Health Care

The Second Victim Experience: Train-the-Trainer Workshop

Lessons Learned from 8 Years of Clinician Support

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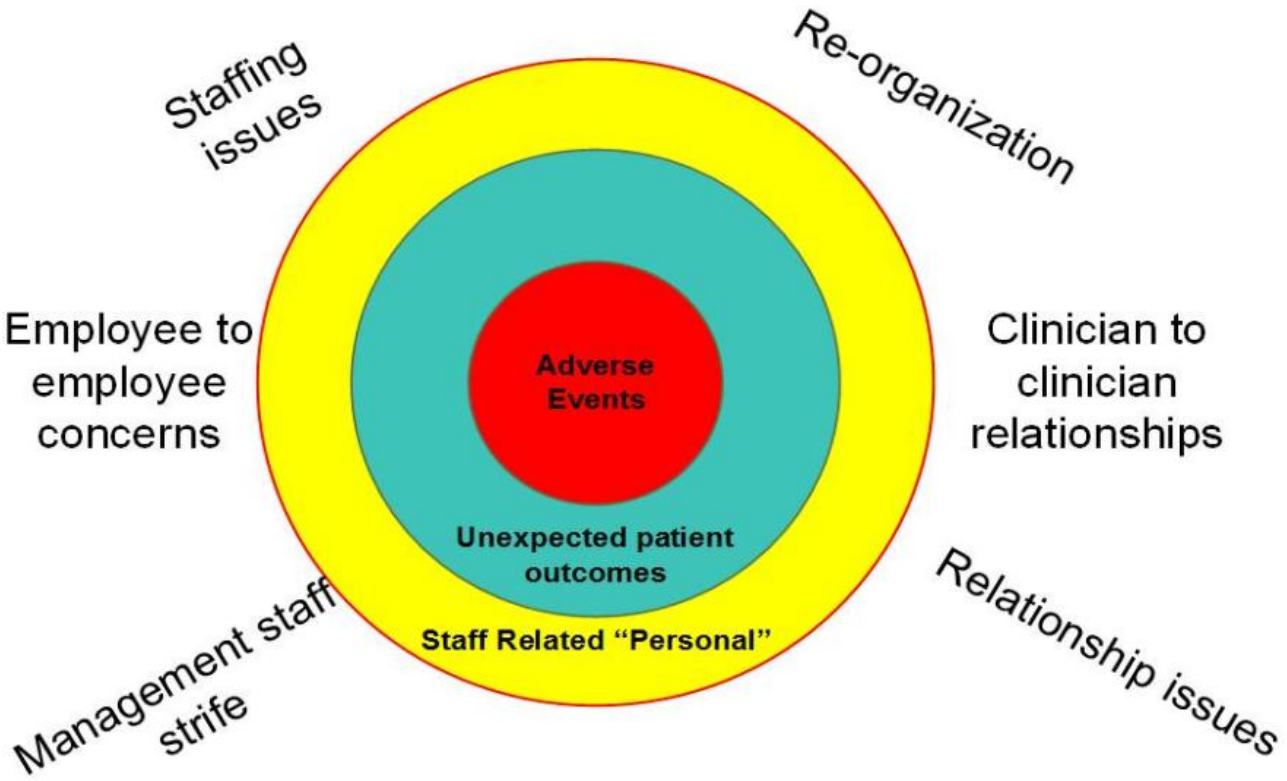
Scope of Services



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INTERACTIONS

Peer Supporter:

Activation: ☐ New ☐ Mentoring (No direct support provided) **Length of Interaction:**

Professional Type: ☐ MD/DO ☐ RN/LPN ☐ Respiratory Therapy ☐ Pharmacist ☐ EMT-P/EMT ☐ Other

Event Type: ☐ Unanticipated Patient Outcome ☐ Adverse Event (Medical Error) ☐ Personal/Professional Crisis ☐ Other

Event Outcome		Risk Factors			
☐	No Harm	☐	Community high profile	☐	Palliative Care
☐	Temporary Harm	☐	Death of a staff member or their spouse	☐	Patient known to staff members
☐	Permanent Harm	☐	Failure to Rescue	☐	Patient that reminds staff of their family
☐	Death	☐	First death under their "watch"	☐	Patient victim of violence
☐	Other	☐	Litigation	☐	Pediatric case (21 years & younger)
		☐	Long term patient	☐	Unexpected patient demise
		☐	Medical error	☐	Young adult patients
		☐	Multiple patients with poor outcomes	☐	Other
		☐	Organ donation		

Referrals		Additional Information
☐	No Referral Made	
☐	Chaplain	
☐	Clinical health Psychologist	
☐	Employee Assistance Program (EAP)	**Comments:**
☐	Personal Counselor	
☐	Risk Management/Patient Safety Team	

☐ Follow-Up #1 **Length of Interaction:**

Referrals		Additional Information
☐	Not Needed	
☐	Chaplain	
☐	Clinical Health Psychologist	
☐	Employee Assistance Program (EAP)	**Comments:**
☐	Personal Counselor	
☐	Risk Management	

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forYOU Team Activations – 8 years

04/01/2009 – 3/31/17

One on One Encounters = 527

Group Briefings = 118 (n=1,004)

Leadership Mentoring = 60

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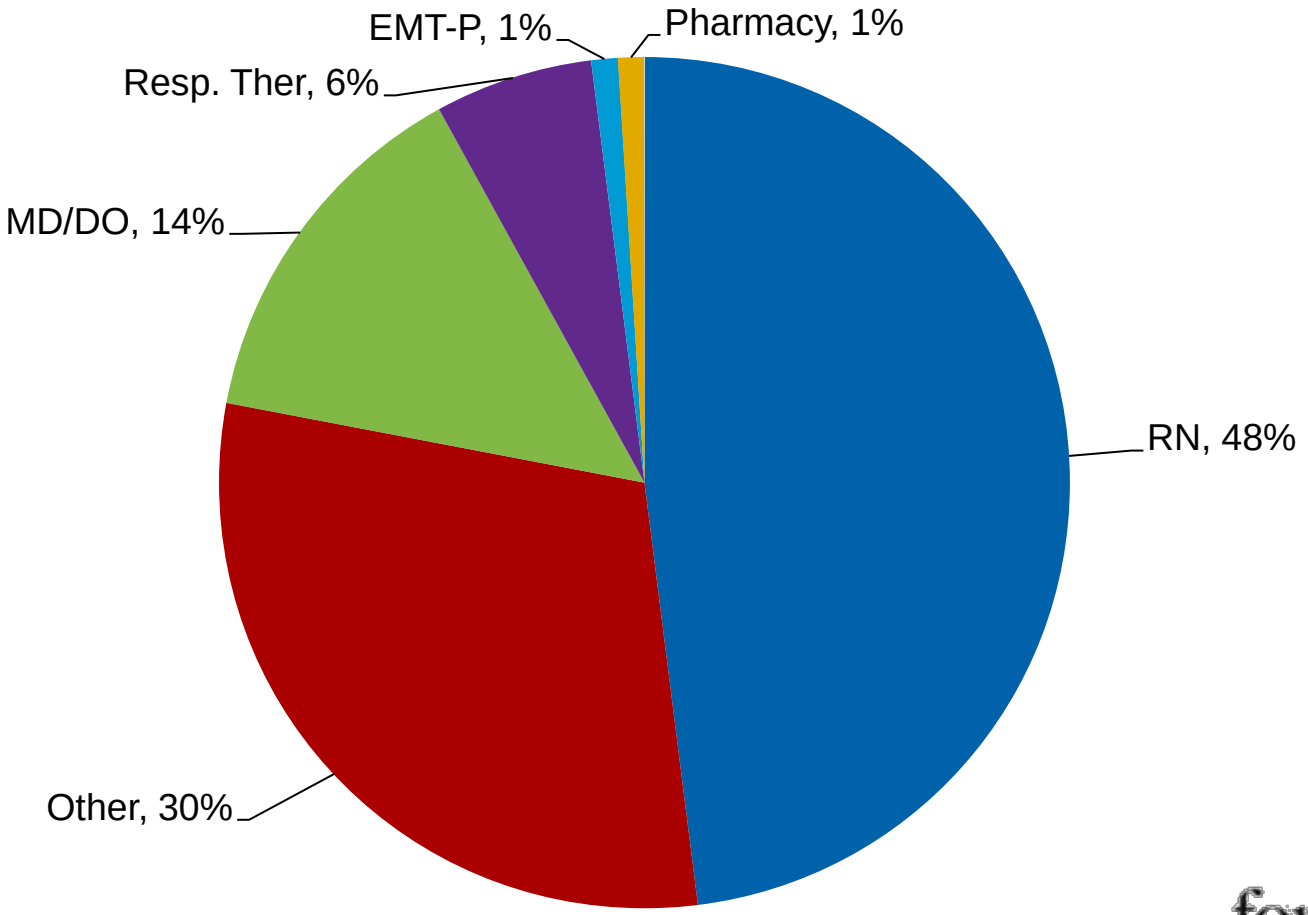
Clinician Support Offered



Reasons for Activations

Unexpected Patient Outcomes- 52%

Other- 35%

(Staff related 'personal' crisis)

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

Medical Errors- 13%

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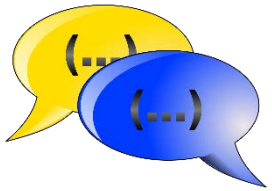
Average Length of Interactions



One on One Encounter = 22 minutes

Group Encounters = 58 minutes

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Referrals to Tier 3

Referral Type	One on One Encounters	Group Encounters
No referral made	599	920
Employee Assistance Program (EAP)	58	7
Personal Counselor	40	5
Risk Mgmt/Patient Safety Team	34	13
Chaplain	13	16
Clinical Health Psychologist	8	
forYOU One-on-One		24

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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?**

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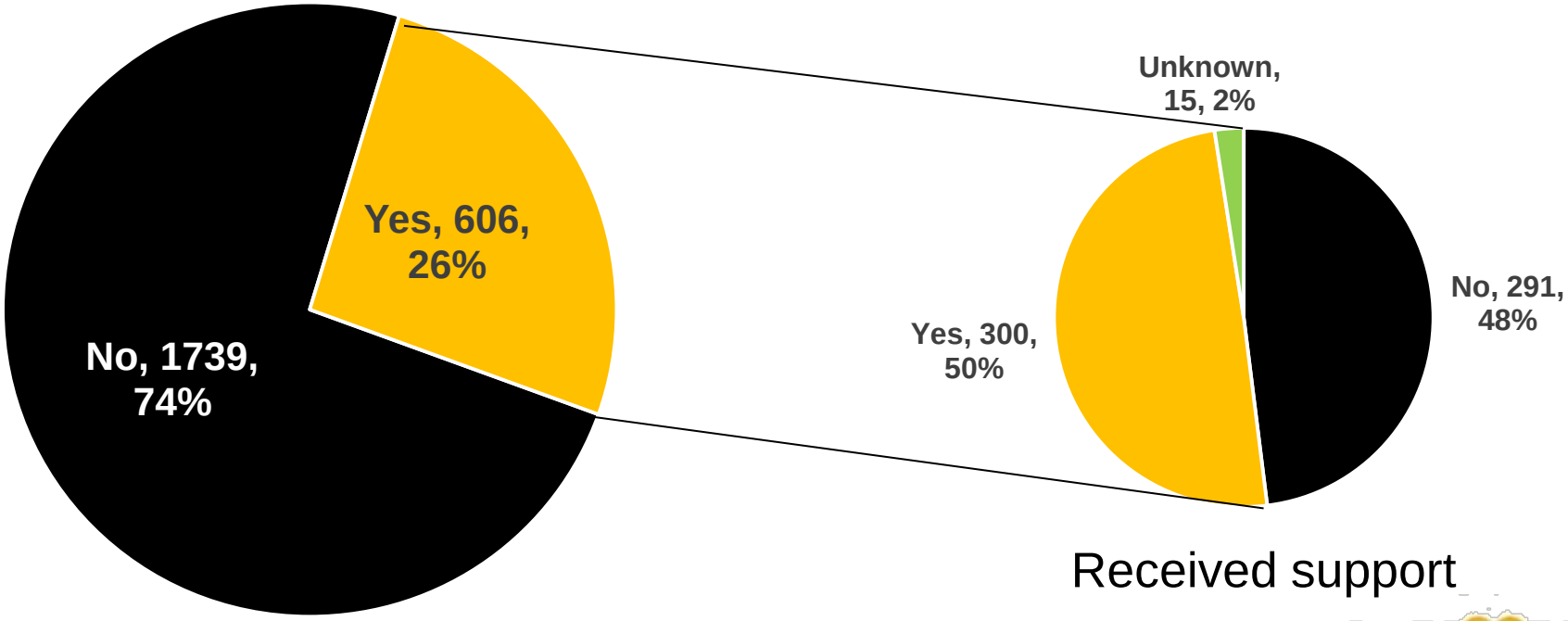
Culture Survey Results (2016)

(n=2,345)

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?"



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Safety Culture Survey

Agency for Health Care Research and Quality (AHRQ)

www.ahrq.gov

3 populations:

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

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?**

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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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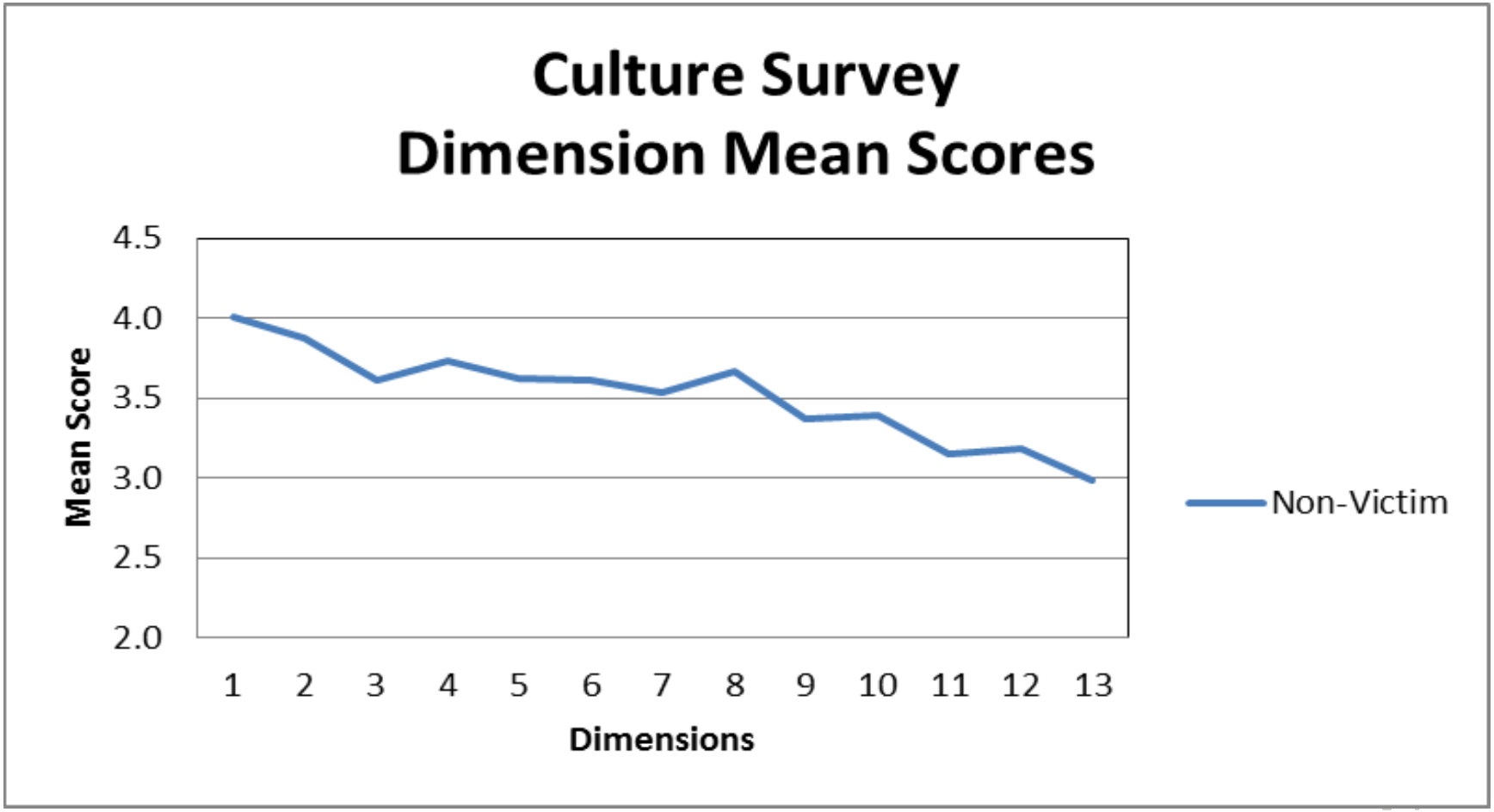
Results



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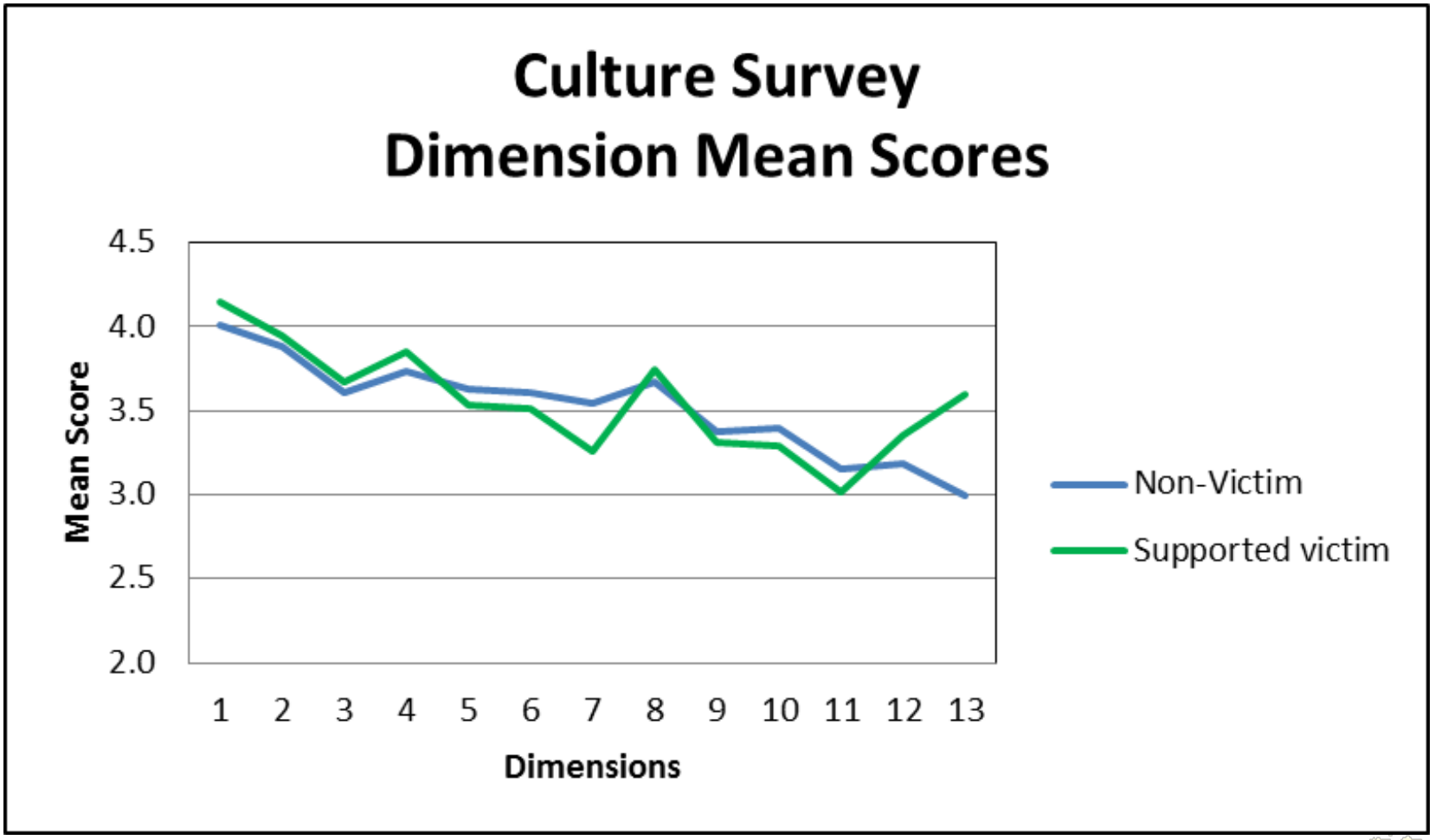
Results



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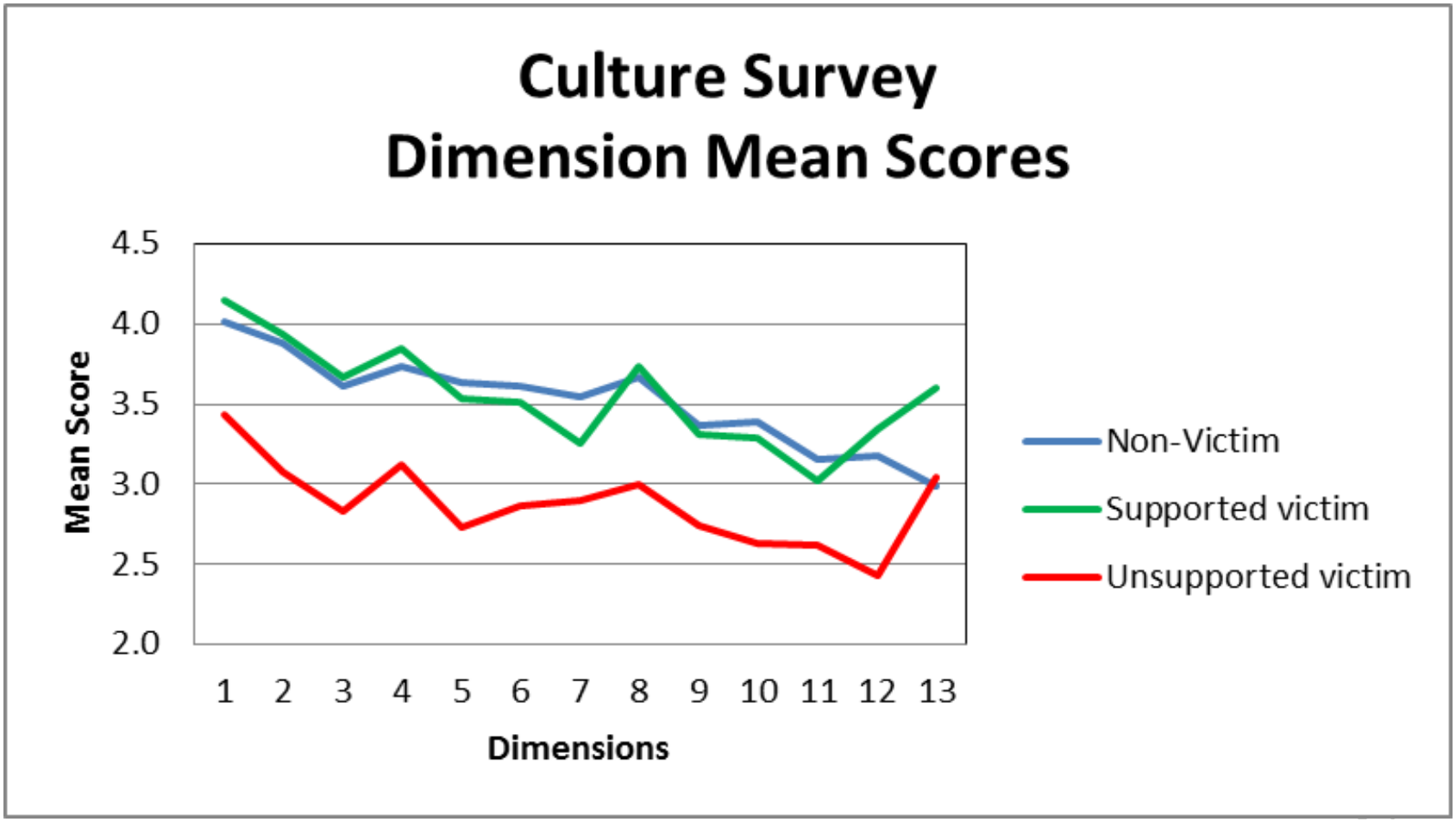
Results



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

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Unit Based Results

Unit	SV Prev. %	SV Support %	Unit Safety Grade	MUHC Safety Grade
A	68%	26%	3.40	4.10
B	64%	13%	2.64	4.10
C	56%	71%	4.17	4.10
D	56%	72%	4.22	4.10
E	53%	25%	3.32	4.10
F	39%	75%	4.11	4.10

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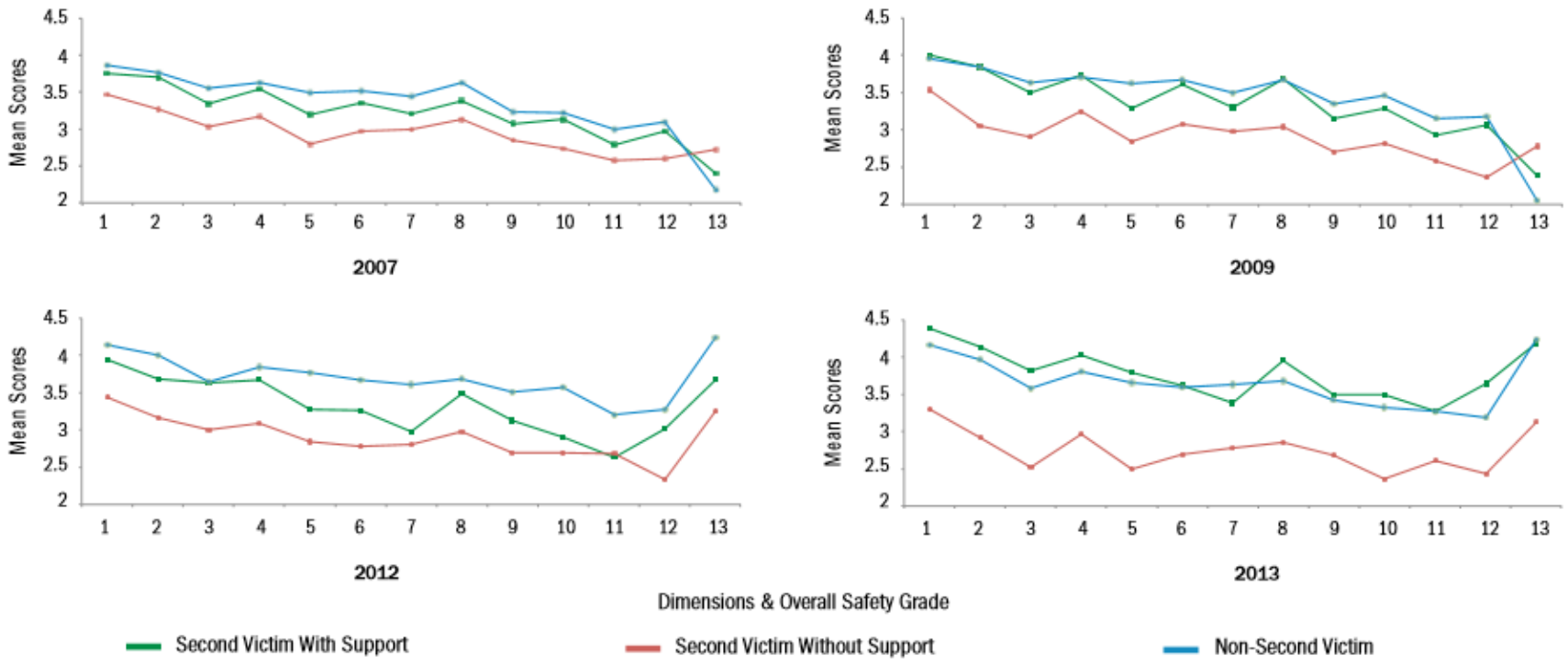
Results by Year



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

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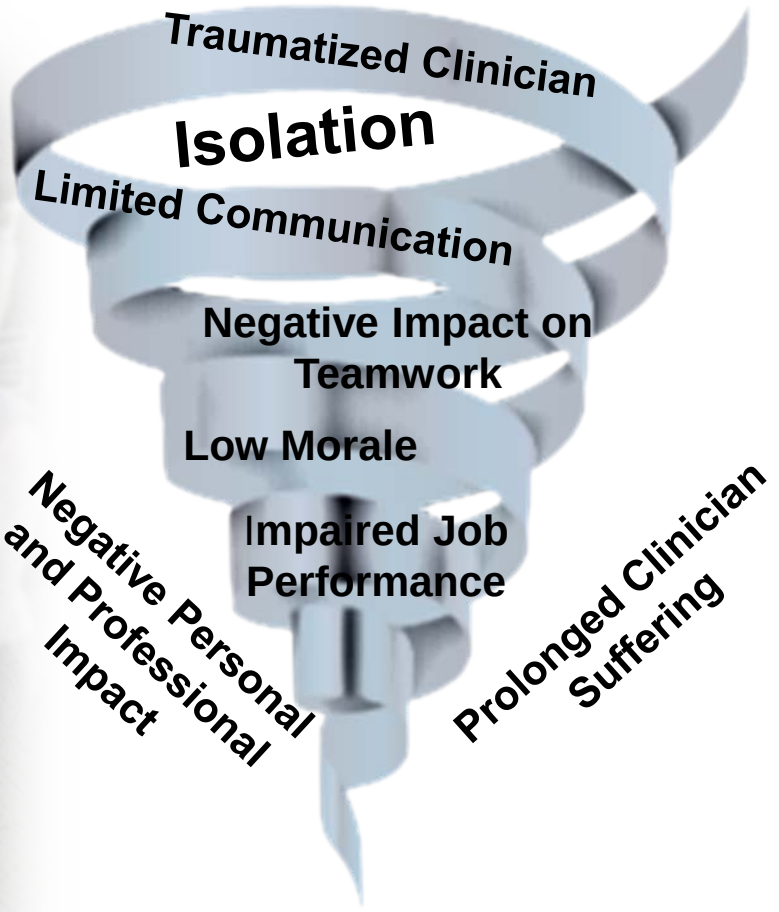
The Aftermath of No Support



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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 have a personal ‘story’ about your experience as a second victim, share it with a colleague in need.
- Recognition of the hidden victims.
- Early intervention= meaningful outcomes

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Questions…

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

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