**ABSTRACT**

The role that nursing education plays in preventing nurses from becoming second victims is not well understood. The literature is replete with initiatives designed to support second victims; the overwhelming preponderance have been developed for and implemented at an organizational level. A pilot study was conducted to investigate opinions of recent BSN graduates about preparation for medication administration, medication error, and their personal experience with error-making and second-victimhood.

**Second Victim Definition**

The “second victim” phenomenon was coined by Dr. Albert Wu after he witnessed the distress experienced by a young resident who had made an error and then was subjected to ridicule, shamed, and blamed by his peers. This definition has evolved and broadened to include any healthcare worker who has been involved in an adverse patient event and then is traumatized by the experience.

**Nurses as Second Victims**

The number of nurses who become second victims each year is unknown. What is known is: It is estimated that over one-half of all healthcare providers become second victims during their careers. Estimated Medication Errors: At least 1 death every day in U.S.; 1.3 million injuries annually. Medical error: 3rd leading cause of death in U.S.; up to 440,000 Americans die each year. Every one of these errors could result in a second victim.

**Impact on Nurses**

Intense emotional distress, self-blame, guilt, shame, professional isolation, suicide, leaving profession.

Examples:

- Kimberly Hiatt: An NICU nurse who made a drug calculation error which resulted in an infant receiving 10 times the prescribed dose of calcium chloride. Hiatt was terminated and over several months became increasingly isolated and depressed. She committed suicide.

- July Thao: An experienced obstetrics nurse who made a drug error on a young woman who came in to deliver her baby. She administered an epidural medication, instead of the ordered antibiotic, into the IV line. The infant survived, but the young mother died. She was terminated and criminally charged. She has since become involved in the patient safety community, sharing her story as a learning experience for others.

**STUDY DESIGN**

A convenience sample of graduates from a four-year BSN program at a state-supported university in the southeastern United States was surveyed. A self-developed questionnaire was distributed in February 2015 to all graduates of the undergraduate nursing program from the preceding five years: 2009-2013, a total of 842 graduates.

**Purpose**

This pilot study was designed to begin to explore the answers to these questions by (1) investigating recent BSN graduates’ experiences with medication safety and medication errors in their practice; (2) gaining a better understanding of how well the BSN curriculum had prepared them for administering medications safely in the clinical environment.

**Data Collection**

A mixed methods design, including both quantitative and qualitative items. Survey collected basic demographics, an estimate of the percentage of time spent administering medications in the current place of employment, their perception of how well the nursing program had prepared them to administer medications safely, to advocate for their patients, and, to advocate for themselves in the clinical environment, had they made a medication error, and, if so, to describe the error in as much detail as they were comfortable with, to tell what factors contributed to making the error, and to describe their feelings after making the error.

**FINDINGS**

A total of 168 former students completed the survey, a response rate of 20%. 4% of time spent administering medications: Range 1-100%, mean average 47.7%

Have you made a medication error since becoming a registered nurse? 86 (55%) said yes, 64 (40%) said no, and 8 (5%) indicated they didn’t know.

4 Main Contributing Factors: Being rushed (35); Technology Issues (22); Communication Failures (19), Being New (13).

**CONCLUSION**

This study demonstrated that our graduates are becoming second victims. It also yielded several areas for future research. Because advocacy skills have been linked to safer patient environments, which should mean fewer errors, it would likely reduce the number of second victims.

1. What is the role of nursing education in preventing nursing graduates from becoming second victims?
2. How might we embed self-advocacy skills more fully into our curriculum?
3. What curricular changes are needed to prepare our students to function and survive in the complex health care environment?
4. What additional skillsets are needed?
5. What are the ‘best practices’ in this context?