When Caring Hurts: The Second Victim Phenomenon

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Upon completion of this presentation, participants should be able to

1. Understand the second victim phenomenon.
2. Describe what you can do differently tomorrow to help a colleague who is suffering as a second victim.
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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


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

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
High Risk Scenarios

- Patient ‘connects’ staff member to family
- Pediatric cases
- Medical errors
- Failure to rescue cases
- First death experience
- Unexpected patient demise
Stages of Healing: The Second Victim Recovery Trajectory

Stage 1: Chaos & Accident Response
Stage 2: Intrusive Reflections
Stage 3: Restoring Personal Integrity
Stage 4: Enduring the Inquisition
Stage 5: Obtaining Emotional First Aid
Stage 6: Moving On

Impact Realization

Thriving
Surviving
Dropping Out

“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!”
What Second Victims Desire...
Second Victim Interventions

Second victims want to feel...

- Appreciated
- Respected
- Valued
- Understood

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

Staff have a way to **get their needs meet** after going through a traumatic event.

**Helps reduce the harmful effects of stress**

**Provides some normalization** and helps the individual get 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
Support Basics

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

Clinicians have unique support needs. Health care facilities have unique culture. Both should be considered when designing a network of support for second victims.

Two types of support
- One on one
- Group
Second Victims Need Support

A systematic literature review of second victimization findings:

1) Significant emotional toll on care providers
2) Need for institutional support programs
3) Varied approaches for support

“Unethical not to have a clinician support program as the evidence supported the emotional toll that being a second victim takes on a clinician and then in turn, their patients as well.”

Guidelines for Clinician Care

Institute for Health Care Improvement

National Quality Forum – Safe Practice 8: Care for the Caregiver

Provide care to the caregivers (clinical providers, staff, and administrators) involved in serious preventable harm to patients, through systems that also foster transparency and performance improvement that may reduce future harmful events.
The leaders make support systems available for staff who have been involved in an adverse sentinel event.

http://www.jointcommission.org/improving_Patient_Worker_Safety/
The forYOU Team is Formed

Addresses research findings
Peer to peer support model
Referral systems coordinated to facilitate prompt care
Two Types of Supportive Intervention
  One-On-One
  Group Debriefings
forYOU Team 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.

- an internal rapid response infrastructure of ‘emotional first aid’ for clinicians and personnel following an adverse event.
The Scott Three-Tiered Interventional Model of Second Victim Support

Tier 3
Expeditied Referral Network
- Established Referral Network with
  - Employee Assistance Program
  - Chaplain
  - Social Work
  - Clinical Psychologist
- Ensure availability and expedite access to prompt professional support/guidance.

Tier 2
-Trained Peer Supporters
- Patient Safety & Risk Management Resources

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.

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.
Lessons Learned….  

• Not all clinicians respond the same - everyone is unique  
• Watch for isolation  
• Many hidden ‘pearls’ within health care systems – Tier 3 inventory  
• Cast a big net - look for ‘hidden’ staff  
• Consider building surveillance into existing practices (i.e. huddles, post code critique, disaster drills, etc.)  
• Team briefings help to build team resilience and enhanced teamwork
A Point to Ponder.....

The Aftermath of No Support

- Negative Impact on Teamwork
- Low Morale
- Impaired Job Performance
- Limited Communication
- Isolation
- Traumatized Clinician
- Prolonged Clinician Suffering
- Negative Personal and Professional Impact
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.
- ‘Be there’!
AHRQ – CANDOR Tool

Communication and Optimal Resolution (CANDOR) Toolkit

Patient Safety Tools and Training Materials

What is the Communication and Optimal Resolution Process?

The Communication and Optimal Resolution (CANDOR) process is a process that health care institutions and practitioners can use to respond in a timely, thorough, and just way when unexpected events cause patient harm.

Based on expert input and lessons learned from the Agency's $23 million Patient Safety and Medical Liability grant initiative launched in 2009, the CANDOR toolkit was tested and applied in 14 hospitals across three U.S. health systems.

What Resources Are Included in the CANDOR Toolkit?

The CANDOR toolkit contains eight different modules, each containing PowerPoint slides with facilitator notes. Some modules also contain tools, resources, or videos.

Give to support people facing the trauma of medical error.

LEARN MORE

www.mitss.org
“The longer we dwell on our misfortunes, the greater is their power to harm us.”  Voltaire

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www.muhealth.org/foryou
References