Second Victim Trauma

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Missouri Nursing Student Association
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Objectives

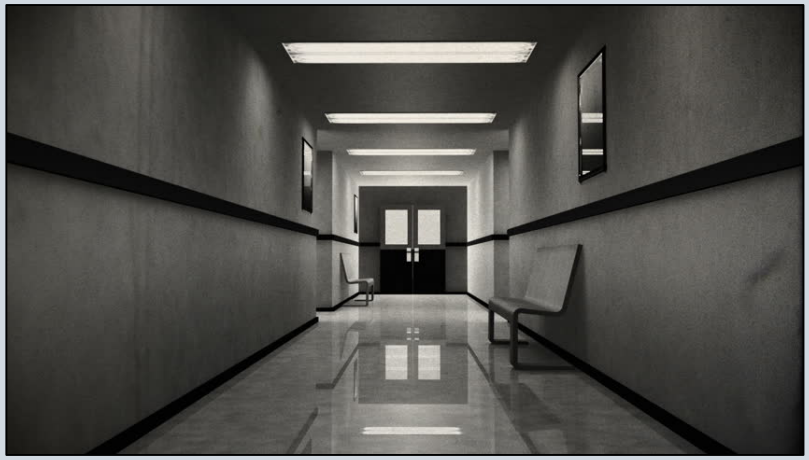
Discuss the second victim phenomenon (SVP).

Describe an overview of the predictable recovery trajectory.

Describe how you can make a personal difference for a colleague suffering after an unanticipated clinical event.

The Cost of Caring… An Occupational Hazard

- Burnout
- Vicarious Trauma
- Compassion Fatigue
- Moral Distress
- Second Victim Response



As Healthcare Providers…

- Our ‘calling’ into healthcare **is to heal**, the idea that we have harmed an individual under our ‘watch’ is devastating
- We **attempt perfection**, it’s painful when we don’t achieve it
- We are **compassionate**, we feel the pain of those we treat
- We strive for the **respect of our coworkers**, we grieve for it’s loss

  - **These are qualities, not weaknesses…**
  - **They’re assets, not flaws…**

Adapted from …..Levesque, M.& Casella, S. (2019). Presentation at the 2019 Healthcare Quality and Safety Conference.

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

Chantler, C., Lancet 1999; 353:1178-91

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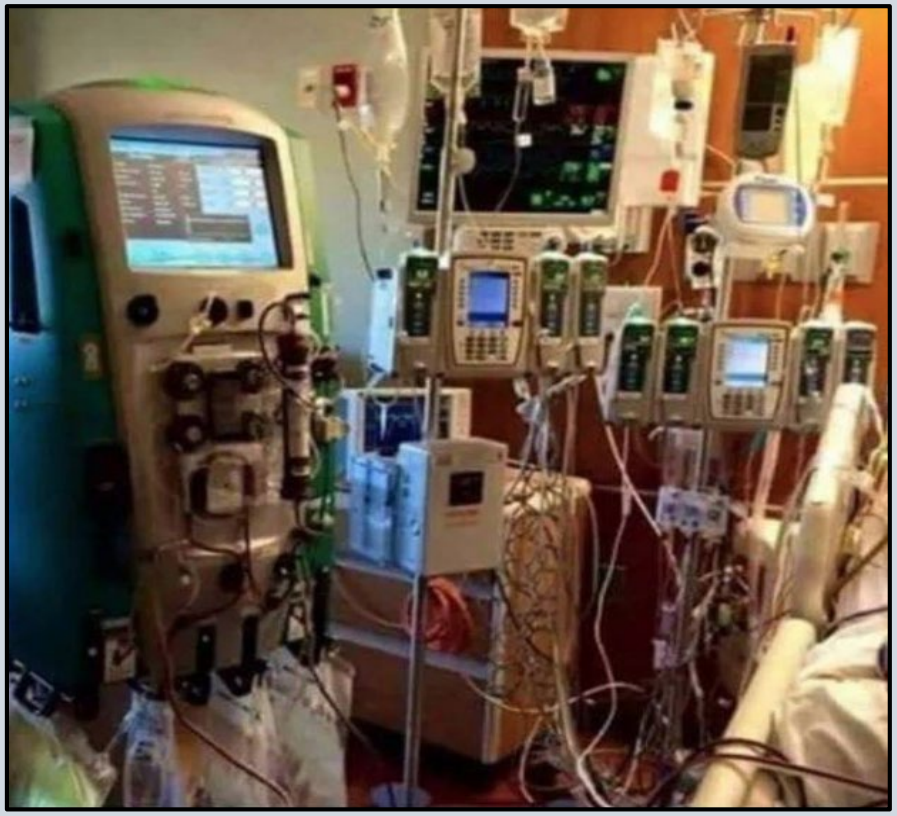

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Chantler, C., Lancet 1999; 353:1178-91

History of the PROBLEM

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

Commonly Heard Phrases

Establishing Prevalence

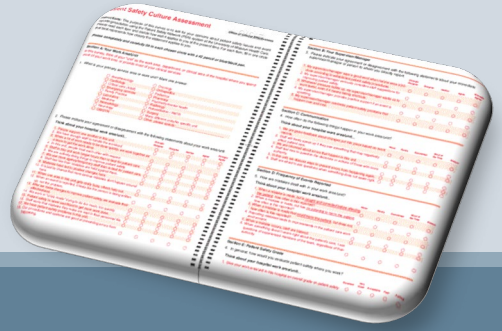
Patient Safety Culture Survey

Agency for Health Care Research and Quality (AHRQ)

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?**

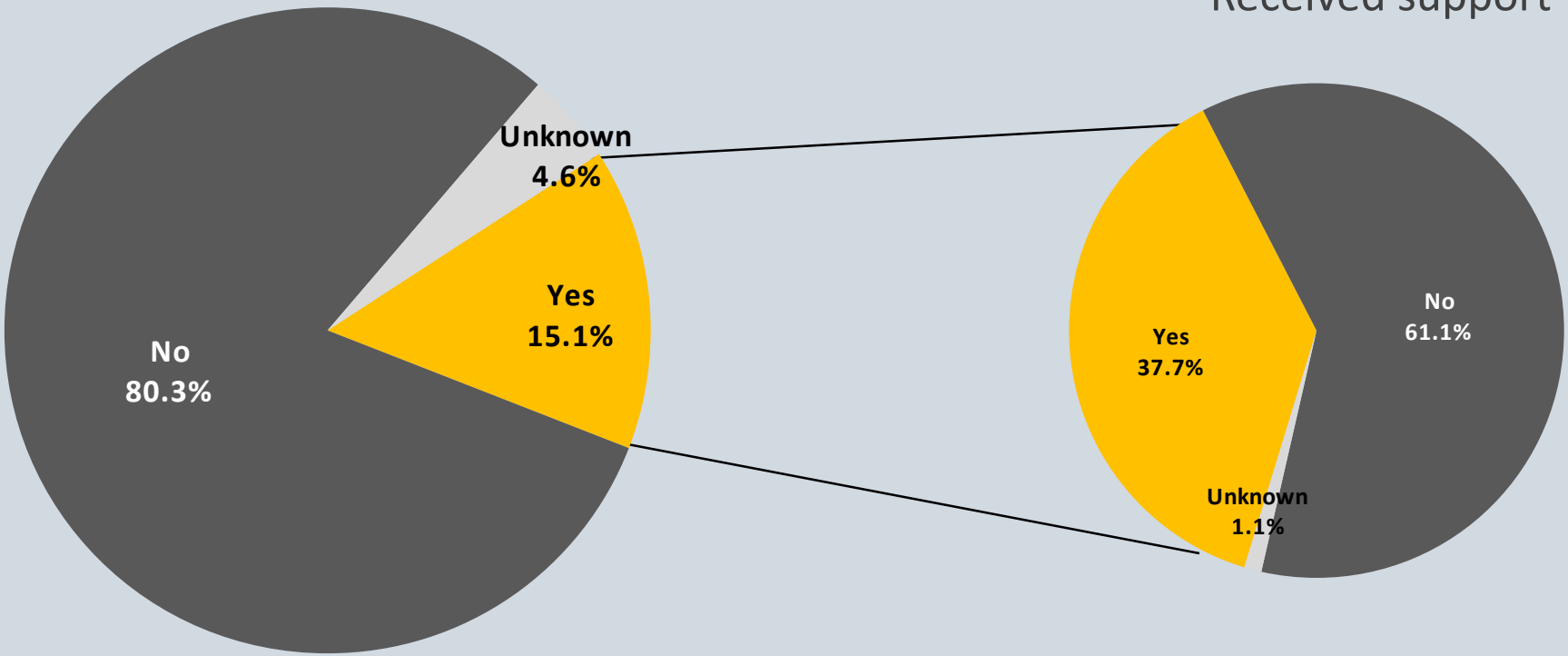


Initial Survey Results (2007)

Staff experienced:

- Anxiety
- Depression

(N=1,160)



Review of the Literature

Medical error: the second victim

Albert Wu, MD

The doctor who makes the mistake needs help too

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.

The Experience 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.

Findings

Suffering clinicians want to feel...

- Appreciated
- Valued
- Respected
- Understood

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

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 their own family

Pediatric cases

Medical errors

First death experience

Unexpected patient demise

Happening NOW: Workplace Violence

Physical/Psychosocial Response

n=11,649 healthcare providers *18 relevant studies*

RESPONSES:

Troubling Memories = 81%

Anxiety/Concern/Worry = 76%

Regret/Remorse = 72%

Fear of Future Errors = 56%

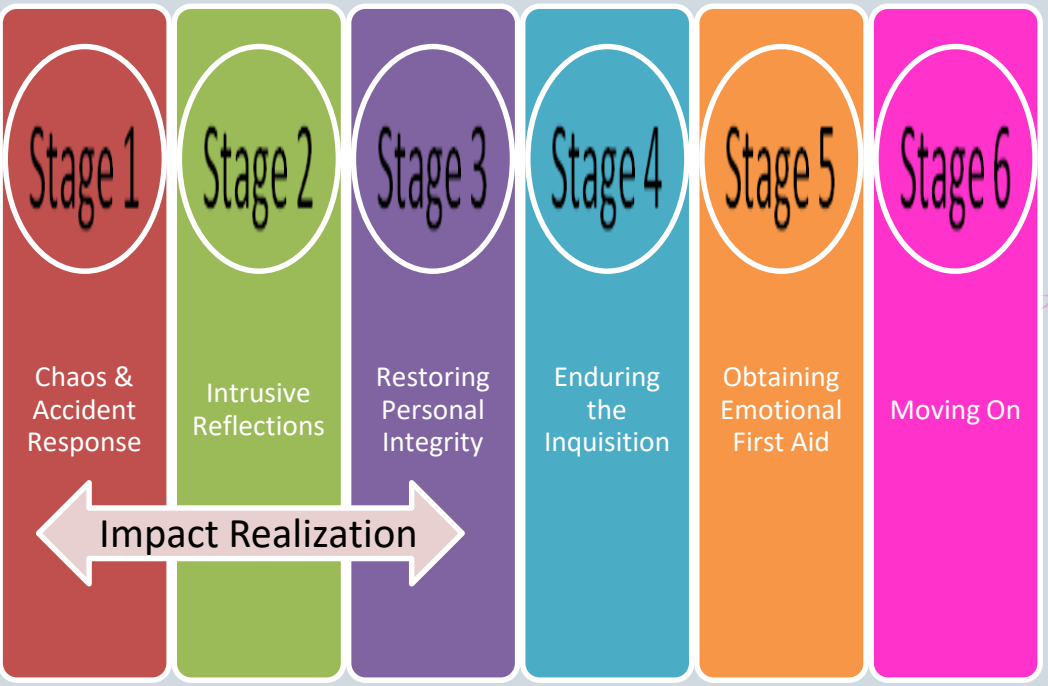
Embarrassment = 52%

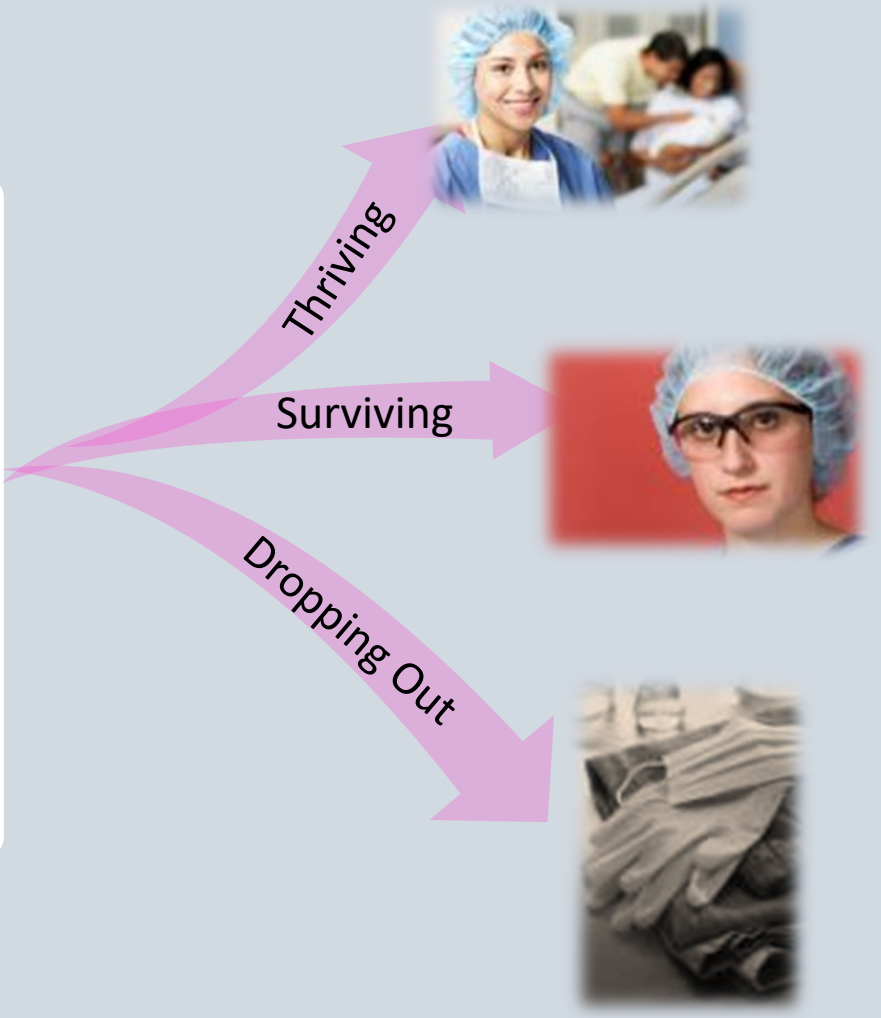
Guilt = 51%

Sleeping Difficulties = 35%

Busch, IM, Moretti, F, Purgato, M, Barbui, C., Wu, A. & Rimondini, M. (2019). *Journal of Patient Safety.* Psychological and psychosomatic symptoms of second victims of adverse events: a systematic review and meta-analysis. Doi: 10.1097/PTS.0000000000000589

A Recovery Trajectory





Chaos and Accident Response

Characteristics:

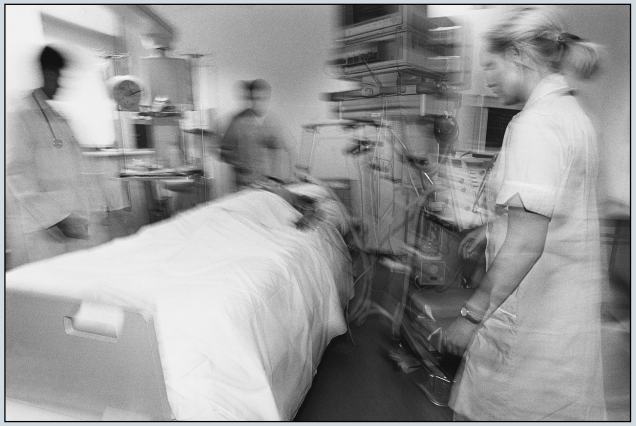
- Error realized/event recognized
- Tell someone/ get help!
- Stabilize/treat patient
- May not be able to continue care of patient
- Clinician commonly distracted

"Right after the… code, I was having trouble concentrating. It was nice to have people take over…that I trusted. I was in so much shock I don't think I was useful."

Intrusive Reflections

Characteristics:

- Re-evaluate scenario
- Self-isolate
- Haunted re-enactments of event
- Feelings of internal inadequacy



"I started to doubt myself... There were some things that I thought maybe if I'd have done it this way it wouldn't have happened…but everything was more clear looking at things in retrospect. I lost my confidence for some time."

Restoring Personal Integrity

Characteristics:

- Acceptance among work/social structure
- Managing gossip/grapevine
- Fear is prevalent

"I thought every single day for months I'd walk in and think everyone knows what happened… I thought these people are never going to trust me again."

Enduring the Inquisition

Characteristics:

- Realization of level of seriousness
- Reiterate case scenario
- Respond to multiple “why’s” about the event
- Interact with many different even responders
- Understanding even disclosure to patient/family
- Physical and psychosocial symptoms

“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.”

Obtaining Emotional First Aid

Characteristics:

- Identify who is safe to confide in
- Hoping someone will reach out
- Getting personal/professional support
- Litigation concerns emerge

"There was nobody I could tell, not even my husband. All I could say is I've had a really horrible day."

Moving On….Thriving

Characteristics:

- Does not base practice/ work on one event
- Minimal adverse effect from event
- Advocates for patient safety initiatives
- Tries to make a difference for the next patient/clinician

"I was questioning myself over and over again…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."

Recovery Paths:

Moving On….Surviving

Characteristics:

- Coping with what happened
- Persistent sadness prevails
- Trying to learn from the event
- Never quite the same……

"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."

Recovery Paths:

Moving On….Dropping Out

Characteristics:

- Feelings of inadequacy/failure
- Leave current role by transferring to different facility/unit
- Consider quitting profession altogether

"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."

Recovery Paths:

The Drop OUT…….

Defined as ‘a career transition as a direct result of a single unexpected patient event’.

Kim Hiatt, RN

Insights Into Dropping-Out

Vast majority in-patient care (77%)

70% related to permanent harm/death of patient

50% were direct care providers

~58% assumed roles with less or equal risk to similar exposure

Rodriquez, J. & Scott, S.D. (2017). Dropping out and starting over: The impact of adverse events on clinicians. *Joint Commission Journal on Quality and Patient Safety.* 44:137-145. DOI: 10.1016/j.jcjq.2017.08.008.

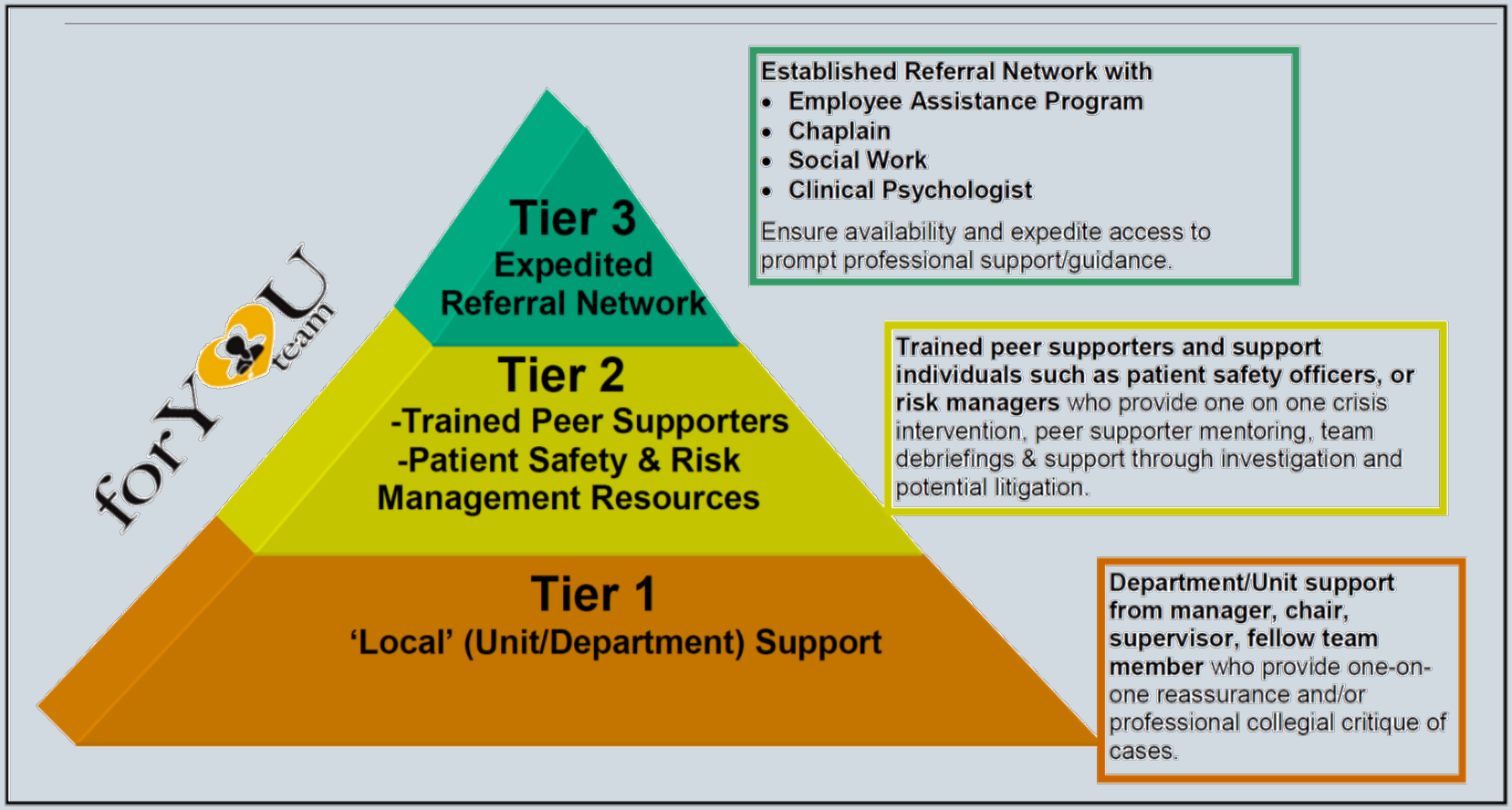
“ I will never forget this experience……This patient will always be with me – I think about her often…… Because of this, I am a better clinician! ”

The forYOU Team is Formed

- Incorporated evidence-based findings
- Peer to peer support model
- Two Types of Supportive Intervention
  - One-On-One
  - Group Debriefings
- Referral systems coordinated to facilitate prompt referrals when necessary

Intervention

The Scott Three-Tiered Interventional Model of Second Victim Support



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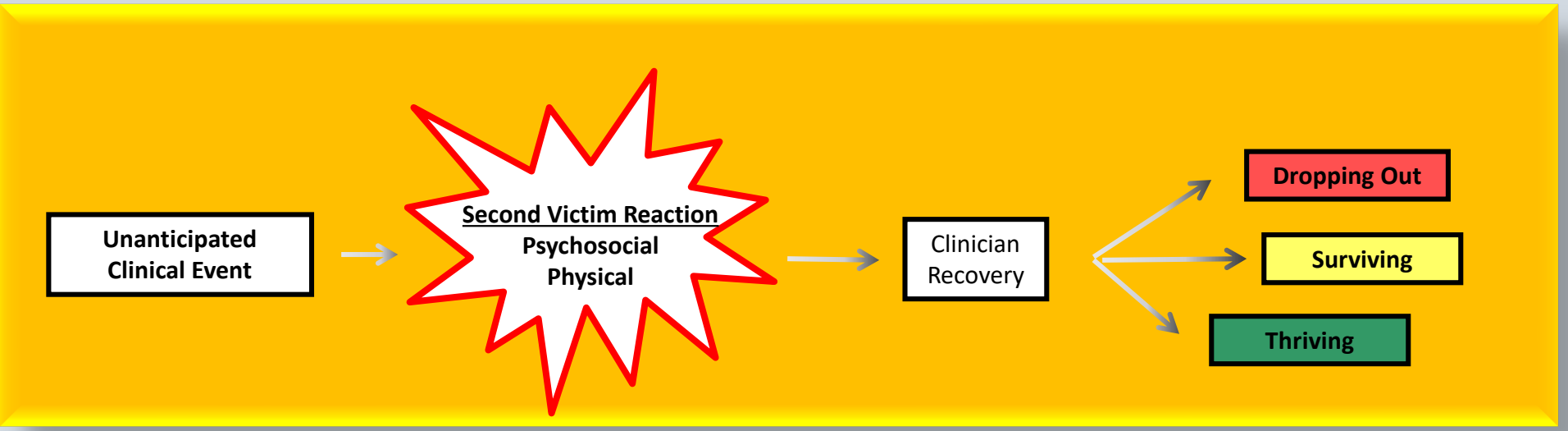
Conceptual Model - Clinician Recovery



forYOU Team Activations

04/01/2009 – 3/31/19

One on One Encounters = 696

Group Briefings = 138 (n=1170)

Leadership Mentoring = 65

Reasons for Activations

Unexpected Patient Outcomes- 57%

Tragic Clinician Event - 31%

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

Medical Errors- 12%

Clinician Support Offered

RNs – 49%

MD/DO – 18%

Respiratory Therapy – 6%

Paramedics/EMTs – 5%

Pharmacy – 1%

Other – 25%

Cost-Benefit

- Cost-benefit analysis of RN support of the Johns Hopkins RISE peer support network.
- Cost of running the RISE program, nurse turnover, and nurse time off were modeled using a Markov Model.
- Specifically compared RNs using RISE and not using formal support after an unanticipated clinical event.
- Results: A net benefit savings of **$22,576** per nurse who initiated a RISE call.

Moran D, Wu AW, Connors C., Chappidi MR, Sreedhara SK, Selter JH & Padula, WV. (2017). Cost benefit analysis of a support program for nursing staff. *Journal of Patient Safety.*

“It’s not a matter of if clinicians are going to experience trauma while providing care, but when and how often.”

Albert Wu, MD

https://news.aamc.org/medical-education/article/when-physicians-are-traumatized

What You Can Do: Key Actions

-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!

-If you are worried about a colleague, reach out!

Self-Care….

Know that you are not alone!

Self compassion is truly important!

What have you done in the past during stressful times to relax?

Who is a trusted colleague who can help you through this experience?

Proactively develop a “perk” file and periodically reflect on happier clinical experiences.

Practice reflection with focus on positive patient encounters.

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.

The Second Victim Phenomenon is one that no one wants to experience, yet…

- Most clinicians have already witnessed colleagues suffering as second victims.
- Most clinicians will have this response 3-4 times (or more) during their clinical years of practice.
- When it does happen, ,most clinicians are unsure of what they are experiencing.
- Most clinicians do not know how to respond or assist others who are suffering.

A Closing Thought….

"Any is Too Many……"

Questions…

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

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References

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