

Halifax 10: The Canadian Healthcare Safety Symposium

HEALTHCARE WORKERS: THE 'SECOND VICTIMS' OF MEDICAL ERRORS

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Case Study

- **8 year old boy to ED after MVA**
- **Needed airway control for facial trauma, oropharyngeal hemorrhage**
- **Rapid sequence intubation by ED MD**



Case Study

- **8 year old boy to ED after MVA**
- **Needed airway control for facial trauma, oropharyngeal hemorrhage**
- **Rapid sequence intubation by ED MD**
- **Oral intubation unsuccessful**
- **Cricothyroidotomy unsuccessful**
- **Cardiopulmonary arrest and died**



What happens to staff after traumatic events?

- “You have to take a new patient”
- “We were returned...to carry on as though none of what we had just seen had occurred.”
- “It was like returning to a war zone”



The ED Physician

- Most of physician’s colleagues were supportive
- Some were critical of actions
- Left clinical medicine several months later



Medical error: the second victim

The doctor who makes the mistake needs help too

When I was a house officer another resident failed to identify the electrocardiographic signs of the pericardial tamponade that would rush the patient to the operating room late that night. The news spread rapidly, the case tried repeatedly before an incredulous jury of peers, who returned a summary judgment of incompetence. I was dismissed by the lack of sympathy and wondered secretly if I could have made the same mistake—and, like the hapless resident, become the second victim of the error.

improvements that could decrease errors. Many errors are built into existing routines and devices, setting up the unwitting physician and patient for disaster. And, although patients are the first and obvious victims of medical mistakes, doctors are wounded by the same errors: they are the second victims.

Virtually every practitioner knows the sickening realisation of making a bad mistake. You feel singled out and exposed—seized by the instinct to see if anyone has noticed. You agonise about what to do, whether to



BMJ 2000

Scorecard for Handling AEs

- **Acknowledgment of safety problem** A-
- **Disclosure to family** A
- **Public disclosure** A
- **Learning from mistakes** B
- **Sensitivity to staff concerns** ??





- "Josie died of dehydration and misused narcotics"



Josie died of sepsis and resulting dehydration



From Closing Ranks to...



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...Under the Bus



- Good disclosure but poor follow through
- At expense of the feelings of health care workers?

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Doing better but feeling worse

Responses to Trauma

- 50% “roll with the punches”
- 30% anxious or depressed, but eventually return to previous levels of functioning
- Most reactions resolve within 10 days to 3 months

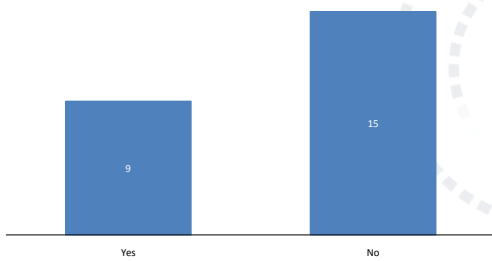
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Responses of Second Victims

- **Recurring thoughts, nightmares**
- **Emotional intensity (shutdown)**
- **Search for meaning**
- **Withdrawal/Social isolation**
- **Physical symptoms/forgetting**
- **Ability to deal with patients can be impaired**

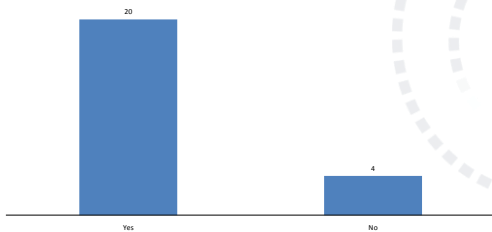


Have you heard of the term 'second victim' ?



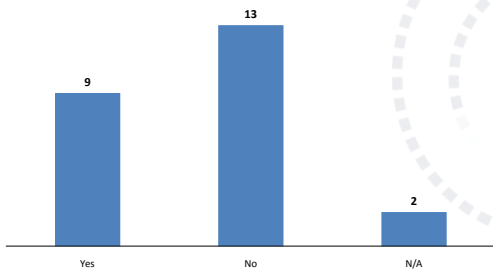


Can you recall an adverse event where you were a second victim?



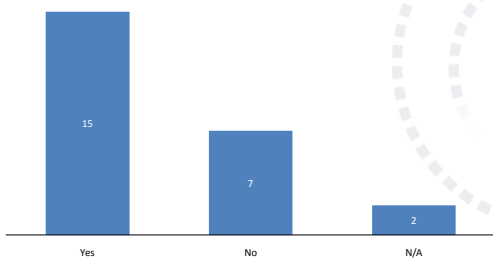


As a result ...did you have any personal problems, such as anxiety, depression, or concern about your ability to perform your job?



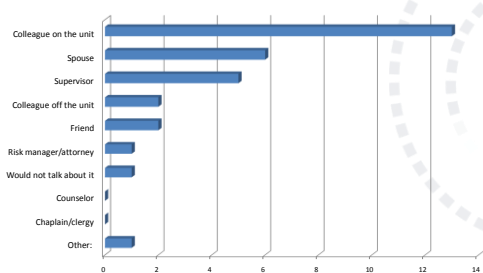
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Did you talk to someone about the situation?



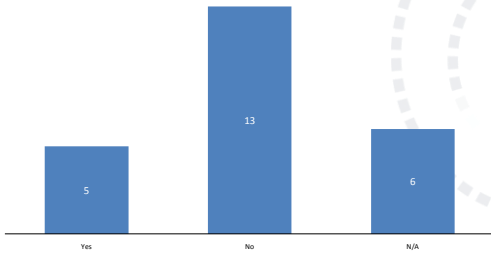
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Who did you talk to?



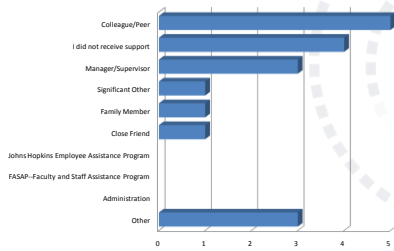
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Did you receive support from anyone in this health system?



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Who supported you following this event?



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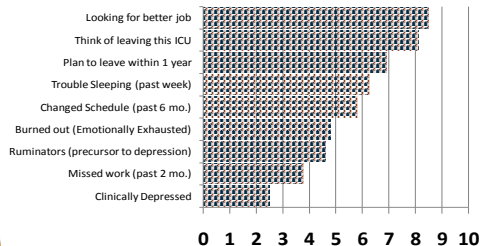
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Preliminary Data (Sexton)

**Nurse Coping: 80 RNs from 2 ICUs
 Shown Here as an ICU of 10 RNs
 Johns Hopkins ICU RN Pilot Data
 funded by the Josie King Foundation**



Peer Response

- What do colleagues say after an adverse event?
- What would you like your colleague to say to you after you were involved in an adverse event?



Things People Say

- Well, I wouldn't have done *that*
- Didn't you realize what would happen?
- What were you thinking?
- Why didn't you do x?
- Nothing
- (Things behind your back)



Why So Little Sympathy?

- Differentiate themselves
 - "Make sure isn't me"
- Fundamental attribution error
 - Attribute own errors to situation
 - Other's errors to personal characteristics
- Deficient education



We are not yet fully evolved



Developmental Stages

2000 Safety



Do No Harm



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Developmental Stages

2001 Disclosure



Being Open

2000 Safety

Do No Harm



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Developmental Stages

2004 Reporting



Learn from Mistakes

2001 Disclosure

Being Open

2000 Safety

Do No Harm



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Developmental Stages

2010 Self Care

Care for Caregivers

2004 Reporting

Learn from Mistakes

2001 Disclosure

Being Open

2000 Safety

Do No Harm



Helping the Second Victim

- Awareness
- Prevention
- Intervention



Increasing Awareness/Sensitivity

- Caregivers work in stressful environments that are often unpredictable and uncontrollable
- Severe adverse events always have second victims



**Sue Scott
University
of Missouri**

**The forYOU team
is here for you!**



Need to talk about a case that is bothering you?
You've cared for our patients — now let us care for you.

The forYOU team is available for any employee, faculty member or student working at a University of Missouri Health Care hospital or clinic. Developed by the Office of Clinical Effectiveness, the forYOU team is a confidential service that provides 24-hour care to employees who are experiencing a normal reaction to a stressful event or outcome. Contact the forYOU team at any time, day or night, by logging ID# 203-6044.

Health Care
University of Missouri Health System





Second Victim Recovery



- Stage 1 – Chaos & accident response**
- Stage 2 – Intrusive reflections**
- Stage 3 – Restoring personal integrity**
- Stage 4 - Enduring the inquisition**
- Stage 5 - Getting emotional first aid**
- Stage 6 - Moving on**



Words That Heal

- **Like patients after adverse events, second victims have**
 - **Emotional Needs**
 - **Informational Needs**
 - **Clinical Needs**



Informational Needs

Reflect, interpret, summarize

- You did everything you could
- These things happen to all of us
- Let me tell you about something that happened to me
- You are a good doctor/nurse



Emotional Needs

- Are you ok?
- You've had a tough break
- Thank you for sharing with me
- How are you coping?

- Verify: are you going to be ok?
- When in doubt, refer



Interventions Needed

- Leverage existing resources
- Trained Peer support
- Crisis response team
- Procedures/Tools
- New interventions



Caring for the Caregivers

- **Expressive writing (Pennebaker)**
- **Paradigm**
 - Write for 3-5 days, 15-30 min per day
 - Anonymous, no feedback



Mechanisms

- **Personal upheavals**
 - disrupt normal cognitive activity
 - undermine social interactions/relationships
- **Writing about an upheaval**
 - reduces the need to inhibit thoughts, emotions, behaviors
 - improves emotional modulation
 - brings about cognitive restructuring
 - frees working memory



Comprehensive Strategy for AEs

- **Governance and leadership set expectations and culture**
- **Policies & processes**
- **Consistent message**
- **Training and support systems**
- **Disclosure to patients**
- **Fair treatment for disclosers**
- **Learning from errors**
- **Caring for caregivers**





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