim syndrome in

1553-7250/$-see front matter
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https://doi.org/10.1016/j.jcjq.2024.05.005

nurses. We wanted a tool that could be used immediately following an adverse event that focused on the nurse and their emotions as opposed to other debriefing models (for example, plus/delta[20]) and would easily integrate into our workflow. We chose to develop a structured debriefing tool, as scripted tools appeared to limit the art of dialogue. We provide suggestions for phrases that can be used during each stage of the debrief. However, facilitators are encouraged to make the interaction as natural and open as possible.

Using suggestions from other articles about mitigating the effects of second victim,[7,10,21] we developed the BONE Break hot debriefing tool to meet our needs. Because we work on orthopedic trauma units, we decided to use the acronym BONE to guide the debriefing process. The tool consists of four stages. During each stage, debrief participants are asked to reflect on the adverse event and offer peer support in a nonjudgmental way.

1. **Buoy/Break:** Nurses took a silent break or short pause to allow for space, then reflected on the statement, "You are a good nurse working in a very complex environment."[7,10] Peers offered support using phrases such as "I cannot imagine what that must have been like for you. Can we talk about it?"[7]
2. **Open-Up:** Nurses invited each other to talk about the adverse event that had just occurred: "This has to be difficult. Are you okay?"[7,10] and "How are you doing after the event?"[21]
3. **Needs:** Nurses assessed one another's needs following the adverse event: "What do you need right now to be able to be successful in returning to work?"[21] They offered each other affirmations surrounding those needs: "I believe in you."[7]
4. **Exit/Evaluate:** Nurses discussed the effectiveness of the debriefing before returning to the floor.

Prior to implementation, we developed an educational presentation for the charge nurses who would facilitate the BONE Breaks with other staff. This two-hour presentation covered why BONE Break was developed and how we planned to implement it. These education sessions also incorporated a teach-back model wherein we presented the charge nurses with four scenarios (see Appendix 1, available in online article) where they practiced implementing and rehearing BONE Break together. These education sessions were recorded and shared with the charge nurses after completion to be used as a reference. Charge nurses were also provided with a small card with the BONE Break outlined that was easy to keep on them and use as a guide in the moment (Figure 1).

BONE Break Pocket Reference Card

B.O.N.E. Break

Buoy/Break: Short Pause = moment of silence to allow space
- I cannot imagine what that must have been like for you. Can we talk about it?
Open-up:
This must have been difficult. Are you okay?
How are you doing after the event?
Needs:
What do you need right now to be able to successfully return to work? I believe in you!
Exit/Evaluate:
Was this helpful?

Figure 1: Shown here is the text of the BONE Break pocket reference card given to facilitators to use in the moment.

HOW TO

Following an adverse event, any nurse that has gone through the education (typically a charge nurse) initiates the BONE Break as soon as possible (ideally within 15 minutes following the event) within the current workflow. Those who were involved in the adverse event are informed that support is available and are invited to a private space to debrief. The charge nurse then walks participants through the BONE Break phases, making sure to focus on emotions and encouragement rather than focusing on how the situation could have gone differently. Debriefing typically lasts 5 to 10 minutes.

Example

A 72-year-old male patient has been admitted to an inpatient unit after a fall at home. He is now status-post right hip repair and requires two staff members to move him from the bed to the chair or commode. At 4:30 a.m.*, the patient calls staff to help him to the commode. As they assist him to sit up in bed, the patient begins making sexually inappropriate comments. The staff clearly set boundaries and ask the patient to stop. Rather than respecting those boundaries, the patient escalates to inappropriate physical actions. Due to the patient's fall risk and current position on the edge of the bed, the staff feel unable to leave the room without jeopardizing his safety. Staff stay in the room until the patient is safely returned to bed.*

BONE Break was successfully implemented following the above scenario. The flow of events can be seen in Figure 2. We chose to highlight this incident as it is something that occurs regularly and can be handled in a variety of ways depending on the culture of the unit or health system. We believe by implementing BONE Break in this situation, the affected nurses felt validated in their response to the patient as well as internally.

Following the incident, the charge nurse on the unit invited the affected nurses to sit down in a quiet space for a debrief. The charge nurse noted that the affected nurses were visibly upset and shared their frustrations with the situation: "I can't believe he'd do that!" "It felt pretty icky." "I don't want to go back in there anymore." Throughout the conversation, the charge nurse offers peer-to-peer reassurance. The nurses were also offered referrals to the Employee Assistance Program (EAP) but declined, stating it would be "too embarrassing even to talk about." The charge nurse then explores what else would be helpful to the nurses to help them find closure and return to work. After coming

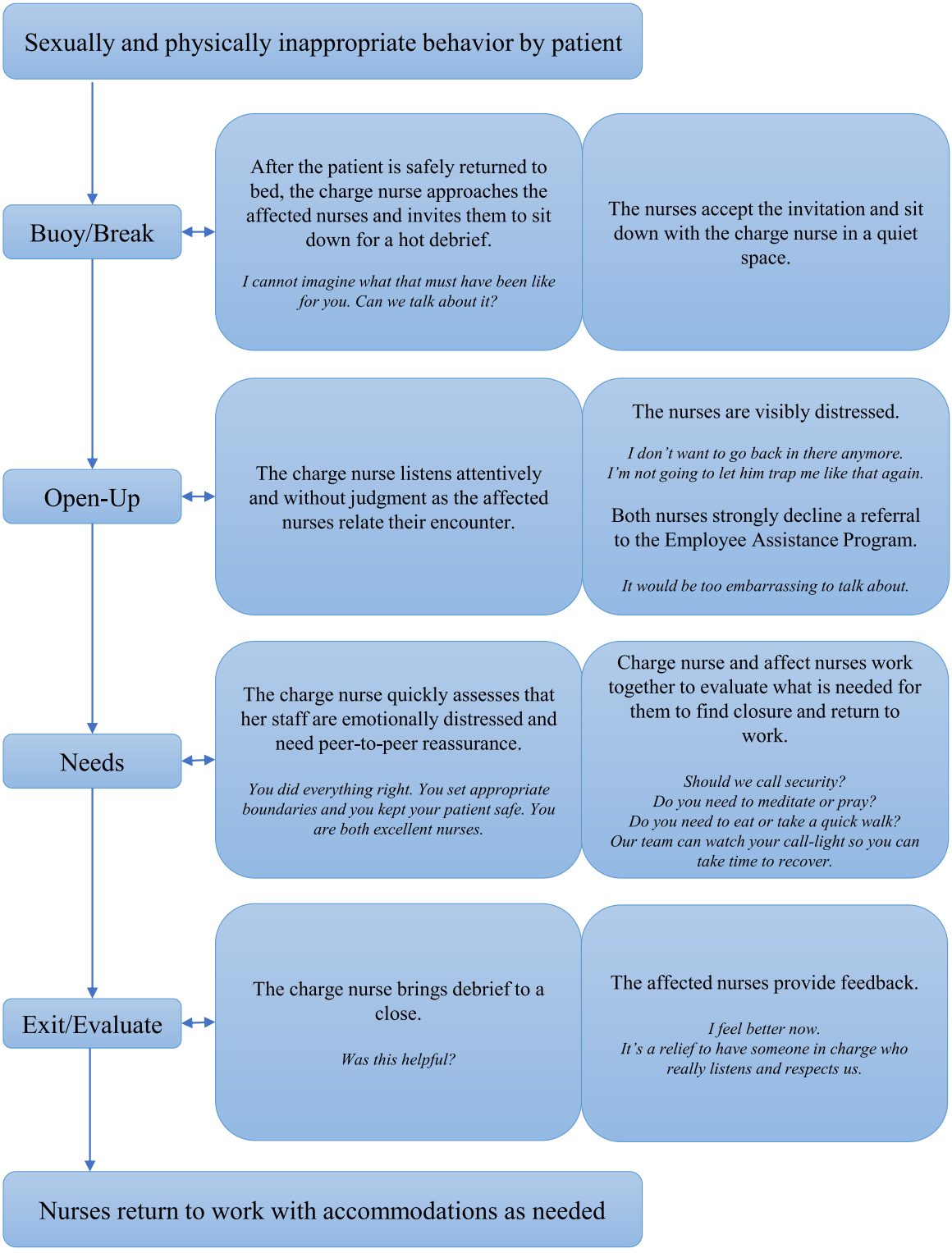


Figure 2: The flow diagram shows the BONE Break process after an adverse event.

up with some solutions, the charge nurse brings the debrief to a close by asking if it was helpful.

RESULTS AND LESSONS

To understand the impact of BONE Break, we examined its use in registered nurses (RNs) on a 24-bed inpatient unit at a large Midwestern hospital from July 2021 to March 2022. Approximately 20 to 25 RNs work on this unit caring for postoperative, trauma, and medical patients. The unit was the newly created unit mentioned previously that prompted the creation of BONE Break. Staff's need for a process surrounding psychological safety prompted higher stakeholder buy-in on this unit. Prior to implementation,

charge nurses on the unit received training and were asked to use the BONE Break tool following every adverse event that happened on the unit in addition to mandatory reporting paperwork and notifications.

Charge nurses were also responsible for collecting data immediately following each BONE Break session, including type of adverse event (for example, fall, medical error, patient death), number of RNs involved in the adverse event, time the BONE Break session occurred in relation to the adverse event, number of RNs present for the BONE Break session, length of the BONE Break session, degree to which participants reported benefit from the BONE Break session, and whether the charge nurse felt able to be a supportive, nonjudgmental listener (Appendix 2).

Over the nine-month time frame, 46 adverse events occurred on the unit encompassing the four most common types: behavioral emergency response team required, rapid response team required, cardiopulmonary arrest, and patient fall with no injury. The BONE Break tool was implemented in 43 of the 46 adverse events (93.5%). Most BONE Break sessions lasted 10 minutes or less (86.0%; $n = 37$). The majority of the BONE Break sessions (95.3%; $n = 41$) were considered helpful.

LESSONS

Throughout the BONE Break development and testing process, we faced wins as well as challenges and limitations that affected our ability to truly measure the impact of the tool. Below we discuss each of these in depth as well as present possible solutions and next steps.

Implementation

Since its inception, the implementation of BONE Break in various units has been fairly easy. Because it was developed in-house, its use matched the culture of the units it was implemented on. The positive staff rapport with unit leadership also eased implementation. These two factors led to an initial buy-in from charge nurses. This buy-in increased through the education provided to them, as it explained how BONE Break could be helpful without being burdensome or interrupting the unit's workflow.

BONE Break is still being used regularly on the original unit we examined. It is also being used in a handful of other units in our hospital as well as another medical center in the same metro area. Other clinics and hospitals in our health system have also shown interest in implementing BONE Break. Our goal is to implement BONE Break in more units and disseminate it widely as an easy-to-implement tool that supports the psychological safety of all health care workers.

Understanding Impact

We have recognized the potential for bias in the BONE Break session evaluations. During our impact study, charge nurses were responsible for rating the benefit of each BONE Break session and how well they were able to be a supportive, nonjudgmental listener. This is likely not a fair assessment of the true feelings of all involved in the debrief. One way of addressing this is to include anonymous surveys from each participant in the session, asking them to rate their level of benefit and how well the charge nurse or BONE Break facilitator was able to be a supportive, nonjudgmental listener.

As more units gain interest in BONE Break, we plan to implement a broader impact study with a methodology that allows us to compare control and intervention units from baseline and over time. Anecdotally, we believe BONE Break has had a large impact on the psychological well-being of our nurses. We look forward to collecting proper data to substantiate this.

SUMMARY AND NEXT STEPS

Second victim syndrome occurs widely throughout the health care field following adverse events. The symptoms of second victim syndrome are similar to those of post-traumatic stress disorder and can become debilitating for those experiencing them. As such, The Joint Commission urged health care organizations to develop a strategy and/or program to support second victims immediately following an adverse event. Here, we presented a new hot debriefing tool, BONE Break, designed to mitigate the symptoms of second victim syndrome. As noted previously, implementation of BONE Break has continued across our hospital, health system, and metro area. Unit and department leadership have shared that they believe the implementation of BONE Break is useful and champion our dissemination of the tool. As its use increases, we plan to implement a broader study of its impact.

Conflicts of Interest. All authors report no conflicts of interest.
Funding. The authors would like to extend our most profound gratitude to our colleagues in the Kern Center and Department of Nursing at Mayo Clinic.

SUPPLEMENTARY MATERIALS

Supplementary material associated with this article can be found, in the online version, at doi:10.1016/j.jcjq.2024.05.005.

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