What is a Second Victim?

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Laura E. Hirschinger, RN, MSN, AHN-BC

Objectives

• Define the term ‘second victim’.
• Describe research findings which describe the stages of recovery for a second victim
• Identify interventional strategies that you can provide to support a health care clinician experiencing the second victim phenomenon.
• Describe resources available to design a clinician support program that meets the needs of your facility.

History of the PROBLEM

Adverse event investigations – individuals at the ‘sharp end’ noted to be experiencing ‘predictable’ behaviors post event
Commonly Heard Phrases

- "...sickening realization of what has happened."
- "This event shook me to my core."
- "I'm going to check out my options as a Wal-Mart greeter. I can't mess that up."
- "I'll never be the same."
- "This has been a turning point in my career."
- "I came to work to help someone today – not to hurt them!"

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...

* Name has been changed

Medical error: the second victim

The doctor who makes the mistake needs help too...
Resident Responses to Errors

- Remorse: 81%
- Guilt: 72%
- Inadequacy: 60%
- Angry at Self: 79%


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?

2007 - Culture Survey Results
(N=1,160)

Staff experienced:
- Anxiety
- Depression

Received support:
- Yes 38.1%
- No 61.1%
- Unknown 0.8%
Prevalence

Estimates 10-50%

- Otolaryngologists – 10% (Lander 2006)
- Health professionals - 30% (Scott 2009)
- Medication errors – 43% (Wolf 2000)
- Health professionals – 50% (Edrees 2011)

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

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. 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."
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?

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

High Risk Clinical Areas

- Surgery
- Rapid Response Teams
- ER
- Flight Teams
- ICU’s
- Obstetrics
- Pediatrics
- Code Blue Teams
- Oncology
High Risk Clinical Areas in Long Term Care?

- Hospital
- Dialysis
- Home Care
- Hospice
- Emergency Room
- Pediatrics
- Oncology

High Risk Scenarios

- Patient ‘connects’ staff member to family
- Pediatric cases
- Medical errors
- Failure to rescue cases
- First death experience
- Unexpected patient demise
What Second Victims Desire…

Research Team Consensus – The Second Victim Trajectory

Second Victim Conceptual Model
Second Victim Interventions

Second victims want to feel...
- Appreciated
- Valued
- Respected
- Understood

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

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
- 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
Established Referral Network:
- Employee Assistance Program
- Chaplain
- Social Work
- Clinical Psychologist

Ensure availability and expedite access to prompt professional support/guidance.

Scott Three-Tier Model of Support

Tier 1: 'Local' (Unit/Department) Support
- Department/Unit support from manager, chair, supervisor, fellow team member who provide one-on-one reassurance and/or professional collegial critique of cases.

Tier 2: Trained Peer Supporters
- Patient Safety & Risk Management Resources
- Trained peer supporters and support individuals (such as patient safety officers or risk managers) who provide one-on-one crisis intervention, peer supporter mentoring, team debriefings & support through investigation and potential litigation.

Tier 3: Expedited Referral Network
- Department/Unit support from manager, chair, supervisor, fellow team member who provide one-on-one reassurance and/or professional collegial critique of cases.

Second Victim Conceptual Intervention Model

First Tier – ‘Local’ support

Department Leaders Key Actions
- 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
Second Tier Interventional Strategy

One on One Support

- Provide Second victim information
  - Informational pamphlets
  - Additional resources
- Follow up with second victim
  - Touch base as needed (1 day - 2 wks) for as many times as necessary

"To have someone call me out of the blue, just to offer support, was a wonderful thing. It was like a burden was lifted off me, knowing I didn't have to get through it alone."

Group Support

- Provide Second victim support to the team
- Facilitated sharing of the case’s impact
  - Thoughts
  - Reactions
  - Symptoms
- Educate
  - Informational pamphlet
  - Additional resources
- Follow up with individual second victims
Third Tier Interventional Strategy

Expedited Referral
- Chaplain
- Social Services
- Employee Assistance Program (EAP)
- Holistic Support

What Would Peer Support Look like for Long Term Care?

Tier 1
'Social' (Unit/Department) Support

Tier 2
Trained Peer Supporters
Patient Safety & Risk Management Resources

Tier 3
Expedited Referral Network

THE FIRST FOUR YEARS – OUTCOMES DATA

04/01/2009 to 03/31/2013
Lessons Learned:

- Not all clinicians respond the same - everyone is unique
- Watch for isolation
- Cast a big net
- Need numerous ways to alert your team for need of support
- Consider building surveillance into existing practices (i.e. huddles, post code critique, disaster drills, etc.)

forYOU Team Activations

04/01/2009 – 03/31/2013

One on One Encounters = 299
Group Briefings = 72 (n=554)
Leadership Mentoring = 39

892

2012 - Culture Survey Results

Staff experienced:
- Anxiety
- Depression

Received support (N=174)
Questions

www.MUhealth.org/secondvictim

Laura Hirschinger Hirschingerl@health.missouri.edu