# The Second Victim Phenomenon

16TH ANNUAL RESEARCH DAY CONFERENCE – CARE FOR OUR OWN: INTEGRATING RESEARCH INTO NURSING PRACTICE

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# Continuing Education Disclosure

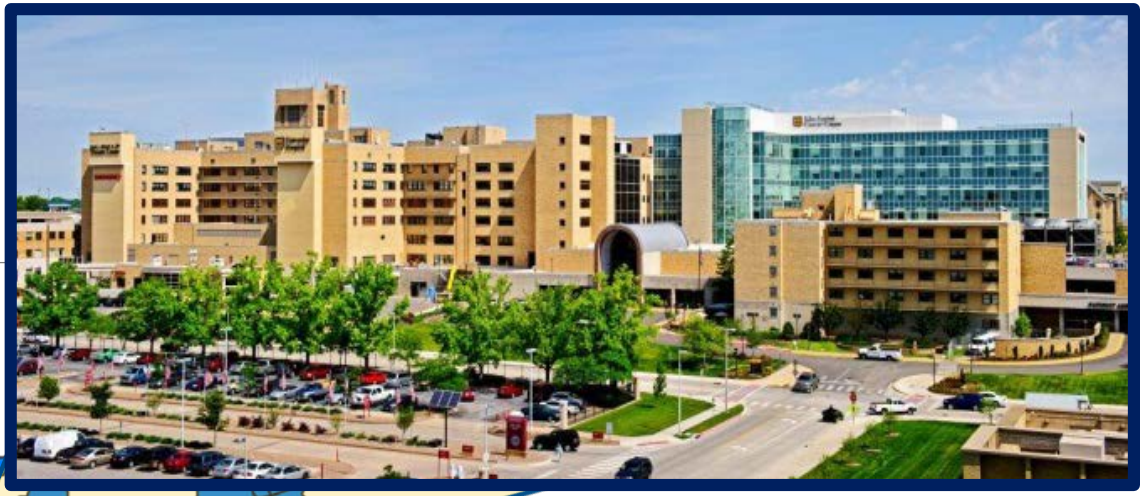
There are no financial disclosures.

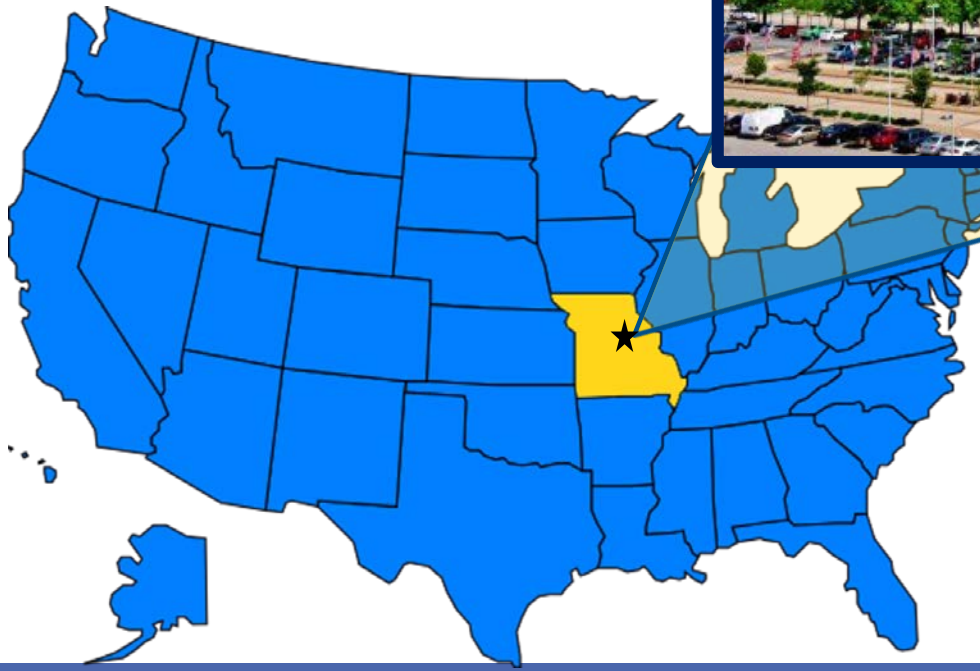
# Today's Objectives

1. Discuss the second victim phenomenon.
2. Describe the signs and symptoms of the second victim phenomenon.
3. Delineate the predictable recovery trajectory with three possible clinician outcomes.
4. Understand the impact of no support on suffering clinicians.
5. Describe current evidence relating to desired clinician support.
6. Describe the use of a nursing theoretical framework to guide interventional strategies.

# University of Missouri Health Care

## Columbia, Missouri





Academic Medical Center

Level One Trauma Center

Five hospitals - 600 beds with 25% having ICU capabilities

65 ambulatory care clinics

More than 6500 employees

# WARNING

| Rated E | Professional Rating |
| --- | --- |
| This content may contain Emotional Labor!!!!! | |

# An Epidemic?

44,000-98,000 deaths/year in U.S. due to preventable adverse events (Kohn et. al, 2000)

Revised estimates at least 210,000 (and possibly more like 400,000) die in U.S due to preventable harm (James, 2013)

With revised estimates: At least 4 clinicians/patient = 840,000 to 1.6 million clinicians impacted

Kohn, LT, Corrigan, JM, & Donaldson, MS. (2000). *To err is human: building a safer health system*. Washington, D.C.:National Academy of Sciences Press.

James, J.T. (2013). *A new, evidence-based estimate of patient harms associated with hospital care*. Journal of Patient Safety, 9(3), 122-128

“Medicine used to be simple, ineffective and relatively safe..... now it is complex, effective, and potentially dangerous."

Sir Cyril Chantler

Lancet 1999; 353:1178-91

# History of the PROBLEM

Adverse event reviews – individuals at the ‘sharp end’ noted to be experiencing ‘predictable’ behaviors post event

# Review of the Literature

## Medical error: the second victim

*The doctor who makes the mistake needs help too*

**Albert Wu, MD**

When I was a house officer another resident failed to identify the electrocardiographic signs of the pericardial tamponade that would rush the patient to the operating room late that night. The news spread rapidly, the case tried repeatedly before an incredulous jury of peers, who returned a summary judgment of incompetence. I was dismayed by the lack of sympathy and wondered secretly if I could

improvements that could decrease errors. Many errors are built into existing routines and devices, setting up the unwitting physician and patient for disaster. And, although patients are the first and obvious victims of medical mistakes, doctors are wounded by the same errors: they are the second victims.

Virtually every practitioner knows the sickening realisation of making a bad mistake. You feel singled

*"Virtually every practitioner knows the sickening realization of making a bad mistake. You feel singled out and exposed…..You agonize about what to do…… Later, the event replays itself over and over in your mind."*

images of illness have in fact created an expectation of perfection. Patients, who have an understandable need to consider their doctors infallible, have colluded with doctors to deny the existence of error. Hospitals react to

failure to do so earlier and, if you haven't told them, wondering if they know.[1–3]

Sadly, the kind of unconditional sympathy and support that are really needed are rarely forthcoming.

Wu, A. (2000). Medical error: the second victim. The doctor who makes the mistake needs help too. *British Medical Journal*, *320*, 726-727.


This event shook me to my core.”
“This has been a turning point in my career.”
“It just keeps replaying over and over in my mind.”
“I’ll never be the same.”
I’m going to check out my options as a Walmart greeter. I can’t mess that up.”

# Second Victim Steering Team

Project Leads – Patient Safety and Risk Management

Team Members

- Case Manager
- Chaplain
- Chief Medical Officer
- Clinical Educator
- EAP
- Employee Wellness
- Health Psychologist
- House Manager/Supervisor
- Nursing Department Managers
- Quality Improvement Specialist
- Researcher - Nursing
- Respiratory Care Manager
- Social Service
- Staff Nurses

# Innovation Team's Objectives

Minimize the human toll when unanticipated adverse events occur.

Provide a 'safe zone' for faculty and staff to receive support to mitigate the impact of an adverse event.

Develop an internal rapid response infrastructure of 'emotional first aid' for clinicians and personnel following an adverse event.

# Second Victims Defined…

*"Healthcare team members involved in an unanticipated patient event, a medical error and/or a patient related injury and become victimized in the sense that they are traumatized by the event."*

Scott, S. D., Hirschinger, L. E., Cox, K. R., McCoig, M. M., Brandt, J., & Hall, L. W. (2009). The natural history of recovery for the healthcare provider second victim after adverse patient events. Journal of Quality and Safety in Health Care, 18, 325-330.

# What is a Second Victim?

A Qualitative Research Project is Initiated……

# Qualitative Research Overview

Participants = 31

Females 58%

Average Years of Experience
- MD 7.7
- RN 15.3
- Other 17.7

Average Time Since Event = 14 months
- Range – 4 weeks to 44 months

Scott, S. D., Hirschinger, L. E., Cox, K. R., McCoig, M. M., Brandt, J., & Hall, L. W. (2009). The natural history of recovery for the healthcare provider second victim after adverse patient events. Journal of Quality and Safety in Health Care, 18, 325-330.

# Commonly Reported Symptoms

- Extreme Fatigue
- Sleep Disturbances
- Rapid Heart Rate
- Increased Blood Pressure
- Muscle Tension
- Rapid Breathing
- Frustration
- Decreased Job Satisfaction
- Difficulty Concentrating
- Flashbacks
- Loss of Confidence
- Grief / Remorse



# Staff Tend To ‘Worry’…

- **Patient**
  - Is the patient/family okay?
- **Me**
  - Will I be fired?
  - Will I be sued?
  - Will I lose my license?
- **Peers**
  - What will my colleagues think?
  - Will I ever be trusted again?
- **Next Steps**
  - What happens next?

# High Risk Scenarios

Patient ‘connects’ staff member to family

Pediatric cases

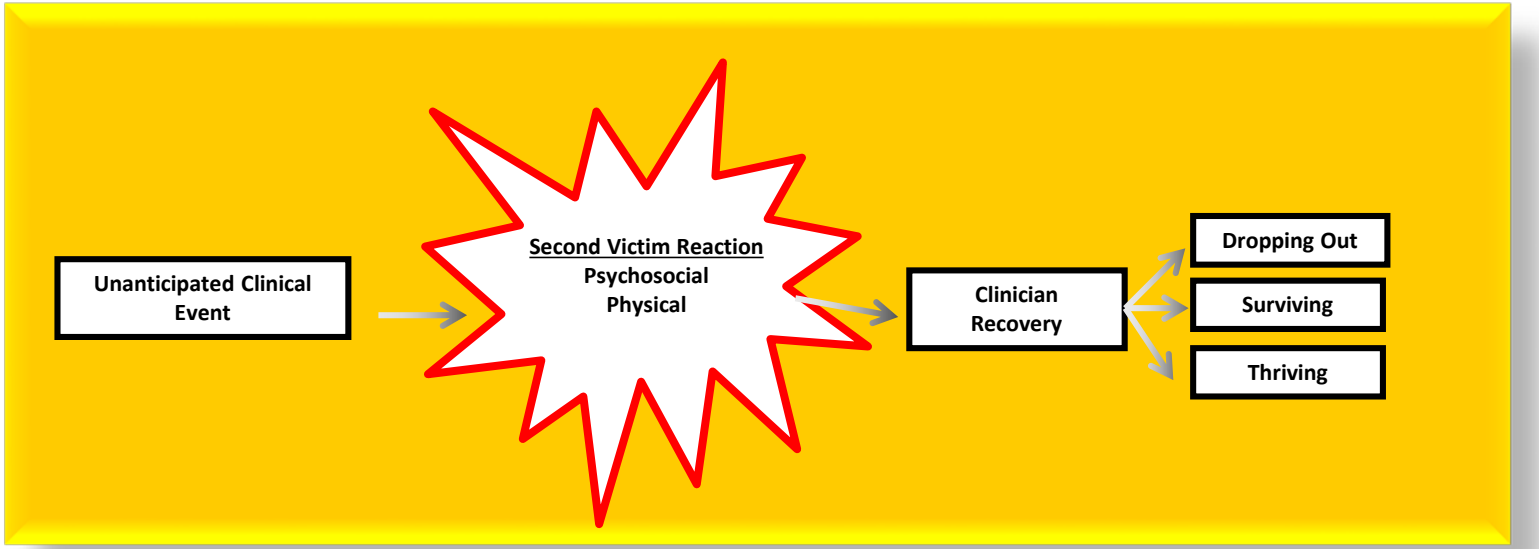
Medical errors

Failure to rescue cases

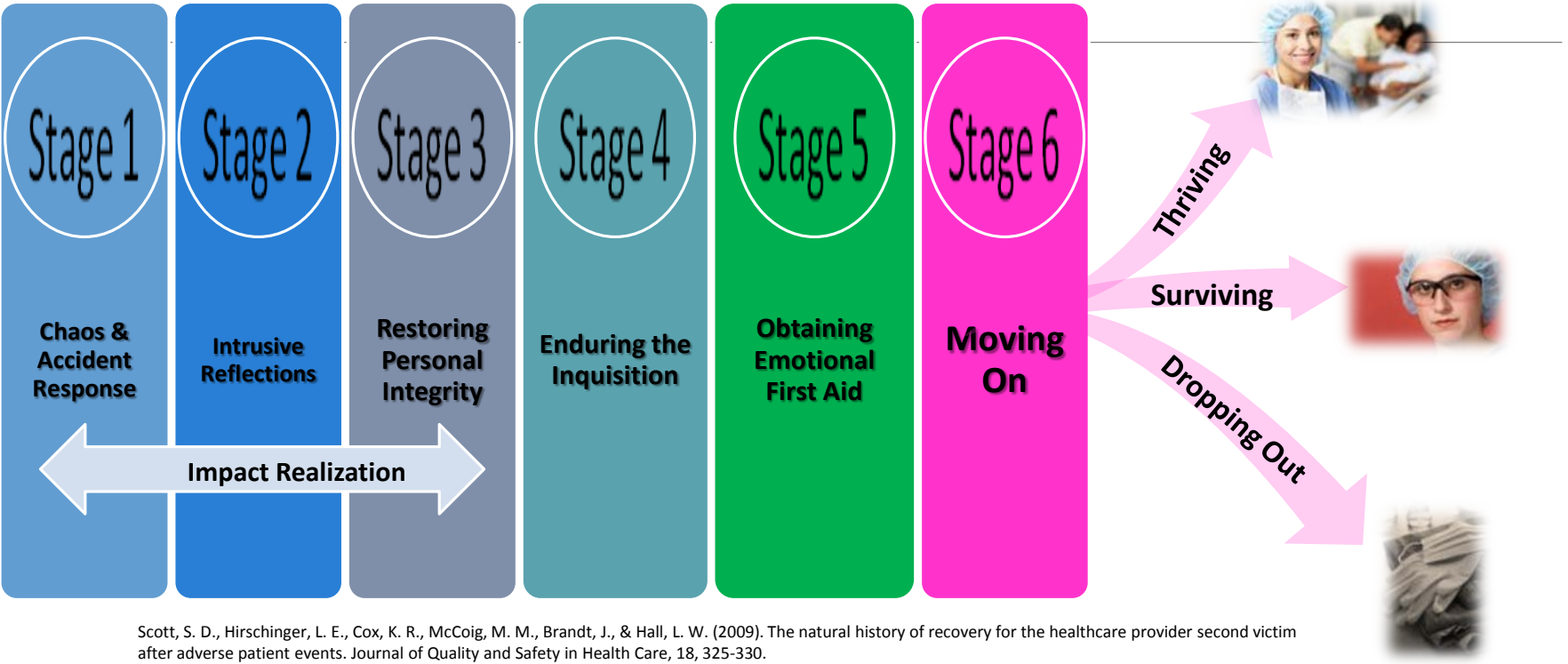
First death experience

Unexpected patient demise

# Second Victim Conceptual Model



# Stages of Healing: Recovery Trajectory

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*“ I will never forget this experience……This patient will always be with me – I think about her often…… Because of this, I am a better clinician! ”*

# The forYOU Team is Formed

Integrates research findings

Peer to peer support model

Two Types of Supportive Intervention

- One-On-One
- Group Debriefings

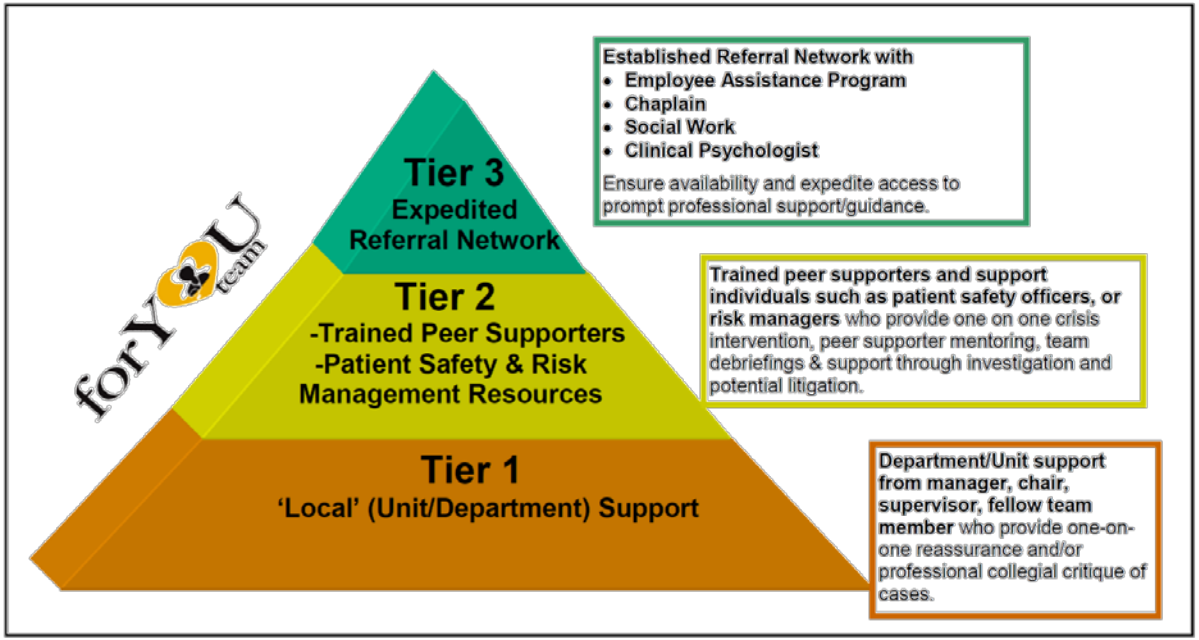
Referral systems coordinated and expedited

# The New Patient Safety Paradigm

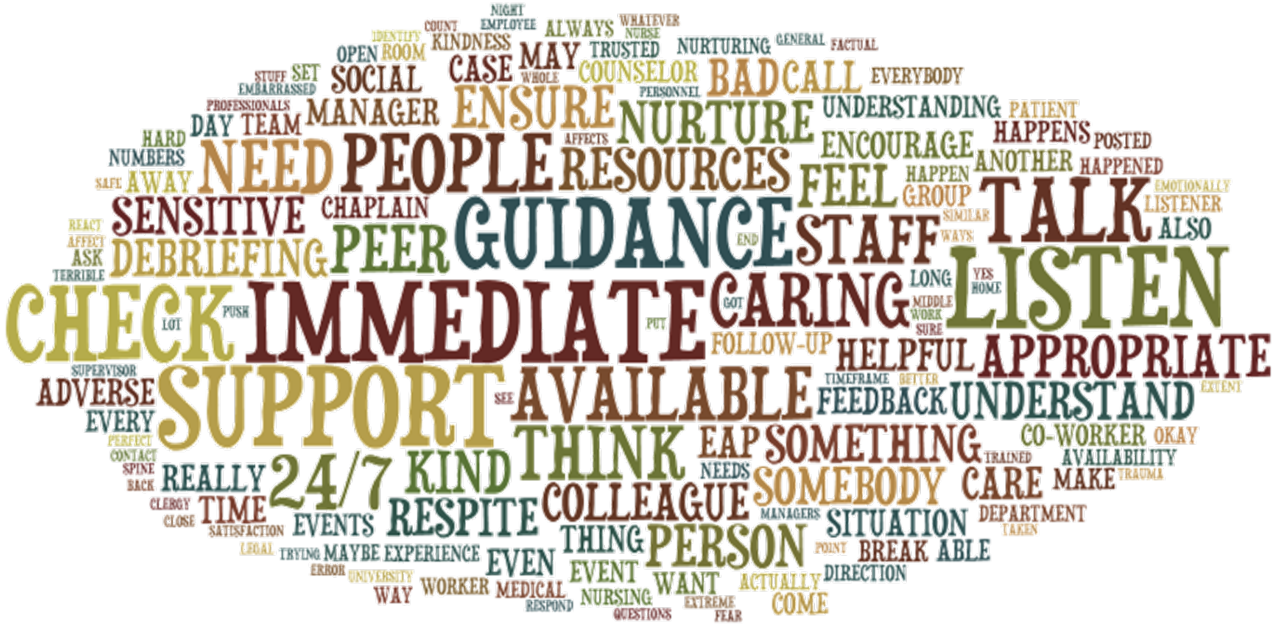
- Open discussions of event response plans
- Active identification of second victims
- Immediate interventional support
- ‘Safe Zones’ for sharing concerns/feelings
- Pre-education of event review process and reference guide

# Support Strategies

**The Scott Three-Tiered Interventional Model of Second Victim Support**



# What Second Victims Desire…



# Second Victim Insights

## Second victims want to feel...

- Appreciated Valued
- Respected Understood

- Last but not least….Remain a trusted member of the team!

# Types of Support Models

- Peer Support Teams
- Individuals Providing Primary Support – Risk Manager, Patient Safety, Various Administrators & Medical Leaders
- EAP referrals
- Individual Unit or Local Managers
- Employee Health or Wellness Centers

# Benefits of a Clinician Support Network

- Staff have a way to **get their needs met** after going through a traumatic event
- Helps reduce **the harmful effects of** work-related stress
- **Provides some normalization** and may help an individual with getting back to their routine after a traumatic event
- **Promotes the continuation of productive careers** while building healthy stress management behaviors

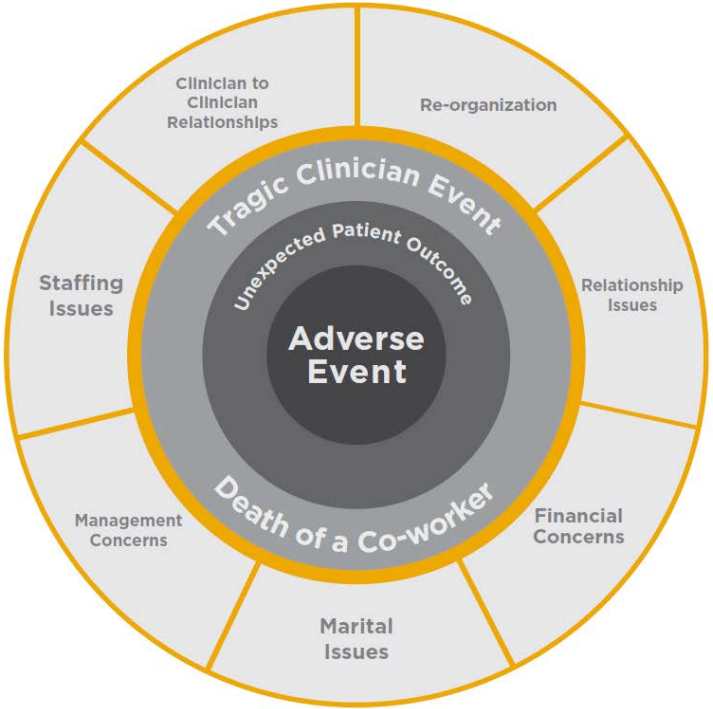
# Challenges to Providing Support

- Stigma to reaching out for help
- High acuity areas have little time to integrate what has happened
- Intense fear of the unknown
- Fear a compromise of collegial relationships because of event
- Fear of future legal woes - HIPAA, confidentiality implications

# Lessons Learned
# Nine Years of Support…….

04/01/2009 to 3/31/2018

# Scope of Service…..Limitations



# Basic Support Strategies

- Be a good listener!
- Do not try to fix it…
- Provide emotional first aid
- Let them know you care…
- Avoid second-guessing performance

forYOU team

# forYOU Team Activations

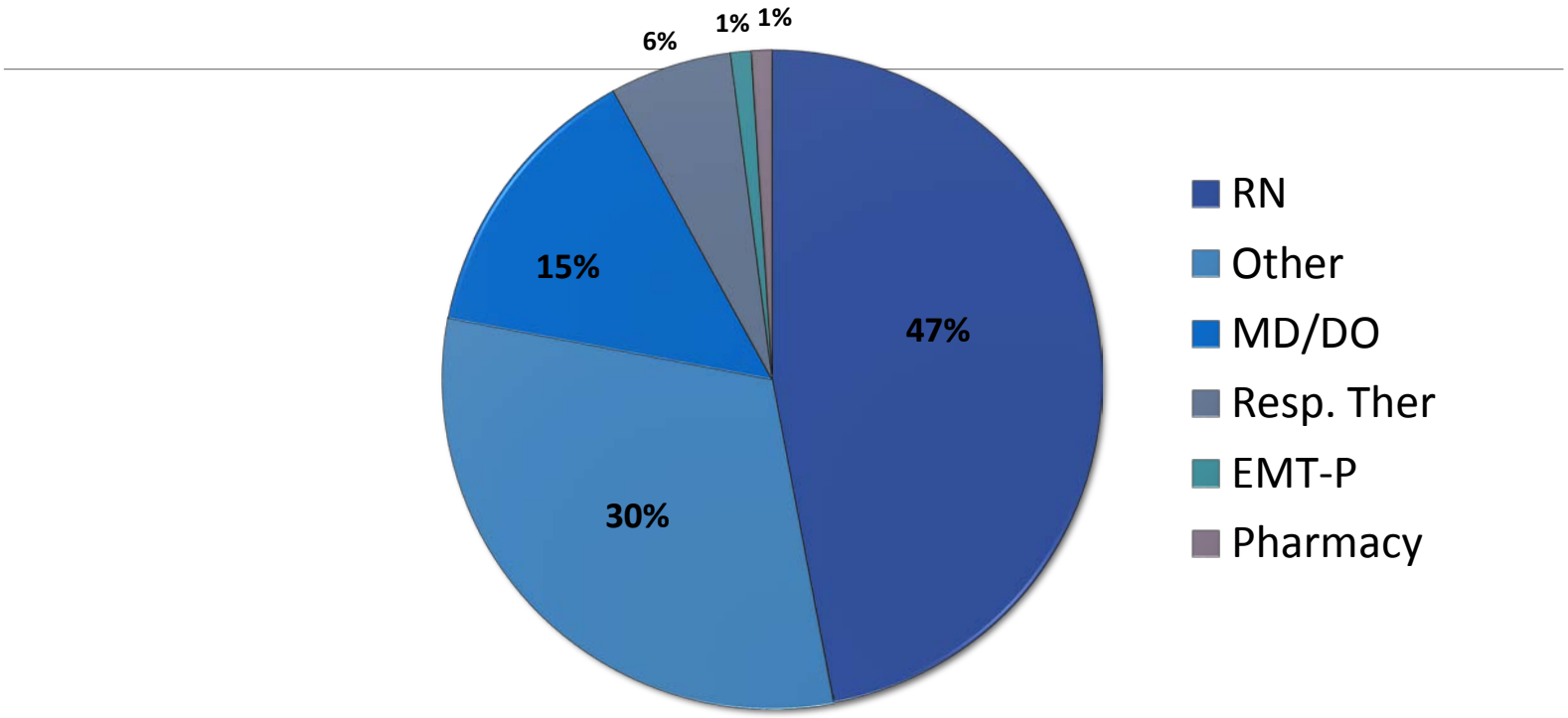
## 04/01/2009 – 3/31/18

**One on One Encounters = 606**

**Group Briefings = 133** (n=1082)

**Leadership Mentoring = 64**

# Professional Type Supported



# Reasons for Activations

Unexpected Patient Outcomes- 51%

Tragic Clinician Event - 35%

(Staff related 'personal' crisis)

- ***Death of a staff member/family member***
- ***Serious illness of staff member***
- ***Litigation Stress***

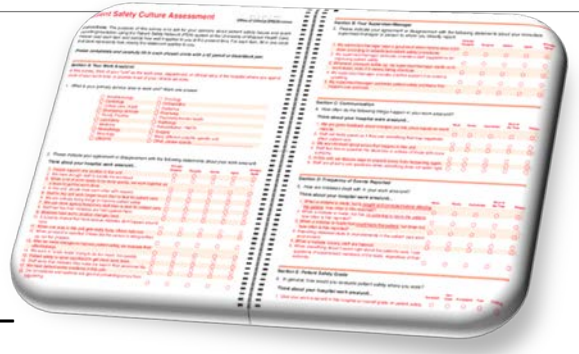
Medical Errors- 14%

# Does Support Really Matter??????

Is there a difference in patient safety perceptions among clinicians exposed and not exposed to a second victim experience?

# Safety Culture Survey

**Agency for Health Care Research and Quality (AHRQ)**
**www.ahrq.gov**



**2 Questions –**

1) **Within the past year, did a patient safety event cause you to experience anxiety, depression, or wondering if you were able to continue to do your job?"**
2) **Did you receive support from anyone within our health care system?**

3 populations:
1) Non second victim
2) Second victim with support
3) Second victim without support

# Patient Safety Culture Survey

| Dimension | Safety Dimensions |
|---|---|
| 1 | Teamwork within units |
| 2 | Supervisor/Manager Expectations & Actions Promoting Patient Safety |
| 3 | Management Support for Patient Safety |
| 4 | Organizational Learning - Continuous Improvement |
| 5 | Overall Perceptions of Patient Safety |
| 6 | Feedback & Communication About Error |
| 7 | Frequency of Events Reported |
| 8 | Communication Openness |
| 9 | Teamwork Across Units |
| 10 | Staffing |
| 11 | Handoffs & Transitions |
| 12 | Nonpunitive Response to Errors |
| 13 Overall safety grade | *'Give your work area/unit an overall grade on patient safety.'* |

Scott, S.D. (2015). Second victim support: Implications for patient safety attitudes and perceptions. *Patient Safety & Quality Healthcare.* 12(5), 26-31.

# Results

## Culture Survey Dimension Second Victim Category

| Dimension | Dimension Title | Mean Scores | | |
|---|---|---|---|---|
| | | Second Victim Support YES | Second Victim Support NO | Non-Second Victim |
| 1 | Teamwork within units | 4.14 | 3.42 | 4.01 |
| 2 | Supervisor/Manager Expectations & Actions Promoting Patient Safety | 3.93 | 3.07 | 3.87 |
| 3 | Management Support for Patient Safety | 3.67 | 2.82 | 3.61 |
| 4 | Organizational Learning - Continuous Improvement | 3.84 | 3.10 | 3.73 |
| 5 | Overall Perceptions of Patient Safety | 3.53 | 2.71 | 3.62 |
| 6 | Feedback & Communication About Error | 3.50 | 2.85 | 3.61 |
| 7 | Frequency of Events Reported | 3.26 | 2.87 | 3.53 |
| 8 | Communication Openness | 3.73 | 2.98 | 3.67 |
| 9 | Teamwork Across Units | 3.31 | 2.72 | 3.36 |
| 10 | Staffing | 3.28 | 2.61 | 3.38 |
| 11 | Handoffs & Transitions | 3.01 | 2.61 | 3.14 |
| 12 | Nonpunitive Response to Errors | 3.33 | 2.43 | 3.17 |
| Overall Safety Grade | 'Give your work area/unit an overall grade on patient safety.' | 3.58 | 3.01 | 2.94 |

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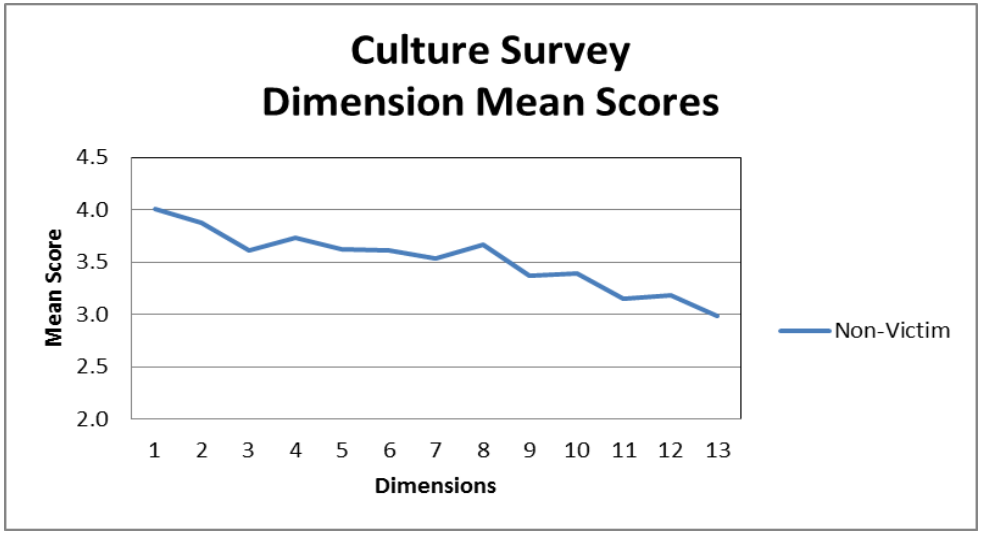


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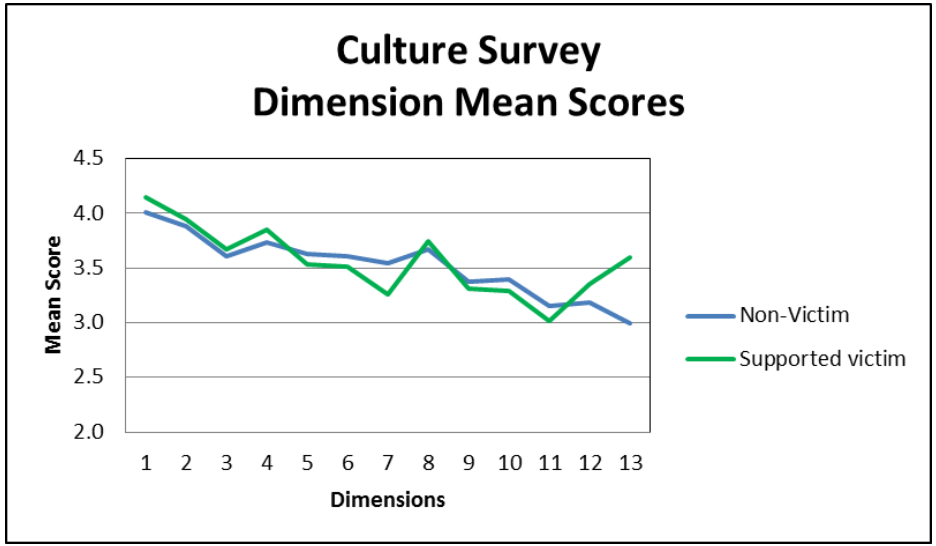


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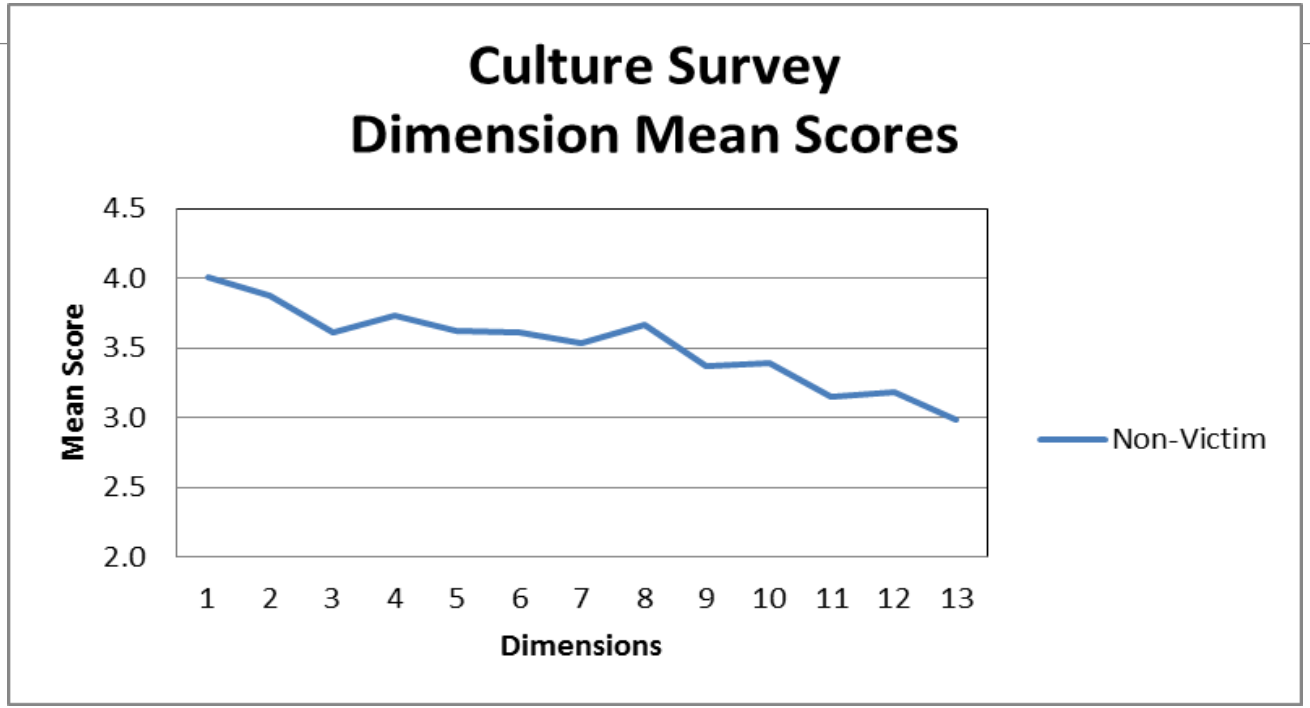


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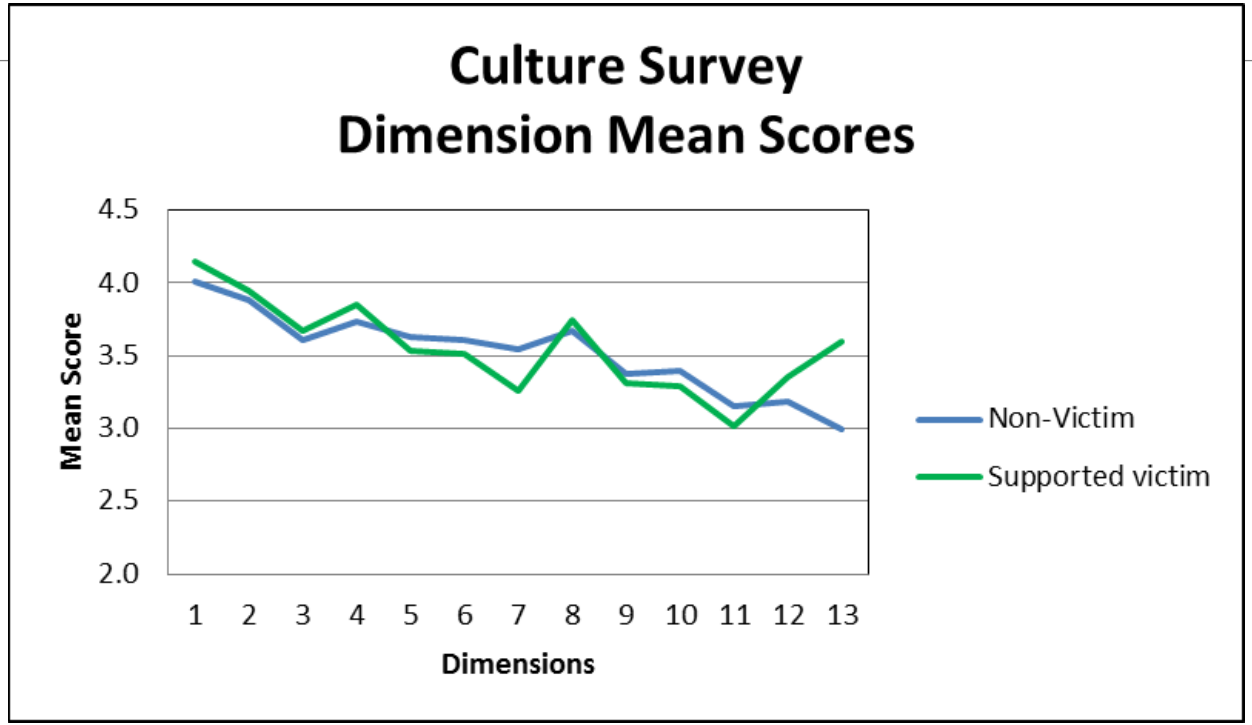


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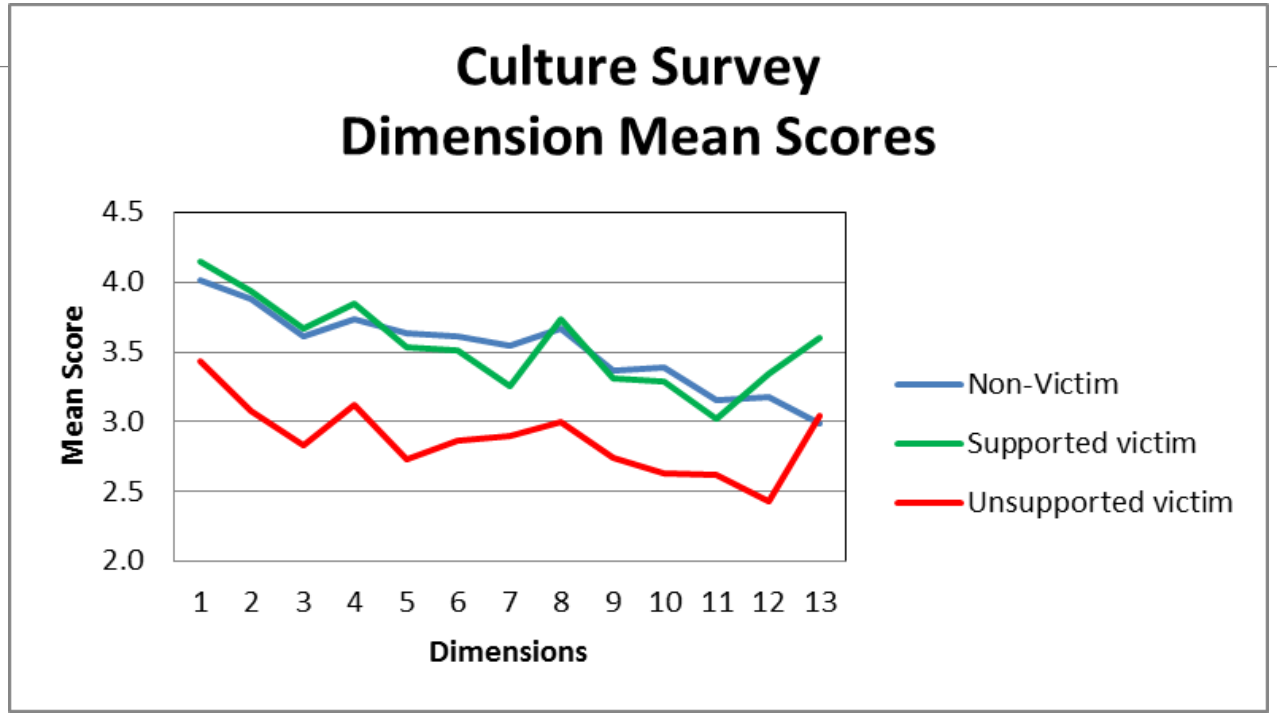


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# Implications

Impact of the second victim experience and the provision of support (or lack thereof) on the individual clinician seems to extend beyond that of the individual clinician into the immediate working environment.

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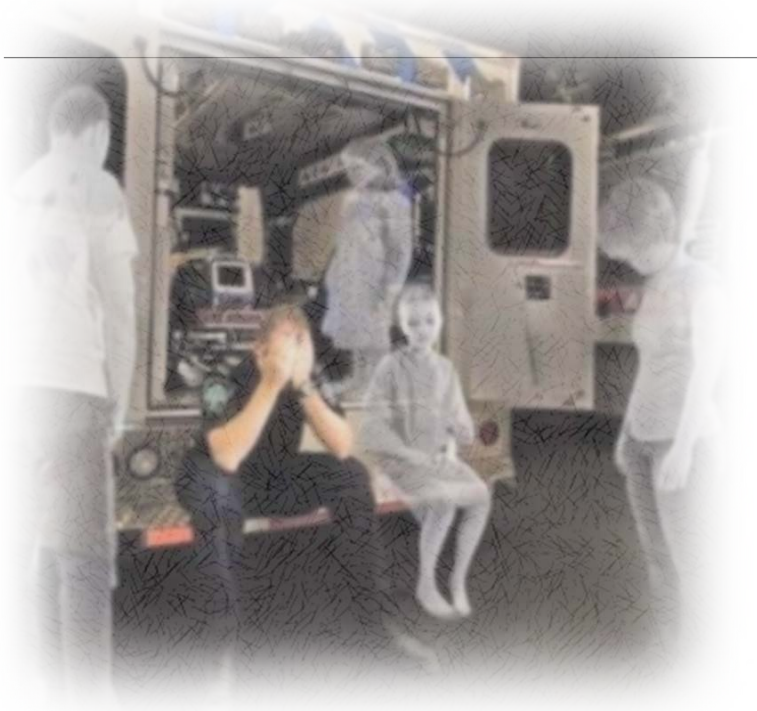
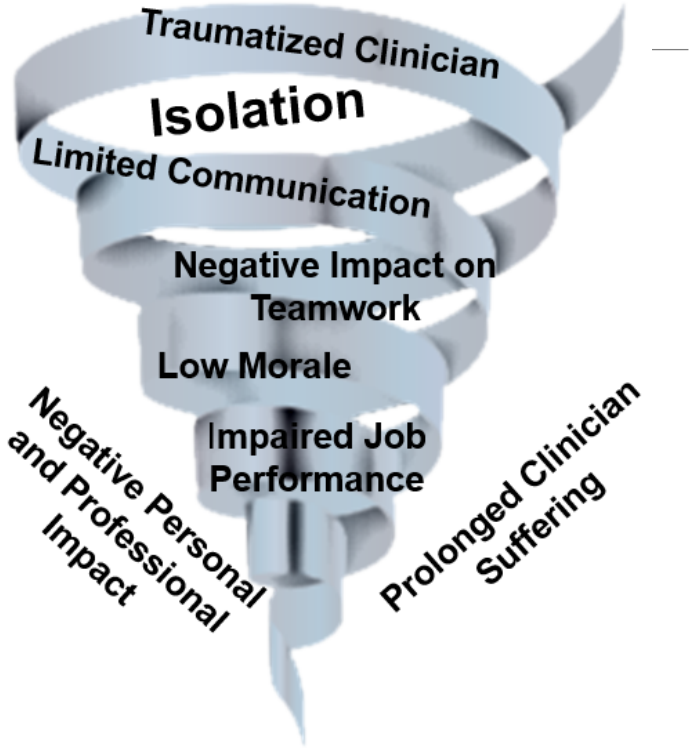
# The Aftermath of No Support





# A Point to Ponder…..


Wu, A.W., Shapiro, J., Reema, H., Scott, S.D., Connors, C., Kenney, L. and Vanhaecht, K. (2017). The impact of adverse events on clinicians: What's in a name? *Journal of Patient Safety*. DOI: 10.1097/PTS.0000000000000256.

# What Can You Do Differently Tomorrow?

Understand the concept of Second Victims

Talk about the Second Victim concept and spread the word– Awareness is the first intervention!

Determine a way that you can make an individual difference.

If you are worried about a colleague >>> Reach Out!

‘Be there’!

# Questions…

***"The longer we dwell on our misfortunes, the greater is their power to harm us."*** ***V*oltaire**

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# References


James, J.T. (2013). A new, evidence-based estimate of patient harms associated with hospital care. *Journal of Patient Safety, 9(3), 122-128.*

Kohn, LT, Corrigan, JM, & Donaldson, MS. (2000). *To err is human: building a safer health system.* Washington, D.C.:National Academy of Sciences Press.

Scott, SD. Second victim support: Implications for patient safety attitudes and perceptions. *Patient Safety & Quality Healthcare*. 2015. 12(5),26-31.

Scott SD, Hirschinger LE, Cox KR, McCoig M, Brandt J, Hall LW. The natural history of recovery for the healthcare provider "second victim" after adverse patient events. *Qual Saf Health Care*. 2009 Oct;18(5):325-30.

Scott SD, Hirschinger LE, Cox KR, McCoig M, Hahn-Cover K, Epperly KM, et al. Caring for our own: deploying a system-wide second victim rapid response team. *Jt Comm J Qual Patient Saf*. 2010 May;36(5):233-40.

Wu, AW. Medical error: The second victim. The doctor who makes the mistake needs help too. *BMJ*. 2000 Mar 18;320(7237):726-7.

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