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

Objective 1	*Action*	*Evidence and Resources*
continued		**Association of Perceived Medical Errors with resident Distress and Empathy. A Prospective Longitudinal Study.** West CP, Huschka MM, Novotny PJ et al. JAMA.2006; 296:1071-1077 http://jama.jamanetwork.com/article.aspx?articleid=203249 *This dramatic 19-minute documentary film exposes the painful impact on clinicians when patient care goes wrong. Healing the Healer also includes eight short special features with a focus on providers and programs. The first half of the video offers a closer look at four providers who share their pain and personal insights for how doctors and nurses can be supported. The second half highlights four programs across the United States where institutions describe how clinicians are treated after an adverse event (n.b.. this video needs to be purchased.)* ***Healing the Healer* [DVD]** A CRICO Video production http://www.rmfstrategies.com/Products-and-Services/Risk-Education-Training-and-Products/Films-and-DVDs **'Healing the healer' trailer on YouTube** http://www.youtube.com/watch?v=JmB8PCEXVgk *A number of coping strategies are used by staff involved in critical incidents. These include:* **Coping with Medical Mistakes and Errors in Judgement.** Goldberg RM, Kuhn G, Andrew LB, Thomas HA. Annals of Emergency Medicine. 2002; 39:287-92 http://www.ncbi.nlm.nih.gov/pubmed/11867981 **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 **The Natural History of recovery for the Healthcare provider 'Second Victim" after Adverse Patient Events.** Scott SD, Hirschinger LE, Cox KR. Qual Saf Health Care.2009;18:325-330 http://www.ncbi.nlm.nih.gov/pubmed/19812092

Objective 2	*Action*	*Evidence and Resources*
To develop a strategy for improving the care of the second victim.	It is crucial to understand what is meant by a just and safe culture so that this can be developed within the ED. Without this it is unlikely the appropriate support for the second victim will be developed.	*This document outlines expected good practice in building a safer culture and managing, reporting and learning from patient safety incidents. It sets out the seven steps that NHS organisations should take to improve patient safety.* National Patient Safety Agency, 2004. ***Seven Steps to patient safety: full reference guide.*** http://www.nrls.npsa.nhs.uk/resources/collections/seven-steps-to-patient-safety/?entryid45=59787 *This white paper introduces an overall approach and tools designed to support two processes: the proactive preparation of a plan for managing serious clinical adverse events, and the reactive emergency response of an organisation that has no such plan.* Institute for Healthcare Improvement, 2011. ***Respectful Management of Serious Clinical Adverse Events*** http://www.ihi.org/knowledge/Pages/IHIWhitePapers/RespectfulManagementSeriousClinicalAEsWhitePaper.aspx *The following two sites outline some of the tools available to assess the safety climate of an organisation and department. If undertaken they should be repeated over time to ensure improvement.* **Agency for Healthcare Research and Quality** http://www.ahrq.gov/professionals/quality-patient-safety/patientsafetyculture/index.html **Institute for Healthcare Improvement, Safety Climate Survey** http://w.primaris.org/sites/default/files/resources/Patient%20Safety/safety%20climate%20survey.pdf *This document aims to build awareness of the importance of human factors in making changes to improve patient safety.* Patient Safety First, 2010. ***Implementing Human Factors in Healthcare*** http://www.patientsafetyfirst.nhs.uk/ashx/Asset.ashx?path=/Intervention-support/Human%20Factors%20How-to%20Guide%20v1.2.pdf *The department should ensure there are opportunities to discuss incidents or error in a non-judgmental and structured manner such as Mortality and Morbidity meetings, action after review. The following resources are designed to support this.* **The UCH Education Centre**, ***Behavioural Programmes*** http://ucheducationcentre.org/behaviouralprogrammes.html **Mortality and morbidity meetings: an untapped resource for improving the governance of patient safety?** Higginson J, Walters R, Fulop N. BMJ Qual Saf (2012). http://qualitysafety.bmj.com/content/early/2012/05/02/bmjqs-2011-000603.full

Objective 2	*Action*	*Evidence and Resources*
continued	Open and honest communication with patients is crucial. Evidence suggests that being open when things go wrong can help staff to cope with the after effects of a patient safety incident.	*This framework is a best practice guide for all healthcare staff, including boards, clinicians and PALS. It explains the principles behind Being Open and outlines how to communicate with patients, their families and carers following harm.* **National Patient Safety Agency, 2009. *Being Open*** http://www.nrls.npsa.nhs.uk/resources/collections/being-open/?entryid45=83726 **National Patient Safety Agency, *Being Open*** www.nrls.npsa.nhs.uk/beingopen
	Consider what systems have been shown to work elsewhere and what elements need to be incorporated into a strategy to support the second victim.	*This paper outlines the core concepts of any support programme.* **Trust: The 5 Rights of the Second Victim.** Denham Cr. J Patient Saf 2007; 3:107-119 *http://hospitalrx.com/pdf/Denham_Trust_The-Five-Rights-of-2nd-Victim_JPS_2007June3%282%29pp107-119_LTR.pdf* *This describes the process followed to develop the second victim support programme highlighted below:* **How to Develop a Second Victim Support Program: A Toolkit for Health Care Organizations**. Pratt S, Kenney L, Scott SD, Wu AW. JtComm J Qual Patient Saf. 2012; 38:235-240 *http://psnet.ahrq.gov/resource.aspx?resourceID=24407* *This toolkit was developed to help healthcare organisations implement support programmes for clinicians.* **MITSS Clinician Support Toolkit for Healthcare Workers**, 2011. http://www.mitsstools.org/tool-kit-for-staff-support-for-healthcare-organizations.html *The following resources highlight systems for supporting the second victim:* **Caring for our Own: Deploying a System wide Second Victim Rapid Response Team.** Scott SD et al. JtComm J Qual Patient Saf 2010; 36(5): 233-240 http://www.psnet.ahrq.gov/public/Scott-JCJQPS-2010-ID-18023.pdf **Building a Clinician Support Program - Assessment Worksheet/Planner** http://www.mitsstools.org/uploads/3/7/7/6/3776466/building_a_second_victim_support_programdecember3.pdf **MITSS 'Disclosure and Apology: What's missing?' Advancing programs that support clinicians.** http://www.mitss.org/MITSS_WhatsMissing.pdf **Factors associated with disclosure of medical errors by house staff.** Kronman AC, Paasche-Orlow M, Orlander JD. BMJ Qual Saf 2012; 21:271-278. http://qualitysafety.bmj.com/content/21/4/271/suppl/DC1

Objective 2	*Action*	*Evidence and Resources*
continued		**Improving the patient, family and clinician experience after harmful events: 'the when things go wrong' curriculum.** Bell SK, Moorman DW, Delbanco T. Acad Med 2010; 85:1010-17 http://www.ncbi.nlm.nih.gov/pubmed/20505403 The following three websites highlight examples from a number of hospitals: **Brigham and Women's Hospital** http://www.mitsstools.org/uploads/3/7/7/6/3776466/peer_support_published.pdf **University of Missouri Health System** http://www.mitsstools.org/uploads/3/7/7/6/3776466/grand_rounds_9-1-10_second_victim.pdf **Brigham and Women's department of Professionalism and Peer Support** http://www.brighamandwomens.org/medical_professionals/career/cpps/PeerSupport.aspx
	There must be a fair and consistent approach towards staff involved in patient safety incidents. All staff should understand what to expect if they are involved in an error.	*The National Patient Safety Agency has developed the Incident Decision Tree to determine a fair and consistent course of action toward staff involved in patient safety incidents.* **National Patient Safety Agency, *Incident Decision Tree*.** http://www.nrls.npsa.nhs.uk/resources/?EntryId45=59900 *This paper details the evaluation of the above tool.* **The Incident Decision Tree: Guidelines for Action Following Patient Safety Incidents,** Sandra Meadows, Karen Baker, Jeremy Butler. Advances in Patient Safety: Vol. 4 http://www.ahrq.gov/downloads/pub/advances/vol4/Meadows.pdf *Staff should be aware of good practice in terms of governance e.g. root cause analysis, incident reporting.* **National Patient Safety Agency**, **Root Cause Analysis (RCA) investigation** http://www.nrls.npsa.nhs.uk/resources/collections/root-cause-analysis/

Objective 3	*Action*	*Evidence and Resources*
To optimise training in supporting the second victim	Disseminate guidance on how colleagues can support one another as they are likely to be the 'first responders' to second victims.	*The following resources can support training in the second victim:* *This tool is from the MITSS (Medically Induced Trauma Support Services)* MITSS Tools***, Supporting a Colleague*** http://www.mitsstools.org/how-to-support-a-colleague.html **Talking with Patients and Families about Medical Error: A Guide for Education and Practice** Robert D. Truog et al, The Johns Hopkins University Press. December 2010.