Creating a Culture of Resident Well-Being

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Pre-Test Question #1

Pharmacy residents experience stress and burnout at similar rates to other healthcare trainees

A. True

B. False

C. Unknown

Pre-Test Question #2

Pharmacy residents enter residency programs fully ready for the emotional and clinical challenges of direct patient care.

A. True

B. False

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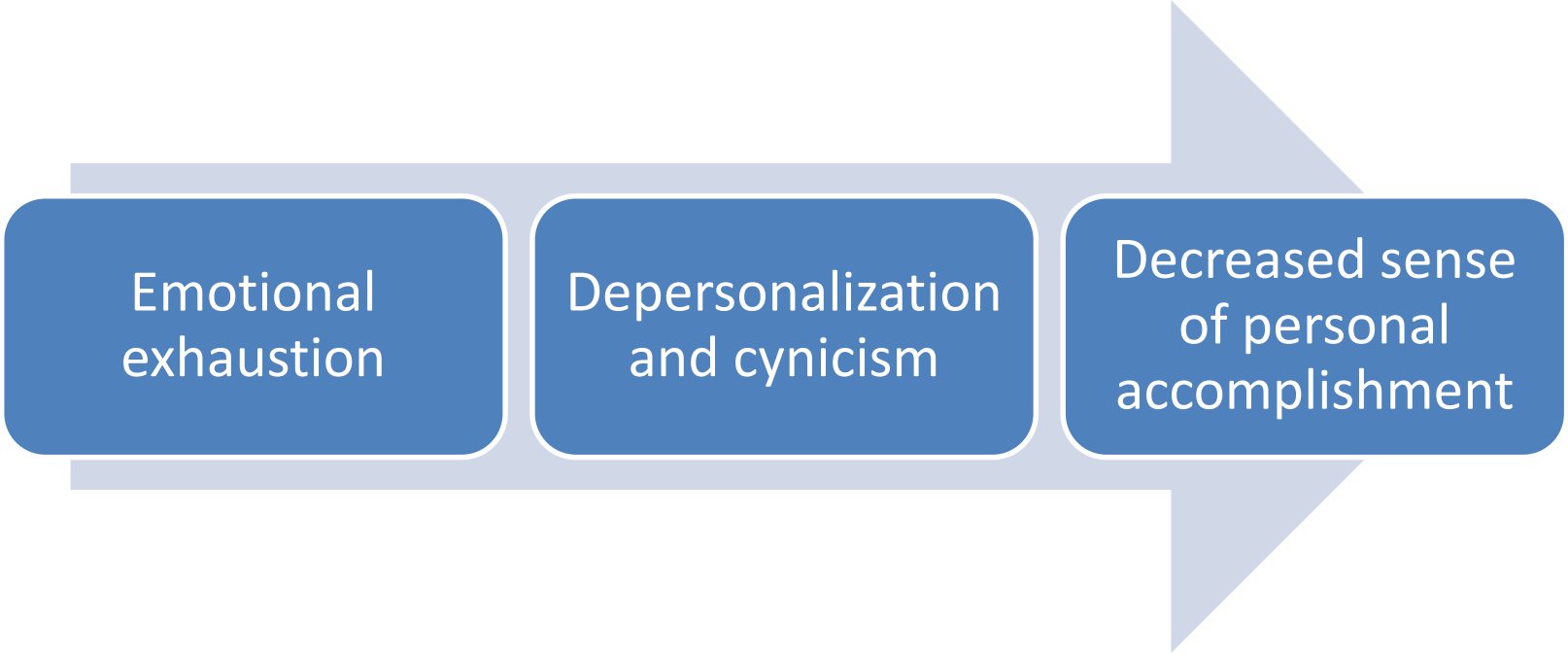
Pathway to Burnout



Am J Health-Syst Pharm 2018; 75:147-52

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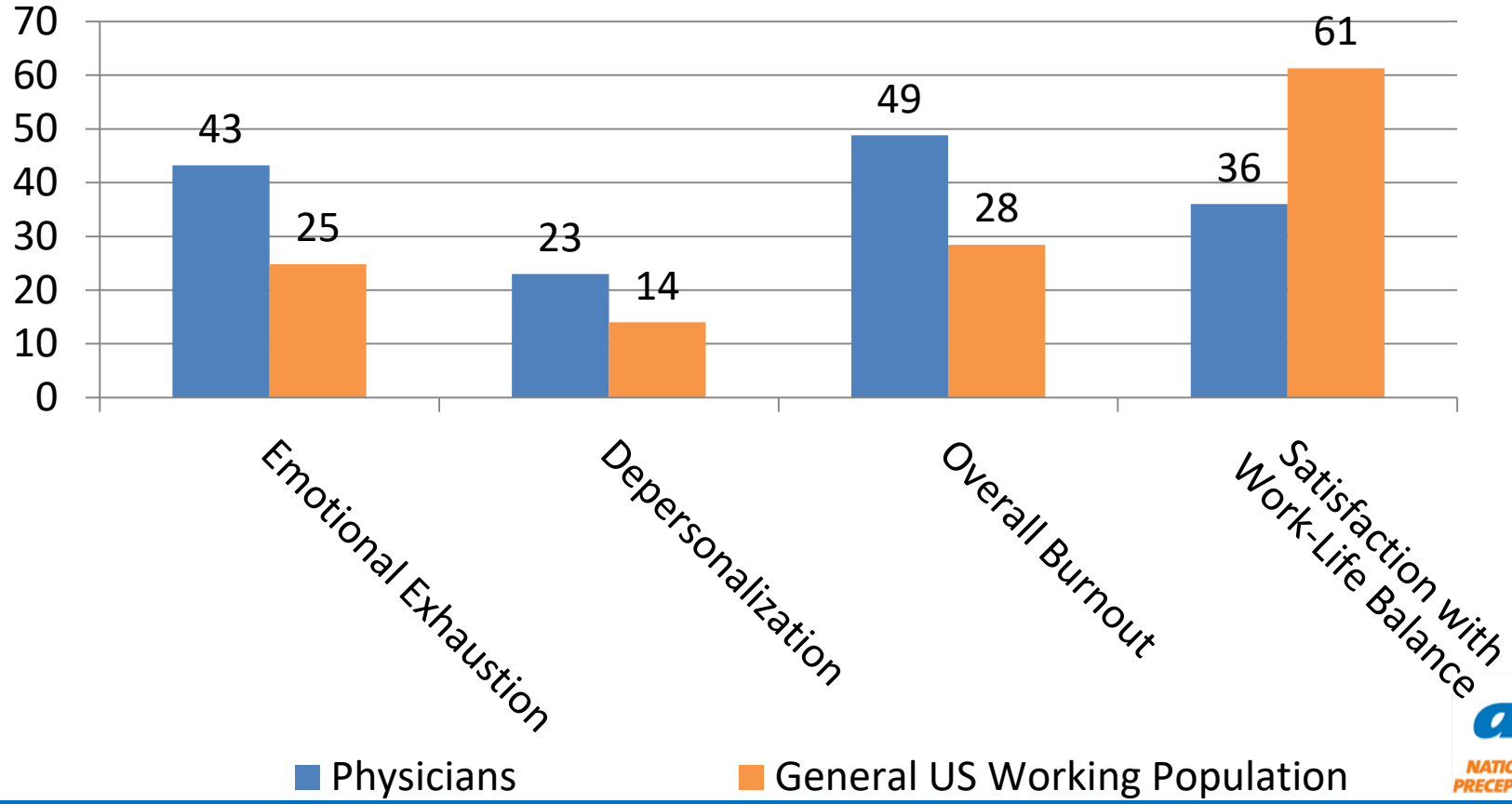
Current Comparative Statistics



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Mental Health in Medical Trainees

- Stressors include heavy workload, sleep deprivation, and difficult patient encounters
- Increased rates of depression, anxiety, and stress
- Negative impact on quality of patient care

Current Status in Pharmacy

?

Preparedness for Emotional Challenges

- Situations reported as “somewhat difficult”
  - Response to cardiorespiratory arrest
  - Family discussion about critically ill patient
- 84% felt somewhat supported by their programs
- Majority of RPDs and residents agree residents could be better prepared for emotional challenges of patient care

Am J Health-Syst Pharm 2015; 72:1475-80

apathy

sleep deprivation

resilience

mental health

suicide

well-being

fatigue

depression

depersonalization

burnout

emotional exhaustion

high stakes

anxiety

stress

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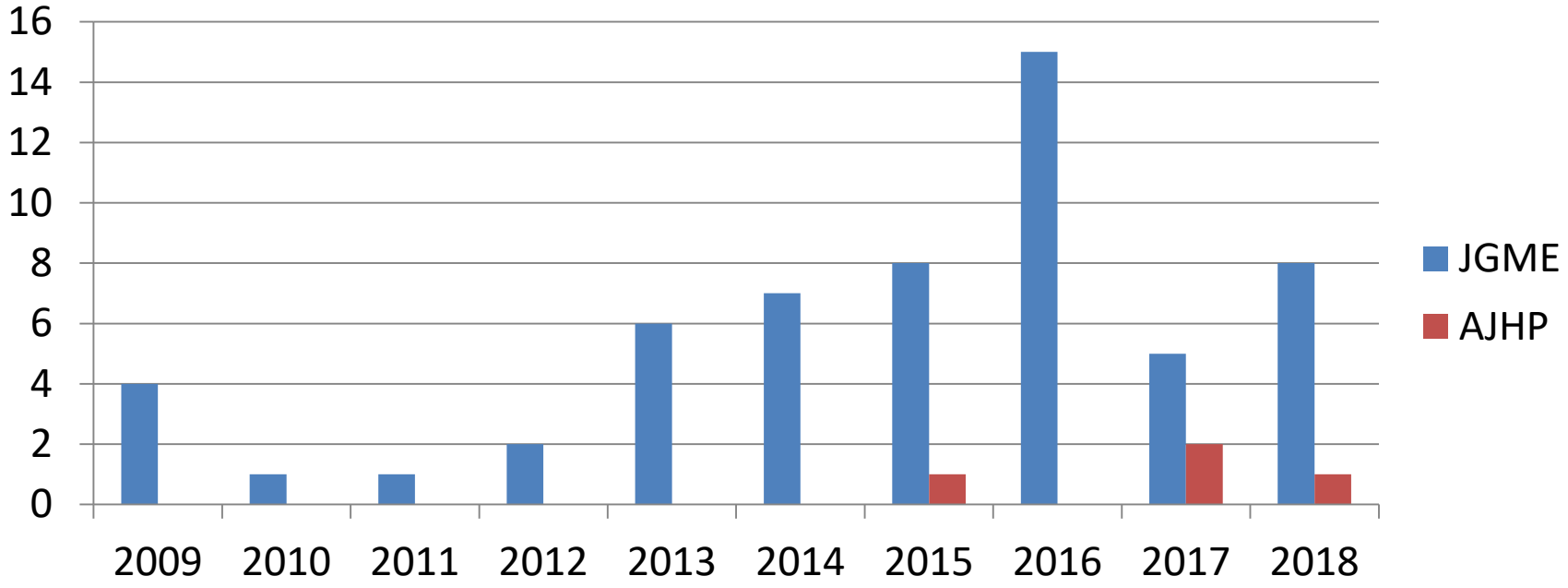
What does “well-being” mean?

Publications on Resident Well-Being



What are the biggest stressors for your residents?

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What are the biggest stressors for your residents?

- Individually write down the top 3 stressors in your residency program
- Turn to the group of preceptors at your table and compare lists

Residency Program Stressors

- Are there any common themes in stressors or perceived stressors from year to year?
- What are some of the different stressors that affect residents in the beginning versus end of the year?

Common Resident Stressors

- Time pressure
- Number of working hours
- Financial situation
- Personal and family relationships
- Exposure to unsettling events
- Emotional challenges in patient care

Am J Health-Syst Pharm 2017; 74:599-604

Identifying & Addressing a Stressor: The UChicago Medicine Example

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UChicago's Clinical On-Call Program

- 24-hour in-house program
- Responsibilities include emergency response and clinical pharmacy services
- Typically 40-50 pages per shift

Structure of on-Call Shifts

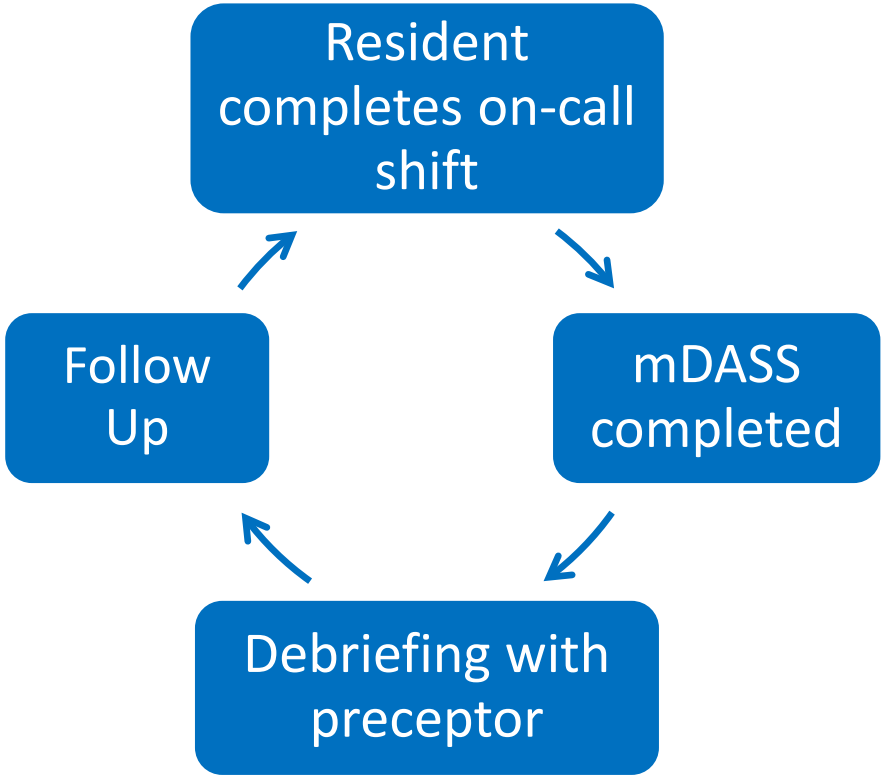
Physician Resident

- Caring for a particular unit/patient service
- Often more than one MD
- High stakes decisions often require attending supervision/decisions
- Post-call debrief for complicated situations

Pharmacy Resident

- Covering entire hospital
- No in-house clinical support after 9:30pm
- Back-up preceptor available for phone discussions
- No formal face-to-face discussions about overnight scenarios

Debriefing Program



- mDASS-21 developed to assess mental health
- Completed for buddy call, first five, midpoint, and final five call shifts
- Debrief occurs immediately after call shift duties are completed

mDASS-21 Tool

I found it hard to wind down.	S
I was aware of the dryness in my mouth.	A
I couldn't seem to experience any positive feeling at all.	D
I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion).	A
I found it difficult to work up the initiative to do things.	D
I tended to over-react to situations.	S
I experienced trembling (eg, in the hands).	A
I felt that I was using a lot of nervous energy.	S
I was worried about situations in which I might panic and make a fool of myself.	A
I felt that I had nothing to look forward to.	D
I found myself getting agitated.	S
I found it difficult to relax.	S
I felt down-hearted and blue.	D
I was intolerant of anything that kept me from getting on with what I was doing.	S
I felt I was close to panic.	A
I was unable to become enthusiastic about anything.	D
I felt I wasn't worth much as a person.	D
I felt that I was rather touchy.	S
I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat).	A
I felt scared without any good reason.	A
I felt that life was meaningless.	D

British J Clin Psych 2005; 44(2): 227-39.

mDASS-21 Interpretation

Severity	Depression	Anxiety	Stress
Normal	0 – 9	0 – 7	0 - 14
Mild	10 – 13	8 – 9	15 – 18
Moderate	14 – 20	10 – 14	19 – 25
Severe	21 – 27	15 – 19	26 – 33
Extremely Severe	28+	20+	34+

British J Clin Psych 2005; 44(2): 227-39.

Post-Call Debrief

- How would you rate your shift?
- What tough situations did you encounter?
- How did you feel?
- How did you prepare for pages?
- What can we do to help you prepare?
- What helps you relax?

Assigning a Stress Perception Score

SPS	Evaluation Criteria
1	Calm & well rested, composed throughout discussion
2	Appears calm, some report of stress over shift but coping well
3	Some stress shows, resident describes stressful events with less ability to cope or manage problems
4	Appears disheveled/unorganized, displays some signs of stress/sleep deprivation such as unclear thought process or inability to articulate responses
5	Visibly stressed (jittery, jumpy, restless) or sleep deprived (dozing off) throughout discussion; describes inability to focus or manage responsibilities of resident on-call
6	Shows signs of emotional exhaustion; becomes tearful or angry during discussion
7	Visibly distressed from a distance; tearful or angry before discussion begins

Triggers for Escalation of Support

mDASS-21 Scoring	SPS Scoring	Debriefer Actions
Severe in any category	≥ 3	- Schedule weekly meetings x 4 (at a minimum) - Offer Employee Assistance Program (EAP)
Extremely severe in any category	≥ 6	- Schedules weekly meetings x 4 (at a minimum) - Strongly recommend EAP

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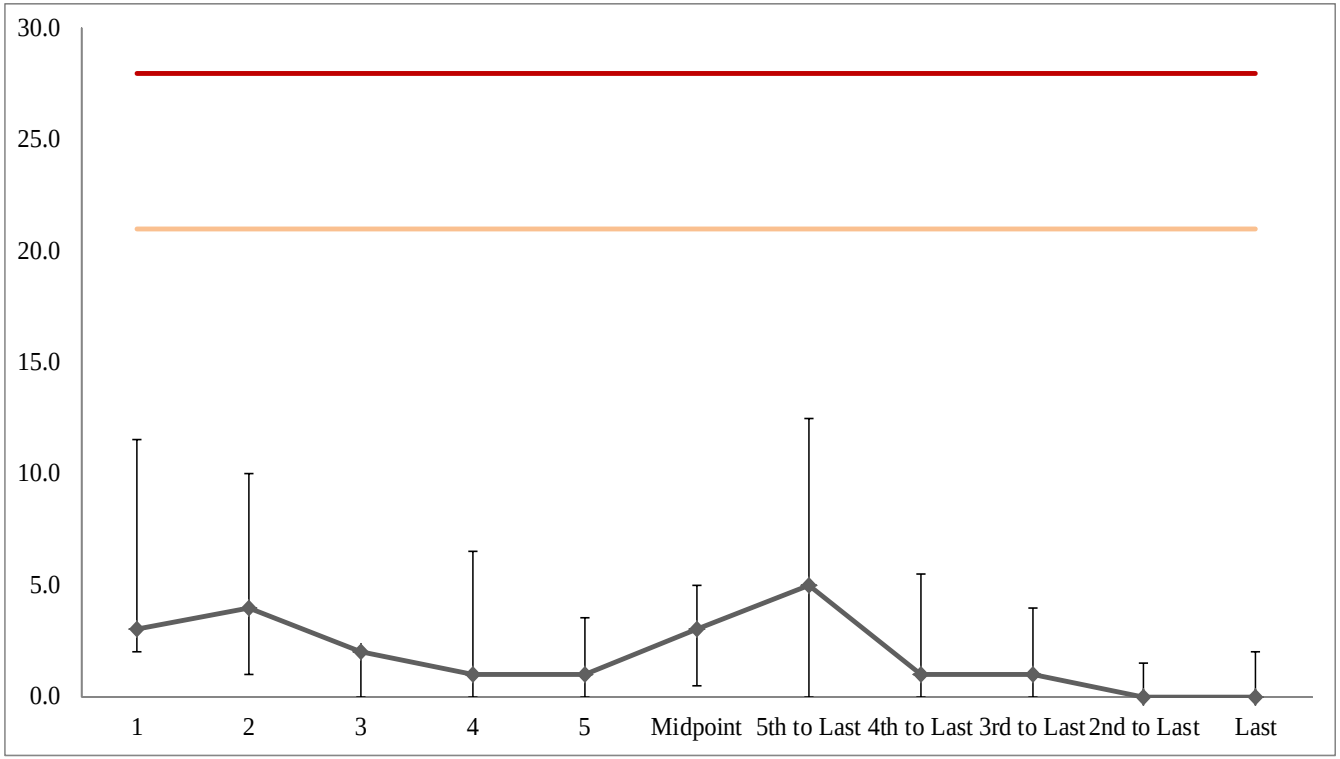
Median mDASS-21 Depression Scores



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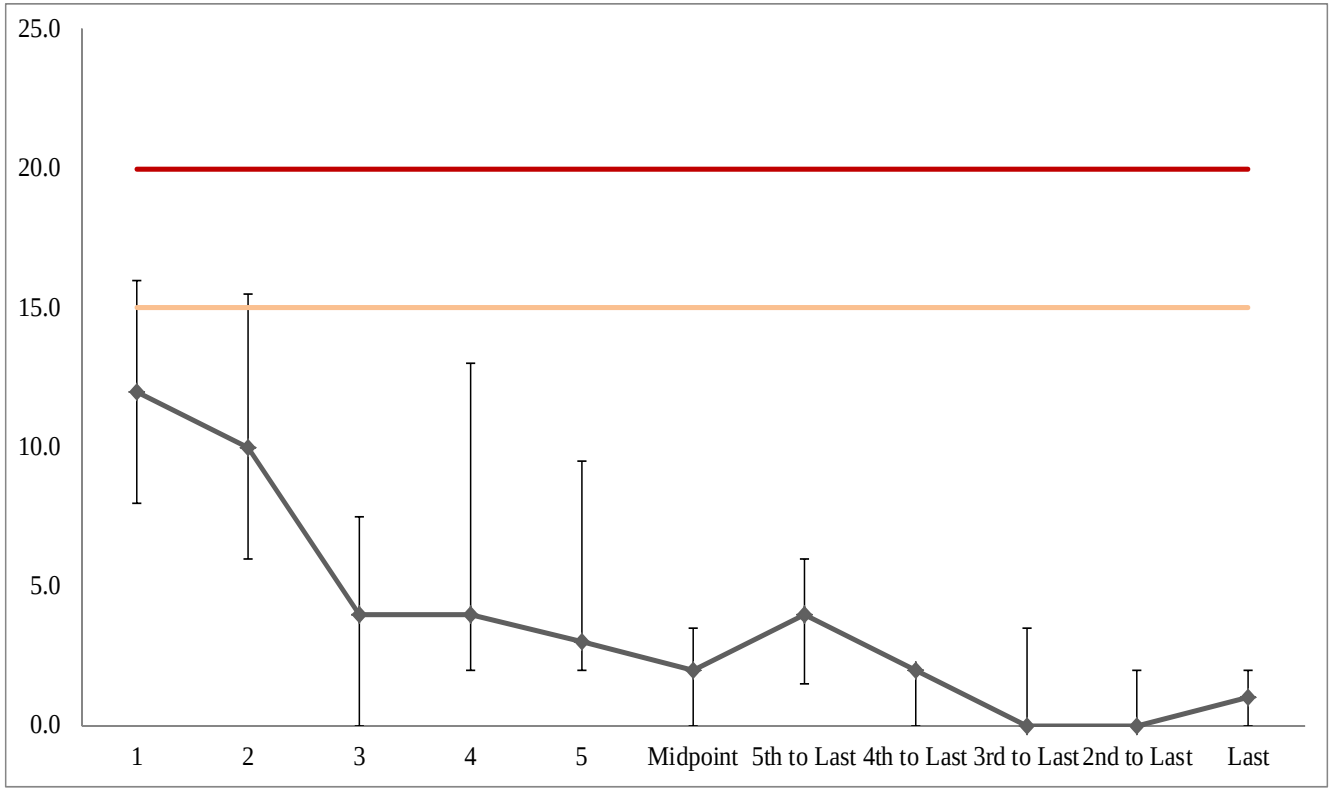
Median mDASS-21 Anxiety Scores



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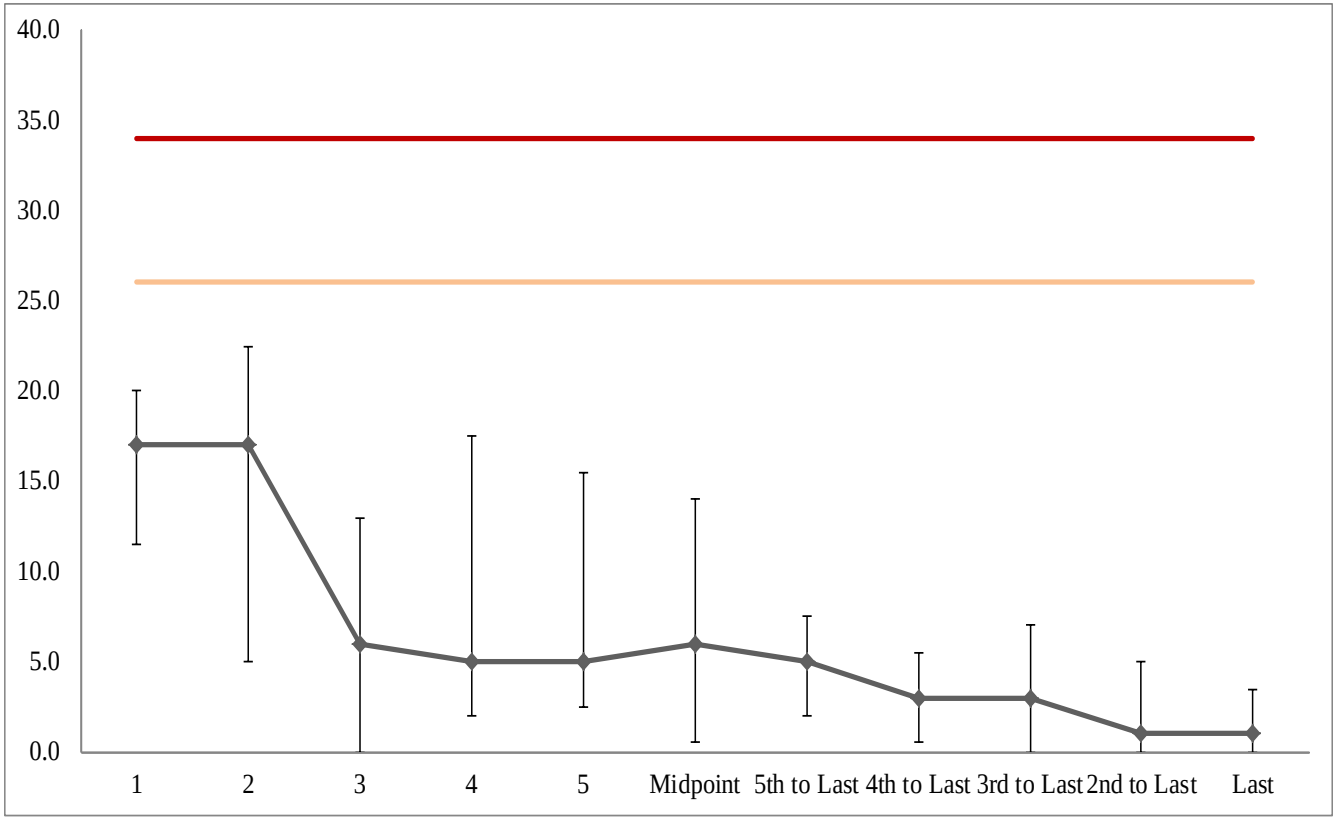
Median mDASS-21 Stress Scores



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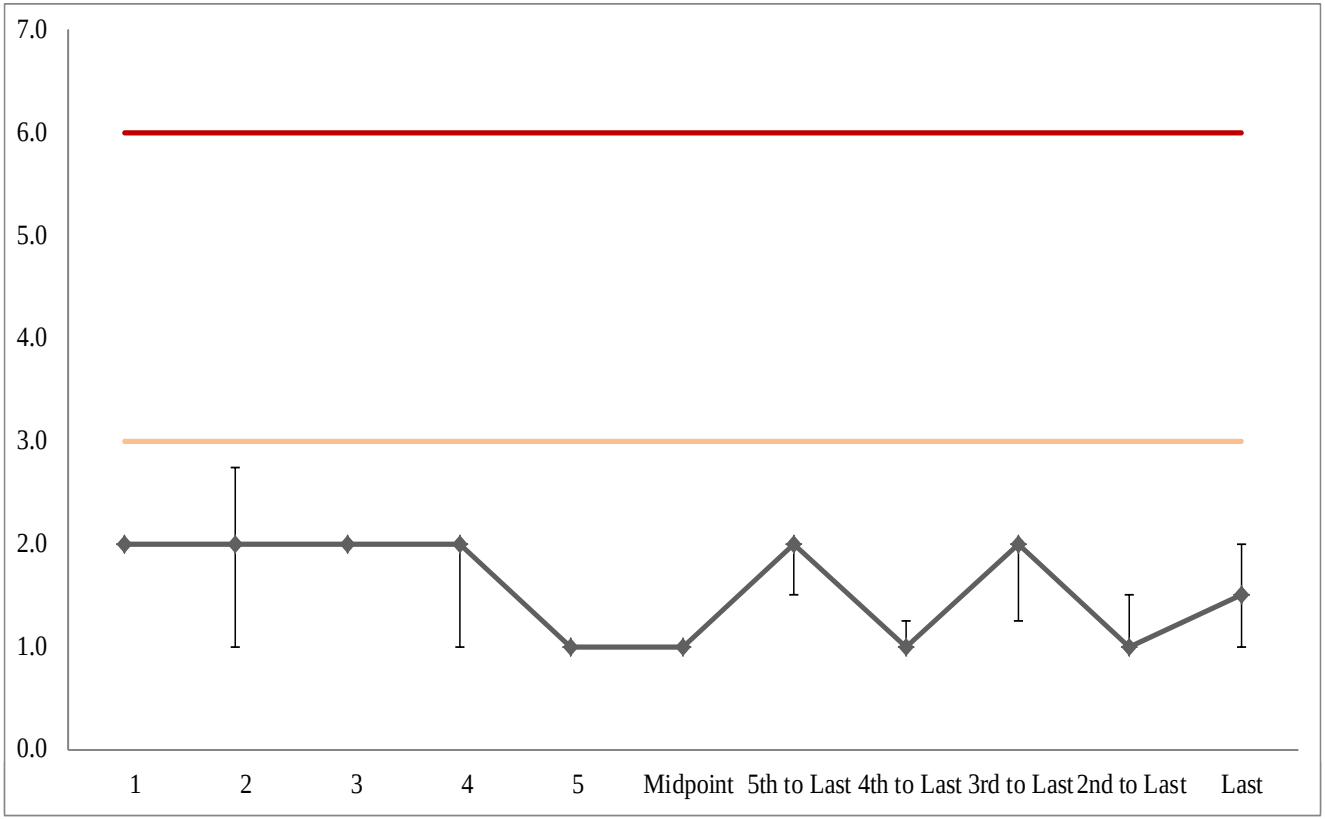
Median Stress Perception Scores



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Additional Support Provided

Time Frame	Weekly Meetings	EAP Offered	EAP Strongly Recommended
First Five Call Shifts	16 shifts	6 residents	2 residents
Last Five Call Shifts	1 shift	0 residents	1 resident

2018 – 2019 Program Changes

- Expanded to PGY2 residents
- Completed for buddy & first three call shifts
- Debriefing questions updated
- Debriefing preceptors expanded
- Considering addition of quarterly burnout evaluation

Case #1

Katie is the pharmacy resident completing her 24 hour on call shift in the hospital. Overnight, she is paged to attend a stroke in the emergency department. Within 15 minutes, she is also paged about a code blue in the medical ICU. She feels overwhelmed with the two emergency situations where medications may be needed and feels stressed that she cannot be in two places at the same time.

Case #1 Follow-Up

What strategies could you provide residents to understand how to deal with multiple emergency responses at the same time?

Strategies to Address Multiple Responsibilities

- Develop a priority list for which emergency response residents should attend to first if they are in this situation
  - Supported by the residents clinical judgement if patient care outweighs provided priority list
- Ensure residents know who else might be available to assist them in situations where they have competing priorities
  - Back- up preceptors, emergency trained staff pharmacists overnight, etc.

Case #2

Cody is pharmacy resident rotating on an Emergency Department learning experience. While he was counseling a patient on discharge antibiotics he over hears one of the providers talking about administering tPA to a patient who is having a stroke. When he goes to the patients room, he realizes the patient has been there for 4 hours and the team is just now asking him for the tPA. He is anxious that there is only a short amount of time left to make his assessment, compound and administer the medication. Additionally, he is stressed about what is the fastest way to physically get the medication to the bedside.

Case #2 Follow up

What materials and support could be provided to the resident to aid in the handling of stressful, time-pressured clinical situations?

Addressing Stressful Clinical Situations

- Develop institutional guidelines that are taught to the residents during their orientation and then reviewed periodically throughout the year
- Provide residents training on bedside compounding for tPA and other factor products that may need to be compounded at the bedside
- Provide a list of locations where high risk, urgent medications are stocked (automated dispensing cabinets versus central pharmacy)

Case #3

Ashley is a pharmacy resident on her PICU learning experience. Over the course of the rotation she found herself getting very attached to the children she was caring for and developing relationships with their parents, family and caregivers. One morning Ashley finds out that a patient passed away from a complication overnight and is emotionally distraught.

Case #3 Follow up

What are some support systems that could be available for residents dealing with unsettling events or emotional challenges in patient care?

Support for Emotional Challenges

- PICU/NICU preceptor conversation
- Multidisciplinary team dialogue
- Residency debriefing program
- Employee assistance program

Common stressors for pharmacy residents include:

A Frequent patient interactions as a student

B Commitment to extended period of training

C Long working hours

D Excitement of new learning experiences

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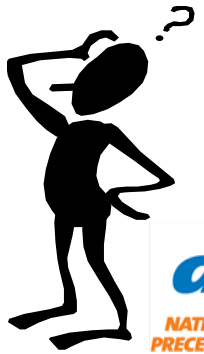
An example of a program developed to identify residents experiencing stress is:

A. A monthly test on clinical skills

B. Post-call debriefing

C. Pairing residents in teams

D. Decreasing expectations of residents



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Key Takeaways

- Stress and burnout are common among healthcare practitioners and trainees.
- Identification of residents at risk for or experiencing high levels of stress can allow for individualized training on coping skills
- A post-call debriefing program allowed preceptors to discuss emotionally, clinically, or physically challenging situations that occurred during a call shift immediately to provide additional support.