Second Victims: Gaining a Deeper Understanding to Mitigate Suffering

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September 1, 2010
History of the PROBLEM

Adverse event investigations – individuals at the ‘sharp end’ noted to be experiencing ‘predictable’ behaviors post event.
Tony’s Story

It was like any other shift for Tony, an RN with more than 15 years of critical care nursing experience, when he was asked to assist with a fairly benign sedation procedure, a task he had performed numerous times that month alone. The procedure was almost completed when something went terribly wrong.....
Commonly Heard Phrases

“..sickening realization of what has happened.”

“I’m going to check out my options as a Wal-Mart greeter. I can’t mess that up.”

“I came to work to help someone today – not to hurt them!”

“This event shook me to my core.”

“I’ll never be the same.”

“This has been a turning point in my career.”
Next steps

What does the literature say?

How are others addressing these problems?

Benchmarking ??
The Emotional Impact of Medical Errors – Practicing Physicians

2007 Culture Survey Results

- 1,160 Respondents
- 16% of respondents (1 in 6) experienced personal problems such as
  - Anxiety
  - Depression
  - Concern regarding ability to do job
- Only 33.7% received support from someone within UMHC.
Second Victim Task Force

Project Leads - Patient Safety and Risk Management

Team Members:

Assistant Nursing Managers x3
Assistant Manager – Respiratory Care
Associate Chief of Medical Staff
Case Manager
Chaplain
Clinical Educator, Center for Education and Development

Coordinator, Quality Improvement
Director, EAP
Health Psychologist
House Manager
Researcher, Center for Healthcare Quality
Social Service
Staff Nurses x 4
A Research Project is Formed

- Qualitative Research Design
- IRB Approved
- Research Subjects
- 60 minute interviews – taped
- Independent researcher reviews
- Consensus meetings
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.”
Second Victims Defined
(continued)

- Frequently, these individuals feel personally responsible for the patient outcome.
- Many feel as though they have failed the patient, second guessing their clinical skills and knowledge base.
Participant Overview

- 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]
Discoveries…

- Medical errors and unanticipated patient outcomes are equally devastating
- Regardless of job title, staff respond in predictable manners
- First tendency of staff seems to be isolation
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 situations that may induce a stress response

- Pediatric cases
- Failure to rescue cases
- **ANY** patient that ‘connects’ a staff member to his/her own family
- First death under “their” watch
- Unexpected patient demise
- Staff member death
"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! ” RN
Research Team Consensus

- Six Stages Finalized
- Stage Characteristics Delineated
- Personal Goals for Second Victim to Continue Healing Identified
- Institutional Goals to Ensure Optimal Second Victim Recovery Identified
Research Team Consensus – The Second Victim Trajectory

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(Individual may experience one or more of these stages simultaneously)

(Individual migrates toward one of three paths)
Stage 1
Chaos and Accident Response

- Error realization / Event recognition
- Get help for the patient
- Stabilize / Treat

“Right after the event and during the code, I was having trouble concentrating. It was nice to have people take over that knew what they were doing that I trusted. I was in so much shock I don’t think I was useful.”
Stage 2
Intrusive Reflections

- Re-evaluate clinical scenario
- Self isolation
- Haunted re-enactments

“I started to doubt myself. This shouldn’t have happened. It was all hindsight but I kept thinking over and over again. There were some things that I thought maybe if I’d have done it this way it wouldn’t have happened or been avoided but everything was more clear looking at things in retrospect. I lost my confidence for some time.”
Stage 3
Restoring Personal Integrity

• Acceptance among work/social structure
• Managing gossip/grapevine
• Fear

“I thought every single day for months I’d walk in and think everyone knows what happened because that’s what happens in a unit where everyone works closely. I thought do they think of me as this loser who doesn’t know what is going on. I thought these people are never going to trust me again.”
Stage 4
Enduring the Inquisition

• Reiterate case scenario
• Respond to multiple “why’s”
• Interact with many different event management staff

“I didn’t know what to do or who to talk to professionally or legally.”

“Clearly, I know we needed to keep that quiet - it might have been helpful to be able to talk to someone else but I couldn’t do that.”
Stage 5
Obtaining Emotional First Aid

• Personal/Professional Support
• Getting/Receiving Help/Support
• Litigation Assistance

“There was nobody I could tell, not even my husband. All I could say is I’ve had a really horrible day. Because of HIPAA laws, our own professional values of confidentiality, we cannot take it home, other than to say I had a patient die today but not about the particular incident.”
Stage 6-A
Moving On….Dropping Out

- Move to a new unit/facility
- Strongly consider quitting role
- Feelings of gross inadequacy

“A fresh start was good for me.”

“I actually ended up moving to a different floor. My new supervisor who oriented me expressed confidence and belief in me and helped me re-grow my own sense of confidence and self belief.”
Stage 6-B
Moving On….Surviving

- Coping, but still have intrusive thoughts
- Persistent sadness
- ‘Hanging in there…’

“I figured out how to cope and how to say yes, I made a mistake. And that mistake caused a bad patient outcome but I haven’t figured out how to forgive myself for that or forget it. It’s impossible to let go.”
Stage 6-C
Moving On….Thriving

• Maintain life/work balance
• Gain insight/perspective
• Make something positive out of the event

“I was questioning myself over and over again about what happened but then I thought … I’ve just had this experience in my life where I had to encounter this tragedy but it made me a better person. It really did, and it gave me insight.”
Interventional Considerations

- A ‘safe zone’ to discuss their response to events
- Peer to peer, confidential
- Knowledge regarding next steps
- Voluntary involvement in supportive interventions
- 24/7 access
Challenges to Providing Support

- There is a stigma to reaching out for help
- High acuity areas have little time to integrate what has happened
- Intense fear of the unknown – what happens to me next?
- Fear a compromise of collegial relationships because of event
- Fear of future legal woes - HIPAA, Confidentiality Implications
forYOU Team is Formed

- Addresses research findings
- Peer to peer support model
- Individual teams from each facility
- Referral systems coordinated
- Formal team training prior to deployment
- Group debriefing process formalized
Project Leads - Patient Safety and Risk Management

Team Members:

Assistant Nursing Managers
Assistant Manager – Respiratory Care
Associate Chief of Medical Staff
Case Manager
Chaplain
Clinical Educator

Quality Improvement Director, EAP
Health Psychologist
House Manager
Physicians
Researcher
Social Service
Staff Nurses
Team characteristics

• 24/7 Pager Availability
• Team Activation (Self, Peer, Manager or Patient Safety Investigator)
• 2 Types of Interventions (One on One Peer Support & Team Debriefings)
Tier 1
- ‘Local’ support / Unit management team
- House Manager
- Local Peers

Tier 2
- Peer to Peer Support
- Patient Safety Office
- Risk Manager

Tier 3
- External support
Second Victim Interventions

First Tier – ‘Local’ support

- Scripting:
  - Key Actions at Key Times
  - Key Words at Key Times
- De-Briefing Techniques
- Working with Staff in Crisis

Tier 1

- ‘Local’ support / Unit management team
- House Manager
- Local Peers
Key Actions at Key Times for Peers and Colleagues

• Be ‘there’
• If experience with a bad event, share it → ‘War stories’ are powerful healing words
• If no experience with a bad event, be supportive and ‘project’ victim’s needs
• Avoid condemnation without knowing the story – it could have been you!
Key Actions – Department Leaders

- Connect with clinical staff involved
- Reaffirm confidence in staff
- Consider calling in flex staff
- Notify staff of next steps – keep them informed
- Check on them regularly
- Activate peer to peer support team
Second Victim Interventions

Second Tier Intervention

- ForYOU Peer Support Team, Patient Safety Representatives, and Risk Management Personnel

Tier 2
- Peer to Peer Support
- Patient Safety Office
- Risk Manager
One on One Support

- Provide Second victim information
  - forYOU Staff & Family pamphlet
  - Additional resources

- Follow up with second victim
  - Touch base as needed (1 day- 2 wks) for as many times as necessary
  - 3 month follow-up

- Evaluation of services offered
Second Victim Interventions

Third Tier Interventional Strategy
-Referral to Clinical Health Psychologist, Chaplains, Employee Assistance Program (EAP), or Personal Counselor.
Our New 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 investigation process and reference guide
Second Victim Concept Awareness

One-on-One Confidential Support

Team Debriefings

24/7 Emergency Pager

Ensure Prompt Referral to Additional Professional Support/Guidance

Mentoring Leaders in Second Victim Support
What Can **You** Do Tomorrow?

• Understand the second victim concept – Awareness is the first intervention!
• Develop a plan to meet needs of staff after a critical health care incident
• Provide additional one on one crisis training to team members in high risk clinical areas
• Determine a way that you can make an individual difference
Questions...

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www.muhealth.org/secondvictims