

SECOND VICTIM IMPACT STUDY IN CONNOLLY HOSPITAL

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Serious Adverse Event



1st
Patient

- Restore Health
- Systems Analysis Review
- Action plan to mitigate similar event occurring

2nd Staff
involved

- Susceptible to further error in the immediate aftermath
- Behavioural changes: defensive medicine

3rd
Organisation

- Loss of public confidence as a result of adverse publicity

Systems Analysis Review

- 'The Staff I'll Never Forget'
- Support available?
- Second Victim



Second Victim: Definition

*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 et al 2009)

Second Victim Response

Emotional Response

- Error realised
- Experience a wave of emotions; distracted
- **Stabilise and treat the patient**

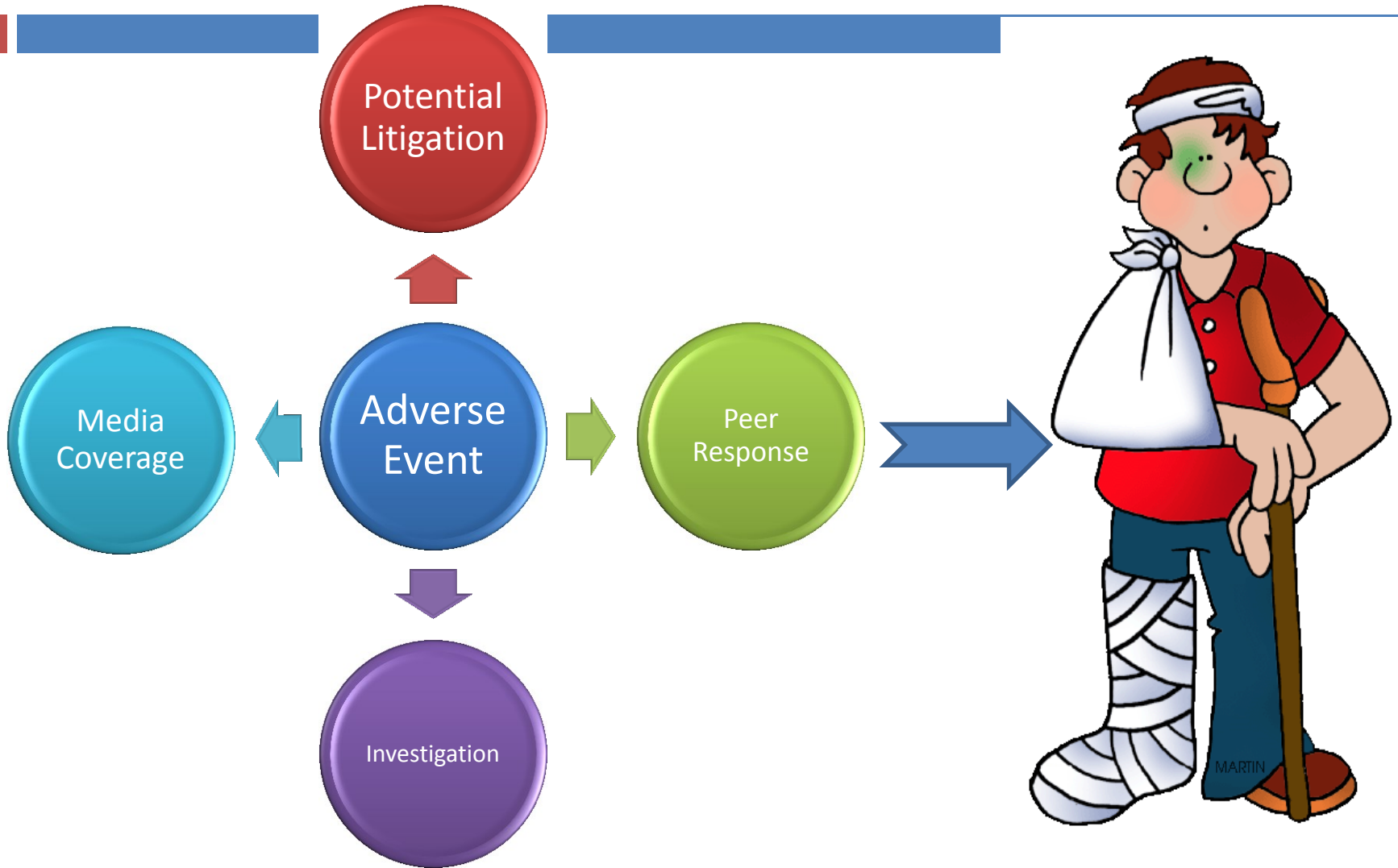
Psychological Symptoms

- Feelings of guilt, anger and shame
- Haunted by re-enactments of the event, self isolate
- **Fear is prevalent**

Physical Symptoms

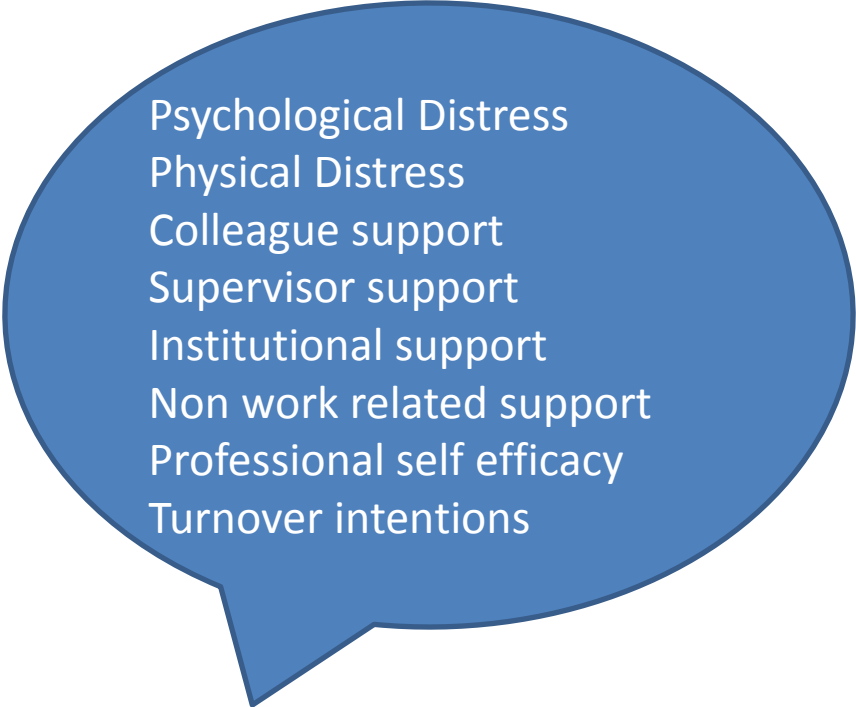
- Nausea; Altered appetite;
- Difficulty sleeping leading to exhaustion
- Ability to concentrate affected

Multiple Second Victim Traumas



Second Victim Experience Study

- **Aim:** To assess the experience of second victims in Connolly Hospital and the support options considered most useful by those experiencing the trauma, with a view to enhancing the culture of quality and safety within the Hospital
- Second Victim Experience and Support Tool (Burlison et al 2016)
- Focus Group
- Sample Strategy
- Response Rate
- Demographic Data



Psychological Distress
Physical Distress
Colleague support
Supervisor support
Institutional support
Non work related support
Professional self efficacy
Turnover intentions

Physical Distress

- Queasy or nauseous (35%)
- Appetite affected (33%)
- Difficulty sleeping (49%)
- Extreme fatigue (66%)

Psychological Distress



- Embarrassment (73%)
- Feeling Miserable (51%)
- Fearful of future occurrences (67%)
- 34% said that they were afraid to attempt difficult or high risk procedures

Self Doubt in Professional Ability

- 50% of respondents reported that they experienced feelings of inadequacy regarding their patient care abilities
- 44% of respondents said that their experience made them wonder if they were not really a good healthcare provider

Colleague Support

- 88% of respondents agreed that a respected peer to discuss the details of what happened was important
- 83% of respondents said that discussing what happened with their colleagues provided them with a sense of relief
- 79% of respondents said that their colleagues helped them to feel that they were still a good healthcare provider despite their mistake

Variation in responses: Females Vs. Males

Female second victims are more likely than males to:

- ❑ Experience exhaustion (73% vs. 46%)
- ❑ Have their appetite affected (36% vs. 26%)
- ❑ Experience feelings of inadequacy (54% vs. 40%)
- ❑ Consider a career outside of healthcare (32% vs. 20%)
- ❑ Consider leaving their job due to stress (45% vs. 29%)

Female and Male respondents agree that:

- ❑ Discussing what happened with their colleagues provided the most useful support

Dropping Out

- Feelings that they are not a good healthcare provider
- Transferring to a different Department or Hospital
- Consider quitting their job

Surviving

- Persistent sadness
- Coping but still have intrusive thoughts
- Trying to learn from the event

Thriving

- Gain insight /perspective
- Maintain life/ work balance
- Does not base practice on one event
- **Gets involved in patient safety initiatives**

Practical interventions to lessen the second victim impact

- Immediately when an adverse event happens:
 - ✓ Show concern for your colleague
 - ✓ They may need time away from the ward to recover and compose themselves
 - ✓ Depending on the severity of the incident, consider if they will be recovered sufficiently to work their next rostered shift
 - ✓ Facilitate a 'hot debrief' at the end of the shift

Proactive interventions designed to lessen the second victim impact

- Consider a formal debriefing session
- Access to a trained counsellor or Employee Assistance Programme
- Raise awareness with staff: accept that staff will and do have an emotional reaction
- Promote attendance at Open Disclosure training
- Support Resilience training

Proactive interventions designed to lessen the second victim impact

- Include staff support measures in policy
- Schwartz rounds
- Learning from Excellence
- Avail of tools that already exist such as (i) the HSE Patient Safety Toolbox talk (ii) the Staff Support Booklet: ASSIST ME



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Review article

The Second Victim: a Review

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ABSTRACT

Amongst the lay and media population there is a perception that pregnancy, labour and delivery is always physiological, morbidity and mortality should be “never events” and that error is the only cause of adverse events. Those working in maternity care know that it is an imperfect art, where adverse outcomes and errors will occur. When errors do occur, there is a domino effect with three groups being involved – the patient (first victim), the staff (second victims) and the organization (third victims). If the perceived expectation of patients on all clinicians is that of perfection, then clinicians may suffer the consequences of adverse outcomes in isolation and silence.

More recently identification and discussion on the phenomenon of the second victim has become a popular research topic. This review aimed to study not only the phenomenon of second victim in general medical care but to also concentrate on maternity care where the expectation of perfection may be argued to be greater. Risk factors, prevalence and effect of second victims were identified from a thorough search of the literature on the topic. The review focuses on the recent research of the effect on maternity staff of adverse outcomes and discusses topical issues of resilience, disclosure, support systems as well as Learning from Excellence.

It is now well documented that when staff members are supported in their disclosure of errors this domino effect is less traumatic. It is the responsibility of everyone working in healthcare to support all the victims of an error, as an ethical duty and to have a supportive culture of disclosure. In addition, balance can be provided by developing a culture of learning from excellence as well as from errors.

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