TRAINEE
NOTEBOOK

ERNST Training School

Intensive training on the Second Victim Phenomenon &
Second Victim Support Programmes

ERNST
The European Researchers' Network
Working on Second Victims

Funded by
the European Union

ERNST
The European Researchers' Network
Working on Second Victims

EUROPEAN COOPERATION
IN SCIENCE & TECHNOLOGY

Funded by
the European Union

CASE STUDY #1

Developing and implementing a support program for healthcare workers involved in a patient safety incident

TABLE OF CONTENTS

Key messages 8

Executive summary 10

Case Study Overview 11

1. Introduction 14

1.1 Case sites 18

2. WHY implement an institutional SV support program? 26

2.1 The second victim problem addressed by international organizations dedicated to Patient Safety 28

2.2 Evidence on economic benefits 31

2.3 Different challenges and other areas of use 34

3. HOW implement an institutional SV support program? 37

3.1 Creating awareness 38

3.1.1 Education on second victim phenomenon 39

3.1.2 Red flag experiences 44

3.1.3 Stakeholders 48

3.1.4 Creating awareness TIPS 52

3.2 Development, resources and design 54

3.2.1 Identification of existing resources and needs 55

3.2.2 Program design and preparation 60

3.2.3 Development, resources and design TIPS 70

3.3 Make it happen 71

3.3.1 Pilot and dissemination 72

3.3.2 Description of the interventions 76

3.3.3 Make it happen TIPS 86

3.4 Evaluation 87

3.4.1 Program feedback and results 89

3.4.2 Evaluation TIPS 98

3.5 Sustainability 100

3.5.1 Overcoming barriers 101

3.5.2 Publicity of the program 102

3.5.3 Staff motivation 104

3.5.3 Sustainability TIPS 107

Next steps 108

References 110

KEY MESSAGES

Do not underestimate the importance of a culture of safety. Fostering a safety culture will have benefits for the patients and their families, for the healthcare workers, for the organizations and for the societies.

One way to enhance patient safety and the workers wellbeing is by protecting the staff, creating a supportive environment, where they feel confident to expose their struggles and insecurities.

Committed leaders are crucial to develop flourishing organizations where everyone is devoted to do their best, every day.

To succeed, it is crucial to continuously promote awareness on the second victim problem and on the intervention itself.

To support the implementation of a program in your institution please consult the **Peer Support Program Implementation Guide A Step-by-Step Guide to Launching a Second Victim Support Service at Your Institution** developed by the European Researchers' Network Working on Second Victims

EXECUTIVE SUMMARY

The second victim phenomenon has achieved more attention in the last years, but the implementation of dedicated solutions at the healthcare institutions is yet limited. This case study considers five different programs, showing the procedures on each site, and encouraging you to make the difference in

The main goal is **to show what can be done by a healthcare institution to support the healthcare professionals involved in adverse events.**

It is structured as follows:

- Introduction (Section 1) – overview of the second victim (SV) phenomenon and case sites description.

- WHY implement an institutional SV support program (Section 2) – explains the reasons to address the SV phenomenon at an institutional level.

- HOW to implement an institutional SV support program (Section 3) – roadmap illustrated by examples from the case sites. Main topics covered: Creating awareness, Development, resources and design, Make it happen, Evaluation, Sustainability.

The document includes learning goals for each stage of implementation of an institutional program to guide the apprenticeship process.

The implementation of an institutional program benefits from the use of existing resources and requires adjustment to the local needs. It also benefits from enhancing the culture of safety of the organisation, improving awareness of the second victim problem and to the program itself, making sure that those who need will ask for help.

CASE STUDY #1 OVERVIEW

AIM: “What can the healthcare institution do to support the healthcare professionals involved in adverse events?”

REASONS To implement a support program:

- Patient safety and patient satisfaction.
- Healthcare workers wellbeing.
- Promotion of a culture of safety.
- Financial benefits.

CASE SITES

1 KoHi Project at Hietzing Clinic (Vienna, Austria)

2 MISE program – online intervention (Spain)

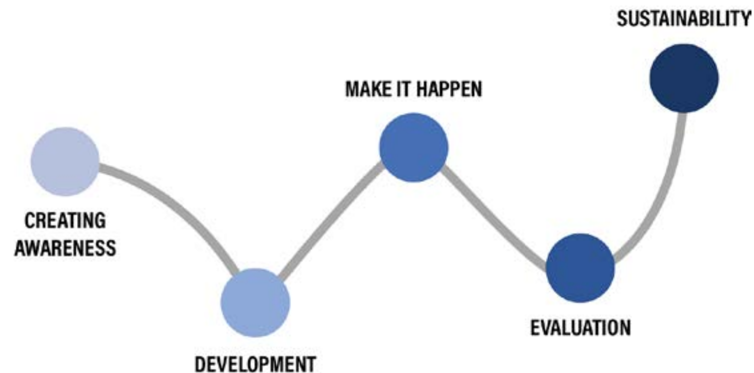
3 RISE (Johns Hopkins Hospital, Baltimore, USA)

4 Second victim support flow at Hospital Israelita Albert Einstein (São Paulo, Brazil).

5 forYOU team (University of Missouri Health System, Missouri, USA)

CASE STUDY #1
OVERVIEW

HOW TO IMPLEMENT



CREATING AWARENESS

- Educational strategies

- Red flag experiencies

- Stakeholders.

DEVELOPMENT

- Identification of resources and needs

- Program design and preparation

MAKE IT HAPPEN

- Pilot and dissemination

- Program description

EVALUATION

- Feedback and results

SUSTAINABILITY

- Overcoming barriers

- Publicity

- Satff motivation

WHAT'S NEXT?

Peer Support Program Implementation Guide - A Step-by-Step Guide to Launching a Second Victim Support Service at Your Institution (ERNST)

1 Introduction

Healthcare workers play an essential role on everybody's life. They promote health and serve our medical needs, working for long hours in stressful environments, and often without proper recognition of their importance.

To improve the healthcare workers' wellbeing is being recognized as a requirement to optimize the health systems performance, as well as the other aspects that compose the Quadruple Aim - enhancing patient experience, improving population health, and reducing costs.[1]

Burnout and dissatisfaction among healthcare workers may jeopardize the quality of care and patient safety. The protection of healthcare workers is included in strategic objectives of **WHO Global Safety Action Plan**[2] and it was recognized the need of creating synergies between health worker safety and patient safety policies and strategies.[3]

Patient safety is concerned on diminishing the preventable harm and its impact, assuming that unsafe care causes the majority of harm in healthcare.[2] However it must be recognized that, despite the efforts, unavoidable adverse events will still occur, and one has to be prepared to address it.

Despite the attention of the healthcare organizations to patient's harm and the efforts to implement safer care, little consideration has been given to the suffering of the healthcare professionals when they become second victims.[4]

According to the **new consensus definition of second victim proposed by ERNST[5]** (European Researchers' Network Working on Second Victims), a second victim is "any health care worker, directly or indirectly involved in an unanticipated adverse patient event, unintentional healthcare error, or patient injury and who becomes victimized in the sense that they are also negatively impacted".

The most prevalent symptoms related to the second victim phenomenon are troubling memories, anxiety, self-anger, regret and distress.[6] It is likely to expect that in some point of their professional life, a healthcare worker will undergo a situation which can trigger these kinds of symptoms[7], arising from adverse events or other situations of increased stress, as near-misses, which are situations that don't reach the patients.

1 Introduction

After an incident, the resources available to healthcare workers typically encompass employee assistance programs or the organization's psychiatric department or clergy.[8] **Dedicated responses to second victims are still scarce, as evidence shows:**

• A cross-sectional study surveyed hospital managers and safety leaders in several Ibero-American hospitals and concluded that procedures for caring the second victims after an adverse event were one of the least frequent interventions regarding the management of such occurrences.[9]

• Scott et al. reported that only one-third of the clinicians who experienced significant emotional distress after an adverse patient event received institutional support. [10]

• Edrees et al, in a survey administered at Johns Hopkins Hospital (before the implementation of RISE program) found that 52% of the workers received support in the institution in which the event happened.[11]

• Furthermore, a study exposed that the majority of healthcare workers didn't believe that their organization responds to medical errors in a nonpunitive and supportive way.[12]

• A study in the United Kingdom revealed that 60% of the obstetric anaesthetists involved in a traumatic event as a maternal death received no support; the majority of these professionals were unaware of the available support resources within their settings.[13]

• Two cross-sectional surveys among healthcare workers in Switzerland recognized the importance of a supportive safety climate, being associated with lower withholding voice and higher speaking up frequency (i.e. facilitating the assertive communication about patient safety). [14],[15]

• Two cross-sectional surveys from Germany indicate that most doctors and nurses involved in a critical incident do not even know the concept of second victim phenomenon at all although they consider themselves to be traumatized. [16],[17]

Even with the increase of awareness on second victim phenomenon that happened on the last years, we still have a long path ahead in which is essential to foster a protective and just culture. Sometimes, the healthcare workers don't recognize their own need of support, after all they see themselves as caregivers, not persons that sometimes need care and protection. The healthcare institutions could and should play a vital role on this issue, developing structured efforts to tackle the second victim problem.

And that's the aim of this case study - to provide a useful roadmap to the healthcare organizations, helping to implement support programs, but also keeping in mind that small changes can do some difference.So, it will be useful no matter the current degree of commitment of your institution. It pretends to answer to the following question: **"What can the healthcare institution do to support the healthcare professionals involved in adverse events?"**

The case study aims to be suitable to **different contexts,** considering the vast landscape of healthcare systems, regulations, financing models and organizational culture across Europe.

1.1 Case sites
General

The interventions presented in this case study are based the following programs:

1 KoHi Project at Hietzing Clinic (Vienna, Austria).

2 MISE program – online intervention (Spain).

3 RISE (Johns Hopkins Hospital, Baltimore, USA).

4 Second victim support flow at Hospital Israelita Albert Einstein (São Paulo, Brazil).

5 forYOU team (University of Missouri Health System, Missouri, USA).

These five sites were chosen because they represent different contexts, encompassing public and private healthcare units from different parts of the world: Europe, North America, and Latin-America.

They also represent different approaches to the second victim problem: while KoHi, RISE and forYOU team are peer-support programs, with emphasis on the role of the colleagues in the crisis management after a patient safety incident, MISE is an online program that empowers the healthcare workers by providing recommendations of how to act after a healthcare incident.

At Albert Einstein's flow of care the local unit leaderships provide support to the healthcare workers involved in an adverse event.

The variety of the programs presented will enable you and your managers to choose the interventions that fit best in your setting.

A brief description of each is presented next.

KoHi Project (Kollegiale Hilfe/Collegial Help - Mental First Aid by Colleagues)

Local intervention.

• **Source/HC organization:**

Clinic Hietzing - Public hospital operated by the Vienna Healthcare Group. One of the largest hospitals in the Austrian capital Vienna, with around 1000 beds and more than 3k employees.

• **Brief description:**

The program started in May 2019 and stablished a comprehensive network of Mental First Aiders. It provides rapid assistance to employees affected by traumatic events through colleagues. To become a KoHi (Collegial Helper) it is required a special training course. KoHi discussions are considered duty time and are strictly confidential.

Between May 2019 and October 2020, 95 employees have been trained as KoHi and ten KoHi talks have been reported.

In addition, there are several professional support services available at Clinic Hietzing that can be recommended by KoHi helpers when they identify the need of additional care. These services can also be used directly by the employees, without a KoHi intervention.

https://klinik-hietzing.gesundheitsverbund.at/

MISE (Mitigating Impact in Second Victims) - online intervention program

Online intervention, available to everyone.

• **Source/HC organization:**

Grupo de Investigación en Segundas y Terceras Víctimas (Second and Third victims Research Group). Project led by Alicante Health Department (Spain) with researchers from 8 different autonomous communities in Spain.

• **Brief description:**

Online program (website) with a preventive approach to the second victim phenomenon.

Two packages:

Informative package: information on basic patient safety concepts and concepts of second and third victims.

Demonstrative intervention package: description of the emotional consequences from adverse events in professionals and recommendations for action following an adverse event.Includes 15 demonstrative videos showing what and what not to do in different clinical situations linked to errors.

Contents in Spanish and English.

https://www.segundasvictimas.es

RISE (Resilience in Stressful Events)

Intervention expanded and deployed along other settings.

• **Source/HC organization:**

The program was developed at Johns Hopkins Hospital (a 1075-licensed bed, urban, academic medical centre) in Baltimore, Maryland, USA.

The program has been expanded on a "Caring for the Caregiver" program to promote dissemination to hospitals across the US.

• **Brief description:**

Peer-support program to provide psychological first aid, emotional support and sharing resources to second victims. RISE comprises an interdisciplinary, voluntary team of healthcare professionals trained to provide timely peer support to individuals or groups. RISE responders serve in an on-call rotation that enables them to answer calls from healthcare workers 24 hours a day, 7 days a week.

Between 2011 and 2018, RISE members supported 3k people.

https://www.hopkinsmedicine.org/armstrong_institute/training_services/workshops/Caring_for_the_Caregiver/

Albert Einstein Hospital intervention for Second Victims

Local intervention of an hospital group.

• **Source/HC organization:**

Sociedade Beneficiente Israelita Brasileira Albert Einstein, São Paulo, Brazil. In 1999, the Albert Einstein Israelite Hospital was the first health institution outside the USA to be certified by the Joint Commission International. The group has more than 11k employees.

• **Brief description:**

The local leaders are trained for SV signs evaluation. When appropriate, they perform psychological first aid and invite the health professionals to activate a flow plan of care that could include psychological or psychiatric care, among other support actions. A check list for leaders is provided.

The health professionals can also ask for help regardless of an event - psychological support channel (24hours a day, 7days a week), a resource previously already available at the institution.

https://www.einstein.br/

1.1 CASE SITES forYOU

forYOU team (University of Missouri Health System, Missouri, USA)

Intervention expanded and deployed along other settings.

• **Source/HC organization:**

University of Missouri Health Care (MUHC), USA. MUHC includes six hospitals located in the mid-Missouri region: University Hospital, Capital Region Medical Center, Ellis Fischel Cancer Center, Missouri Orthopaedic Institute and University of Missouri Women's and Children's Hospital.

It is an academic health system with more than 5 thousand faculty, and staff.

• **How:**

forYOU Team intends to provide 'emotional first aid' service specifically designed to provide crisis support and stress management interventions for healthcare events emotionally challenging and stressful using a Three-Tiered Interventional Model of Support for Second Victims. The first tier promotes basic emotional first aid at the local unit; the second tier provides guidance by specially trained peer supporters and patient safety officers and risk managers; the third tier provides professional counselling support (employee assistance program, chaplain, social work, clinical psychologist).

Health professionals can ask for help 24/7 by direct contact with peer supporters or the core team members, and also by telephone or email.

This intervention has inspired numerous programs in the US - as RISE (shown here) and YOUMatter, on a pediatric institution [18]-, and abroad – as the Always There program, developed on a mental healthcare setting in Queensland (Australia).[19]

https://www.muhealth.org/about-us/quality-care-patient-safety/office-of-clinical-effectiveness/foryou

2 WHY implement an institutional SV support program?

Some supporting arguments to the implementation of dedicated programs to second victims are:

• **Patient safety and patient satisfaction.** Patient safety is an attribute of quality of care[20]. The capacity of providing safe care by a professional who is suffering is compromised because psychological preconditions could be a risk factor to the occurrence of errors in the future. Also, it is likely that a second victim starts to practice defensive medicine. Supporting second victims is important to guarantee patient safety.

• The **staff wellbeing** has been highlighted as one of he pillars of Quadruple Aim, a compass to optimize health system performance[1] and its protection is one of the strategic objectives of WHO Global Safety Action Plan[2]. The utilization of support programs has been associated with greater resilience among healthcare workers.[21]

• Promotion of a strong **culture of safety** within the organizations as raising awareness to the second victim problem and patient safety in general.

• **Financial reasons** – the evidence shows that the second victims' problem has financial impact, and the burden could be reduced with appropriate programs.[22]

Below we will present some highlights regarding:

• What is being stated about the second victims by important organizations on Patient Safety.

• The economic benefit of the implementation of those interventions.

• The consideration that an intervention dedicated to second victims could be used to face unexpected challenges (as COVID-19) and to address different problems from those for what the program was designed for (as workplace violence).

2.1 The second victim problem addressed by international organizations dedicated to Patient Safety

The core international organizations dealing with Patient Safety have already mentioned the importance of providing support to healthcare workers.

• The **WHO Global Safety Action Plan 2021-2030**[2] defines as a strategic objective to "Inspire, educate, skill and protect health workers to contribute to the design and delivery of safe care systems". Within this objective, Strategy 5.5 is dedicated to "design care settings, environments and practices to provide safe working conditions for all staff". Safe working conditions includes the enhancing of well-being.

• The **WHO Health Worker Safety Charter**, [3]presented on the World Patient Safety Day, on September 17th 2020, with the slogan "health worker safety: a priority of patient safety" reinforces the importance of caring for those who care.

• The **OECD Health Working Paper no 130: "The economics of patient safety Part IV: Safety in the workplace: Occupational safety as the bedrock of resilient health systems"**[23], emphasizes that improving health care workers wellbeing also improves health system resilience.

• The **Joint Commission** has stated several safety actions to consider for supporting second victims: [8]

· Instil a just **culture for learning** from system defects and communicating lessons learned.

· Engage all team members in the **debriefing process** and sharing of the lessons learned from the event analysis.

· Provide **guidance on how staff can support each other during an adverse event** (i.e., how to offer immediate **peer-to-peer emotional support or buddy programs**).

· If the Employee Assistance Program is the sole source of support for second victims, **consider creating supplemental programs** after evaluating the EAP's structure and performance.

2.1 The second victim problem addressed by international organizations dedicated to Patient Safety

• **The Institute for Healthcare Improvement (IHI)** has developed a white paper to help the institutions on responding to a serious clinical event [4]. The staff is seen as a priority and it is emphasized that most harm comes from bad systems, not bad people:

Elements that should be considered by the organizations:

· Accountability should be appropriate. Do not jump to conclusions; ask "What happened?" and not "Who did it?"

· Send clear messages of support to all staff involved: "We'll figure this out together."

· Establish and practice principles of a fair and just organizational culture.

· **Appoint a trained staff member who staff involved in the event can contact 24 hours a day, 7 days a week.**

· **Offer support through Employee Assistance Programs, peer support groups, and other professionals.**

· Stay aware: Some colleagues can be supportive and others damaging.

Evidence of economic benefits 2.2

There is a growing body of evidence showing the cost-benefit of the interventions, despite some hardships on performing the evaluations, due to confidentiality concerns.

RISE

The results of a cost-benefit analysis of RISE program showed a positive net monetary benefit of over 22k dollars after 1year when the costs of the program are compared with the costs of time-off and turnover of nurses.

The study indicates that the costs of these interventions could be relatively low and associated with potential cost savings to the organizations.

To find more, please consult Moran et.al[22].

2.2 Evidence of economics benefits

• The recognition that consequences associated to the second victims' phenomenon as increased professional's turnover and loss of productivity could have significant costs justifies the implementation of dedicated programs:

Considering the 3 potential paths in the recovery process:

Dropping out
Surviving
Thriving

Associated with decreased work productivity, time off from work and, in last case, quitting.

Monetary losses

To know more about the recovery of a healthcare worker, please consult Scott et. al[10]

- When a second victim receives help trough a dedicated intervention, the likelihood of thriving, building resilience from the event, is stronger, instead of leaving the institution or remaining being plagued by the event.

- After a second victim experience, the clinical practice of a healthcare worker could change, and problems such as difficulties in concentration, adversely affected clinical judgment, and loss of confidence were identified. [24]

These circumstances could increase the risk of further avoidable adverse events which can harm another patient, with financial consequences as well.

- The interventions dedicated to the second victims could make benefit from the resources already existing in the institutions, as we ll see afterwards. There's no need of hiring new staff to implement an intervention, so there's no need of a high budget.

2.3 Different challenges and other areas of use

Healthcare organizations might consider that a structured intervention could be relevant in broader situations than those for which the program was designed for, as exampled with the cases of workplace violence and COVID-19.

Please note that the healthcare workers can be victimized not only by the occurrence of adverse events, but also by another stressful situations in their workplace, such as near misses, or unexpected outcomes like a patient's avoidable death, even when not associated with patient safety issues.

- **Workplace violence exposure**

RISE leaders noticed that they were receiving an increasing number of referrals for exposure to workplace violence.)

Workplace violence (WPV): Incidents where staff are abused, threatened or assaulted in circumstances related to their work, including commuting to and from work, involving an explicit or implicit challenge to their safety, well-being or health.[25]

In the specific case of WPV, health care workers are first victims, as being the direct target of these events.

Despite that, the emotions experienced are similar to those suffered when becoming a second victim. For that, peer support interventions could also be useful to assist workers in the aftermath of a WPV exposure.

Although more research is necessary to evaluate the success of peer-support initiatives for WPV, the organizations should consider that a program to promote workforce safety could be useful in broader circumstances than the second victim's problem.

You can find more about the expansion of peer-support initiatives to meet needs associated WPV in Busch et. al.[26]

• **COVID 19**

The exceptional circumstances of COVID-19 pandemic had a tremendous impact on healthcare workers, exacerbating stressors and making visible the need of protecting the ones who provide care.

The impact of COVID-19 on healthcare workers is a line of interest of pan-European researchers, among other critical topics related to the second victims. [27,28]

In an unexpected crisis, having an easily accessible support program to provide emotional support to the second victims could be beneficial to reduce burnout.

On this issue, you may also consult:

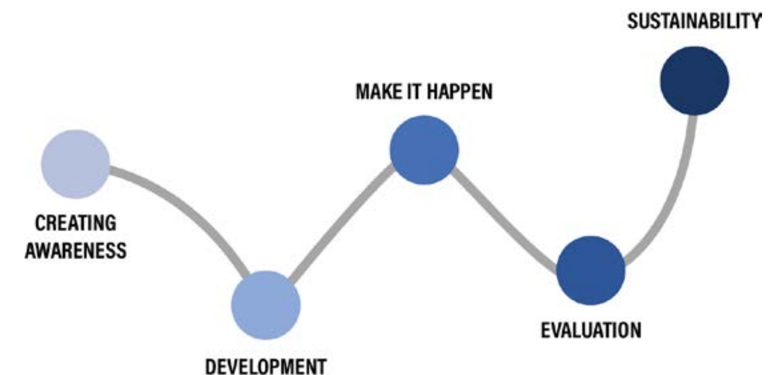
- Recommendations for maintaining capacity in the healthcare system during the COVID-19 pandemic by reinforcing clinicians' resilience and supporting second victims. [29]

- The development of a Digital Platform (website and app) to provide support to health care workers and other staff due to COVID pandemic. [30] The website link is:

https://secondvictimscovid19.umh.es/p/home.html

In this section we will follow the roadmap. Each of the steps will be illustrated by the actions taken in the programs selected to the case study.

ROADMAP



Along the way, you will find your learning goals. In the end of each section there's a blue box with useful tips that you can potentially use in your setting.

3.1 Creating awareness

SUSTAINABILITY
MAKE IT HAPPEN
CREATING AWARENESS
EVALUATION
DEVELOPMENT

Our journey begins by stating the importance of recognizing the existence of the second victim problem within the organizations. It is divided in three sections, on the following topics:

• Providing **educational resources** within the institutions improves the recognition of the problem, empowers the workers, managers and leaders and could persuade them to take the next step, by applying what they've learned.

• **Red flag experiences** are described here because these occurrences led the institutions to act against the second victim problem.

The knowledge about these major events could inspire you and your leaderships to do more in your organization regarding second victim's suffering and patient safety in general.

• **Engaging stakeholders** is a crucial step when preparing successful interventions.

Education on SV phenomenom 3.1.1

Learning goal: To describe different educational strategies to create awereness about second victim phenomenon.

Learning tips, check:

http://www.segundasvictimas.es/

https://www.muhealth.org/about-us/quality-care-patient-safety/office-of-clinical-effectiveness/foryou

3.1.1 Education on SV phenomenon

3.1.1 Education on SV phenomenon

One should recognize the need of education and training of the healthcare staff on second victim problem. This must be seen as an opportunity to instil a safety culture and improve the quality of care.

MISE was built to develop a set of tools that helps healthcare workers to recognize situations that could led to second victim symptoms, their consequences, and the do's and don'ts after an adverse event. It empowers the workers reducing the personal and professional impact of the adverse events.

The materials are available for free, and the explanations are complemented with demonstrative videos. Furthermore, MISE is an example of an intervention implemented beyond the organizational level of the healthcare units.

http://www.segundasvictimas.es/

forYOU team has an online page with several information regarding the second victim phenomenon and with available online resources and marketing materials for employees and patients.

https://www.muhealth.org/about-us/quality-care-patient-safety/office-of-clinical-effectiveness/foryou

3.1.2 Red flag experiences

Learning goal: To discuss why red flag experience can increase the awareness of patient safety issues and second victims' problem.

3.1.2 Red flag experiences

In some institutions the occurrence of devastating events raised the awareness on patient safety issues and second victim's problem. It might be elucidative to take a look into two situations that had happened, and the response gave by the institutions involved:

RISE - Josie King was an 18-month child in 2001. One day, she felt into a bathtub and burned more than half of her body with second degree burns. After a stay in Johns Hopkins Hospital Department of Paediatrics on which she received skin grafts, everything had seemed to be well until she developed a central line-associated bloodstream infection. The infection led to septic shock, and she died.

This event was highly publicized and produced significant burden in the staff, who was personally and professionally affected. A review of the incident made the hospital leaders to recognize the need to offer a program to support the healthcare workers and to promote a no blame culture.

https://josieking.org/

ALBERT EINSTEIN - Julia Lima

In February 2015, the 27 years-old ballerina sought medical help for acute pain in coccyx. She was diagnosed with Cockett's syndrome, a condition that causes iliac vein compression by the overlying right common iliac artery and predisposes to the formation of blood clots.

She developed a deep venous thrombosis and died after a surgery in Albert Einstein Hospital, São Paulo, Brazil.

The root cause analysis showed a chain of errors during Julia's care and several actions took place. Her family launched Julia Lima's Council with hospital representatives, with the objective of engage the health professionals and the society for the cause of patient safety. It encompasses Julia Lima prize to distinguish professionals and institutions who develop solutions to enhance patient safety across Latin America.

The hospital also noted the burden that this case caused on the staff, and inclusively there were several dropouts of the institution after the incident. That was the catalyst for develop a second victim's care flow within the institution.

https://fiquepordentro.ensinoeinstein.com/premio-julia-lima-incentiva-a-disseminacao-de-boaspraticas-na-seguranca-do-paciente

3.1.3 Stakeholders

Learning goal: To identify relevant stakeholders and justify their importance.

3.1.3 Stakeholders

Some examples:

KoHi

The project team made efforts to involve all the relevant stakeholders at an initial stage.

They considered, at the clinic level: hospital management, all executives, the staff representation, the department of personnel development, the department for communication and marketing, the professional group of psychologists, the 2nd psychiatric 24 department and the hospital chaplaincy. At the level of the Vienna Healthcare Group: general management and the department for legal affairs.

KoHi Project also counts with several partners:

- The Psychological Service Center of the Vienna Healthcare Group, providing training;

- Karl Landsteiner Institute for Clinical Risk Management, RheinMain University – will evaluate the project as part of a joint study.

forYOU

It has been an involvement of key leaders of MUHC, including hospital executives, members of quality improvement / safety teams, and the legal department.

3.1.4 Creating awareness TIPS

• Share these stories.

• Get to know the available online resources.

• Explain to your colleagues and leaders how these stories had inspired the people in those organizations to do more to improve patient safety and to protect the caregivers.

• Inform your colleagues and leaders of online training programs. Share the CA19113 materials.

• Encourage your managers to include these subjects on the training programs of the institution and to organize meetings.

• Start thinking about the stakeholders that should be involved to tackle second victim problem in your setting.

3.2 Development, resources and design

SUSTAINABILITY
MAKE IT HAPPEN
CREATING AWARENESS
DEVELOPMENT
EVALUATION

Developing an intervention requires time, effort and willingness. When planning a program, it is necessary to know profoundly the context in which it will be implemented, so it should start with a situation analysis, identifying the resources available and needs to address.

Then the interventions will be chosen and planned.
As we mentioned before, second victims dedicated programs normally are put in place by the existing staff, so the main cost will be the time spend on program duties.

When preparing the intervention the budget should also take in consideration the costs with training, the informatic support to the program (e.g. website, software) and how the program will be publicized.

It is important to define the program mission and objectives, the roles of the different elements. You can find a list of recommended roles and responsibilities of the workforce of a peer support program in the ***Peer Support Program Implementation Guide.***

3.2.1 Identification of existing resources and needs

Learning goal: To describe the potential facilitators for a program implementation.

3.2.1 Identification of existing resources and needs

KoHi

When it comes to implement a new service, it is wise to build on something that already exists - inside the institution as we're going to see exemplified by KoHI, and outside too, as exemplified by RISE.

Performing a target consultation is essential to make sure that the interventions will be aligned with the expectations of those who will take benefit from them, as in this case, the healthcare professionals - since the beginning RISE is concerned in receiving insights from Johns Hopkins Hospital workers.

At Clinic Hietzing, the relevance of the second victim problem and the need to have dedicated support was already present for several years. There had been unsuccessful efforts to build up a program, until a decisive moment: the offering of a new training course "Mental First Aid" for basic employees. This course was provided by the Psychological Service Centre of the Vienna Healthcare Group. So, the idea of using that practice-oriented advanced training to implement a second victim support program was born and a conceptualization phase had started. Nowadays, the Psychological Service Centre of the Vienna Healthcare Group is involved in the project, providing the KoHi training together with the KoHi project team from the Clinic Hietzing.

RISE

A multidisciplinary Program Development Team led the strategic plan and implementation of RISE. One of the first steps taken was an inventory of existing **resources** outside the institution. Some initiatives that inspired RISE team were: - Medically Induced Trauma Support Services (MITSS) Toolkit for Building a Clinician and Staff Support Program. Linda Kenney, a patient who was harmed by an adverse event, founded MITSS.

The organization's team was involved in the development of a second victim program at Brigham and Women's Hospital (Boston, USA). - The pioneer ForYou Program, designed to help second victims at the University of Missouri. To understand the types of support needed, a **survey** was conducted to collect primary data.

- First, it assessed the awareness of SV issue and the worker's personal experience. From those who had suffered problems after a patient adverse event, just a small minority had obtained help from the organization's Faculty and Staff Assistance Program (FASAP), a psychologist or psychiatrist, or pastoral care services.

- Then, a second part was focused on the identification of supportive strategies that healthcare workers would like to see implemented. The main results indicated the preference for an institutional peer support program. The results also suggested that workers would like to receive support immediately after an event. You can find the detailed results on the article by Edrees et. al.[11]

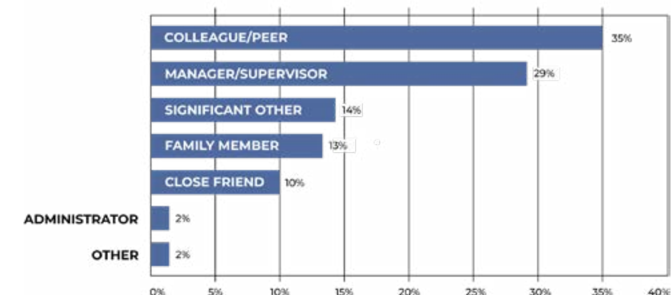
3.2.1 Identification of existing resources and needs

forYOU

The University of Missouri Health Care (MUHC) research team developed a qualitative and quantitative study to understand the needs for support and design specific interventions:

- Qualitative study: **Interviews.** From October 2007, 31 interviews were applied to healthcare providers to understand the suffering experience and to elicit the specific healing interventions that participants believed to be effective to support second victim in their healing process. The interviews led to the identification of the 6 stages of recovery 10 already mentioned in section 2.2.

- Quantitative study: **Survey.** It was designed to quantify the frequency and nature of the second victim experience and to solicit desired characteristics of an effective institutional support response. In February 2009, a 10-item Web-based survey was applied to RISE forYOU 29 approximately 5,300 faculty and staff at MUHC. One of the most important findings was the preferred source of support:



Also, it became clear that the responders would prefer internal support, instead of involving external professionals and the responses led to the definition of 8 themes describing the general infrastructure desired.

You can find more information about the interviews and the survey on the article by Scott et al (2010).[31]

3.2.2 Program design and preparation

Learning goal:

To identify what should be the steps for a program preparation in a healthcare institution.

Learning tips: You can consult the conceptualization phase of KoHi project.

3.2.2 Program design and preparation

After an accessing phase, the interventions should be chosen and prepared. Within this section we're going to take a closer look into peer support programs, because they seem to be the preferred way of receiving support by healthcare workers, according to the research already conducted.

Peer support programs are interventions in which the pairs take an essential role by providing assistance to the colleagues in need. Peers could be pairs within the same unit, or in some cases, as total confidentiality is intended to be ensured, the peer comes from a different unit of the institution. They are specially trained to perform this task and even when not on duty time to the program, they play a significant role within their units, as being more aware about the second victim problem and the signs of alarm.

Advantages of training peer supporters:

• Peer supporters provide mental first aid to the second victims and could activate specialized support, if needed.

• Peer supporters spread knowledge and sensibilize their department colleagues to the second victim's problem and patient safety in general. They act as champions within their units.

• Peer supporters will therefore contribute to enhance organizational culture of safety.

• As the peers are part of the staff of the institution, their training is economically viable.

You can find The Steps of a Peer Support Intervention at **Peer Support Program Implementation Guide.**

Despite the relevance that we are giving to peer support programs at this stage, it must be said that when choosing the intervention that best fits in your setting, regarding the resources available and the context, other kind of programs may be considered. And that's the reason why we included other interventions alongside KoHi and RISE, both peer support-based, in this case study.

3.2.2 Program design and preparation

KoHi

The conceptualization phase of KoHi project lasted for several months in Clinic Hietzing, in spring 2018. The **project goals** were defined:

- Establishing and sustainably securing the framework conditions for an hospital-wide network of mental first aiders at the Clinic Hietzing.

- Training of 5 to 6 employees per department (approx. 150 persons) as psychological first aiders from spring 2019 until the end of 2020.

The training course lasts five hours and takes place during duty hours at Clinic Hietzing.

Since the beginning, the project stablished the need of training employees from a wide range of occupational groups, because traumatic events affect not only clinically active employees.

Ideally, KoHi's are from the same professional group and hierarchy level of the worker that seeks support. KoHi 32

Considering so, training of several professional groups was performed - physicians, nursing professions, medical, therapeutic, and diagnostic health professions, mental health professionals, service assistants, administration and patient safety.

Some initial initiatives at Clinic Hietzing consisted of:

• An information event for all the employees of Clinic Hietzing (October 2018) – it was an opportunity to share ideas and respond to questions.

• Other presentations.

• Mailings.

• Managers were asked to nominate interested and suitable employees from different professional groups for Collegial Help.

3.2.2 Program design and preparation

MISE program is designed to empower those who get the training in a perspective of, in first place, education and awareness, and also helping them to individually overcome difficult situations. It can be seen more than just institutionally based, as the development of such a kind of program could and should be widespread, reaching a very high number of people.

The design of MISE was based on a literature review and experts' auscultation. The contents to include were chosen and demonstrative videos were recorded acted out by professional actors.

The design of MISE is detailed in an article by Mira et al. (2017).[32]

RISE

The establishment of RISE (Resilience In Stressful Events) consisted in four phases. The first two are present in this section, while Phase 3 and 4, encompassing the pilot and program expansion are presented in the next section (implementation):

Phase 1 - Program development - JAN 2010 / ∞
Phase 2 - Recruiting & training peer resp. - JUN 2011 / ∞
Phase 3 - RISE Pilot - NOV 2011 / JUN 2012
Phase 4 - Hospital, Wide Expansion - JUN 2012 / MAR 2016

Phase I – Program development

- Development of the workplan, logistics and procedures for the program

- Identification of team members to provide peer support

- Choice of the training and resources necessary

- Definition of mission and team objectives:

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

RISE Team Objectives:

1. Increase awareness of the second victim phenomenon in healthcare's high-risk environment.

2.Provide multi-disciplinary, one-to-one or group, peer-support in a non-judgemental environment.

3. Equip managers and employees with healthy coping strategies to promote well being:

a. Offer tools to support managers in their roles when responding to second victim events.

b. Provide first responder tips to all employees before, during and after an event.

3.2.2 Program design and preparation

4. Reassure and guide employees to continue thriving in their roles:

a. Develop a nonpunitive approach to handling stressful patient-related events.

b. Define policies and procedures for the RISE program.

Phase II – Recruiting and training of RISE peer responders.

The initial recruitment was made by invitation. Subsequently peers self-nominated to the program (responding to a structured application and submitting letters of recommendation).

Peer responders receive training on Psychological First Aid.

An article by Edrees et al (2016) [33] describes the steps involved in the implementation of RISE.

Albert Einstein flow of care is, as will see later, focused on the institutional responses to the occurrence of adverse events in a more formal way, providing assistance by the localleaderships and quality managers, as the program itself has born because of their concerns.

forYOU - According with University of Missouri Health Care, six components should be identified for development of a hospital-wide second victim support structure: (1) identify a core steering team, (2) identify an executive sponsor, program director, and administrative coordination, (3) develop unit-based teams, (4) develop team branding/marketing, (5) educate and train peer supporters, and (6) track data to ensure effectiveness.

UHC spent approximately three years in the program' planning, design, testing, and in specialized training for implementation of the support program.

The results of the interviews and the survey conducted to the design of a framework of caring (The Scott Three Tiered Interventional Model of Support), which will be addressed on section 3.3.2. The framework guided the design of the intervention, with the shaping of the internal resources to provide a 24hours/7-day available assistance.

Initial team training: The interprofessional 51-members team consists of physicians, nurses, social workers, respiratory therapists, among others. They received more than 18 hours of training, comprising didactics, small group work, and simulations.

Also, an **administrative framework** was set: the program has a general coordinator and several team leaders within each facility. They are available 24/7 to provide support for the forYou team members.

- **Are there any resources that could be used and adapted?**

Inside your institution: talk to your quality/ safety managers, check the psychological help offerings at the organization.

Elsewhere: check associations, universities in the nearby.

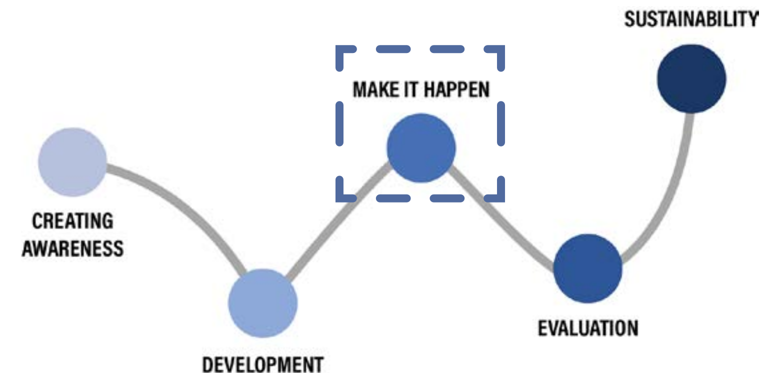
- **Encourage your quality managers to screen the needs of healthcare workers within your organization.**

- **If you don't have a peer support program in your institution, the first thing to do is to help to instil a culture of safety and awareness to the second victim's phenomenon.**

- **You can be an *informal champion.*** Talk to your colleagues and explain the importance of seeking help. Even when there aren't any dedicated second victim structures, the organizations might have a professional support service, offering psychological help.

- **Be aware of the basics "do's and don'ts" when you identify someone that is suffering.**

Make it happen 3.3



At this point, the designed initiatives are put in practice. In some cases, like large settings as Johns Hopkins Hospital, it is advisable to initiate the program in a small scale, as a pilot. After some time, the pilot is evaluated and the expansion of the program is considered, perhaps with some changes and adaptations whose need had been identified by pilot assessment.

The next topic presents the example of RISE pilot, the following topic present the description of the interventions considered.

3.3.1 Pilot and dissemination

Learning goal:

To discuss the benefits of RISE pilot that took place on the Paediatrics' Department of Johns Hopkins Hospital between November 2011 and June 2012.

3.3.1 Pilot and dissemination

RISE

Phase III - RISE pilot took place on the Paediatrics' Department of Johns Hopkins Hospitalbetween November 2011 and June 2012.

The choice of the pilot site was based principally on the strong commitment by the leadershipof this unit to develop RISE. It was the service were Josie King died, and several second victimswere identified afterwards.

The pilot evaluation was used to identify barriers and successes on implementing RISE. In thefollowing section (evaluation), we will discuss those aspects.

You can find more about RISE Pilot in the article by Dukhanin et al. (2018)[34]

Phase IV – Hospital-wide expansion of the program

In June 2012 the program was expanded to the entire hospital. Alongside with the initialpresentation to the staff, other efforts were made to promote awareness:

- Website with promotional videos.
- Publicity through internal publications and computer screensavers.
- Presentations to target department and units.
- Recruitment of unit-level champions – they act as promoters of the program.

3.3.2 Description of the interventions

Learning goal: To describe the communication process and interaction among the healthcare teams implementing the intervention.

In this section we describe the interventions that we are considering in the case study, giving additional information about each program.

KoHi - Collegial help provides rapid assistance to employees affected by traumatic events - lowthreshold,on-site, through colleagues.

HOW IT WORKS?

• When an employee needs help, he contacts the KoHi via telephone.

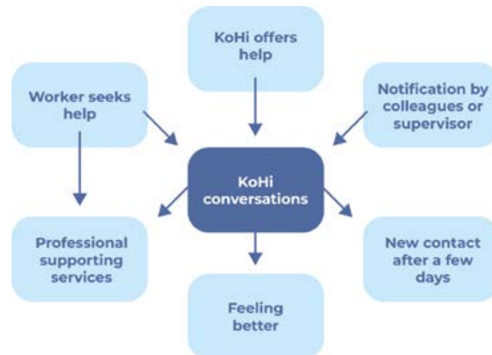
• But there are other ways of activation of the support: when a KoHi identifies acolleague that could need help he could offer to talk. In other cases, colleagues or supervisorscould signal the need of KoHi help.

• **The conversation** between the KoHi and the Second Victim takes place, and the KoHiprovides assistance and support. It is strictly confidential.

• When it seems necessary and it is desired, the KoHi contacts the person again in theext few days after the interview.

• The KoHi could also recommend professional psychological services available at theinstitution, which can be used anonymously, confidentially, and free of charge. These servicescan also be directly reached by the employee.

3.3.2 Description of the interventions



DEBRIEFING:

• After every meeting, the intervention is reported to a member of the KoHi supervisionteam, by phone-call. The debriefing uses a standardized reporting protocol and is subject tostrict data protection regulations.

• The debriefing allows to collect data and ensure the quality of the assignments as wellas to prevent suffering of the KoHi itself.

REGULAR MEETINGS:

• Regular KoHi networking meetings proportionate a space for case reflection,exchange of experience and practice, and joint further development of the system.Participation in these meetings is mandatory for KoHi at least once a year.

• Follow-up training sessions are scheduled after three years.

MISE is a self-paced training program available online, initially designed for Spanish frontlinehealthcare professionals. It has a preventive role, by empowering the healthcare workers todeal with adverse events and the second victim phenomenon.

HOW IT WORKS? The website is available at www.segundasvictimas.es. The registration is free and the programis structured in two packages:

Informative package – includes basic patient safety concepts, adverse eventscharacteristics within primary and secondary settings, and the concept of second and thirdvictims.

Demonstrative package – includes a description of emotional consequences fromadverse events in professionals, recommendations for action following an adverse event. Itintegrates open disclosure, how to support a colleague and to personally cope with secondvictim experience. This package includes demonstrative videos showing the do's and don'ts.

3.3.2 Description of the interventions

RISE provides timely peer support to employees who face a stressful patient related event. The servi- ce is available 24/7.

HOW IT WORKS?

• The healthcare worker activates RISE by paging the RISE team.

• The on-call RISE peer responder responds to the pager by calling back within 30 minand planning a meeting with the caller, ideally within the next 12 hours.

• Two peer responders are on call at a given time – if the first happens to work in thesame unit than the caller, the situation will be handled by the second responder. Each peer responder is expected to on duty time 1 week every 3 months; they are released from theirunit managers for the required time.

• At the **encounter**, the peer responder provides psychological first aid (PFA) andemotional support.

• The peer responder informs the caller of the avai- lable resources within theorganization that might be helpful, providing a list (e.g., employee assistance program,community counselling, exercise).

• The interactions between the peer-responder and the caller are **confidential.** The only exception is when the peer identifies that there is potential for imminent harm (e.g., suicide feelings); in this case, the peer responder activates the necessary resour- ces to prevent harm.

DEBRIEFING:

• After the meeting, the peer responder activates a debriefing meeting where he receives support from the other members of RISE team. It is as well a learning opportunity for other peers.

• The peer responder also fills a Peer Responder En- counter Form and a Peer Responder Assessment Form after each encounter, which are used to inform the program evaluation.

REGULAR MEETINGS:

• One-hour monthly meetings provide discussion of the literature and sharing of experiences. The meetings are enriched with storytelling sessions and role-play exercises.

3.3.2 Description of the interventions

Albert Einstein - As we saw on Julia Lima's case, it became clear for quality and safety managers of HospitalIsraelita Albert Einstein the need of having a dedicated structure to support healthcarewor-kers in the aftermath of an adverse event. They have been making efforts to instil a cultureof no-punish-ment where the workers feel safe to talk about their emotions.

HOW IT WORKS?

• The service leaderships were trained to detect se-cond victim's signs and to provide mentalfirst-aid. When something wrong happens, they provide as-sistance. They also couldencourage the worker to take some days-off or vacations when needed.

• The risk managers can also activate the second victims flow of care in the aftermath of anadverse event.

• The worker could be invited to have a psychologi-cal evaluation and, in some cases, couldbe transfe-rred to psychiatric surveillance.

• A flow chart was designed to guide the flow steps, also provides information about thesecond victim's symptoms and a checklist for the leaderships, gui-ding the actions to takewhen the conversation oc-curs.

• Complementary to the flow, it also exists a psycho-logical helpline as part of supportservices of the ins-titution.

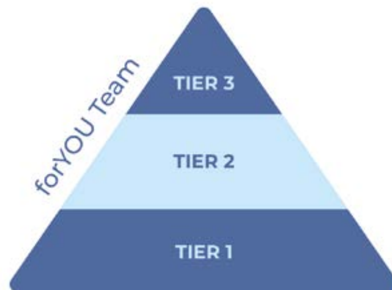
• All these procedures are independent of the wor-ker's performance evaluation.

DEBRIEFING:

• Albert Einstein Hospital leaders are also concerned about caring of the professionalswho deal with ca-tastrophic events analysis, as the risk managers or the unit leaderships whomay have an increase of burnout by dealing with those situations., and they are assessingmeasures to implement on this issue.

3.3.2 Description of the interventions

Scott Three-Tiered Interventional Model of Second Victim Support



ForYOU - HOW IT WORKS?

ForYOU team program is divided in three different "level" of support:

- TIER 1: It is reassured if the potential second victims are "ok" after a clinical event. Promotes basic first aid at the local/departmental level by colleagues/peers and local unit leaders with basic awareness training on second victim problem, signs and symptoms and essential support needed. - When necessary, Tier 2 is activated.

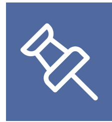
- TIER 2: Further guidance to previously identified second victims. It provides crisis intervention by specially trained peer supporters (rapid response team members). They are a network strategically embedded across the services. - When needed the second victim is referred to the patient safety team and the risk managers, to offer support through internal event investigation process and legal actions.

- When an entire team is affected by an event, the peer supporters could also activate groupdebriefings. - The Tier 3 could be activated when the situation exceeds the expertise of the TIER 2 members.

- TIER 3: It consists of additional care professionals (employee assistance program personnel, chaplain, social workers, clinical psychologists...). Because of their expertise, some of them are also a part of TIER 2, and they also mentor the TIER 2 members, to help them to recognize profound emotional trauma.

REGULAR MEETINGS: Monthly meetings provide a space to case reflection and ongoing mentoring, in a de-identified manner, to maintain the confidentiality of the victims.

3.3.3 Make it happen TIPS



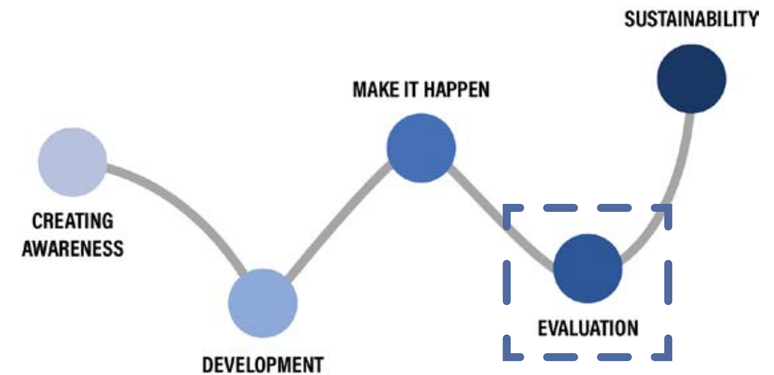
Your setting is large and diverse, turning more difficult to implement an extensive program? **Try to implement the intervention in a sub-section, as a pilot first.** It will allow to test the ideas before widespread.

Make sure that the second victims don't feel shame or fear of asking for help in your institution. Ensure the confidentiality of the support.

Think about caring of those who will be providing support to the second victims by promoting debriefing meetings and exchange of experiences.

Define a team leader accountable for coordinating all program components to mentor peer support team members.

Evaluation 3.4



The evaluation component of a program is crucial. Collecting data about the implemented intervention and appraising the information will guarantee the continuous improvement, as long as allowing to access its effectiveness.

Second victim's confidentiality is a requirement for support programs, preserving the professionals in suffering. This aspect could constitute a challenge for program evaluation, and it must be assured that no conflict exists. Evaluation should incorporate perceptions of the utility of the program from the professionals, but also objective and cultural measures.

3.4 Evaluation

The experience shows that the utilization of programs to support SV is still low. Sometimes the healthcare workers could be unaware of the existence of the service, and in other cases inhibition of seeking help or fear of being charged could subsist. According to that, it is vital to **promote the program continuously** to guarantee that the workers are properly informed.

The existing survey Second Victim Experience and Support Tool (SVEST) can guide the implementation and evaluation of quality of supportive resources to second victims over the time. It consists of 29 items representing 7 dimensions that reflect perceptions of second victim-related symptoms and the quality of the support services. It's been developed and validated in the United States, and it's been already translated and cross-cultural adapted to other languages. You can find more details about SVEST in Burlinson et a. (2017)[35] article.

3.4.1 Program feedback and results

Learning goal: To Identify the strengths and barriers of the support intervention (you can choose one intervention or more).

3.4.1 Program feedback and results

Learning goal: To identify evaluation indicators to assess the effectiveness of the support program along the time and tools.

3.4.1 Program feedback and results

Strengths and barriers that had been identified at our case sites:

KoHi Project is focused on continuous improvement. A collaboration between Clinic Hietzing, the Karl Landsteiner Institute for Clinical Risk Management and RheinMain University of Applied Sciences is evaluating the impact of the program.

The data is being collected by:

- Surveys of all staff at Clinic Hietzing on the second victim problem.
- Evaluation of KoHi training courses.
- Evaluation of reported KoHi talks.

The experience of the first ten KoHi outreaches according to the KoHi's assessment, were effective and helpful for the persons concerned.

The data indicates that the first talks didn't overstress the KoHi and their confidence increased with each subsequent outreach.

MISE evaluation was made by:

• An independent agency specialized in the evaluation of health websites. It accessed the design, structure, and quality according to a certification standard. The program was awarded with the level of Advanced Accreditation. Some **strengths** identified were the usability, confidentiality, transparency, credibility and updating of information. **Areas for improvement** include elements related to website users, editorial policy and accessibility.

• Academic and safety experts who were invited to explore the website and then respond to a questionnaire about its clarity, usefulness and suitability. The evaluation of these aspects was positive (about 9/10 in all the aspects covered).

• A group of professionals who followed the program and answered to knowledge tests. It showed the improvement of knowledge about second victim phenomenon. The mean time to complete MISE was five hours.

An important strength of this program is being a low-cost intervention, easily accessible to a large number of people.

3.4.1 Program feedback and results

RISE

Since the implementation, RISE team leaders have been evaluating the program successes and challenges.

• To preserve the confidentiality of the service and to respect the victim's emotional state, **no data is collected directly from the callers.**

• Therefore, data was collected through:

- Staff surveys (administered collectively to all workers)

- Peer Responder Encounter Forms – provide information about the event and the RISE call. The information **could not identify a specific person or event.**

- Peer Responder Assessment Form – in which the peer appraises his interaction with the caller. It includes a short description of the encounter, the peer responder evaluation of the suitability of RISE training to respond to that particular call and recommendations on improvements to the program.

Strengths of RISE:

• Based on staff local insights (as showed at development section);

• Considered existing resources;

• The results of program evaluation endorse the need of a structured program dedicated to the second victims, with benefits for providers, patients, and the organizations.

Challenges in the implementation:

• Lack of recognition of the magnitude and importance of the second victims problem.

• Confidentiality concerns.

• Risks of exposure to legal or disciplinary actions.

• Financial limitations (that limits the capacity for formal mechanisms for data collection and monitoring) – the program is based on voluntary efforts of hospital staff.

• The major challenge is to increase the number of calls – to promote the usage if the program by the second victims.

3.4.1 Program feedback and results

Albert Einstein

At Hospital Albert Einstein besides the good feedback of those who accepted to take the flow of care, it became evident the resistance of the health professionals in accepting help, being more apparent when the workers don't have employment bond to the hospital.

forYOU

Monitoring phase was developed to evaluate the program and improve effectiveness.

Some of the following aspects were considered:

-Number of one-on-one deployments with trained forYOU Team members.

-Types of clinicians receiving support.

- Number and period of time that lasted the team debriefings.

- Attendance number to the debriefing meetings.

3.4.2 Evaluation TIPS

• Check if there is a validated version of SVEST (or other validated survey) for your context.

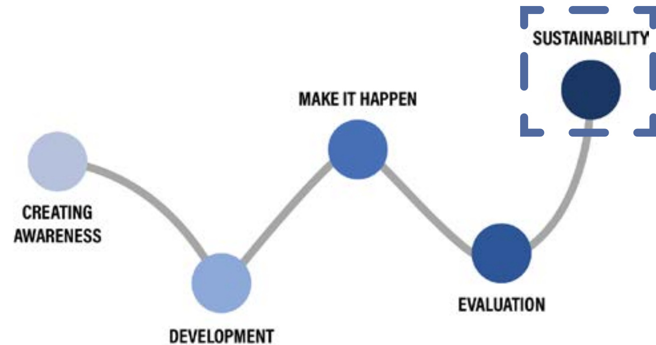
• If there is no institutional support at your institution, the survey can be the first step before the implementation of a program.

• After the implementation, it can be used for program evaluation.

• Continuous improvement is the key for successful interventions – do not skip the evaluation of your intervention.

• Submitting your program at an accreditation program (as MISE did) would help to ensure the quality of the intervention and inspires confidence in your work.

3.5 Sustainability



The sustainability of these kind of projects is probably one of the major challenges. Improvements in organizational culture take years to stablish, therefore programs and interventions will need several years to be as effective as desired. To sustain the supportive interventions is crucial to address the needs and culture of the target organization. As stated before, is important to continuously evaluate the program, and to introduce changes when appropriate.

Proofing the cost benefit of a program is important to justify its relevance to the institution managers. We already talked about that in section 2.2.

And it is important to emphasize the importance of an engaged leadership to the continuity of the programs.

Overcoming barriers 3.5.1

Learning goal: To identify the different strategies and pillars that will help to overcome barriers and make the program more sustainable overtime.

3.5.2 Publicity of the program

Learning goal: To identify different strategies to promote the program among the healthcare institution.

The program should be continuously publicized to promote awareness of its existence.

KoHi

Some measures taken in Clinic Hietzing were:

- Project homepage at clinic's intranet.
- Emergency page at clinic's intranet.
- All new employees in the clinical professions are informed about the offer.
- Posters with the names and telephone numbers of all trained collegial helpers in the respective area and an "indication list" describing the signs of a psychosocial crisis.
- Small, orange magnetic buttons are used to increase the visibility of the KoHi.

3.5.3 Staff motivation

Learning goal: To identify different strategies to keep the teams motivated.

Peers' motivation and competence is also a vital aspect to effectively sustain the peer support programs.

Some examples :

RISE program leaders explored the sustainment and retention factors for volunteers of the program in terms of:

- **Satisfaction with their duties** – 96% were satisfied or strongly satisfied.
- **Autonomy** – 84% held positive or strongly positive views about their personal autonomy in performing their RISE duties.
- **Meaningfulness of work** – all respondents held positive or strongly positive views.
- **Self-perceptions of impact** - 93% had positive or strongly positive views of the impact of the program.
- **Level of personal RISE competency** - 89% were positive or strongly positive in assessing their level of RISE competencies.
- **Burnout as a result of RISE duties** – 72% disagreed or strongly disagreed with the idea that RISE duties caused their burnout.

3.5.3 Staff motivation

• **Personal resilience** – 56% had a positive or strongly positive perception of their personal resilience in general.

Peers also expressed dedication and personal affinity to the team mission, shared enthusiasm, joy and feelings of respect and value.

The retention rate is very high, and these findings support the idea that duty time on RISE contributes to peers personal and professional growth, empowerment and resilience.

For a full description, please consult the article by Connors et al (2021).[36]

Sustainability TIPS

• The sustainability of the program will be based on its foundations – the organizational culture, the associated costs, the effectiveness feedback and of course, on the retention of those who compose the intervention itself. **If your intervention is peer-based, it could be important to access after a while their satisfaction and retention.**

• **Publicize your program continuously. Organize meetings, send regular emails and add screensavers to the computers.**

NEXT STEPS

• As a result of Case Study#1 please consider if there are some elements of these interventions that may be difficult to implement in your country.

• Spread the word. Talk to your colleagues about the second victim phenomenon and share your thoughts. Try to engage your leaders and to promote awareness at your institution.

• If you are on a position of developing a program, inspire yourself in these case sites.

For a ready-to-use guide, please consult **Peer Support Program Implementation Guide** - *A Step-by-Step Guide to Launching a Second Victim Support Service at Your Institution.*

• If you want to know more about the second victim phenomenon, please consult the materials developed by ERNST - The European Researchers' Network Working on Second Victims.

Find more contents on the website:
https://cost-ernst.eu/

SPECIAL THANKS TO:

• Miriam Abloescher (Clinic Hietzing, Vienna Healthcare Group, Austria).

• Fernanda Fernandes, Haggeas Fernandes and Claudia Garcia (Hospital Israelita Albert Einstein, Brazil).

• José Joaquín Mira (ERNST Action Chair; Fundacion para el fomento de la investigación sanitaria y biomédica de la comunitat valenciana ; Universidad Miguel Hernandez).

REFERENCES

1. Bodenheimer T, Sinsky C. From triple to quadruple aim: care of the patient requires care of the provider. Ann Fam Med. 2014 Nov 1;12(6):573–6.

2. Organization WH. Global Patient Safety Action Plan 2021-2030 Towards eliminating avoidable harm in health care. Geneva: World Health Organization; 2021.

3. Organization WH. Charter: health worker safety: a priority for patient safety. Gevena: World Health Organization; 2020.

4. Conway J, Federico F, Stewart K, Campbell M. Respectful management of serious clinical adverse events (Second Edition). IHI Innovation Series white paper Cambridge, Massachusetts: Institute for Healthcare Improvement [Internet]. 2011; Available from: www.IHI.org

(5) Vanhaecht, K., Seys, D., Russotto, S., Strametz, R., Mira, J., Sigurgeirsdóttir, S., Wu, A. W., Põlluste, K., Popovici, D. G., Sfetcu, R., Kurt, S., & Panella, M. (2022). An Evidence and Consensus-Based Definition of Second Victim: A Strategic Topic in Healthcare Quality, Patient Safety, Person-Centeredness and Human Resource Management. International Journal of Environmental Research and Public Health, 19(24), 1–10. https://doi.org/10.3390/ijerph192416869

6. Busch IM, Moretti F, Purgato M, Barbui C, Wu AW, Rimondini M. Psychological and Psychosomatic Symptoms of Second Victims of Adverse Events: A Systematic Review and Meta-Analysis. Journal of Patient Safety. 2020;16(2):E61–74.

7. Seys D, Wu AW, Gerven E van, Vleugels A, Euwema M, Panella M, et al. Health Care Professionals as Second Victims after Adverse Events: A Systematic Review. Evaluation and the Health Professions. 2012;36(2):135–62.

8. The Joint Commission, Division of Healthcare Improvement. Supporting second victims - Quick Safety Issue 39. 2018.

9. Mira JJ, Carrillo I, García-Elorrio E, Andrade-Lourenção DCDE, Pavan-Baptista PC, Franco- Herrera AL, et al. What Ibero-American hospitals do when things go wrong? A cross-sectional international study. International Journal for Quality in Health Care. 2020;32(5):313–8.

10. Scott SD, Hirschinger LE, Cox KR, McCoig M, Brandt J, Hall LW. The natural history of recovery for the healthcare provider “second victim” after adverse patient events. Quality and Safety in Health Care. 2009;18:325–30.

11. Edrees HH, Paine LA, Feroli ER, Wu AW. Health care workers as second victims of medical errors. Polskie Archiwum Medycyny Wewnetrznej. 2011;121(4):101–7.

12. Pratt S, Kenney L, Scott SD, Wu AW. How to develop a second victim support program: A toolkit for health care organizations. Joint Commission Journal on Quality and Patient Safety [Internet]. 2012;38(5):235–40. Available from: http://dx.doi.org/10.1016/S1553-7250(12)38030- 6

13. McCready S, Russell R. A national survey of support and counselling after maternal death. Anaesthesia. 2009;64(11):1211–7.

REFERENCES

14. Schwappach D, Richard A. Speak up-related climate and its association with healthcare workers' speaking up and withholding voice behaviours: A cross-sectional survey in Switzerland. BMJ Quality and Safety. 2018;27(10):836–43.

15. Schwappach DLB, Niederhauser A. Speaking up about patient safety in psychiatric hospitals – a cross-sectional survey study among healthcare staff. International Journal of Mental Health Nursing. 2019;28(6):1363–73.

16. Strametz R, Koch P, Vogelgesang A, Burbridge A, Rösner H, Abloescher M, et al. Prevalence of second victims , risk factors and support strategies among young German physicians in internal medicine (SeViD-I survey). 2021;8:1–11.

17. Strametz R, Fendel JC, Koch P, Roesner H, Zilezinski M, Bushuven S, et al. Prevalence of second victims, risk factors, and support strategies among german nurses (Sevid-ii survey). International Journal of Environmental Research and Public Health. 2021;18(20):1–15.

18. Merandi J, Liao N, Lewe D, Morvay S, Stewart B, Catt C, et al. Deployment of a Second Victim Peer Support Program: A Replication Study. Pediatric Quality & Safety. 2017;2(4):e031.

19. Morris D, Sveticic J, Grice D, Turner K, Graham N, Morris D, et al. Collaborative Approach to Supporting Staff in a Mental Healthcare Setting : Always There " Peer Support Program. Issues in Mental Health Nursing. 2022;43(1):42–50.

20. Institute of Medicine (US) Committee on Quality of Health Care in America. Crossing the Quality Chasm. Washington, D.C.: National Academies Press (US); 2001.

21. Connors CA, Dukhanin V, March AL, Parks JA, Norvell M, Wu AW. Peer support for nurses as second victims: Resilience, burnout, and job satisfaction. Journal of Patient Safety and Risk Management. 2020;25(1):22–8.

22. Moran D, Wu AW, Connors C, Chappidi MR, Sreedhara SK, Selter JH, et al. Cost-Benefit Analysis of a Support Program for Nursing Staff. Journal of Patient Safety. 2017;00.

23. de Bienassis K, Slawomirski L, Klazinga N. The Economics of Patient Safety Part IV: Safety in the Workplace: Occupational safety as the bedrock of resilient health systems [Internet]. OECD Health Working Papers no. 130. 2021. Available from: http://ezproxy.usp.ac.fj/login?url=https://www.proquest.com/working-papers/economicspatient-safety-part-iv-workplace/docview/2575911710/se-2?accountid=28103

24. Srinivasa S, Gurney J, Koea J. Potential Consequences of Patient Complications for Surgeon Well-being: A Systematic Review. JAMA Surgery. 2019;154(5):451–7.

25. International Labour Office, International Council of Nurses, World Health Organization, Public Services International. Framework guidelines for addressing workplace violence in the health sector [Internet]. Joint Programme on Workplace Violence in the Health Sector. Geneva: International Labour Office; 2002. Available from: https://tinyurl.com/52wr79s8

26. Busch IM, Scott SD, Connors C, Story AR, Acharya B, Wu AW. The Role of Institution-Based Peer Support for

REFERENCES

Health Care Workers Emotionally Affected by Workplace Violence. Joint Commission Journal on Quality and Patient Safety. 2021;47(3):146–56.

27. Carrillo I, Tella S, Strametz R. Studies on the second victim phenomenon and other related topics in the pan-European environment : The experience of ERNST Consortium members. Journal of Patient Safety and Risk Management. 2022;1–7.

28. Mira JJ, Cobos-Vargas Á, Astier-Peña MP, Pérez-Pérez P, Carrillo I, Guilabert M, et al. Addressing acute stress among professionals caring for COVID-19 patients: Lessons learned during the first outbreak in Spain (March–April 2020). International Journal of Environmental Research and Public Health. 2021;18(22).

29. Strametz R, Raspe M, Ettl B, Huf W, Pitz A. Recommendations: Maintaining capacity in the healthcare system during the COVID-19 pandemic by reinforcing clinicians' resilience and supporting second victims. German Coalition for Patient Safety, Austrian Network for Patient Safety; 2020.

30. Mira JJ, Vicente MA, Lopez-Pineda A, Carrillo I, Guilabert M, Fernández C, et al. Preventing and addressing the stress reactions of health care workers caring for patients with COVID-19: Development of a digital platform (Be + against COVID). JMIR Mhealth Uhealth. 2020;8(10):1– 17.

31. Scott SD, Hirschinger LE, Cox KR, McCoig M, Hahn-Cover K, Epperly KM, et al. Caring for our own: Deploying a systemwide second victim rapid response team. Joint Commission Journal on Quality and Patient Safety. 2010;36(5):233–40.

32. Mira JJ, Carrillo I, Guilabert M, Lorenzo S, Pérez-Pérez P, Silvestre C, et al. The second victim phenomenon after a clinical error: The design and evaluation of a website to reduce caregivers' emotional responses after a clinical error. Journal of Medical Internet Research. 2017;19(6):1–14.

33. Edrees H, Connors C, Paine L, Norvell M, Taylor H, Wu AW. Implementing the RISE second victim support programme at the Johns Hopkins Hospital: A case study. BMJ Open. 2016;6(9).

34. Dukhanin V, Edrees HH, Connors CA, Kang E, Norvell M, Wu AW. Case: A Second Victim Support Program in Pediatrics: Successes and Challenges to Implementation. Journal of Pediatric Nursing [Internet]. 2018;41:54–9. Available from: https://doi.org/10.1016/j.pedn.2018.01.011

35. Burlison, J.D., Scott, S.D., Browne, E.K., Thompson, S.G., & Hoffman JM. The second victim experience and support tool (SVEST): Validation of an organizational resource for assessing second victim effects and the quality of support resources. J Patient Safety. 2017;13(2):93–102.

36. Connor CA, Dukhanin V, Norvell M, Wu AW. RISE: Exploring volunteer retention and sustainability of a second victim support program. Journal of Healthcare Management. 2021;66(1):19–31.

CASE STUDY #2

The path of a healthcare professional in the aftermath of a patient safety incident

TABLE OF CONTENTS

Key messages 120

Executive summary 122

Case Overview 123

Amelia's Story 124

Ignoring and Hiding vs Recognizing and Reporting 128

Still Ignoring vs Speaking Up 132

No Support vs Activation of Institutional Support 136

Avoiding the First Victims vs Open Disclosure 140

Whishing That Won't Happen Again vs Building Resilience 144

Roadmap 148

Next steps 149

Appendix 150

References 152

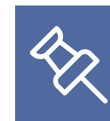
KEY MESSAGES

When something unexpected happens the first thing to do is to report the situation. Only based on what was reported we can learn and intervene in the system to improve it. Also, reporting is crucial to ensure the appropriate management of the incident, and protect the workers involved.

The institutions should work to foster just culture, recognizing that most of the failures are due to bad design processes, fragile structures and/or weak systems, but where there's also individual accountability.

Flourishing organizations are predisposed to open discussion about patient safety issues, where all the viewpoints should be considered.

An institutional structure to deal with the second victim issues should be available, guaranteeing appropriate guidance and support.



The disclosure of an adverse event to the patients and their families is an ethical duty that facilitates the relation and trust between all parts involved.

It's not just an apology or a brief discussion about what has happened, but it also means that the first victims would be informed about the introduced measures to prevent further similar incidents.

This brings the patient to the centre of healthcare, giving them voice and involving them in the co-design of healthcare improvements.

EXECUTIVE SUMMARY

In a healthcare setting, when an incident occurs the staff involved could experience distress and suffering. Their mental health could be affected, as well as their capacity to take care of the subsequent patients, compromising patient safety. **This harmful experience of the healthcare professional in the aftermath of an incident is called the second victim phenomenon.**[1]

This is the second case study of ERNST – The European Researchers' Network Working on Second Victims. The first focused the implementation of institutional/organizational responses to tackle the second victim problem. This second case study is centred on the experience of healthcare workers - the second victims - their feelings while coping with the situation, the importance of certain behaviours and choices, and finally the outcomes of the recovery process.

It will start with a story, explaining the occurrence of an adverse event – the case of Amelia, a patient that suffered harm following a vaccine administration. It is a real situation that happened in Spain. Regarding this, a video explaining the occurrence of the event and its causes was made by FISIABIO, the Foundation for the Promotion of Health and Biomedical Research of Valencia Region, Spain. The story is briefly described in this case study, but you can also find the video here:

https://cost-ernst.eu/explanatory-videos/.

A fictious continuation of the story was created, focusing on the experiences of the professionals involved, and revealing alternative paths that might be followed. For each step, it is presented an unwanted response, the "wrong way", and an appropriate response, the "right way". It culminates with the results when moving on from what had happened.

The next page presents an overview of the Case Study:

CASE STUDY #2 OVERVIEW

AIM: To understand the path of a healthcare worker in the aftermath of a situation that could cause a second victim experience.

Starting from:

Amelia's case.

A serious adverse event after an incorrect vaccine administration.

Following the paths of the healthcare workers involved:

- **Actions**

- *Ignoring and Hiding VS Recognizing and Reporting*

- *Still Ignoring VS Speaking Up*

- *No Support VS Activation of Institutional Support*

- *Avoiding the First Victims VS Open Disclosure*

- **Consequences**

- *Whishing That Won't Happen Again*

High probability of seld-disappointment, desolation, frustration and fear to fail again, emotional distress.

- *Building Resilience*

Continuous improvement of quality and safety and build resilience, feeling that are not alone.

AMELIA'S STORY

Amelia W. was a 21 years-old Spanish student. She had just been admitted to the Erasmus Program in the United Kingdom (UK). Concerned about living abroad for the first time, she consulted the internet looking for preventive measures to take. She thought that it would be advisable to take the tuberculosis vaccine (BCG).

She went to a preventive consultation where she was informed that BCG vaccine wasn't required to travel to the UK, but she could buy it at the pharmacy if she wanted, so the vaccine was prescribed without any additional details. She bought the vaccine at a community pharmacy and again no further information about the vaccine was given.

In the next day, she went to the healthcare centre for a medical appointment with Dr Olivia, her general practitioner. The doctor asked a nurse to administrate the vaccine. The only nurse available, Eva, had started to work there only two days before. She had just finished her nurse degree, so it was her first work experience.

To administrate the vaccine, Eva drew all the liquid from the vial, diluted it and administrated it intramuscularly. In the end she recorded the vaccination at the electronic medical record.

The usual dose of the BCG vaccine is 0.1ml. The vial contained 1ml, so the dose administrated was ten times higher. Also, BCG is administered intradermally and not intramuscularly.

A few hours later Amelia started to feel pain on the local of administration of the vaccine. She returned to the health centre. When she got there, both the Dra Olivia and nurse Eva had finished their shifts. Another doctor prescribed a painkiller, which should stop the pain soon.

However, Amelia got worse, with dizziness and vomiting, fever, and discomfort. So, in the next day, she returned to the health centre. After observing Amelia, Dr Olivia asked the nurse Eva if she had noticed something abnormal during the administration of the vaccine. Eva hadn't noticed anything abnormal. She confirmed that she administered intramuscularly the vaccine, using the entire vial content.

At this point, Eva and Olivia realized the mistake and they both felt anxious and scared about Amelia's health and about what could happen next.

You might think that in your own setting, this story wouldn't had happened. But remember that:

- The procedures and regulations are different between countries.

- Even when there are appropriate guidelines, sometimes the real-life practices don't follow them. The professionals' behaviours could be influenced by, for example, work overload, insufficient staffing, lack of experience, lack of appropriate knowledge and internal factors (i.e., stress, demotivation, tiredness).

AMELIA'S STORY

There are also of course careless behaviours that involve negligence, but these are a minor cause of adverse events.

When something wrong happens, there is a chain of events that was responsible or has contributed to it.

Please consult the Appendix if you want to know more about the chain of error that led to the situation.

In this story we can identify:

- A first victim – Amelia, who had suffered disastrous consequences to her health and to her life. Her family members were also first victims as they felt the burden caused by the event as well.

- A second victims – Eva and Olivia. When they became aware about the situation, they started to suffer from emotional distress. In the next sections we will see how they can handle the situation.

- A third victim – the healthcare centre could suffer from loss of reputation and bear the burden of the economic costs: both from potential legal suits as well as from the indirect effect of reputation damage on services demand.

The case study will now focus on the experience of the second victims. Please keep in mind the following topics when reading the continuation of the story:

Learning goal:

- To list some of the emotions that the workers involved in this type of situation could experience.

- To consider the potential consequences for the next patients when treated by a healthcare worker involved in that scenario.

- To describe some key factors that may influence each of the pathways (right/wrong way).

- To describe potential barriers to act as recommended and how to overcome them.

Ignoring and Hiding vs Recognizing and Reporting

Eva was paralyzed by the fear, how unlucky she was, having to deal with this situation in her first week of a new job. She didn't have a friend to talk to, all people were new, and they seemed so busy that she didn't find the courage to address any of her colleagues. What would she do?

Olivia couldn't stop thinking that she should have done more and better when observing Amelia.

IGNORING AND HIDING

They hoped the abscess would heal very soon so they decided to not tell anyone about the case.

Above all what was important was to take care of Amelia, so there was no need to create more drama about the situation.

Olivia was extremely concerned about losing the respect of the staff. The idea of being fired worried Eva.

RECOGNIZING AND REPORTING

Despite those terrible feelings, immediately after realizing the error, they called the quality manager of the institution, reporting what had happened and seeking guidance for what to do next.

The report of the adverse event led to further root cause analysis, and it culminated with the implementation of new safety procedures regarding uncommon vaccines as BCG.

Immediately after the report of the event, the risk-manager informed Olivia and Eva about the existing resources to help them to cope with the situation.

When an incident happens, reporting is crucial. It allows to appropriately understand what happened and to inform preventive actions in the future.

An effective reporting culture only exists when there's also a positive environment, with no blame concerns. [2]

Reporting is also important to inform risk managers about team members which can be potential second victims of the incident, as being an opportunity for reach them and provide information about protective resources available.

Ignoring and Hiding vs Recognizing and Reporting

The safety culture of the organisation is crucial to prevent safety failures, with special emphasis on continuous learning and the existence of space to open discussions about safety. Blame concerns should be avoided at all costs, as they undermine that goal. That being said, in a minority of situations, as for neglect behaviour, the individuals should be held accountable. **The term just culture** can be defined as “an environment which seeks to balance the need to learn from mistakes and the need to take disciplinary action.[3] It recognizes that most safety failures are due to weak systems but also gives space to appropriate accountability when necessary. The boundaries between those two situations should be well defined.

In 2020, the WHO published a report2 dedicated to patient safety incident reporting, explaining the purpose, strengths, and limitations that can be useful to establish/improve a reporting system.

Please consult: World Health Organization. Patient Safety Incident Reporting and Learning Systems: technical report and guidance. Geneva: WHO; 2020.

Still Ignoring vs Speaking Up

Amelia's health wasn't improving as quickly as they wished, and she would require further treatments. She was always in the mind of Eva and Olivia.

As the hours were passing, they were feeling even more anxious.

STILL IGNORING

In Olivia's mind, talking about what happened wasn't a priority – she was an experienced professional, she would deal with the anxiety. Eva was so ashamed, she wanted to talk to someone, but she couldn't trust in anyone, because they were all strangers at the centre. She considered talking with her family or a friend, but she couldn't get the courage to do that.

At this point, they started to avoid talking to each other, because it seemed to increase the guilty feelings.

At the same time, another professional in the centre was dealing with loneliness. Miguel, a nurse, was concerned about the quality of some material used to treat wounds, as well as the disinfection protocol which seemed inappropriately implemented. But he wasn't confident enough to say anything, he was afraid of a punishment from his chief, who seemed to don't like him much. So, he tried to do his best, but without warning anyone about this.

SPEAKING UP

Olivia and Eva decided to talk with two colleagues about what had happened, explaining the mistaken administration of the vaccine. The colleagues felt staggered, but they quickly reassured Olivia and Eva that everything would be ok.

All the staff became aware of the event and the majority felt that the incident could also had happened to them. The staff became mindful that something had to be done regarding patient safety in these situations.

After this, the nurse Miguel got comfortable to talk about something that had been in his mind, but that he had never shared before. He was concerned about the quality of some material used to treat wounds, as well as the disinfection protocol, which seemed inappropriately implemented. He revealed his concerns to their chief and team colleagues, and the case was discussed. Some procedures were changed because of the ease of communication in the institution.

Still Ignoring vs Speaking Up

Communication between healthcare staff is crucial and its absence could harm patient safety. Effective communication should be based on mutual trust, sharing of perceptions, and confidence in the efficacy of preventive measures[3]. It should be open and respectful, involving all team members and should help to anticipate future problems.

Speaking up is defined as "assertive communication of patient safety concerns through information, questions or opinions where immediate action is needed to avoid patient harm"4. In the "right" story, presented in the right column, Miguel shared his concerns with his team, and it led to the adoption of new preventive measures after the team members had discussed their insights and opinions.

But as we see on the left column story, he could have stayed silent. Eventually, if something wrong were to occur afterwards, he would probably think that he should have said something. This behaviour could be named as **withholding voice**, meaning "an intentional behaviour not to verbalise ideas, information and opinions for the improvement of patient safety". [4]

Please note that speaking up it's not entirely related with the aftermath of an adverse event – it is in fact part of a patient safety culture which empowers the staff to openly discuss safety related subjects, so it should be always present.

To help to understand how health care professionals think about voicing their concerns, Okuyama et al.[5] designed a model for speaking-up behaviour:

Okuyama A, Wagner C, Bijnen B. Speaking up for patient safety by hospital-based health care professionals: a literature review. BMC Health Serv Res. 2014;14(61).

No Support vs Activation of Institutional Support

A few days later, both Olivia and Eva were still suffering. Eva was dealing with recurrent insomnia and Olivia felt, for the first time in her professional life, that she wasn't good enough for her job.

NO SUPPORT

Olivia knew that there was some kind of support within the institution for these situations. She heard about a colleague who received psychological support after a patient's death, but she didn't want to talk about Amelia's case with anyone. She would handle by herself, for sure.

Eva wasn´t aware of the supporting tools that she could activate within the healthcare institution.

ACTIVATION OF INSTITUTIONAL SUPPORT

Initially Olivia was renitent in accepting help but eventually she decided to use the peer support helpline. She had a conversation with a trained peer where the focus was her emotions and psychological first aid was provided. She learned how to deal with those feelings, and she decided to prioritize her mental health in the future.

Eva also had a meeting with a peer supporter. But a few days later she felt that she would need more help to deal with the situation, so she started to see the psychologist of the professional support service of the institution.

No Support vs Activation of Institutional Support

The importance of having an institutional support program dedicated to the second victims was addressed by Case Study [1]. A common problem when the program is implemented is the lack of adherence by the workers, as shown in the left column. That can be due to a scarce safety culture, fear of consequences, or lack of information.

Please consult the Case Study 1 to know more about different programs that could be implemented to address the second victim's problem and the Peer Support Program Implementation Guide to a stepby- step guidance.

Avoiding the First Victims vs Open Disclosure

In the subsequent days, before getting worse and being transferred to the hospital care, Amelia visited the care centre several times, accompanied by her mother.

AVOIDING THE FIRST VICTIMS

Although they were very concerned about Amelia's health, both Olivia and Eva stopped to provide care to Amelia. Olivia managed to transfer her case to another medical team within the unit. They continued to follow her evolution by distance.

Amelia and her family were extremely confused about what had happened, but they found no convincing answers in the health centre. They considered to take legal actions because they weren't receiving appropriate responses.

OPEN DISCLOSURE

As soon as possible, Olivia and Eva had a disclosure conversation with Amelia and her mother. The risk-manager of the institution was together with them. They apologized and explained what caused the reaction, what probably should have been done, listening to Amelia's and her mother's feelings.

They continued to follow her case and to talk with Amelia even after her transfer to another care unit.

A few months later, they called Amelia and her mother for a meeting where they showed all the conclusions of the event chain analysis and explained all the preventive measures implemented. This was crucial to Olivia and Eva because they felt they could move on.

Avoiding the First Victims vs Open Disclosure

Patient-centred healthcare entails the need for an open communication in all situations. Disclosure after an adverse event implies numerous challenges[6].

Open disclosure can be defined as an "open discussion with a patient (and/or their support person(s)) about a patient safety incident which could have resulted, or did result in harm to that patient while they were receiving health care"[7]. As seen is the right column, it implies an exchange of information between the professionals and the first victims, taking place over several meetings.

In Australia the Clinical Excellence Commission developed a handbook7 to support the open disclosure process. You might consult it here:

Clinical Excellence Commission. Open disclosure Handbook. Prevention is Better than Cure. Sidney: Clinical Excellence Commission; 2014.

Whishing That Won’t Happen Again vs Building Resilience

Eventually Amelia had to be submitted to a surgery, and then she also had to do six months of chemoprophylaxis. She abandoned her dream of studying out of borders and gave up of the Erasmus programme.

WISHING THAT DON’T HAPPEN AGAIN

Olivia was getting more apathic day after day. Even her patients thought that she wasn’t truly concentrated in the appointments. The time passed, and she continued revising the incident day after day. The feel of sadness and the lack of pleasure from her work persisted for a long time.

For several weeks, Eva tried to cope with the insomnia, the anxiety, the guilty feelings. Every time that she had to do something at work, she felt fear and doubted herself. In the end, she concluded that she couldn’t handle with it anymore and she quitted. She decided to do something else, she thought that after all she wasn’t prepared to be a nurse and she started to look for another job.

BUILDING RESILIENCE

Although the experience of Amelia’s case remained in the memory of Olivia and Eva, they both felt that they could move on and doing better every day.

They became interested in patient safety issues and they supported the implementation of educative programmes for patient safety and second victims at the institution. Her feedback was also important to carry out improvements in the peer support program. The safety culture within the institution became stronger.

Whishing That Won't Happen Again vs Building Resilience

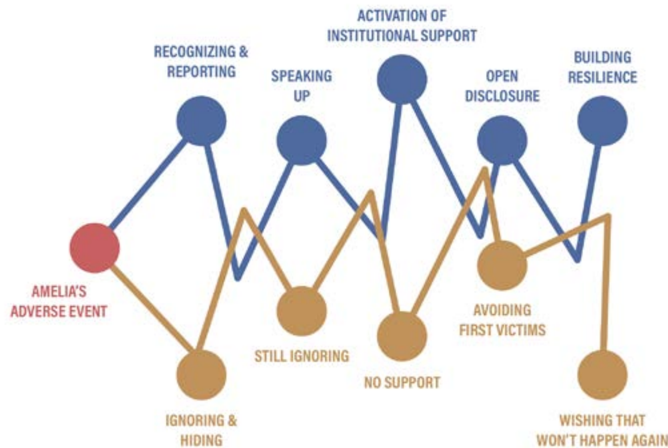
This section sums the end result of a second victim situation at the final stage of the recovery, moving on, as explained by Scott[8]. In the unwanted way (left column) Olivia was **surviving**, as coping but with persistent sadness and intrusive thoughts, and Eva decided to **drop-out**, leaving the institution. In the building resilience path (right column), both were **thriving**, learning from the event, and making better from that while taking appropriate care of their mental health.

To know more about the six stages of the natural history of recovery of the second victims please consult:

Scott SD, Hirschinger LE, Cox KR, McCoig M, Brandt J, Hall LW. The natural history of recovery for the healthcare provider "second victim" after adverse patient events. Qual Saf Heal Care. 2009;18:325–30.

ROADMAP

When following Amelia's story and further events regarding the experience of the two health professionals, Olivia and Eva, two distinct pathways were followed. They are summarized in the image below:



The blue line represents the right or wanted way and on contrary, the orange line represents the wrong or unwanted way.

That said, one can imagine, in a real situation the paths could have intersections, because the choices and decisions could be either "right" or "wrong" along the way.

NEXT STEPS

• As a result of Case Study#2 please try to make an inner exercise. What would be your response to a situation like that? With whom would you talk to?

• While thinking on being at the situation of Eva and Olivia, you probably felt that some aspects of a good response are only possible in a healthy working environment. Discuss these issues with your colleagues, try to make space to an open discussion when the problems came. Try to engage your leaders too.

• If you want to know more about the second victim phenomenon, please consult the materials developed by ERNST - The European Researchers' Network Working on Second Victims.

Find more contents on the website:
https://cost-ernst.eu/

APPENDIX

It is worth to explain what led to the adverse result for Amelia. The chain of event is summarized below:

Nurse Eva:	**Doctor Olivia:**
- First week of work. - Insufficient training on vaccines. Most of vaccines are administered IM and comes in single doses vials (not in this case). - Checked Amelia's file for allergy history (inexistent).	- Reviewed the story but didn't perform a tuberculin test due to the pressure of the family to be vaccinated immediately. - No experience with the BCG vaccine, which hadn't been administrated at the centre for years. - Didn't asked nurse Eva if she knew how to administer
Directorate of Nursing:	**Pharmacist:**
- Had the urgency to fill a position for a new nurse but didn't ensure the adequate protection of her work and didn't apply a reception protocol, due to staff constraints.	- Didn't warn Amelia that the vial contained 10 doses.

Health authorities:	**Government:**
- Although some similar events had occurred before, no specific information for professionals or a prescription assistance algorithm was developed to prevent them.	- By forcing a restrict contract policy for health care workers, it led to increasing staff fatigue and drop-off of the institutions.
Academic authorities of the university of Amelia:	**European health authorities:**
- Didn't offered information about preventive measures before travelling.	- Didn't established a vaccination regimen for mobility on Erasmus program.

For more details, please watch the video at ERNST website:

https://cost-ernst.eu/explanatory-videos/

REFERENCES

1. Wu AW. Medical error: The second victim. BMJ. 2000;320:726–7.

2. World Health Organization. Patient Safety Incident Reporting and Learning Systems: technical report and guidance. Geneva: World Health Organization; 2020.

3. Organization WH. Global Patient Safety Action Plan 2021-2030 Towards eliminating avoidable harm in health care. Geneva: World Health Organization; 2021.

4. Schwappach D, Richard A. Speak up-related climate and its association with healthcare workers' speaking up and withholding voice behaviours: A cross-sectional survey in Switzerland. BMJ Qual Saf. 2018;27(10):836–43.

5. Okuyama A, Wagner C, Bijnen B. Speaking up for patient safety by hospital-based health care professionals: a literature review. BMC Health Serv Res. 2014;14(61).

6. Wu AW, McCay L, Levinson W, Iedema R, Wallace G, Boyle DJ, et al. Disclosing adverse events to patients: International norms and trends. J Patient Saf. 2017;13(1):43–9.

7. Clinical Excellence Commission. Open disclosure Handbook. Sidney: Clinical Excellence Commission; 2014.

8. Scott SD, Hirschinger LE, Cox KR, McCoig M, Brandt J, Hall LW. The natural history of recovery for the healthcare provider "second victim" after adverse patient events. Qual Saf Heal Care. 2009;18:325–30.

CASE STUDY #3

Patient safety incident in a hospital setting

TABLE OF CONTENTS

Key messages 157

Executive summary 158

Case Overview 159

Mr. Manuel's Story 160

Topics for discussion 164

Notes 170

Acknowledgment 175

Funding 176

KEY MESSAGES

Patient safety incidents are the result of a chain of latent failures, predisposing conditions, and/or active failures. The healthcare worker is part of a team, and the team developing their activities in a system under specific conditions.

A strong safety culture includes robust perceived psychological safety for the healthcare workers, enabling them to speak up by discussing safety concerns and to disclose any problem that could occurs.

An effective communication with patients and families is essential to avoid litigation, a situation that could represent significant suffering for all involved.

EXECUTIVE SUMMARY

In a healthcare setting, when an incident occurs the staff involved could experience distress and suffering. Their mental health could be affected, as well as their capacity to take care of the subsequent patients, compromising patient safety. **This harmful experience of the healthcare professional in the aftermath of an incident is called the second victim phenomenon.**

This is the third case study of ERNST – The European Researchers' Network Working on Second Victims. The first focused the implementation of institutional/organizational responses to tackle the second victim problem. This third case study, as the second, is centred on the experience of healthcare workers - the second victims -, their feelings while coping with the situation, the importance of certain behaviours and choices, and finally the outcomes of the recovery process.

The case study starts with a story that was created by collecting several real situations that had happened in a hospital setting in Lisbon, Portugal but that could had happened in a hospital elsewhere. This case gives rise to a fictious situation describing a series of failures when treating an elderly patient, resulting in serious harm and a litigation process. It is an opportunity to consider the implications of some specific issues regarding the second victim experience and patient safety in general.

The next page presents an overview of the Case Study:

CASE STUDY #3 OVERVIEW

AIM: To understand the path of a healthcare worker in the aftermath of a situation that could cause a second victim experience.

Starting from:

Mr. Manuel's case.

A serious adverse event after a wrong blood transfusion.

Considering crucial points for the experience of the healthcare workers in the aftermath of the event:

Mr. MANUEL'S STORY

Mr. Manuel Ferreira was a 78-year-old retired engineer. He was widowed and he lived alone at his home; he had full autonomy on the activities of daily living. His son was a lawyer and, despite living abroad, he kept a close accompaniment of his father's life.

One day, Mr. Ferreira received a call from the lab where he had done routine analysis prescribed by his family doctor/general practitioner (GP) to inform that he had an anaemia, unnoticed before. Mr. Ferreira immediately called his GP, but he found that he was on vacation, so he decided to go to the emergency service (ER) of the hospital nearby. His personal antecedents were diabetes, high blood pressure and severe hearing loss.

At the ER, the clinical team found that Mr. Ferreira was suffering of tiredness for several weeks. There were no relevant changes on the objective examination. The doctor decided that he had to stay in the hospital because of the 7,5 g/dL value of haemoglobin, low Mean Corpuscular Volume (microcytic anaemia), and to facilitate the realization of further exams. Then, Mr. Ferreira was admitted to the Medicine Unit of the hospital, staying in a double-bed room with another patient who, for coincidence, was also named Manuel, although his last name was Pereira. Mr. Manuel Pereira suffered of dementia and occasionally had periods of time, space, and person disorientation.

During Mr. Ferreira's second night at the hospital, a nurse came by and called for his roommate, Mr. Manuel Pereira. Because of his hearing impairment, Mr. Ferreira thought that she was calling him and replied. Despite the existence of a transfusion protocol at the hospital, it wasn't properly followed. The nurse didn't confirm the patient' identification label in the wrist and started the transfusion of an erythrocytic concentrated unit saying to the patient that it was prescribed by his doctor. Mr. Ferreira wasn't expecting a transfusion, but he didn't have understood much of his doctor explanations previously that afternoon, so he allowed the procedure without saying anything.

The nurse had to leave the bedroom just a few moments after the transfusion started, because she had numerous tasks to do. The hospital was dealing with some human resources constraints, due to recent retirements, staff turnover and vacations. The number of beds that each nurse was responsible for was at that time twice the normal.

Mr. MANUEL'S STORY

About one hour later, she returned to Mr Ferreira's bedroom, and all seemed to be ok. Then, she finally got time to do the records on the electronic system and she noticed a big mistake: she had changed the patients' names, so the wrong patient was receiving a transfusion! She ran to the bedroom and stopped the procedure. She called the shift's nurse leader to report the situation and she also called the emergency doctor to give knowledge of what happened.

Maria, the nurse, felt absolutely devastated, but she continued her work. She started to fear what could happen next, so she didn't report the incident on the institution's report platform as her team leader asked.

The patient's blood types where not compatible, Mr. Ferreira suffered a serious reaction to the transfusion and had to be admitted latter that night at the intensive care unit.

In the next day the assistant doctor gained knowledge of the situation and had to inform Mr. Ferreira's son, accompanied by the director of the service. They simply told them that something unexpected happened, with damaging consequences to the patient; clearly, they weren't interested in detailing too much of what had happened. The patient's son reacted with anger, and that was the beginning of a conflictual relationship, that culminated with a lawsuit where he asked for compensation for physical and moral damages.

Mr. Ferreira survived the incident and was discharged from the hospital a month later. However, he was very debilitated and became dependent on the activities of daily living.

Nurse Maria struggled to continue at the same hospital, because she felt that all eyes were on her and that the team hadn't properly supported her. Nobody had talked to her about her feelings or expressing concern about her. Because the event hadn't reached the quality management team, no formal support had been offered. The cycle of tiredness, anxiety, guilt, and shame culminated with a sick leave for several weeks.

TOPICS FOR DISCUSSION

You might think that in your own setting, this story wouldn't had happened. But remember that:

- The procedures and regulations are different between countries.

- Even when there are appropriate guidelines and protocols, sometimes in the real-life practices don't follow them. The professionals' behaviours could be influenced by, for example, work overload, insufficient staff, lack of experience, lack of appropriate knowledge and internal factors (i.e., stress, demotivation, tiredness).

There are also of course careless behaviours that involve negligence, but these are a minor cause of adverse events.

When something wrong happens, there is a chain of events that was responsible or had contributed for it.

In this story we can identify:

- A first victim – Mr. Manuel Ferreira, who was autonomous before and became dependent on the activities of daily living. His son is also a first victim.

- A second victim – nurse Maria. After struggling to remain in her work, she ended to drop-out.

- A third victim – the healthcare centre(hospital), suffering a lawsuit and loss of reputation.

Learning goal:

- Considering the following topics:

o Speaking-up
o Incident report
o Institutional support
o Open disclosure

How can they relate to the second victim' experience (Maria's)? Regarding them, what should had been different in the situation presented?

Learning tip: For more information about those four topics, please consult the Training Manual, available at https://trainingmanual.cost-ernst.eu/

TOPICS FOR DISCUSSION

- Considering this situation, how can the second victim experience influence the relations with the first and third victims and their outcomes (and vice-versa)?

TOPICS
FOR DISCUSSION

- Discuss if there are other patient safety subjects that might have influenced the second victim' experience or that should be of interest to discuss in this context

NOTES

NOTES

NOTES

ACKNOWLEDGMENT

This notebook was result of a great collaboration and work of the following contributors:

- **Working Group 3- Making it Happen - of the ERNST** (leaded by *Paulo Sousa*)

Design

- *Alejandro Rodríguez Sánchez* -

ERNST Training School trainers

- *Bojana Knezevic* (Host organizer of Training School)
- *Joana Fernandes* (Notebook Development Leader)
- *José Joaquín Mira* (ERNST Chair)
- *Reinhard Strametz* (ERNST Vice Chair)
- *Sandra Buttigieg* (WG4 Leader)
- *Sofia Guerra Paiva* (Training School Coordinator)

Support staff

- *Amaya Vara González*
- *Maja Vajagić*

FUNDING

This notebook is funded by *COST Association:*

This publication is based upon work from COST Action CA19113 supported by COST (European Cooperation in Science and Technology).

COST (European Cooperation in Science and Technology) is a funding agency or research and innovation networks. Our Actions help connect research initiatives across Europe and enable scientists to grow their ideas by sharing them with their peers. This boosts their research, career and innovation.

Website: https://www.cost.eu/

TRAINEE
NOTEBOOK

ERNST Training School

Intensive training on the Second Victim Phenomenon &
Second Victim Support Programmes

ERNST
The European Researchers' Network
Working on Second Victims

Funded by
the European Union