QuickSafety
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Supporting second victims

Issue:

When a patient suffers an adverse event, many people are affected — the patient, his or her family, and the health care providers. The provider most directly involved in the event becomes the "second victim." While the patient's and family's needs become the priority for the health care organization, the provider may be emotionally traumatized by the event, and have lasting effects that persist for months or years afterward.[1] If not treated, a second victim experience can harm the emotional and physical health of the individual and subsequently compromise patient safety.[2]

Second victim effects include difficulty sleeping, reduced job satisfaction, guilt and anxiety (including fear of litigation or job loss) — all of which affect medical judgment. For some, recurrent memories of the event contribute to burnout, depression and suicidal ideation.[1] Contributing to the trauma is the potential for isolation from colleagues, who may avoid the health care worker. During the months that follow an adverse event, the health care worker may experience characteristics of post-traumatic stress disorder.[3]

The term "second victim" was coined in 2000 by Dr. Albert Wu, a professor of health policy and management at the Johns Hopkins School of Public Health. Currently, there is disagreement about the use of the term. A recent review article in which Dr. Wu is the lead author concludes that while there are compelling arguments both for and against the use of the term, there is no broad study that asked health care providers or the general population what term they would find most appropriate.[4] The article did not suggest alternative terminology.

Prevalence of second victim

It is estimated that nearly half of health care providers could experience the impact as a second victim at least once in their career.[5] A 2014 survey of 1,755 physicians outside the U.S. found most physicians had been involved in a serious safety event and most admitted to experiencing second victim effects.[6]

A recent survey of surgeons revealed that 80 percent recalled having at least one intraoperative adverse event within the past year of their practice. The affected surgeons reported the event had a substantial emotional impact on their well-being, including strong feelings of sadness, anxiety, and shame, some to the extent that they needed formal psychological counseling.[7]

"I am a second victim" — a Joint Commission employee

I was a nurse in the OR suite with a clinician performing a cervical epidural steroid injection. Post-op, the patient developed a spinal hematoma that led to permanent paralysis. It was later discovered that the patient had been taking a new anticoagulant that should have been discontinued days prior to the procedure. Since the patient completed consents and received instructions at his physician's office prior to coming to our facility for the procedure, the pre-procedure screening did not catch this medication change. This was at a time when pre-procedure checklists were not utilized.

Days after the event, the director of nursing asked me to her office to discuss the patient safety event; it was never discussed after that. I continued working with the same team, but the event was like an elephant in the room all the time. I kept wondering, 'What did I do wrong? How did this happen?' I felt guilty and had doubts about my skills as a nurse.

The event occurred before the second victim concept took off. I was never asked how I felt. I was never offered any type of emotional support. It wasn't until I had been working at The Joint Commission for a while that I met with a director who talked about the second victim experience. I was able to convey that learning about the science of patient safety, latent failures, and human factors helped me process the incident. I still think about the event, but I have a better understanding of how the system failed this patient.

(Cont.)

The Joint Commission.

Second victims often suffer in silence

Often, clinicians will not actively seek support but instead suffer in silence or wait to be approached. Many support programs rely on employees, supervisors, or risk managers to connect the affected health care worker with supportive services or support providers. A 2013 survey of members of the American Society for Healthcare Risk Management (ASHRM) revealed that only 18.2 percent of respondents' organizations automatically referred team members to supportive services following an adverse event.[1] The study concluded that there is a need for institutions to adopt improvements, such as referrals by watchful department leaders, and proactively reaching out to support all clinicians after adverse events, regardless of whether support appears necessary.[1]

The resources typically available to staff and leadership after an adverse event occurs is the hospital or organization's clergy, psychiatric department, or employee assistance program (EAP). In a qualitative study based on semi-structured interviews with patient safety officers in acute care hospitals in Maryland, participants identified numerous barriers to staff utilizing EAPs or other supportive services, including:[8]

- Taking time away from work to access the support services.[1,8]
- Fears or doubts about the confidentiality of services.[1,8]
- Concern that support would be placed in a permanent employee record.
- Concern that accepting emotional support might affect malpractice premiums.
- Possible negative judgments by colleagues.
- Stigma associated with accessing services.
- Ineffective support.[1,8]
- A lack of understanding of the purpose of the second victim support program.
- A lack of awareness on the EAP's part on how to support second victims.

Safety Actions to Consider:

The Joint Commission urges health care organizations to take the following actions to support second victims as soon as possible after an adverse event occurs. By addressing the traumatized health care worker, organizations can help ensure that other patients are protected from the domino effect that adverse events can have on health care worker performance.

- Instill a just culture for learning from system defects and communicating lessons learned.[8]
- Engage all team members in the debriefing process and sharing of the lessons learned from the event analysis.
- Provide guidance on how staff can support each other during an adverse event (i.e., how to offer immediate peer-to-peer emotional support or buddy programs).
- If the EAP is the sole source of support for second victims, consider creating supplemental programs after evaluating the EAP's structure and performance.

If your organization has, or decides to create, a second victim program, be sure it includes the following components:

- A strong patient safety culture, which is an essential foundation for implementation of a clinician support program.
- Obtain buy-in from organization leadership and the board.
- Engage executive champions.
- Develop an educational campaign to introduce the second victim concept, reduce stigma and biases, increase awareness and the utilization of services. Staff should know exactly what to expect if they are involved in an adverse event and how to access support.
- Develop policies and procedures, including guidance for direct first responders.
- Develop the program using evidence-based guidance, and ensure that the program is applied fairly toward all staff.
- Identify the current confidentiality protections designed for the support program. Leaders may want to seek legal counsel about options for preserving confidentiality since state laws vary.[1]
- Create additional tiers of service for those who do not recover with peer support or who endure litigation.[1]

- Identify professional resources for external intervention to ensure that the unique needs of each clinician are met.
- Survey health care workers to determine benchmarks of program effectiveness (one resource is the Medically Induced Trauma Support Services (MITSS) Toolkit). Repeat the surveys regularly to track progress.[1]
- Measure utilization, but keep in mind that low rates of use may reflect program deficiencies or barriers to access rather than lack of need.[1]
- Measure effectiveness of the program and services; revise the program, if needed.

Because of the time required to improve organizational culture, an effective second victim program and services can take years to implement and embed into an organization.[9]

Resources:

1. White AA, et al. Risk managers' descriptions of programs to support second victims after adverse events. *Journal of Healthcare Risk Management*, 2015;34(4).
2. Quillivan RR, et al. Patient safety culture and the second victim phenomenon: Connecting culture to staff distress in nurses. *The Joint Commission Journal of Quality and Patient Safety*, 2016;42(8):377-386.
3. Institute for Safe Medication Practices. Too many abandon the "second victims" of medical errors. ISMP Medication *Safety Alert!* July 14, 2011.
4. Wu AW, et al. The impact of adverse events on clinicians: What's in a name? *Journal of Patient Safety*. 2017.
5. Seys D, et al. Health care professionals as second victims after adverse events: A systematic review. *Evaluation & The Health Professions.* 2012;36(2):135-162.
6. Stewart K, et al. Supporting "second victims" is a system-wide responsibility. *British Medical Journal*. 2015;350:h2341.
7. Han K, et al. The surgeon as the second victim? Results of the Boston Intraoperative Adverse Events Surgeons' Attitude (BISA) study. *Journal of American College of Surgeons*, 2017;224(6):1048-56.
8. Edrees HH, et al. Do hospitals support second victims? Collective insights from patient safety leaders in Maryland. *The Joint Commission Journal on Quality and Patient Safety*, 2017;43:471-483.
9. Pratt S, et al. How to develop a second victim support program: A toolkit for health care organizations. *The Joint Commission Journal on Quality and Patient Safety*. 2012;38(5):235-240.

Note: This is not an all-inclusive list.

Other resources:

forYOU: Developed by the University of Missouri Health Care, this program is an emotional "first aid" rapid response team for clinician support following an adverse event.

Medically Induced Trauma Support Services (MITSS) Toolkit: Developed by Beth Israel Deaconess Medical Center, Boston

RISE (Resilience in Stressful Events): The Johns Hopkins Hospital's program is a multidisciplinary peer responder team trained to support second victims.