Second Victim: Caring for the Care Giver

by

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Abstract

In many healthcare organizations the needed support for second victims is lacking or unavailable. This paper describes the evaluation of debriefing support program for nurses who are second victims. Unanticipated and tragic patient outcomes will happen to excellent healthcare providers, the results being anxiety, depression, guilt, and fear. The effects of being a second victim can result in post-traumatic stress and compassion fatigue, with providers ultimately leaving the profession. After obtaining IRB approval, a volunteer debriefing support program was implemented. Validated surveys and an encounter form were utilized to collect data to identify the prevalence and effects of second victim and the impact of the support program. The results establish the prevalence of second victim and the need for a debriefing program. A debriefing program increases staff resilience following adverse events and it expedites the recovery of the healthcare provider to improve quality of care, patient safety, and staff engagement and retention.
Second Victim: Caring for the Care Giver

Many people choose health care as a profession to help others and when the help turns into harm it can have devastating effects on the caregiver. Highly trained and compassionate caregivers can experience adverse patient events that can leave them traumatized for days, weeks, and even years after an event. (1) The caregiver traumatized by an adverse event is considered the second victim, noting the first victim is the patient and the third victim the organization. (2, 3) In 2000, Dr. Albert Wu (3) introduced the term second victim and Scott (2) further defined it as, “healthcare providers who are involved in an unexpected adverse patient event, medical error and/or a patient related injury that becomes victimized by the event.” Adverse events related to patient tragedies such as loss of life, harm from violence, a first patient death experience, relating to the patient’s trauma, the death of a child, or a traumatic painful experience can affect even the most resilient health care professional. (4) Many second victims unsupported from these events suffer career-related stress and anxiety. (2) Providing patient care will always have risks for mistakes and unexpected outcomes.

Adverse events are happening in one out seven hospitalized patients and hospital leaders are strongly focused on improving the quality of patient care and outcomes around these events. (5) Inadequate resources, staffing challenges, decreasing capital, and system failures are challenges for hospital leaders as these factors can contribute to patient adverse events. (1) But it is the emotional impact of these adverse events that leave many caregivers feeling they have failed their patient; second-guessing their clinical skills and knowledge leading to decreased morale, engagement, and retention. (2, 4) Creating an organizational support-debriefing program provides a resource for the support of staff and leads to improving quality of care and patient
safety. The second victim phenomenon is prevalent among health care workers and hospital leaders must take care of those who take care of our patients.

Background

In recent years organizations have recognized that most errors are not due to human negligence, but a problem in a workflow process or system. (6) Although many organizations have embraced new practices, healthcare providers continue to be viewed in many of these situations as incompetent or neglectful by the organizational leadership. (6) An organization that is anchored in a fair and just culture will make the difference not only in the life of the second victim but aide in the healing of the organization. (7) When reviewing an adverse event case, the second victim should contribute in the debriefing or rapid improvement event to identify needed changes in practice. Before an organization can expect the second victim to effectively contribute they must be provided the necessary support following an adverse event. Many organizations fail to provide the necessary elements of a needed support system. Many times the second victim can only find assistance outside their organization or are unable to move forward when the needed support is lacking or unavailable. (5) Encouraging second victims to contribute to constructive changes can aid in the healing process of the healthcare provider and the organization. (5) The question organizations should be asking is, “What kind of support can be provided on the individual and organizational level?” (5)

One of the organization’s first programs in aiding staff was instituting the Compassion Fatigue Resiliency program within the large academic medical center. (8) Compassion fatigue is the combination of burn out and secondary traumatic stress. (8, 9) It is the relational nature of secondary traumatic stress that comes from the emotional distress of exposure to another’s trauma. (8) Add to that the chronic perception that perceived that perceived demands as a
caregiver outweigh perceived resources and burnout develops. (9) The hospital program educates hospital staff about the effects and interventions for managing compassion fatigue. (9) A study involving the hospital’s inpatient oncology staff revealed 44% to be at high risk for burnout. (8)

Since its inception, over 550 hospital staff has attended the hospital’s Compassion Fatigue Resiliency Program. (9) An initial pre-course survey measuring burnout and secondary traumatic stress has revealed approximately 47.1% of staff are at high risk for burnout, and 37.5% are at high risk for secondary traumatic stress. (9) The post course surveys have shown a decline in burnout and secondary traumatic stress. In the first two years of the program there has been a statistical improvement shown in burnout \( t = 4.50, P < .01 \) and secondary traumatic stress \( t = 4.72, P < .01 \). (8) Results show that compassion fatigue resiliency program is successful by providing staff skills for managing stress in the workplace. The next step for the hospital was the creation of a program for providing assistance when caregivers experience a traumatic event during their workday. It is now known that those who are involved in an unexpected adverse patient event, medical error and/or patient injury are known as “Second Victims” and these adverse events can lead to secondary traumatic stress.

For many hospitals, the establishment of a debriefing support program can help to identify how the organization should react when adverse events occur and focus on the root causes of any incidents. (1) The key goal is to minimize the human toll when unanticipated adverse events occur, provide a “safe zone” for staff to receive support, and develop an internal rapid response team focused on “emotional first aid” for staff following an adverse event. (4) Errors are not always the direct fault of the health care provider but when not addressed effectively can continue to lead to further incidents. (1) The organization should be one of the first identified resources for health care staff to reach out to. Seeking social support, accepting
responsibility, distancing, escape-avoidance, and problem solving are several identified strategies identified by those who are affected by an adverse event. (10) Josten, Cipparrone, Okuno-Jones, & DuBose (10) noted the common forms of support in order of most common to least:

1. Colleagues
2. Family and friends
3. Patient and patient family
4. Manager
5. Institution support

Too few organizations support caregivers experiencing the stress of an adverse event. The debriefing support programs can aide organization support that will increase awareness of second victim, and equip health care providers with healthy coping skills to thrive in their role and go on providing excellent patient care. (10)

**Purpose**

This study involved the development and evaluation of a second victim program with the following aim: For the healthcare provider who has experienced second victim phenomena, does having an organizational support-debriefing program decrease secondary traumatic stress in comparison to no support program?

**Plan**

The organization leadership has consistently demonstrated strong support for just culture, safety, compassion fatigue support, and policies that ensure adverse events are carefully debriefed for system review. Along with the organization employee assistance program it was proposed a second victim debriefing support program could provide additional staff support with
potential benefits of increased retention; decrease psychological distress, increased employee engagement, and aide in best practice.

The planned intervention is a debriefing support program within the organization to support and counsel the healthcare provider within twenty-hour hours of an adverse event. The program provides on-demand rapid intervention, ranging from immediate first aid support through professional counseling in a three-tier model. The support model is in 3 tiers known as the Scott Three-Tiered Integrated Model of interventional support. (4)

- Tier I – promotes basic emotional first aid at the “local” or departmental level. Scott estimated that as many as 60% of second victims will receive sufficient support at this level. This tier provides one-on-one reassurance and/or professional collegial critique of cases. Individual unit leaders and colleagues/peers from within their respective departments receive basic awareness training. (4).

- Tier II – this middle tier provides guidance and nurturing of previously identified second victims. Scott projected this tier will meet the needs of an additional 30% of second victims. Specially trained peer supporters are imbedded within clinically high-risk departments. When necessary, these peer supporters can provide one-on-one crisis intervention, peer support mentoring, team debriefings, and provide other internal resources, such as to patient safety experts for support during the aftermath of an event through an institutional investigation. (4).

- Tier III – this tier ensures prompt availability and access to professional counseling support and guidance. These mentors can facilitate and support Tier II rapid response team members as they guide second victims through the various stages of recovery.
Tier 3 professionals include chaplains, EAP, social workers, and clinical health psychologists. (4)

The creation of a second victim program required training of a debriefing support team.

The volunteer debriefing support team included: nurse managers, nursing educators, case management, chaplain service, nurse practitioners, physicians, employee assistance program manager, clinical psychologist, house supervisors, quality improvement, social service, risk management, clinical educator, human resources, and staff nurses. The first program meeting with a group of twelve from the various departments earned strong support and their stated commitment. A pre and post knowledge survey was administered to all participants in the support team before consults began. The knowledge survey was developed by Scott (2) to measure the knowledge attained by staff on the topic of second victim for education and training needs. The team training was provided prior to consults. The training included defuse techniques, communication interventions, and working with staff in crisis.

Methods

The target population for the second victim programs is the nursing staff and other healthcare providers of a 1200 bed academic tertiary center. The pilot project for the second victim program focused on three of the seven intensive care units. 70 beds with approximately 300 employees that manage patients with highly complex acuity levels. After IRB approval, individual staff members were informed of the proposed program through the use of flyers and brochures. In addition, there was ICU staff meetings and huddles with staff informing them on 24-hour availability with contact by email or phone. Staff members working on the pilot areas were given an overview of the program and a professional quality of life (ProQol) survey prior to the beginning of the pilot and 3 months after to measure prevalence of compassion fatigue.
A mixed methods approach was used to study the impact of the second victim pilot program. The initial measurement of the prevalence of compassion fatigue was obtained by distributing a ProQol survey created by Dr. Beth Stamm to all nursing staff working on the pilot units. (11) The qualitative component included analysis of the themes identified from the encounter interview forms. The ProQol is a 30-item scale designed to measure three variables: compassion satisfaction, burnout, and secondary traumatic stress. (11, 12) The items on the scale are about experiences in professional caregiving, both positive and negative. (11, 12) The inter-scale correlations show 2% shared variance with secondary traumatic stress and 5% shared variance with burnout. (12) All forms utilized by raters used the same questions, instructions, and scales.

For each debriefing encounter participants were informed of the program and provided informed consent. Following a debriefing encounter, each participant completed a debriefing interview form to quantify the frequency and nature of their second victim experience (2). Information gathered from the encounter forms were used to quantify types of triggering events and their risk factors. In addition, quantified the type of referrals needed if any along with identifying commonality statements made by the second victims.

**Results**

ProQol surveys were distributed approximately 300 employees. Forty completed the surveys prior to the pilot interventions and 61 completed the 3-month post survey. The low response rate was possibly due to the limited time frame to inform by verbal and written methods. Roles of the respondents included nurses, physicians and allied health, the majority of who were registered nurses. Prior to the pilot 42.5% of staff were at high risk for secondary
traumatic stress, with a decline noted post survey to 26.2%. The ProQol percent at risk in which the P-value (p<.05) was defined to be statistically significant for secondary traumatic stress.

A total of 35 individual registered nurses (RNs) participated in the second victim debriefing and/or peer support, with a total of 52 encounters. There were a variety of events that triggered the need for a debriefing.

(Insert Figure 1: Roles)

(Insert Figure 2: ProQOL Percent of Risk)

(Insert Figure 3: Reported Responses to Stress)

(Insert Figure 4: Types of Events)

The results quantified the frequency and nature of the second victim experience requesting support response. Outcome data from the utilized surveys and interviews established the on-going need for the project. The commonality of narrative statements submitted stated were guilt, anger, frustration, shame, sadness, depression, and fear. Other commonalities from statements were sleep disturbances, nightmares, headaches, and a loss of confidence. Common events that triggered the need for the debriefing support team were unexpected patient demise, patient death, violent patient, and adverse event of a peer. An additional narrative statement that held strong commonality was the desire to leave their chosen profession. After utilizing the second victim debriefing support each reported they had a desire to stay and a need to return to their chosen profession. They were able to enhance their individual coping skills with the stressors of the environment.

**Discussion**

Patient safety is the primary goal of nursing and health care organizations. Errors are not always the direct fault of the health care provider but when not addressed effectively can
continue to lead to further incidents. (6) The effects of an adverse event reach beyond the injured patient and their families. For many healthcare providers the impact of an error can result in guilt, anger, frustration, shame, sadness, depression and fear. (13) Several healthcare providers feel personally responsible for the patient. (2) For many hospitals, the establishment of a debriefing support program can help to identify the type and nature of adverse events that occur and to support staff while finding the root cause of incidents. The debriefing support program aids in minimizing human toll when an unanticipated adverse events occurs, provides a “safe zone” for staff to receive support, and provides an internal rapid response team focused on “emotional first aid” for staff following an adverse event. (4) Providing support for the second victim after an adverse event confirms the caregiver has valuable clinical abilities, shows respect, and reassures the caregiver that they are a valuable and trusted member of the team. (2,4)

The second victim phenomenon affects all health care providers. The implications for health care practice and the nursing profession are vast. (6) Further research is needed to fully understand the effectiveness of a debriefing support program.

Conclusion

Second victim is the term used to describe a caregiver that has experienced a medical error or adverse patient event. (2, 3) The caregivers who do not receive support can develop burnout and secondary traumatic stress lasting years after the event. Health care organizations and leaders must acknowledge the significance for providing the needed resources and support. The ongoing development and implementation of a support debriefing support program is important for the healing of the caregiver and organization.
References

1. DeWit M, Marks C, Natterman J, Wu A. Supporting second victims of patient safety events: Shouldn’t these communications be covered by legal privilege. *Journal of Law, Medicine, & Ethics*, 2013; 852-858.


Figures 1-2

Figure 1: Roles

![Roles Chart]

- RN
- Allied Health
- Tech
- Secretary
- Other

Pre/P

- n=55
- n=73

Figure 2: ProQol: Percent at Risk

![ProQol Chart]

- Compassion Fatigue
- Burnout
- Secondary Traumatic Stress

- n=40
  - 30.0%
  - 25.0%
  - 25.0%
- n=61
  - 23.0%
  - 21.3%
  - 26.2%
- n=40
  - 30.0%
  - 25.0%
  - 42.5%
Figure 3: Reported Responses to Stress

Reported Responses to Stress

52 Encounters

- Helplessness: 14
- Fear: 16
- Crying: 10
- Anger: 7
- Frustration: 13
- Anxiety: 13
- Nightmares: 18
- Insomnia: 18

Figure 4: Types of Events

Types of Events (n=52)

- Other: Ebola: 2
- Multiple Patients with bad outcomes: 1
- Suicide Attempt: 4
- Patient reminds staff of their family: 3
- Patient known to staff members: 1
- Unexpected patient demise: 5
- Medical Error: 3
- Staff Member: 2
- Victim of Violence: 1
- First death: 0
APPENDIX A. STATEMENT OF ORIGINAL WORK

Academic Honesty Policy

Capella University’s Academic Honesty Policy (3.01.01) holds learners accountable for the integrity of work they submit, which includes but is not limited to discussion postings, assignments, comprehensive exams, and the dissertation or capstone project.

Established in the Policy are the expectations for original work, rationale for the policy, definition of terms that pertain to academic honesty and original work, and disciplinary consequences of academic dishonesty. Also stated in the Policy is the expectation that learners will follow APA rules for citing another person’s ideas or works.

The following standards for original work and definition of plagiarism are discussed in the Policy:

Learners are expected to be the sole authors of their work and to acknowledge the authorship of others’ work through proper citation and reference. Use of another person’s ideas, including another learner’s, without proper reference or citation constitutes plagiarism and academic dishonesty and is prohibited conduct. (p. 1)

Plagiarism is one example of academic dishonesty. Plagiarism is presenting someone else’s ideas or work as your own. Plagiarism also includes copying verbatim or rephrasing ideas without properly acknowledging the source by author, date, and publication medium. (p. 2)

Capella University’s Research Misconduct Policy (3.03.06) holds learners accountable for research integrity. What constitutes research misconduct is discussed in the Policy:

Research misconduct includes but is not limited to falsification, fabrication, plagiarism, misappropriation, or other practices that seriously deviate from those that are commonly accepted within the academic community for proposing, conducting, or reviewing research, or in reporting research results. (p. 1)

Learners failing to abide by these policies are subject to consequences, including but not limited to dismissal or revocation of the degree.
Statement of Original Work and Signature

I have read, understood, and abided by Capella University’s Academic Honesty Policy (3.01.01) and Research Misconduct Policy (3.03.06), including the Policy Statements, Rationale, and Definitions.

I attest that this dissertation or capstone project is my own work. Where I have used the ideas or words of others, I have paraphrased, summarized, or used direct quotes following the guidelines set forth in the APA Publication Manual.

Learner name and date       Michele A. Gatzert   08/14/2015

Mentor name and school      Dr. Debbie Nogueras     Capella University