Second Victim Phenomena in a High Reliable Organization Hospital Setting: A Multidisciplinary Multi-Site Research Study



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Defects, Zero Harm

Doing Right, Every Time,

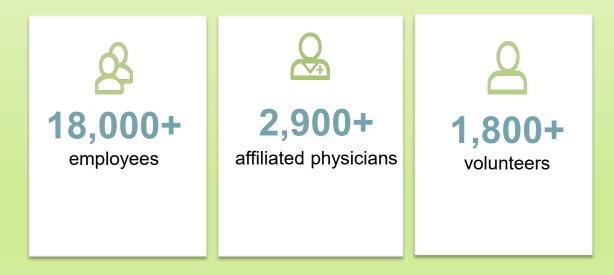
Founded on The <u>Sharp Exp</u>erie

Creating a Cun.





- Largest private employer in San Diego
- Largest health care system in San Diego



Not-for-Profit Serving 3.2 Million San Diego County Residents

Objectives

- Define the second victim phenomenon
- Describe the emotions related to the phenomenon
- Verbalize findings of this multidisciplinary multi-site research study





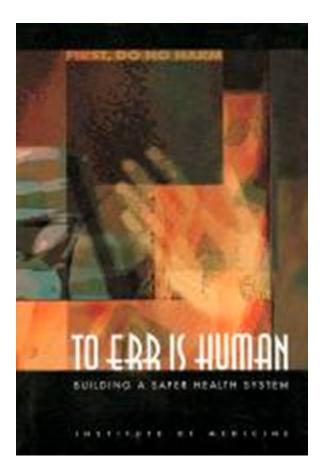
Healthcare is a High Risk Industry

Medical errors occur every day causing:

- 400,00-500,000 deaths annually
- Injury to 1 in 7 hospital patients
- Costs of > 140 billion annually
- It is the 3rd leading cause of death

Reasons include, but not limited to:

- Healthcare associated infection
- Medication errors
- Surgical errors
- Diagnostic inaccuracies
- Systems failures



Leapfrog Hospital Safety Grade Website.http://www.hospitalsafetygrade.org/newsroom/display/hospitalerrorsthirdleading-casueofdeath-improvementstooslow.Published October 23, 2013. Updated April 24, 2018. ***



Definition of the Second Victim

"Health care providers who are involved in an unanticipated adverse patient event, medical error and/or a patient related injury and become victimized in the sense that they are traumatized by the event." *Centerforpatientsafety.org*









Just Imagine







Building a System Collaborative



CAREforYou Collaborative





Study Objectives

1. Identify how many licensed professional healthcare providers within our system self-identify as second victims and length of time since the occurrence.

2. Measure the perceptions of any psychological and/or physical symptoms associated with the second victim experiences.

3. Measure the perceived quality of existing support resources.

4. Identify additional interventions that could be deployed to facilitate resolution of psychological or physical symptoms associated with a second victim event(s).





Study Design

- IRB approved
- Mixed method design
- Outlook email survey link
- 5 hospitals
- 5 disciplines
- Implied Informed Consent with participation
- Data collection: May 2018







Second Victims Experience & Support Tool (SVEST)



Modified Instrument

- 49 items
- Cronbach alpha .89
- 7 Dimensions
- 2 Outcome Variables:
 - Intent to turnover
 - Absenteeism





SVEST: Seven Dimensions

- Psychological Distress
- Physical Distress
- Colleague Support
- Supervisor Support
- Organizational Support
- Non-Work Related Support
- Professional Self-efficacy







System SVEST Research Results

Total Respondents N=890

Departments (most common):

- Critical Care (ICU/PCU)
- Acute Care
- Emergency Department
- Surgical Services
- Labor and Delivery
- MIS
- Rehab

Descriptive Statistics:

Mean age: 45 years

Years within system: 12.5 years

Years in profession: 17





System SVEST Research Results

73% (645 Respondents)

have experienced an event at Sharp that caused them **physical** or **psychological distress** related to an adverse patient safety event.

About 65% of those experienced this event in the last five years.





Symptoms and Thoughts

- Psychological Distress 44%
- Physical Distress 35%
- Intent to Turnover 27%
- Absenteeism 33%







Perceived Inadequacy of Supports and Self Efficacy

- Colleague Support 4%
- Non-Work Related 9%
- Supervisor Support 10%
- Organizational Support 15%
- Professional Self-Efficacy 44%







Differences: Hospitals & Disciplines

Few differences between the 5 hospitals and 5 disciplines

Hospitals

 Respondents employed at our Psychiatric Hospital had lower Psychological Distress compared to the other 4 hospitals (p=.043-.007)

Disciplines

 Psychological distress & Colleague Support were higher among Pharmacists compared to Social Workers (p.=.007)

Correlations Among Variables

- The greater the colleague support the lower the physical and psychological distress as well as their intent to turnover
- When supervisor support is high participants also felt supported by their organization and their colleagues
- The lower the organizational support the greater the turnover intention and physical and psychological distress





Regression Analysis: Predictors of Outcome Variables

 Physical Distress was the highest predictor of <u>Turnover Intention</u>

.....Followed by Org Support, Colleague support and Professional Self-Efficacy

 Turnover Intention was a weak predictor of <u>Absenteeism</u>





Desired Forms of Support

Support Option	Percent Agreement
A respected peer to discuss details of what happened	87%
An employee assistance program providing free counseling	81%
The ability to take time away from my unit	78%
A peaceful location to recover and recompose	76%
A confidential way to get in touch with someone 24/7	73%
A discussion with my manager or supervisor	70%
The opportunity to schedule time with a counselor	64%





Qualitative Data

Two open-ended questions:

- 1. "Are there any <u>additional forms of support</u> that would be helpful or preferred?"
- 2. "Is there anything else you would like to share?"



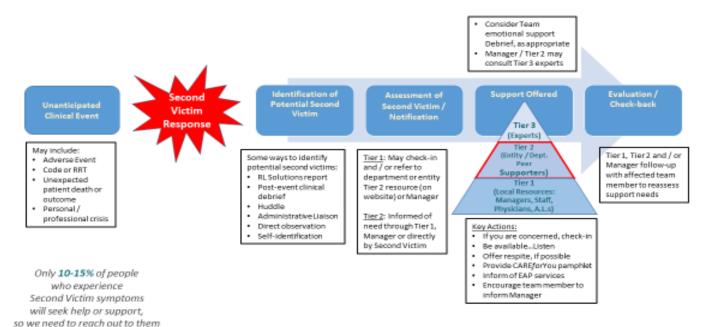




CAREforYou Program Model

CAREforYou Program

Program Goal: To identify and provide support to every person who is significantly impacted by an unanticipated adverse event or outcome







Recommendations

- Offer time away from the unit in a peaceful location
- Increase post-incident debriefings
- Increase training to managers and leads
- Encourage Employee Assistance Program utilization
- Build entity and system level collaborative





Lessons Learned

- A 5 hospital research design was ambitious difficult to reach all stakeholders
- Survey Monkey distributions are only effective with employees who read email
- Reaching physicians via a Medical Staff Office distribution list is difficult and created a study limitation
- Building a second victim support program aligns with our High Reliability Organizing culture





Thriving Vs Dropping Out









Just Imagine







Questions?

Thank you!

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