The Second Victim

HOW TO SUPPORT –PRACTICAL STEPS

SHIRLEY REMINGTON

Second Victim: Origin of the term

Albert W Wu (2000) Medical Error: The second victim, the doctor who makes the mistake needs help too *BMJ Volume 320; 726-72*

"Although patients are the first and obvious victims of medical mistakes, doctors are wounded by the same errors: they are the second victims."

Second Victim

Second victims are healthcare providers who are involved in an unanticipated adverse patient event, in a medical error and/or a patient related injury and become victimized in the sense that the provider is 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.

–Scott 2009 BMJ Quality and Safety

TRUST- Charles Denham

Charles Denham, chairman of Texas Medical Institute of Technology, proposes five human rights for second victims

Treatment that is just: Assume innocence and good intentions, and treat all parties fairly.

Respect: No blame or shame for human fallibility.

Understanding: Compassion for the grieving and healing that the second victim will experience.

Supportive care: Psychological and support services.

Transparency: Allow second victims to participate in learning opportunities and the prevention of future medical errors.

Incidence

RCP Clinical Medicine 2014- study
83%experienced incident 76%affected 25%PTSD 41% incident unreported

Earlier studies 10-40% PTSD like syndrome 1-4% leave profession

USA up to 98,000 deaths annually from medical error

Second Victims

- Complex – resolution delayed –multiple processes
- Resembles complex PTSD
- Many Studies describing- few on effective intervention.

Scott et Al 2009-recovery trajectory

- 1 -Chaos and accident response
- 2-Intrusive reflections-what if?
- 3-Restoring integrity- support sought understanding impact on personal professional level
- 4-Questions from others concern re impact of action
- 5- getting emotional first aid
- 6-Moving on ,surviving , dropping out or thriving

Psychological and emotional responses

- Loss of trust
- Feelings of inadequacy and loneliness
- Perceived indifference from colleagues
- Anger, guilt, frustration, shame
- Inability to think or concentrate
- Distress when exposed to events that remind them of the trauma
- Hypervigilance/flashbacks/avoidance and emotional numbing
- Anxiety, depression , substance abuse
- Desire to connect with others with similar experiences

Other effects

- Cognitive- loss concentration, distractible
- Physical- sleep, eating, fatigue
- Behaviour- withdrawal others, obsession with finding information related to accident

Coping Strategies- Pinto et Al 2013

- Problem focused
- Emotion focused
- Discussing with others
- Identifying learning

Helping-personal

- Normal routine
- Talking about event
- Relaxation exercises and Exercise
- Back to work and site of problem
- Time with family and friends
- Eat normally –no excess caffeine ,nicotine, alcohol
- Expect to get better
- Increased care-driving other activities

Hindering- personal

- Social /work isolation
- Overly high expectations-takes time.
- Avoiding talking about issue.
- Not getting help
- Getting tired
- Not eating

Emotional First Aid – Providing Support

- "*I heard about yesterday. How are you doing?*" (If the answer is "fine", keep talking.)
- Explore feelings: *"That's got to be tough. Are you sleeping okay."*
- Normalize the event: *"There is a well-described phenomenon in which healthcare providers themselves can be traumatized by a medical events, just like first responders and cops."*
- Ask how they have coped with stressful events in the past.
- Steer conversation away form focus on the medical details of the case and back to their symptoms, coping.
- Follow-up: *"I will give you a call tomorrow, but here is my number if you want to talk about this at all before then."*

Hindering –Others Actions

- Not discussing problem
- Avoiding person
- Anger with individual
- Blame
- Implying Weakness

The severity of outcome is not a good predictor of outcome for the second victim.

- DROPPING OUT
- SURVIVING
- THRIVING
- *Determined by…*
- Professional community and social support.
- Resilience of the second victim
  - Enhancing personal resilience
- Resilience of the organisation
  - Creating a Just Culture

Tim Woodcock

Sources of support

- Colleagues –senior
- Family and Friends
- Other agencies

Practical aspects

- Psychological safe space
- Initial
- Continuing
- Ideal support

Initial support

- What needs to be done on day
- Practicalities-making notes and incident form
  -interaction patients/ relatives
  -continue with clinical work?
  -someone to talk to-who?
  -getting home
  -rest of the day

Clarity on Future Processes

Psychological debrief-no –clinical group debrief –third victims

Guided Reflection –on the day and beyond

- With mentor – verbal used with feedback
- Emphasis on positive thinking areas
- Identifying use of strengths
- Explore areas that need reframing thoughts
- Self compassion
- Planning written reflection and review
- Thinking about the rest of the day –what works for you-being human-enjoyment
- Reverse mentoring
- 3 good things

On going support

- Return to work- scope of work
- Observed behaviours
- Offered specialist support-when and who
- Recurrent issues-reinstituting support
- Concerns re-revalidation
- Involve in decisions
- Keep informed and involved
- Let individual lead process – be prepared to intervene
- Involve in on going learning

Signs of problems from 4 weeks

- Emotional blunting
- Emotional volatility
- Absenteeism-professional activities
- Presentism- but disengaged
- Failure to engage with processes

Support

- Empathy not sympathy
- Compassion
- Supportive challenge
- Non judgemental
- Independent-safe space
- Flexible
- High E-IQ
- Peer at least
- Take time-don’t interrupt

SELF COMPASSION

- Understanding
- Empathy
- Forgiving
- Recognising you have done your best
- Treating self as others

The Organisation

Developing culture

Leadership

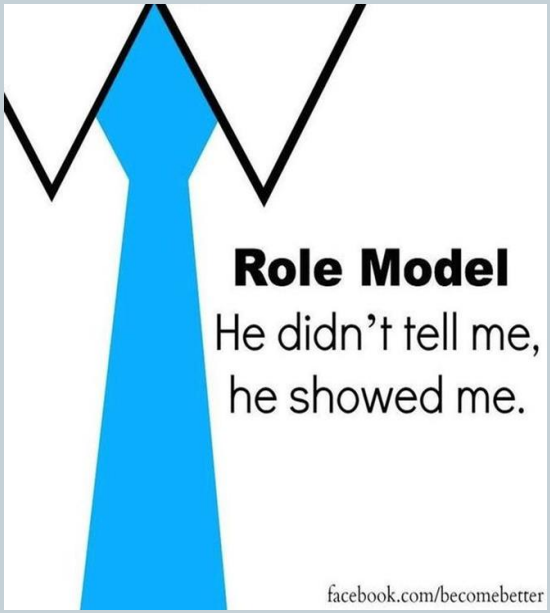
Local planning

Developing Culture

- Internal relationships
- Open approach to learning from incidents/complaints - no blame.
- Clear processes
- Safety – patients /staff
- Professionalism as part training CPD

Leadership

- Style- approach/ delegation
- Defined process for medical accident/ complaints-including learning and clinicians right to support
- Defined support systems
- Flexibility
- Openness - confidentiality balance
- Development of professional learning/appraisal



How organisational culture supports staff

- No blame culture and just
- Honest and transparent – the norm
- Blame , humiliation and gossip not tolerated
- Aware of staff self blame and systems to mitigate
- Value and encourage peer support
- Use and encourage positive reflective practice
- Encourages individual wellbeing

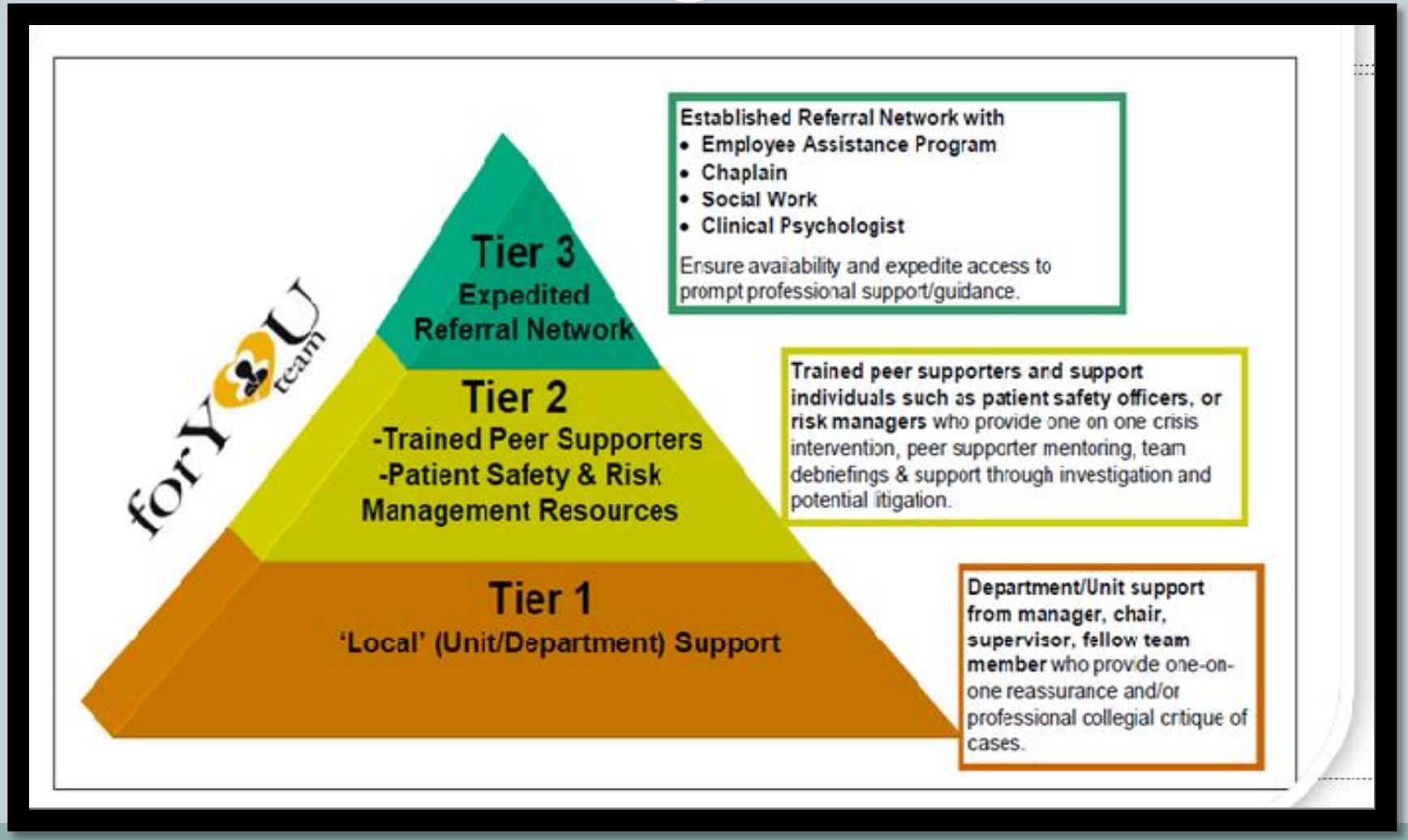
Trust Board Level

- Defined internal plan for supporting staff involved in investigations
- Financial awareness of impact on staff
- Investment in support systems
- Schwartz rounds/stress awareness
- Support system – John Hopkins (RISE), University of Missouri

Organisational Actions

- Make resources available
- Train staff and make them aware
- Develop peer support-recruit and train
- Ensure this aspect is in incident and complaint policies
- Audit and quality assure
- Share good practice and commit longterm

The Scott Three-Tiered Interventional Model of Second Victim Support



Colleges –EM and others

Supporting the Second Victim
Sue Robinson

Introduction

Second victims are health care providers who are involved in an adverse patient event, or medical error and become victims because they are traumatised by the event[1]. Despite this term being first coined in 2000 by Professor Wu of John Hopkins[2] it is only in recent years that those responsible for training and managing doctors have actively established processes to support staff involved in critical incidents that cause harm to their patients.

Purpose

To enable the senior team within an ED to develop a framework that:
a) acknowledges the impact error can have on staff
b) enables staff involved in incidents to be effectively supported so that they can recover and return to work
c) acknowledges that occasionally a more formal intervention may be required and is able to facilitate this

References

1. Scott SD, Hirschinger LE, Cox KR, McCoig M, Brandt J, Hall L. The natural history of recovery for the healthcare provider 'second victim' after adverse patients events. Qual Safe Health Care.2009;18:325-330.
2. Medical Error: the second victim. The doctor who makes mistakes needs help too. BMJ.2000;320:726-727

Objective 1	*Action*	*Evidence and Resources*
To understand the concept of the second victim.	Caring for the member of staff involved in a medical error is often overlooked. It is important the whole team understand the impact a clinical error can have on staff and the wider health care system.	**The Second Victim Phenomenon: A Harsh Reality of Health Care professions.** May 2011 Perspective Scott SD. http://webmm.ahrq.gov/perspective.aspx?perspectiveID=102 **Medical error: Impact on and management by French General Practitioners in training. A study of 70 questionnaires and 10 semi structured interviews.** Venus E, Galam E, Aubert J et alBMJ Qual Saf 2012; 21:279-286. http://qualitysafety.bmj.com/content/early/2012/01/02/bmjqs-2011-000359.abstract **The Emotional Impact of Medical Errors on Practicing Physicians in the United States and Canada.**Watermann AD et al. Jt Comm J Qual Patient Saf. 2007;33:467-476 http://www.ncbi.nlm.nih.gov/pubmed/17724943 **Residents' Responses to Medical Error: Coping, Learning, and Change.** Engel K, Rosenthal M, Sutcliffe KM. Acad Med.2006;81:86-93 http://www.ncbi.nlm.nih.gov/pubmed/16377827

Remember Value of R and R-being human

- Normal activity
- Novelty
- Positive thinking
- Support

Looking after ourselves

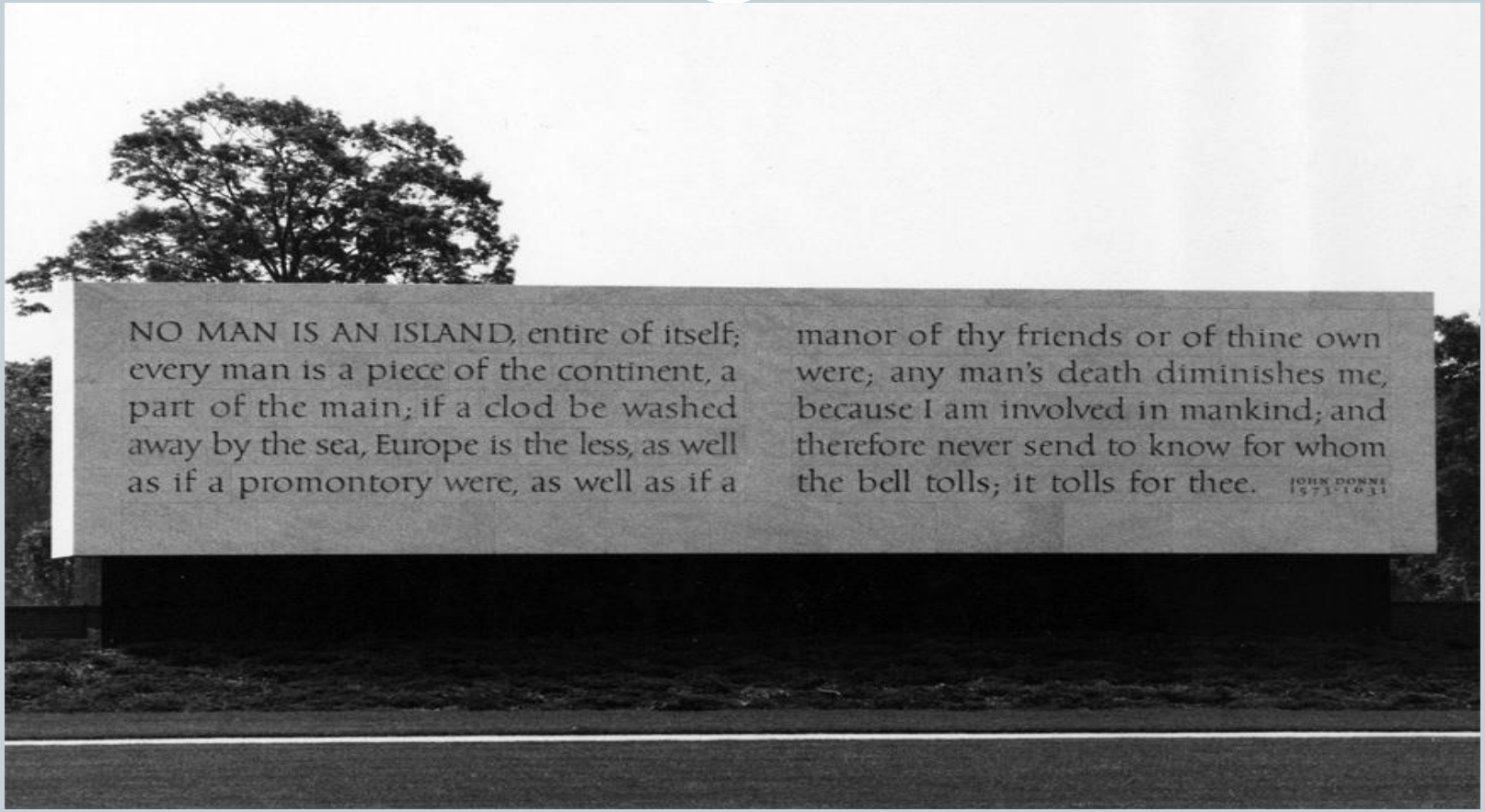
Resilience and wellbeing

Take Homes

RESPECT AUTONOMY
PREPARE WITH GOOD HABITS
BE THERE
START TODAY

DEVELOP CULTURE AND ORGANISATION

Finally- random acts of kindness



- Thanks and Questions

Information sources

- AAGBI-2005-Catastrophes in Anaesthetic Practice- managing the aftermath
- RC Psychiatrists PTSD leaflet
- Doctors for Doctors ,BMA and other specialist support.
- Pinto et al. Surgical complications and implications for surgeons well being December 2013 BJS
- MITSS (Medically Induced Trauma Support Services) www.mitss.org
- Seys et Al Health Care Professionals as second victims after adverse events:a systematic review March 2013 Eval. Health Prof
- Australian Guidelines for incident management
- Kiaser Permanate Guidance