

# Peer-support: a coping strategy for nurses working at the Emergency Ambulance Service

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**Abstract.** *Background and aim of the study:* Working in the emergency medical service often exposes nurses to highly stressful situations and can impact their quality of life. Among the strategies aimed at mitigating the effects of this phenomenon, peer-supporting represents an emerging model used in the emergency medical service setting. The aim of the study is to explore the experiences, the opinions and feelings of emergency medical service nursing staff in relation to the use of the peer supporting model. *Methods:* A semi-structured interview was carried out. Participants were recruited on a voluntary basis from an emergency medical service in the north of Italy. Interviews were audio-recorded and the data extracted were anonymised. *Results:* 14 nurses participated in the study. The totality of the participants recognized that their daily clinical practice, especially when involving paediatric patients, can have a profound emotional impact on their life in general. Furthermore, interviewees admitted that their personal coping mechanisms did not seem to be entirely effective when processing their painful experiences. The majority of the participants were in favour of introducing a peer-supporter in the ambulance service. *Conclusions:* This study emphasises the need to implement emotional support tools for non-hospital emergency nurses in daily clinical practice, in order to facilitate emotional decompression secondary to particularly stressful interventions as soon as possible. The peer-supporting strategy could represent, in this direction, a valid and shared model. ([www.actabiomedica.it](http://www.actabiomedica.it))

**Key words:** peer support, coping, resilience, nurse

## 1. Introduction

Daily care practice clearly demonstrates how it is not always possible to achieve complete recover or even stable results of change within the treatment processes that allow a person to return to an initial health condition. In such situations, nurses often can only observe the pain of another human being and accept the emotions and feelings that this brings out. When nurses feel overwhelmed by a feeling, in order for this feeling to become an opportunity for inner strength and personal resilience, they should not dismiss it but

they should try to listen to it and recognize its origin, giving it meaning. This allows the person to accept those feelings and still relate to the client, without fearing the feelings and sensations that could arise in the nurse from this relationship (1). When emotions and feelings experienced by the nurse are not adequately elaborated and accepted, they can become a source of enormous stress with related consequences on a psychological, physical, social and working level, which in turn can result in emotional exhaustion, depersonalization, a low sense of personal fulfilment and psychiatric disorders (2).

The context of emergency-urgency seems to represent in this sense a particularly critical area. In fact, nurses in such settings frequently face intense existential and emotional experiences and at the same time they are required to constantly guarantee high levels of health services in work contexts in which human and instrumental resources are often limited (3).

Emergency nurses are very well clinically trained but they often admit having difficulties in an interpersonal relationships and communication (4). There are numerous stressors that affect the staff in the extra-hospital emergency and these range from the unpredictability of the emergency event to the variable age of the patients, from the high level of responsibility to the absence of feedback for the work performed (5). Several studies have shown that the rate of nurses working in the critical field and showing indicators of Post-Traumatic Stress (PTSD) and burnout fluctuates between 20-30% (6, 7).

The ability to pay attention to one's emotional health should be an important resource for nurses in order to provide quality of care. This approach is defined by the American Holistic Nursing Association as "self-care", an expression that refers to the self-care that the health worker exercises towards his health and includes the promotion and maintenance of his state of well-being, as well as the treatment and management of acute, chronic, and physical and or mental disabilities (8).

There are numerous strategies that aim to manage emotional wellbeing and mental health, from mindfulness techniques (9) to proactive coping methods, which consist in hypothesising a situation that could potentially occur and plan possible methods to deal with the problem (10). In last few years, the concept of "defusing" has been applied to the context of the territorial emergency. This term refers to emergency psychological assistance or to an emotional first aid (11). This is a peculiar form of debriefing, which allows the creation of a protected environment, where the health care professional can talk about personal emotional experiences. Therefore, the "defuser" is trained to be a facilitator in the elaboration of the person's experience, through empathic listening and the way the conversation is structured. A more recent model is that of the peer-supporter, or peer support, described as:

"A voluntary, non-evaluative and mutually beneficial collaboration between two health care professionals of similar experience who have participated in the training and who wish to incorporate new knowledge and skills into the practice"(12).

In this regard, McDonald argues that the support of social networks, or support among work colleagues, is an essential and effective form of protection against adverse work events. Over the years, relationships of mutual help are built, among colleagues, through sharing similar experiences that allow to face the daily work challenges in a positive way. Furthermore, the importance of external support represented by good family relationships, friendships and sentimental relationships is highlighted, as they promote self-esteem and increase personal emotional security (13).

In 2001, the hospital managers of the Department of Paediatrics at the Johns Hopkins Hospital in Baltimore recognized the need to provide a support program to employees, following the difficulties faced by the staff in dealing with the management of the experience of a critical event. This was implemented following a clinical audit during which some staff reported to have been emotionally and professionally negatively impacted by traumatic events. A project called Resilience in Stressful Events (RISE) was therefore launched, which was a peer support program among health care professionals who collaborate in everyday care. This was created on the basis of an initial survey from which emerged that workers who had suffered stress after critical events were very keen to participate in such a project. The RISE program was created to provide assistance to healthcare professionals who experience a stressful event and aims at ensuring timely multidisciplinary peer-to-peer support in a non-judgmental environment, providing new tools to healthcare professionals who can thus identify healthy coping strategies and promote their general well-being. The trained health care professional (peer responder) calls back the requesting colleague within a maximum of 30 minutes after receiving the request and they have a phone interview in the event they are unable to meet him in person. During the interview, the peer responders do not ask questions related to the event. The support provided is in fact focused on the feelings, emotions and psychological experience of the caller (defusing) rather

than on the technical details of the event (debriefing). According to privacy laws, all interactions and information are confidential and protected by professional secrecy, with the exception of receiving information of possible imminent damage to self or others (14).

Helping nurses cope more effectively with stress after major critical events, the program has the potential to reduce nurse turnover and productivity losses associated with burnout and moral distress related to adverse events. The cost-benefit analysis showed that the application of the peer support program provided substantial investment savings of \$ 1.81 million on the annual budget for each nurse who participated in the program (15). Furthermore, in Italy there are experiences of application of peer-supporting techniques among the nursing population. For instance, since 2011, the Regional Emergency Urgency Association (AREU), based in Lombardy, designed and implemented a program of peer-support post critical event, based on active listening, managed by peers trained and assisted by health emergency psychologists. The objective was to facilitate emotional decompression and to reduce the phenomenon of isolation by identifying social support networks and promoting individual and team resilience (16).

## 2. Purpose of the research

The purpose of this research is to investigate any signs of emotional distress related to clinical performance with a strong emotional impact in emergency ambulance service nurses. Furthermore, this study aims at exploring whether the presence in the team of one or more colleagues, specifically trained to provide emotional support as facilitators for emotional decompression (peer-supporter), can represent according to participants' perceptions an effective tool for managing work-related stress.

## 3. Methods and tools

This is a qualitative study, carried out through a semi-structured interview, consisting of two main questions taken from qualitative studies conducted on

critical area nurses in the literature. The questions are: "Could you describe how you felt when faced with one or more particularly significant and intense events related to your work, including sensations, thoughts and emotions?" (17) and "Could you describe the strategies you employed to deal with the emotional impact of these experiences?" (18). To this question it was added: "And have you ever tried to talk and find support in your colleagues?"

Participants were invited to discuss and express their emotions and perceptions in various situations that occurred during work. The research, with the authorization of the organization, was conducted at the Italian emergency ambulance service, called "118" and it was focused on nursing staff. The recruitment of the participants took place on a voluntary basis and the consent form for data processing for research purposes was signed. The non-probabilistic sampling included, with no distinctions, nurses working at the emergency ambulance service "118" in a hospital in northern Italy, who had experience in the extra-hospital emergency.

Data collection took place in July 2018, after consent for carrying out this study was given by the Bioethical Committee of the University of Bologna. The interviews were audio-recorded and conducted anonymously, in an environment known to the participants, in which they could feel at ease, in order to facilitate them expressing their experiences and emotions. The interviews were conducted and analyzed by all the researchers after having been faithfully transcribed on digital text documents, reporting in brackets some relevant non-verbal gestures, and after having evaluated the nodes and relationships generated by the nVivo qualitative research software<sup>12</sup>.

## 4. Results

The participants who voluntarily joined the project were 14 nurses (28.6%), 6 men and 8 women, out of a total of 49 nurses working on ambulances. The total duration of the interviews was 224 minutes and 53 seconds, average interview duration is 16 minutes and 4 seconds. Participants had been working at emergency ambulance service 118 for a minimum of 8 months to a maximum of 17 years.

The results of the study can be classified into three main macro areas:

1. the need to receive emotional support from colleagues
2. individual coping strategies implemented
3. participants' perceptions of peer-supporting as a resource that could facilitate processing personal experiences and feelings concerning subjectively complex events on an emotional level.

#### 4.1 *The need for emotional support*

The need to receive support from colleagues as a result of interventions of strong emotional impact seems to be widely recognized and shared by the participants in the study. In fact, half of the participants tend to express it in a rather clear and explicit way, as it can be seen by the following reported comments.

Nurse 1

"The only thing I regret is that no one asked me: "Do you want to talk about it with someone? Do you need to talk to someone about your emergency intervention?" I kept my experience inside, I elaborated the event by myself".

Nurse 3

"A colleague who is very dear to me joined me at the ambulance station and as soon as I saw him I threw my arms around his neck and I started crying".

Nurse 8

"I see that my colleague needs to say something".

Half of the interviewed nurses remember and report having experienced at least one significant and traumatic experience shortly after the beginning of their professional career in the emergency ambulance service 118, particularly within the first 2 years. Taking this into consideration, it clearly emerged that the most feared intervention in terms of emotional repercussions is the one related to the management of paediatric patients. In fact, all the participants indicated this as the most significant experience from an emotional point of view, due to the difficulty in managing the relationship with the victim's parents.

Nurse 1

"I uncover the child from this blanket and there was ... something ... it is difficult to describe, but it was

completely crashed, this child was destroyed [...]. The really burdensome task was really this, those twenty minutes during which the family was looking for an answer from me".

Nurse 3

"What really scared me, or at least at the beginning, I had just been left by myself immediately after the orientation, is the death by submersion syndrome of a 7-year-old child in a pool of sewage on a farm. [...] I found myself alone and my inexperience caused me to lose control, feeling unable to properly perform".

Nurse 4

"Because pediatric intervention is a high stress factor, not so much because you are treating a child, but the parents are the ones you must deal with".

Nurse 6 reported:

"What scares us the most are paediatric accidents. So, I never want to hear a child... that there is a child in cardiac arrest or about an accident with children involved".

Nurse 13

"But like with any intervention on the child, you get more emotionally involved".

Suicides, road accidents, deaths from cardiac arrest in young adults follow the list of the most feared interventions. During the interviews, a significant presence of intrusive thoughts and details concerning the event emerged. This shows how some particularly intense events are indelibly engraved in the memory of the nurse who lived them.

Nurse 3

"I remember this sunset, the nauseating smell coming from the sewage and the waste in contact with the sun must have emitted... and another thing that I remember is that my eyes burned and [puts a hand around his neck and swallows] this acrid taste in my mouth definitely caused by the gas".

Nurse 11

"One thing I remember, often it's the small details that touch you the most, trying to fix the braces on the child's teeth that had practically jumped out and you could see this piece of iron coming out ... so at least I tried to fix it for him before his father could see him".

Nurse 5

"And I remember the darkness, I remember a bit

of fog, the flashing lights, the torches of the traffic police...”.

Even the intervention on suicides seems to have a significant emotional impact.

Nurse 4

“I felt a bit of burnout because of all these suicides, which were linked to pre-existing family problems”.

Nurse 6

“Suicide is something that has a huge emotional impact on me, not because the image I see, but because I wonder what drives a person to do this”.

From the analysis of the interviews collected, some prevailing emotions emerged in particular: helplessness, caused by the impossibility of offering an effective and fully successful intervention, desperation and fear. These can be seen from the comments below:

Nurse 1

“Helplessness, because I couldn’t do anything, nobody could do anything”.

Nurse 6

“It made me feel helpless”.

Nurse 7

“There and then I couldn’t stop massaging him, it was maybe something ... I didn’t want to”.

Nurse 10

“We were all terrified, whether we showed it or not we all were”.

When the need for emotional support was investigated, the issue of the consequences of health interventions on the personal life clearly emerged. These consequences have effects on the short-term and long-term. In fact, more than one third of the interviewees pointed out that, in some way, the emergency clinical event did not end with the clinical performance, but continued to have an impact on their emotional, physical, social and family sphere. This is clear in the following reported comments:

Nurse 1

“I don’t know, I know I managed to get over it, but I can’t really tell you how I processed it. I know I’ve thought about it every day for at least 6 months”.

Nurse 8

“In the following years I had a big problem with

hand dermatitis and I work with my hands, so and I have always wondered “why hand dermatitis?” [...] and afterwards, I don’t know but I just couldn’t be in a confined space”.

Nurse 3

“I find it hard to talk about it” [...] “That was the worst summer of my life and my family’s life... in the pool, by the sea, in short, anything”.

Nurse 12

“Those thoughts about the emergency interventions are the ones you can’t get rid of, and you think about them over and over... you take them home and think about them over and over again”.

#### 4.2 Self-care and coping

From the elaboration of the interviews it can be noted that, consciously or unconsciously, all nurses have somehow adopted personal coping strategies in response to the stress caused by some very difficult emergency interventions mentioned above. A number of nurses claim that in order to deal with the repercussions of the emotional impact some care interventions cause, it is necessary to apply a real emotional detachment. Others advocate the need to be detached in order to ensure effective work performance, while others find that having only a restricted contact within a limited time frame with the patient and his family proves to be beneficial. Some coping strategies employed by emergency nurses are reported below:

Nurse 5

“I’m applying a great detachment to the limit of cynicism”.

Nurse 4

“I can’t get emotionally involved, it can’t touch me, otherwise I can’t work”.

Nurse 2

“Be immediately detached...because anyway at that precise moment I had to put my emotions aside because I have a duty to carry out”.

Nurse 7

“So when you arrive you have work to do, so the mind gets focused on what you have to do.” “[...] maybe on one side it protects you because you see the patient only for 10 minutes and then he’s gone”.

Nurse 12

“The ambulance service 118 has the characteristic of treating patients as quickly as possible and so it’s easier. In the hospital emergency room the traumatic situation persists because the patient’s relatives are still there”.

It should be noted that other participants in the study face the clinical event through psychological mechanisms such as denial and removal. Furthermore, in order to reduce the emotional burden, defusing a situation and using irony seem to be effective tools employed by emergency nurses, while others show that they let go of what they experienced through crying.

Nurse 2

“I remove emergency interventions from my mind. I hardly remember them. I do my duties, I live the situation in the moment and then I let go, but letting go is a rational response”.

Nurse 4

“I don’t filter those experiences, otherwise I can’t survive. It’s an automatic process, it’s like an emotional self-defence”.

Nurse 12

“The strategy that we all put into practice, in my opinion everyone does it, is playing down”.

Nurse 3

“I immediately cried, I cried, I cried my eyes out”.

Another category of participants seems to find in games, sports or recreational activities a valid answer to face the need to decompress the emotions related to their work.

Nurse 12

“I don’t know, I manage quite well stress and anger doing sport...”.

Nurse 14

“Do you know how decompress my emotions? I run”.

Nurse 8

“I noticed that maybe being in contact with nature, animals, helps me a lot”.

### 4.3 Peer support

The answer to the question that aimed at investigating the possible benefits of relating to one another using peer-support shows that more than half of the interviewed nurses find relief in talking with their colleagues after a particularly stressful emergency intervention. In addition, talking with colleagues after the day shift seems a well-established practice that maintains group cohesion through sharing what happened during shift work, as suggested by the comments reported below:

Nurse 5

“Once the emergency intervention is over, we are back... yes, perhaps we are fortunate that when an intervention ends, we find ourselves together and we talk about it among ourselves. You start telling each other about your feelings a bit”.

Nurse 11

“At the end of the day we take coffee together in the kitchenette and we process it, we talk about the most complicated situation ... and there it is ... a nice emotional outlet, a nice moment of growth, sharing...”.

Nurse 6

“Well, I did this job thanks to my colleagues, who listened to me relating the events that happened”.

A high number of the interviewed nurses considered as a positive solution the possible integration within the group of a peer supporter, as a tool that could facilitate the expression of what nurses felt during an emergency intervention perceived as traumatic. The main motivation for having a peer supporter is the feeling of certainly being understood, compared to the possibility of simply opening up with a different professional therapist.

Nurse 1

“Therefore, talking to a person who has the same skills, abilities and knowledge you have would probably be more meaningful”.

Nurse 2

“We speak the same language, we felt the same emotions and then maybe we also related to each other from a technical point of view, but the technical as-

pects about your job come later. Listening is essential and yes dialogue is too”.

Nurse 12

“I have in front of me someone who understand perfectly what I’m saying. 90% of the time he went through the same, more or less...”.

Some nurses have declared that they would prefer to consider the inclusion of a psychologist with respect to peer-supporters, without dismissing how useful and beneficial the presence of peer-supporters could guarantee. This idea put forward by this group of interviewees stems from the possibility of choosing whom to contact and from knowing that there would be adequate training at the base of group discussions among colleagues. The reasons for this are: fear of being judged, possible distortion of reality, lack of respect for one’s privacy, fear of overwhelming colleagues and fear of having someone new, such as the peer supporter, in their team. This is evident from the following comments:

Nurse 5

“The psychologist is someone you trust, your colleague, you know, you need to go and look for him”.

Nurse 13

“Why does someone do this? And why doesn’t he do that? How much does he earn do this job? This is how tensions are generated”.

Nurse 12

“In front of an external figure, most likely someone feels more free to open up. [...] I mean we all may-be talk to someone you know you can talk to ... and avoid other people you are certain would refer your personal matters to others ... or that make a mountain out of a molehill”.

Nurse 14

“... surely it can be useful to have an external person, but in this context, as I said before, we are not prepared, a professional figure of this type could be seen as something foreign to the ambulance service 118”.

The main results of the study are summarized in table 1.

## 5. Conclusions

The totality of the participants identifies as a factor of high stress, as well as the most feared event, the emergency management of paediatric patients, in particular when they are traumatized. This is evident not only from the fact that the paediatric emergency is the event most frequently talked about, but also from the fear associated to the idea that such an event could happen. Furthermore, suicide is mentioned by some nurses as emotionally critical especially in the event this might involve acquaintances or adolescents. It was found that direct contact with these events can often trigger feelings of helplessness, fear and despair in the emergency nurses.

Since paediatric and suicide events cause serious repercussions on nurses’ emotional state, there is a strong need to pay particular attention to those nurses who carry out these types of emergency interventions, even more so if they have been working in this setting for a short period of time, in order to facilitate emotional decompression as quickly as possible and minimize any undesirable consequences. In fact, some participants admit that their work often also influences their personal sphere, both short and long term. During the interviews, precise details regarding some environmental features of the scene of an accident emerged (eg: smells, sunset, flashing lights, noises and objects on the scene) and some characteristics of the scene (where the victims’ parents / relatives were and some words they said). These details are significant as they reveal how profound the emotional impact can be.

The most common self-care strategies employed to cope with emotional stress appears to be conversing with colleagues who were at the scene of the accident present or on the same shift. This fact confirms what has been written in the literature, regarding the importance for nurses to perceive and actually receive support from their colleagues (12). Other employed and mentioned strategies during the interviews are emotional detachment on the verge of cynicism, removal, denial, physical activity, wanting to be close to a loved one, limiting contacts with the victim, playing down. Some participants mentioned crying as a way to cope with emotion and let them out. It emerged that these adopted strategies are sufficient to overcome the event

**Table 1.** Results divided into subcategories

<b>High emotional impact healthcare services</b>	Paediatric trauma Suicide
<b>Time when the reported event occurred</b>	Half of the interviewed nurses report some highly intense emotional experience soon after the beginning of their working experience at the emergency ambulance service 118. The majority of them had such an experience in the first two years of their career
<b>Main experienced emotions</b>	Helplessness Fear Disperation
<b>Repercussions on nurses' personal life</b>	Short term Long term
<b>Employed coping strategies</b>	Talking to a colleague about a clinical intervention perceived as traumatic, emotional detachment almost to the point of cynicism, physical activity, playing down, removal, denial, limiting any contact with the victim and the victim's relatives, crying, wanting to be close to a loved one
<b>Personal opinions regarding the presence of peer-supporters compared to the presence of a psychologist at the ambulance station 118</b>	The majority of nurses is in favour of peer-supporters. The motivation is based on the fact that they recognise the peer-support as someone that can understand what nurses really mean when relating a traumatic event, being one of their colleagues
<b>Nurses' Perceived obstacles</b>	A minority of nurses does not exclude the effectiveness and the value of a peer-supporter, however the perceived obstacles are: fear of being judged, possible distortion of reality, lack of respect for one's privacy, fear of overwhelming colleagues and fear of having someone new, such as the peer supporter, in their team

at first, but often do not help in complete emotional processing.

The idea of a peer supporter was introduced and it was clearly explained to nurses that the person would be precisely a "peer" who, following a specific training in psychological first aid, is willing to listen to colleagues who identify the need to talk about an emotionally complex event in order to facilitate the elaboration of the emotion related to the experience. When interviewees were asked what their opinion was regarding the presence at the ambulance station of a peer-supporter, the majority of nurses were in favour. The main motivation behind this high consensus appears to be the fact that the peer-supporter is

by definition a peer, therefore a person able to fully understand the type of experience related by nurses, thus identify oneself with it. A minority of the participants, although they do not exclude the usefulness and validity of a peer-supporter, report some perceived obstacles, such as fear of being judged, possible distorted of reality of an intense personal experience, no respect for privacy, fear of overwhelming one's peers, fear of a new person within the group and the need to work on the group in preparation for the inclusion of this new person.

At the end of the study it can be stated that emergency nurses working at the ambulance service 118, due to the critical nature of the interventions they

carry out, at times experience emotions capable of affecting their emotional well-being and in some cases they struggle to cope with these adverse work events. These types of events occurred during their work and personal life experiences can become dangerously intertwined in identification dynamics that increase the psychological burden of an event, with repercussions on contexts other than work related, even in the medium and long term. The results emerged underline that, in order to prioritise prevention, the peer-supporting model, viewed as a non-judgmental interview with a suitably trained colleague, could prove to be a valuable aid to be activated especially in specific situations deemed to have a high emotional impact, such as the management paediatric patients or suicide.

### Limitations

Limitations are due to the small sample size.

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**Conflict of interest:** Each author declares that he or she has no commercial associations (e.g. consultancies, stock ownership, equity interest, patent/licensing arrangement etc.) that might pose a conflict of interest in connection with the submitted article

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