strengthen workforce stability and support safe clinical practice.

Keywords: workforce; psychological burnout; mentors; job satisfaction; nurses

Improving the Banning of Patients from Halifax Mobile Outreach Street Health

J. MacDonald, B. Marval

Background and Objectives: Halifax Mobile Outreach Street Health (MOSH) aims to bring quality, low-barrier care to people who struggle to access care through conventional means. However, MOSH confronts instances where the behaviour of these vulnerable patients may jeopardize the safety of staff, property, or other patients. In addressing these instances, MOSH must occasionally limit a patient's access to care via temporary suspensions or bans. They currently lack robust, formalized policies to inform these difficult decisions. This paper seeks to address this gap by exploring the current street health landscape and providing tangible opportunities for improving MOSH's banning practices.

Methods: This paper, via an environmental scan, explored the interventions, protocols, communication, and research practices being utilized by five equity-based organizations across Canada, with similar missions to MOSH. These five institutions, namely CoolAid, Ottawa Inner City Street Health, The Alex, Sanguen Health, and The HUB, were interviewed using a pre-set questionnaire. It equally explored the relevant literature pertaining to MOSH's primary issue, via a literature review. Findings from these two search avenues were then compiled and analyzed according to their potential risks/benefits as well as certain considerations regarding their implementation.

Results: Results of the environmental scan highlighted strategies to minimize agitation, approaches to banning and reintegration, communication, and research. This, coupled with the results of the literature review, yielded 13 strategies or areas of potential improvement for MOSH to consider. These included: behavioural contracts, optimization of clinic spaces, patient-centred staffing, incentivization of care, a client navigation system, increased appointment times, formalized de-escalation protocols, interactive clinic spaces, violent incident forms, comprehensive intervention programs, disruptive behaviour committees, communication protocols, and banning protocols.

Discussion: The results highlighted several opportunities, that could be grouped into three main categories: implementing collegially-informed practices, optimizing clinic spaces to improve patient experiences, and formalizing previously unformalized protocols. These avenues focused not only on the formalization of protocols, but also on finding ways to minimizing the factors contributing to ban-worthy instances. Addressing any of these themes, or the potential strategies pertaining to them, requires an expertise that only MOSH can provide. The analytic summary of this paper's findings may act as a resource for MOSH to utilize at their discretion.

Conclusions: Banning clients at MOSH limits an already marginalized patient's access to healthcare. The findings of this paper will hopefully provide opportunity and guidance in addressing this concern. This will aide MOSH in further achieving the equity-based based goals of their initiative.

Keywords: ban; street health; improving

Experiences and Correlates of Adverse and Traumatic Events in Pediatric Perioperative Providers

J. Gowie, E. Nielsen, M. Kiberd, S. Bird

Background and Objectives: There is growing evidence of the prevalence of secondary traumatic stress (STS) and its negative impacts on healthcare workers (HCWs). Physicians can also be affected by adverse, or unintended, events (AEs), referred to as second victims of medical error. This interdisciplinary study evaluates the experiences and correlates of AEs and STS across pediatric perioperative personnel and identifies support preferences.

Methods: A cross-sectional survey was administered to pediatric perioperative HCWs. STS was quantified using the Professional Quality of Life measure. The Second Victim Experience Support Tool – Revised identified dimensions of impact following AEs and preferences for support.

Results: The 74 respondents represented anesthesia, surgery, and nursing disciplines (n=21,17,36) with a mean (SD) age and years of experiences of 43 (±11) and 18.6 (±11). 75% identified as female. Of participants, 97.3% reported experiencing at least one AE and 91.9% had experienced one traumatic event. STS over the past month was characterized as low by 52.6% and moderate by the remaining 48.4%. Women had a higher likelihood of experiencing moderate STS, ($\chi^2(1)=7.21$, $p=0.007$) with no differences between disciplines. The probability of experiencing moderate STS decreased with age (OR=0.92, p=0.07) and years of experience (OR=0.94, p=0.027). The most strongly desired support was respected peer-based discussions, 4.52 (±0.65).

Discussion: Experiences of adverse and traumatic events were common. As nearly half of HCWs reported moderate STS, regardless of position, interdisciplinary discourse and action is recommended.

Conclusions: This study reinforces the importance of peer-based discussion for support and the protective nature of prior clinical experience.

Keywords: secondary traumatic stress