Supporting Our Second Victim Colleagues: the Case for Peer Support Programs in Healthcare

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Kimberly Hiatt

• Nurse for 24 years

• Seattle Children’s Hospital

• Medication error (September 2010):
  – child 5 mo/patient dies
  – dispensed 1.4 grams of CaCl instead of 140 milligrams

• Dismissed from job
What about....?

• What about the doctor who wrote this order?

• What about the pharmacist that approved this order?

• What about the process/system that set them up?
Kimberly Hiatt commits suicide after 7 months after the event

The suicide of Kimberly Hiatt, a nurse who accidentally gave an infant a fatal overdose last year at Seattle Children's hospital, has closed an investigation but opened wounds for her friends and family members.

Devastated nurse committed suicide after she accidentally gave baby fatal overdose

By RACHEL QUIGLEY
UPDATED: 14:31 EST, 27 June 2011

Too many abandon the "second victims" of medical errors
From the July 14, 2011 issue

Nurse's suicide highlights twin tragedies of medical errors
Kimberly Hiatt killed herself after overdosing a baby, revealing the anguish of caregivers who make mistakes

http://seattletimes.nwsource.com/html/localws/2014830569_nurse21m.html
Objectives

1. To describe the ‘second victim’ phenomenon & its impact on patient care
2. To list the objectives & goals of the Johns Hopkins RISE Program
3. To review study results on assessing the need for organizational second victim support programs among acute care hospitals
Objective #1:
To describe the second victim phenomenon & its impact on patient care
Second Victims

Second victims:
- Healthcare providers who are involved with a patient-related adverse event or medical error, and as a result, experience emotional and sometimes physical distress
  - First victim: patients and families
  - Term coined by Dr. Albert Wu: 2000

Second victims often
- Feel personally responsible for the outcome
- Feel as though they have failed the patient
- Second guess their clinical skills and knowledge

Signs & symptoms
- Similar to Post Traumatic Stress Disorder symptoms
- Physical and psychological distress
- Negative emotional responses
- Impaired performance
Signs & Symptoms of Second Victims

- **Short term:**
  - shock
  - helplessness
  - worry and depression
  - guilt and inadequacy
  - anger
  - poor concentration and memory
  - intrusive thoughts and nightmares
  - sleep disturbance
  - physical symptoms
  - social avoidance

- **Long term:**
  (Indistinguishable from posttraumatic stress disorder)
  - recurrent experience of the event
  - avoidance
  - emotional numbing
  - chronic signs of hyper-arousal including sleep disturbance, irritability, poor concentration, diminished memory
  - withdrawal and depression
  - social functioning can be impaired, and personal and professional relationships can suffer
Impact of Error on Second Victims and the Organization

1. Impact on the individual
   • Clinical conditions
     o Post-Traumatic Stress Disorder (> 3 months)
     o Acute Stress Reaction (up to 1 month)
   • Stress Reactions & Distress

1. Impact on the organization and healthcare team

2. Management & treatment of psychological care
   • Continuum of Care
# Prevalence of Second Victims

<table>
<thead>
<tr>
<th></th>
<th>Study 1</th>
<th>Study 2</th>
<th>Study 3</th>
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<tbody>
<tr>
<td><strong>Prevalence</strong></td>
<td>10.4%(^1)</td>
<td>30%(^2)</td>
<td>43.3%(^3)</td>
</tr>
<tr>
<td><strong>Population</strong></td>
<td>otolaryngologists</td>
<td>sample of medical students, physicians, and nurses</td>
<td>physicians, nurses, and pharmacists, and other healthcare professionals</td>
</tr>
<tr>
<td><strong>Feelings/symptoms</strong></td>
<td>described an error they were involved in during the past 6 months</td>
<td>personal problems related to anxiety, depression, and challenges in their ability to provide care during the past 12 months</td>
<td>the error had a moderately severe or severe harmful effect on their personal lives</td>
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Limited studies on second victims

• Limited literature
  – Prevalence of second victims: 10.4% - 43.3%
  – Studies on concept of second victims:
    • Switzerland, Belgium, Sweden, Italy, the United Kingdom, and the United States
  – Descriptions of organizational support programs
  – Little documentation of the steps involved in their development
  – Limited resources for evaluating the feasibility and effectiveness of these programs
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 dismayed 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.

Strangely, there is no place for mistakes in modern medicine. Society has entrusted physicians with the burden of understanding and dealing with illness. Although it is often said that “doctors are only human,” technological wonders, the apparent precision of laboratory tests, and innovations that present tangible images of illness have in fact created an expectation of perfection. Patients, who have an understandable need to consider their doctors infallible, have colluded with doctors to deny the existence of error. Hospitals react to every error as an anomaly, for which the solution is to ferret out and blame an individual, with a promise that “it will never happen again.” Paradoxically, this approach has diverted attention from the kind of systematic 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 tell anyone, what to say. Later, the event replays itself over and over in your mind. You question your competence but fear being discovered. You know you should confess, but dread the prospect of potential punishment and of the patient’s anger. You may become overly attentive to the patient or family, lamenting the failure to do so earlier and, if you haven’t told them, wondering if they know.1-5

Sadly, the kind of unconditional sympathy and support that are really needed are rarely forthcoming. While there is a norm of not criticising,4 reassurance from colleagues is often grudging or qualified. One reason may be that learning of the failings of others allows physicians to divest their own past errors among

Examples of support interventions/programs

• Support programs for hospital workforce
  – Medically Induced Trauma Support Services (MITSS)
  – University of Missouri: forYOU program
  – Kaiser Permanente Program
  – Boston Children’s Hospital: The Office of Clinician Support (OCS)
  – Brigham and Women’s Hospital: The Center for Professionalism and Peer Support (CPPS)
  – Johns Hopkins Hospital: Resilience In Stressful Events (RISE) Program

• Support for other psychological trauma
  – Psychological First Aid (PFA) & RAPID-PFA
  – Critical Incidence Stress Management (CISM)
  – Support programs for the military
Objective #2:
To list the objectives & goals of the Johns Hopkins RISE Program
The Johns Hopkins Hospital

• 1,075-licensed bed, urban, academic medical center in the state of Maryland, USA

• Medical errors and adverse patient-related events are inevitable
  – reported, investigated and debriefed with staff

• Several events occurred...

• Hospital leadership created second victim taskforce to establish an organizational support program/service for second victims
Our Current Infrastructure

• Patient Safety & Quality Departments
• Risk Management
• Employee Assistance Program
• Chaplain Services
• Occupational Health
• Human Resources

..... no clear pathway to help second victims cope with their emotions
Organizational Assessment

• Organizational survey was administered at 2nd Annual Johns Hopkins Patient Safety Summit in June 2010

• Results (n=140):
  – Two-thirds reported experiencing emotional distress following an unanticipated adverse event
  – More than half had reached out for support from a peer or colleague
  – The need for a peer support program to benefit second victims in the Hospital

RISE Team: Resiliency In Stressful Events

Mission:
“To provide timely support to employees who encounter stressful, patient-related events”

Objectives:
1. Increase awareness of the “second victim” phenomenon
2. Provide multi-disciplinary, one-to-one or group, peer support in a non-judgmental environment
3. Equip managers & employees with healthy coping strategies to promote well-being
4. Reassure & guide employees to continue thriving in their role
Developing the RISE program

Phase 1: Developing the RISE Team

Phase 2: Recruiting and training Peer Responders

Phase 3: Launching RISE pilot in Department of Pediatrics

Phase 4: Launching RISE hospital-wide
Phase 1: Developing the RISE Team

- The RISE Leadership team
- The RISE team:
  - trained Hopkins employees, Peer Responders, who volunteer to support second victims through a dedicated pager 24 hours a day, 7 days a week
- A project charter to include RISE scope of services
What does RISE do?

• Supportive and attentive conversation

• Facilitate resources within the hospital that might be helpful

• Provide 24/7 available support

• One to one or group support
What does RISE NOT do?

• We are not counselors or psychiatrists

• We do not investigate or report back to supervisors

• We do not problem solve

• We do not fix employment problems
Phase 2: Recruiting and Training of Peer Responders

• 40 individuals were invited to participate

• RISE Leadership team met with peer responders to discuss:
  1. Roles and responsibilities: attend training, respond to RISE calls, and participate in monthly Peer Responder meetings
  2. On-Call Schedule
  3. RISE binder: policies and procedures, evaluation tools, and additional resources.
Contacting RISE

Event happens

Second victim pages RISE
- Referrals: self, manager, legal/risk management, peer

RISE page received by Peer Responder

Peer Responder meets with second victim

Peer Responder activates debriefing with RISE team to discuss de-identified interaction with second victim
- learning opportunity for RISE team
- support for the Peer Responder
Training Peer Responders

1. Psychological First Aid (PFA)
   - used to describe early interventions to address emotional distress
   - goals of PFA are similar to that of physical first aid
     - stabilize, mitigate psychological distress, facilitate recovery, and promote access to additional resource

2. Peer Responder meetings
   - Educational sessions: lecture presentations, Role-play, Video excerpts, Handouts, Narratives

3. Debriefings
**stabilize** psychological and behavioral functioning, **mitigate psychological distress** and dysfunction, **facilitate recovery** and return to adaptive psychological and behavioral functioning, and **promote access to additional resources**
Phase 3:
Launching RISE pilot in the Department of Pediatrics

• Launch of *Awareness Campaign*
  • significance of stress after unanticipated events, the second victim problem, peer support, resilience, and stress management

• 3 one-hour sessions held during all three shifts
R.I.S.E.
Resiliency In Stressful Events

Have you experienced:
• a stressful, patient-related event?
• a medical error?
• a distressing patient outcome?

Do you need emotional support?

◆ The RISE Team can help ◆

Our team of trained peer responders provide non-judgmental, confidential, peer-to-peer support

Pager # 410.283.3953
Phase 4: Launching RISE hospital-wide

• Kick-off was held at the 4th Annual Johns Hopkins Patient Safety Summit in 2012

• Additional Peer Responders were recruited

• Assessment of Peer Responder perceptions
  – Peer Responders desired additional training to increase competence and confidence levels in responding to second victims
Implementing the RISE second victim support programme at the Johns Hopkins Hospital: a case study

ABSTRACT

Background: Second victims are healthcare workers who experience emotional distress following patient adverse events. Studies indicate the need to develop organisational support programmes for these workers. The RISE (Resilience In Stressful Events) programme was developed at the Johns Hopkins Hospital to provide this support.

Objective: To describe the development of RISE and evaluate its initial feasibility and subsequent implementation. Programme phases included (1) developing the RISE programme, (2) recruiting and training peer responders, (3) pilot launch in the Department of Paediatrics and (4) hospital-wide implementation.

Methods: Mixed-methods study, including frequency counts of encounters, staff surveys and evaluations by RISE peer responders. Descriptive statistics were used

***Available online: October 2016***
Objective #3:
To review study results on assessing the need for organizational second victim support programs among acute care hospitals
Study Overview

• **Objective:**
  – To assess patient safety leaders’ perspectives on the concept of second victims and support programs

• **Methods:**
  – In-depth, semi-structured interviews
  – 43 patient safety representatives from 38 acute hospitals in Maryland
  – Descriptive statistics were generated for hospital and participant characteristics

• **Response Rate:** 83%

*Manuscript accepted in Journal of Patient Safety (2016)*
PART I:
Does One Size Fit All?
Assessing Need for Organizational Second Victim Support Programs

• Objectives:
  – To assess the extent of the second victim problem,
  – To determine the availability of emotional support services, and
  – To assess the need for organizational support programs.

• Results:
  – All participants reported that they and their executives were aware of the second victim problem.
  – All participants believed that hospitals should offer organizational support programs.
  – There continues to be a stigma associated with speaking up and accessing support if it were offered.

Part II: Do Hospitals Support Second Victims? Collective Insights from Patient Safety Leaders

• **Objectives:**
  – To describe the extent to which organizational support for second victims is perceived as desirable by the hospitals, and
  – To identify existing support programs

• **Results:**
  – All of the hospitals offered Employee Assistance Programs to their employees, but there were gaps in the services
  – Moreover, there are no valid measures in place to assess the effectiveness of these services.
  – Participants identified a need for peer support, both for the second victim and for individuals who provide that support.
  – Approximately 6 Maryland hospitals offer a second victim support program, with differences in structure, accessibility, and outcomes.

*Edrees H, Morlock L, & Wu A. [manuscript in draft]*
Significance of the Study

• Addresses the need to develop second victim support programs
• Builds on an ongoing collaboration with JHH and other organizations in the development of a second victim peer support training program
• Supports public health practice, policy, & research implications for organizations interested in developing peer support structures
• Promotes a healthier workforce
Research Implications & Future Work

1. Quantifying the prevalence of second victims

2. Validate interview questionnaire and data collection tools

3. Target audiences in different settings:
   • Collect data on second victims
   • Focus on senior executives
   • Implications in other settings such as: ambulatory care or long-term care facilities, and local health departments, or physicians’ offices

4. Implications for developing an ideal support program

5. Address influencing factors in willingness to develop a program: organizational resources, priorities, culture, transparency, and funding

1. Ability to align current patient safety infrastructure with a second victim program, such as incident reporting system
How can your organization participate

• Acknowledge the problem of the second victim

• When errors happen, encourage staff to be involved in system changes that will mitigate future errors

• Hold debriefings and offer formal organizational support and coping strategies for individuals

• Develop multidisciplinary second victim support programs that align with existing organizational infrastructure
  – Communicate and collaborate with institutions that have existing or emerging programs
Supporting Clinicians After Medical Errors

Supporting clinicians after medical error
From "special measures" to "good" in a year

THE BMJ AWARDS FINALISTS

Supporting clinicians after medical error
Party manifestos: what they pledge for the NHS
Multiple sclerosis: managing relapse
CPD/CME hours

MOBILE APPS
Can healthy people benefit?

Supporting clinicians after medical error
The needs of these "second victims" are often ignored

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Clinicians who are unable to cope with their emotions after a medical error or adverse event are suffering in silence. These healthcare providers are often sold to take care of the next patient without an opportunity to discuss the details of the event or share how this has affected them personally and professionally. While patients and families are the first victims of such events, we refer to the healthcare providers who are involved as the second victims.¹

Second victims may feel guilt, fear, anxiety, or anger and experience social withdrawal, disturbing and troubling memories, depression, and insomnia.¹ They tend to doubt their clinical skills, feel as though they have failed the patient, and worry about what their colleagues think. They are embarrassed to request emotional support and feel that the organisation has abandoned them. Often, these experiences are symptom of not only one healthcare provider but a few members of the healthcare team who have either taken care of the patient or were affected by the error because of their role in the organisation or their physical proximity to the event. This can affect the provider-patient relationship, and if not managed properly, organisations can face clinical and financial challenges.⁵

Over time, second victims may develop signs and symptoms related to post-traumatic stress disorder (PTSD). As a result, these healthcare providers have difficulty forgiving themselves and some may even commit suicide.⁶

Recent international headlines highlighted the emergence of second victims related to second victims’ experiences. These range from direct sentinel events, such as that of Kimberly Mintz the nurse who committed suicide after a medical error in the US, to more diffuse errors of disclosure, as in the case of Jacintha Saldanha, the nurse who received a radio prank call asking about the health of the Duchess of Cambridge in the UK.

Addressing the problem of second victims can be a sensitive topic given its stigma attached to being involved in a medical error. Over the past decade, system changes in healthcare have focused on disclosure, reporting, and patient safety culture.⁴ However, little attention has been paid to creating systems that help second victims after an unexpected adverse event.

There continues to be limited research in this field. In fact, few studies have examined the prevalence of second victims, with reported rates of 10.4%, 39.3%, and 43.3%.⁷ Several academic and healthcare institutions in Switzerland, Belgium, Sweden, Italy, the United Kingdom, and the United States have conducted studies into the concept of second victims. Many of these studies focused on dealing with the signs and symptoms of second victims after adverse events.⁸ Other studies introduced frameworks, models, and roadmaps for how to meet second victims’ needs.⁹ Although these studies have been useful in further understanding the problem of second victims in healthcare, future studies should focus on organisational culture and the willingness of second victims to access support services after an unanticipated adverse event. Additional studies should also focus on identifying and mitigating institutional barriers for supporting second victims.

Structured support
When errors happen, second victims may not know who to turn to for guidance. In some instances, informal support offered by colleagues may be harmful. Insensitive comments addressed to the second victim or others about the event can negatively affect those involved. Avoiding contact or conversation with the second victim can also cause harm.

To meet these challenges, several institutions have developed formal organisational support programmes that allow healthcare workers to cope with their emotional distress by seeking timely support in a confidential, non-judgmental environment. For instance, the Medically Induced Trauma Support Services (MITSS) has developed a toolkit of resources to help organisations establish second victim programmes.¹⁰ Hospitals and healthcare systems in the United States, such as the University of Missouri, Brigham and Women’s Hospital, Boston Children’s Hospital, Kaiser Permanente, and Johns Hopkins Hospital, have developed organisational support programmes for staff. Each of these second victim support programmes has been incorporated into or was aligned with the organisation’s response to adverse events. Not only have these institutions embraced the concept of second victims, but they have also
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  – Johns Hopkins Second Victim Advisory Board

• Maryland Patient Safety Center
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Questions?

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