

Second Victim Case Studies

Case #1

Event:

A 64 year old diabetic was admitted with sudden onset of left sided weakness. Initial head CT scan was negative. The patient was admitted for observation. The RN noted increased drowsiness approximately 5 hours post admission. The resident physician was contacted but she was busy in the ER and was not available to re-assess the patient. An order was given to repeat the head CT scan. Repeat CT scan remained negative. 15 minutes later, the resident physician found the patient unresponsive. The Rapid Response Team was activated. HR-86 BP 158/86. Patient transferred to ICU when the serum glucose was noted to be 25. The patient's condition stabilized but uncertain about permanent harm.

Case #2

Event:

A 45 year old male visitor collapsed in the main lobby of your hospital after visiting his hospitalized father in the ICU. He was transferred to the ER for assessment and diagnosed with acute MI. The patient was admitted to the ICU in critical, but stable condition. On hospital day # 3, the patient stated, "something is not right today..." The pulmonary critical care fellow re-enforced that everything was looking good and that he would more than likely be moved to a floor bed later that day. The primary nurse also offered reassurance. Approximately 35 minutes after these discussions, the monitor alarmed with v-fib. A Code Blue was promptly called. After 60 minutes the patient was pronounced dead. The patient's wife, two children (8 & 5), mother, and hospitalized father were all present when the code was initiated.

Case #3

Event:

A 12 year old, involved in a motor vehicle accident, was en route to your ER. The ambulance arrives with security present to assist with unloading. Upon arrival to the ER entrance, the patient went into cardiac arrest with chest compressions initiated by paramedics. The mother, a well-known attending physician in the Family Medicine Department, was present when the ambulance arrived. Members of the security team and receptionists assist the mother and numerous other family members present. The hospital's trauma team was present with aggressive resuscitation attempts initiated. However, attempts were unsuccessful and the patient was pronounced dead 75 minutes after arrival.

Case Study Questions

Questions for peer supporter:

List potential staff member(s) that could potentially be a second victim.

What type of interventional support is indicated? (individual or team)

When would you have the conversation?

Any special considerations for case?