Caring for the 2nd Victim of a Medical Mishap

2016 Presentation by Patrice Spath

A Medical Mishap Leads to Multiple Victims

First Victim	Patient & Family
Second Victim	Caregivers (direct involved) & team members (indirectly involved)
Third Victim	Organization & Management

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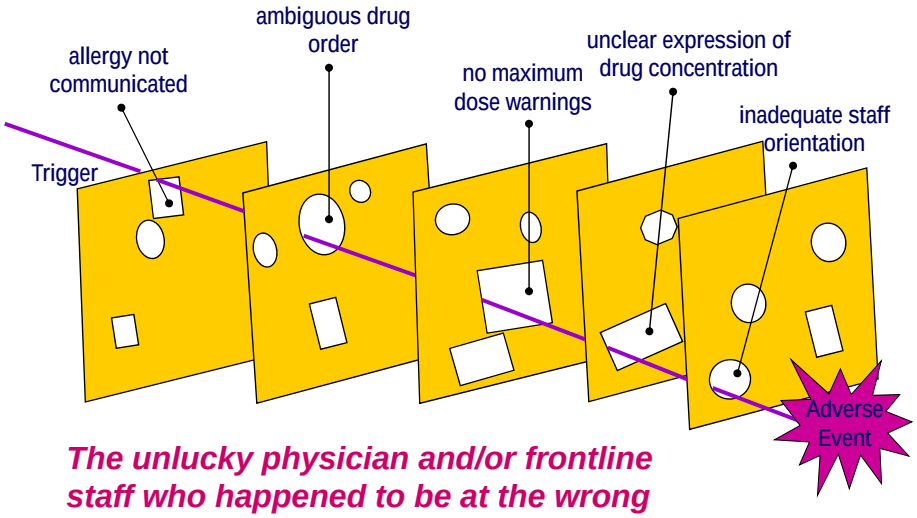
2nd Victims of a Medical Mishap



The unlucky physician and/or frontline staff who happened to be at the wrong place at the wrong time

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Prevalence

- Every healthcare provider can become a second victim (doctors, nurses, pharmacists, therapists, social workers, …)
- It is estimated that almost 50% of healthcare providers are a second victim at least once in their career

Edrees, H., Paine, L., Feroli, E., & Wu A. (2011). Health care workers as second victims of medical errors. *Pol Arch Med Wewn, 121*(4), 101-108.

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Prevalence

- A 2010 survey in the University of Missouri Health Care system found that one in three caregivers (30 percent) had experienced a patient safety event within the past year that had caused personal problems such as anxiety, depression, or concerns about the ability to perform one's job.

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Personal Impact of Mistakes

- 92% of surveyed doctors in one study reported that they had been involved with a near miss or error
- 81% of doctors reported experiencing at least one of these symptoms after an incident:
  - Less confidence in their abilities as a physician
  - Inability to sleep
  - Lower job satisfaction
  - Professional reputation harmed

Waterman AD, Garbutt J, Hazel E, *et al.* (2007). The emotional impact of medical errors on practicing physicians in the United States and Canada. *Jt Comm J Qual Patient Saf, 33,* 467–476.

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Personal Impact of Mistakes

- Physician trainees are even more profoundly affected and elicit intense emotional responses and much personal distress
- Remorse, anger, frustration, fear, guilt, embarrassment are commonly reported – these effects can be long lasting with some doctors feeling permanently affected as a result

Robinson, S., & Brown, R. (2013). *Supporting the second victim*. London: The College of Emergency Medicine. http://secure.collemergencymed.ac.uk/Shop-Floor/Safer%20Care/Safety%20in%20your%20ED/Second%20Victims

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Joint Commission: What's Required

- Leadership Standard: EP 9. The leaders make support systems available for staff who have been involved in an adverse or sentinel event

Note: Support systems provide staff with additional help and support as well as additional resources through the human resources function or an employee assistance program. Support systems also focus on the process rather than blaming the involved individuals.
(*2015 Comprehensive Accreditation Manual for Hospitals*: The Patient Safety Systems Chapter)

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What is Your Organization's 2nd Victim Support Process?

- Do you have mechanisms in place to provide 2nd victims with psychological first aid
- Do you empower 2nd victims - debrief them about what will happen next?
- Do you offer them the opportunity to be involved in the event investigation as an active participant?
- Is the support process run by peers not managers?
- Have you ever facilitated an encounter between the 1st and 2nd victims?

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5 Rights of Second Victims

- **Treatment that is just**. Second victims deserve the right of a presumption that their intentions were good, and they should be able to depend on organizational leaders for integrity, fairness, just treatment, and shared accountability for outcomes.
- **Respect.** Second victims deserve respect and common decency and should not be blamed and shamed for their human fallibility.
- **Understanding and compassion.** Second victims need compassionate help to grieve and heal, and leaders must understand the psychological emergency that occurs when a patient is unintentionally harmed.
- **Supportive care.** Second victims are entitled to psychological and support services that are delivered in a professional and organized way.
- **Transparency and opportunity to contribute.** Second victims have a right to participate in the learning gathered from the error to share important causal information with the organization and to provide the victims with an opportunity to heal by contributing to the prevention of future events.

Denham, C.R. (2007). TRUST: The 5 rights of the second victim. *Journal of Patient Safety*, *3*(2), 107-119.

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At a Minimum

- Hold a debriefing meeting within 72 hours (ideally 24 hours) following the event
  - The meeting should include employees directly involved or who witnessed the sentinel event
  - Management and other people not directly involved with the incident should not be included in the session
- Engage a mental health professional or other qualified facilitator to assist in the debriefing process

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At a Minimum

- Debriefing is NOT a fact-finding meeting. The purpose is to:
  - Help employees understand some of the reactions they may have and encourage employees to gain support from each other
  - Give people an opportunity to verbalize their thoughts and feelings about the incident
- Strongly recommended: employee attendance at the debriefing meeting is mandatory
- Hold a follow-up debriefing to allow employees to discuss any feelings which have come up since the time of the first debriefing and share coping strategies

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Managers Support Those Involved

- After the event (weeks or even months) watch for signs the 2nd victim needs additional counseling
  - Irritability
  - Fatigue
  - Negativity
  - Nervousness
  - Poor health or aches and pains
  - Critical and demanding behavior
  - Drug or alcohol abuse
  - Apathy
- Sentinel events can sometimes trigger memories of painful and unresolved past incidents in a person's career and more assistance from a mental health professional may be needed

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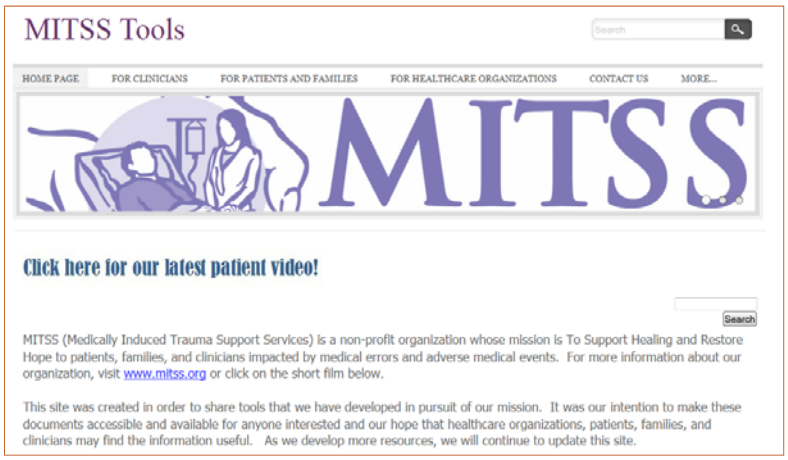

http://www.mitsstools.org/

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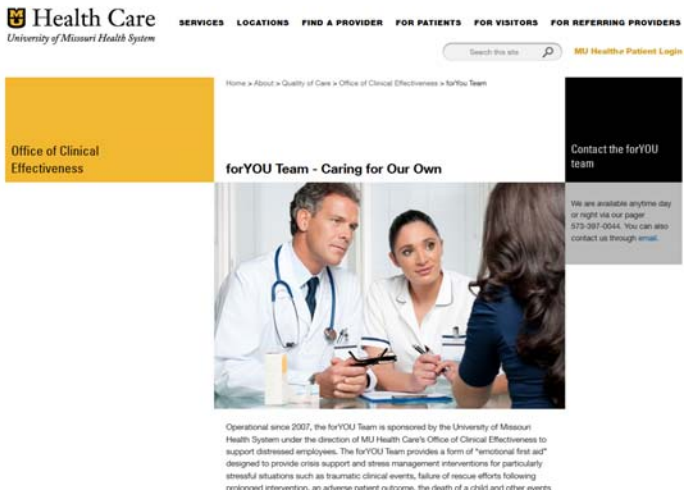

http://www.muhealth.org/about/qualityofcare/office-of-clinical-effectiveness/foryou-team/

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Final Thoughts

- Second victims need support to cope with the aftermath of an adverse event
- Support structures (short and long term)
  - Immediate support
  - Peer support
  - Professional support (outside of the organization)
- Not only the affected caregiver, but also the team around him or her

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Final Thoughts

- Barriers to 2nd victim support
  - Medical error remains a taboo
  - Threat of professional loss of respect
  - Lack of institutional (community) support
- Leadership and culture is necessary
  - Open dialogue
  - No blame, no shame
  - Culture of continually improvement