The Patient Safety Education Program™
CANADA

Module 19: The Healthcare Provider's Experience of Patient Safety Incidents

Emanuel LL, Taylor L, Hain A, Combes JR, Hatlie MJ, Karsh B, Lau DT, Shalowitz J, Shaw T, Walton M, eds. *The Patient Safety Education Program – Canada (PSEP – Canada) Curriculum*.

Acknowledgements to Abigail Hain for the writing of this module and to Susan Scott University of Missouri Health Care System, Dannie Currie, Laurel Taylor, and to Joan Fernandez, Canadian Patient Safety Institute for review and editorial contributions of the module.

PSEP – Canada is a partnership between the Canadian Patient Safety Institute (CPSI) and the Patient Safety Education Program, which is housed at MedStar Institute for Quality and Safety (MIQS), a division of MedStar Health, Columbia, Maryland, USA. The PSEP – Canada Curriculum is an adaptation of the PSEP Core Curriculum. PSEP has received support from the Jewish Healthcare Foundation, the Pittsburgh Regional Health Initiative, the Zell Center for Risk Research, California Healthcare Foundation, The Commonwealth Fund, and the Health Research and Education Trust in the form of the 2008 Edwin L. Crosby Fellowship that was awarded to Dr. Emanuel. PSEP is a not-for-profit educational program. It began as a collaboration among Linda Emanuel, Martin Hatlie, John Combes, and Joel Shalowitz.

Those who have become certified PSEP – Canada Trainers by taking a 'Become a PSEP – Canada Trainer' course that was provided by PSEP – Canada may use the title of PSEP – Canada Trainer, as well as template materials, such as fliers, that are provided by PSEP – Canada and also use the appropriate designated marks to hold educational seminars using the PSEP – Canada *Core Curriculum*. The Patient Safety Education Program in the US reserves the sole right to designate Master Facilitators who teach at 'Become a PSEP – Canada Trainer' conferences.

Visit **www.patientsafetyinstitute.ca** for further information.

Contact PSEP – Canada by e-mail at **PSEPCanada@cpsi-icsp.ca**, or

PSEP – Canada

Canadian Patient Safety Institute, #410,

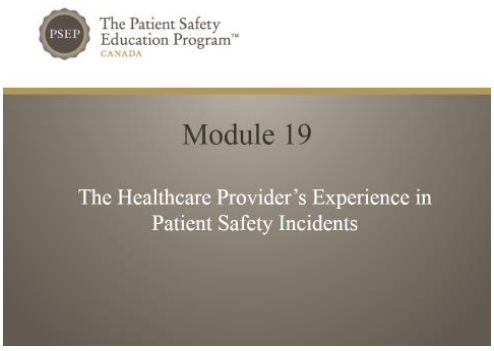
1150 Cyrville Road,

Ottawa, KIJ 7S9

Phone: 613-730-7322

Abstract

Slide 1



This module provides PSEP – Canada trainers with evidence informed content on the health provider experience of patient safety incidents (PSIs), as well as exemplars on successful and innovative provider support programs. Strategies that organizations can use to support healthcare professionals during and after patient safety incidents have also been outlined.

Health providers who have been involved in patient harm incidents are often devastated by these experiences and filled with guilt and shame. They are said to 'suffer in silence'. Influences such as healthcare complexity, organizational culture, health professional cultures, fear of litigation or regulatory reprimand, as well as a problem based approach to issues surrounding healthcare failures contribute to the spiritual, emotional, cognitive and behavioural difficulties health providers experience following an unintended patient harm incident.

Keywords

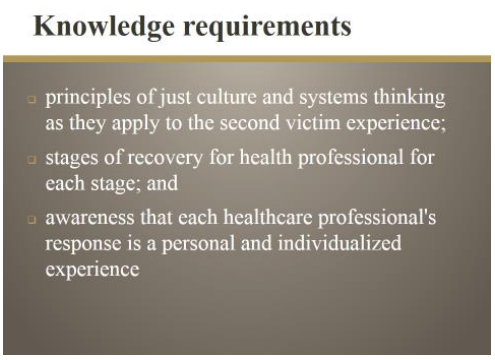
Second victim, peer support in patient safety incidents, organizational resilience, health provider resilience, healthcare error, adverse events, patient safety incidents, litigation, professional practice.

Teaching methods

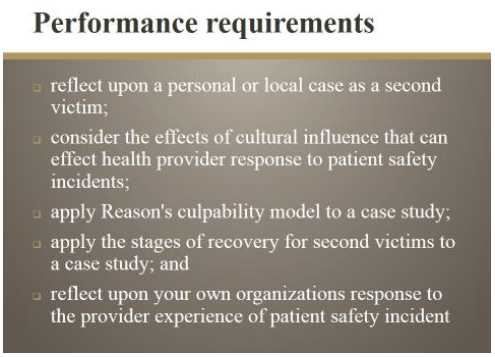
Mini-lecture, case study, trigger tape video, guided reflection, small and large group work

Objectives

Slide 2



Slide 3



Overall Objectives

1. Understand what is known of the incidence and prevalence of the health provider experience of patient safety incidents;
2. Consider individual, situational and organizational influences which effect healthcare professionals' experience of patient safety incidents;
3. Describe the impact of patient safety incidents on healthcare professionals;
4. Review the stages of recovery for health professionals involved in preventable patient harm incidents; and
5. Identify strategies organizations can use to support healthcare professionals during and after patient safety incidents.

Knowledge requirements

The knowledge elements include an understanding of:

- the principles of just culture and systems thinking as they apply to the second victim experience;

- the stages of recovery for health professional second victims along with the supports needed for each stage; and
- awareness that each healthcare professional's response to involvement in a patient safety incident is a personal and individualized experience

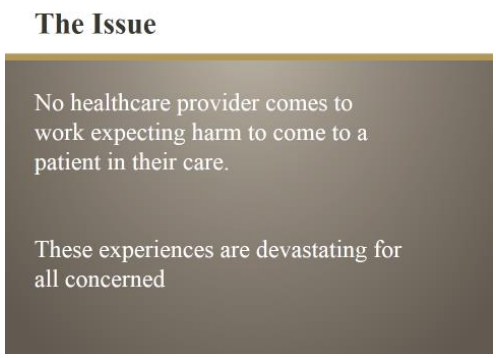
Performance requirements

The performance elements include the ability to:

- reflect upon a personal case or local case of a healthcare professional's experience as a second victim;
- consider the effects of cultural influence from within the professions that can effect health provider response to patient safety incidents;
- apply Reason's culpability model to a case study;
- apply the stages of recovery for second victims to a case study; and
- reflect upon your own organizations response to the provider experience of patient safety incident

Introduction

Slide 4

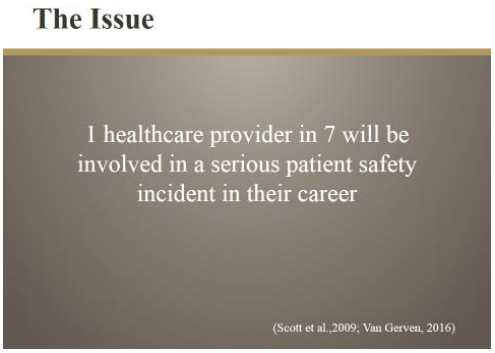


The Issue of the Healthcare Provider Experience in Patient Safety Incidents

The complexity of healthcare delivery has increased exponentially in recent decades (Cilliers & Hofmeyr, 2011; Dekker, 2013; Zimmerman & Plesk, 2001), with many patients living longer with chronic disease and receiving multiple modalities of treatments. Zimmerman (2001) has written extensively on complexity science and healthcare systems. In her model of complexity, healthcare environments are depicted as complex for the most part but all too often may represent chaotic systems. PSEP – Canada Module 1: Systems Thinking: Moving Beyond Blame to Safety, discusses a systems approach to patient safety and quality improvement as well as the principles of complexity science that are of interest to professionals working in health system safety.

Healthcare professionals are under more pressure than ever to maintain highly skilled, sophisticated, efficient and compassionate care that frequently includes vulnerable system failure/error-prone transitions through varied parts of the healthcare system, from high acuity hospitals to patients' homes. And rightly, society expects a guarantee of safety from health professionals and the health system – the stakes are high. Knowledge gained from other high-risk industries such as aviation as well as increased specialization and standardization has helped practitioners and health care leaders navigate these complexities for patients and their families (Vincent, 2010).

Slide 5



As well, health systems are engaging in enhanced transparency and outcome measurement spurring improvement and accountability (Berry & Nicklin, 2015). Despite the many efforts to ensure safe care; near miss and patient harm incidents (encompassed in the term patient safety incident) in healthcare continue to happen, some resulting in patient death and serious harm (Baker et al., 2004; Chan & Cochrane, 2016; Matlow et. al., 2012, Makary et.al., 2016). Healthcare providers do not come to work intending to harm a patient while providing care. So when a patient is harmed in the process of care, these incidents are devastating for all concerned. Health professionals navigate complexity each time they interact with the health system and it is estimated that one provider in seven will contribute to a significant harm incident in their career (Scott et al.,2009) with an overall prevalence reported to be as high as 50% or more (Van Gerven, 2016).

Health providers are most often unprepared to deal with resulting feelings of failing their patient, shredded professional confidence, shame, guilt, confusion and helplessness when they find themselves contributing to unintentional and avoidable patient harm. The psychological aftermath of these experiences can result in the development of complex psychological conditions such as burnout and depression (Seys et al., 2013) with somatic outcomes as severe as post-traumatic stress disorder (PTSD) and incidents of suicide (Dekker, 2013). These findings undermine recent gains made with system approaches to patient safety that proactively address error traps and failures, as well as "just culture" initiatives that seek to avoid blame when inadvertent harm results from system failures. Feelings of self-doubt and failure, both personally and professionally, quickly surface for health professionals when things go wrong. These very human responses speak to the deeply personal, fundamental root of the challenge of healthcare failures that test the

most sophisticated preventative systems and just culture approaches. Health providers can be paralysed with guilt following significant events and subsequently have difficulty engaging in reporting and improvement activity. Incident reporting may also be suboptimal when healthcare teams approach system failures with a sense of fatalism that the business of healthcare is full of risk and incidents are inevitable.

As well, culturally professional nuances such as fulfilling the hero role, valorizing individualism, the myth of perfection (Clancy, 2012; Patel, 2011; Peters & King, 2012; Vincent, 2013), and not being open to fallibility and critique from colleagues constrain a trusting dialogue in patient harm incidents, system failures and lapses. (Aasland, Jones & Gupta, 2004; Aubin, 2015)

Sometimes hierarchical power dynamics between and within professions also contribute to limiting conditions for patient safety by undermining psychological safety (Epsein, Lingard, Baker & Regehr, 2006). In autocratic conditions or bullying atmospheres team members may not feel empowered to speak up when they feel uncertain about process or witness risky conditions (Frankel, Leonard & Denham, 2006).

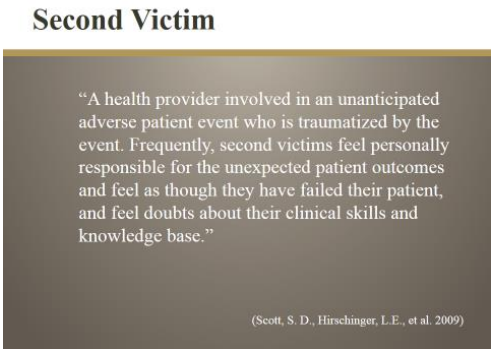
All of these influences act as powerful inhibitors to transparency, meaning-making, recovery and learning for health professionals involved in patient safety incidents. Current understandings highlight that while ubiquitous blame cultures are diminishing in place of systematic approaches to failures and latent error, the source of suffering in these cases is often perpetuated by the cultural influences within the professions themselves (Delbanco & Bell, 2007; Liao, Thomas & Sigall, 2014; Seys et. al., 2012b). For example, student and novice physicians, nurses, as well other novice health professionals have described less than ideal conditions for learning and psychological safety on their clinical rotations. This phenomenon has been described as the hidden curriculum and can be heavily influential on young professionals who may take on less than professional behaviours or create workarounds in order to fit into a team (Benner, 2006; Liao et al., 2014). Negative professional cultural influences contribute to a denial of important peer social support structures for healthcare providers during their time of need following patient safety incidents (Jaffer & Dekker, 2015). As a result of these and other dynamics, providers may be reluctant to report incidents, feel stigmatized, fear litigation which may limit support-seeking by healthcare professionals.

Very little evidence exists on the outcome experiences for health professionals, leaders or caregivers other than physicians and nurses who are directly involved in incidents at the sharp end of care. Only a few discussion articles address the fallout of patient safety incidents for managers, quality and patient safety professionals as well as senior leaders, CEOs and even Board members. In many cases these leadership and administrative professionals are supporting others through difficult circumstances and little attention has been paid to supports that may eventually be needed by these groups. Intense media attention in crisis scenarios can be particularly hard on senior leadership and boards. Provider support programs post-incident need to consider all potentially affected individuals. Recently, a research team from Leuven University in Belgium has initiated a

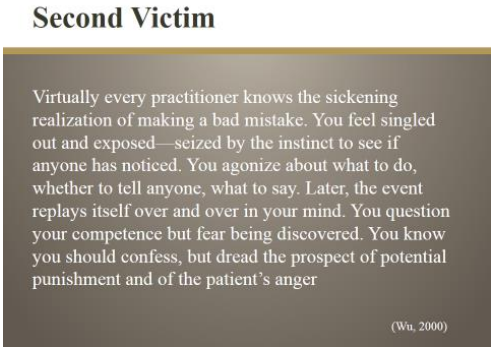
series of small studies aimed to describe the experience of management and leadership in serious patient safety incidents.

Description of Health Provider Response to Patient Safety Incidents

Slide 6



Slide 7



Albert Wu (2000) stimulated a much-needed dialogue about the provider experience of mistake making and system failure in healthcare with a timely and authentic conversation that resonated deeply with many clinicians. His candid, and compassionate, approach to discussing the issue offered a very human contemplation on fallibility. His observations remain relevant today and highlight that despite our subsequent progress and understanding of systems failure and just culture approaches, health professionals are often quick to blame themselves on a personal level for failures and lapses in safe care. He noted that stepping into disclosure, apology, and eventual learning from error experiences, takes deep courage, resiliency and time. He reflected, "Virtually every practitioner knows the sickening realization of making a bad mistake. You question your

competence but fear being discovered. You know you should confess but dread the prospect of potential punishment and of the patient's anger" (Wu, 2000).

Wu's use of the term "second victim" to identify the experience of providers involved in patient harm incidents has added a valuable dimension to our understanding of patient safety issues and solutions. Patients and families suffer in patient harm incidents as first victims and the primary emphasis must be placed on the patient and family when these events occur. However, Wu brought forth the notion that providers were also suffering and falling through the cracks as second victims. There is now a recognition that providers often experience emotionally traumatic symptoms and feelings following patient safety incidents (Dekker, 2013). Table 1 outlines some common healthcare provider responses following a patient safety incident.

Table 1

Common Healthcare Provider Responses Following Patient Safety Incidents

Patient Concern

Adapted from the University of Missouri Health Care System's ForYOU program

Is the patient/family okay?

What have they been told?

How did they respond?

What does the patient need?

Me

Will I be fired? (Nursing and allied health professionals)

Will I be sued? (Medical staff)

Will I lose my license? (All professional groups)

Peers

What will my colleagues think?

Will I ever be trusted again?

Will I still be a respected member of my team?

Next Steps

Who will contact me to discuss the case?

If a lawsuit does happen, when will I know? How will I hear about it?

What do I need to do?

Common Phrases

"I had a sickening realization of what happened."

"I don't deserve to be a doctor."

"This will change the way I come to work from now on."

"This has been a career-changing event."

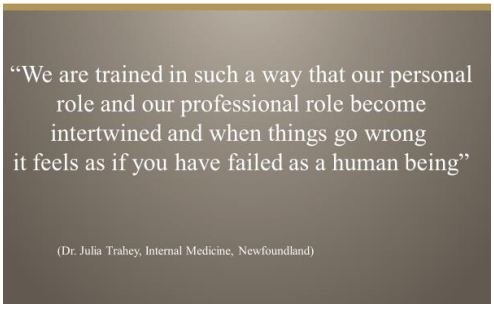
"I came to work today to help someone, not to hurt them."

"This is a turning point in my career."

"This event shook me to my core. I'll never be the same again."

Adapted from the University of Missouri Health Care System's ForYOU program

Slide 8



Providers however, have few supports in place. Often there is little to no cultural appetite within the professions and in some organizations to openly discuss incidents. In 19 out of 41 articles examined in a systematic review, providers reported symptoms as severe as post-traumatic stress disorder following patient safety incidents (Seys, et. al., 2012). Poor patient outcomes and greater perceived personal responsibility are associated with more intense reactions and personal anguish (Engle et al., 2009). When patient harm has occurred, those involved are often likely to blame themselves which may in turn undermine any personal, professional and system-wide learning and system improvement. Reactions to patient safety incidents and adverse outcomes in health care are greatly magnified because so much can be at stake (Vincent, 2010). Despite increasing knowledge of system failure and breakdown contributing to healthcare failures, clinicians frequently continue to blame themselves (Dekker, 2013; Jones & Treiber, 2012; Vincent, 2010).

Dr. Julia Trahey's comment in slide 9 highlights the personal and professional role for those in healthcare can often be intertwined and that the emotional journey for providers following a patient safety incident becomes both a personal as well as a professional one.

Is Second Victim the Right Term?

There has been controversy with the terminology of second victim. Providers and patients have recently expressed dissatisfaction with the term. Patient groups involved in advocating for safer care, with members who have often been involved in deeply personal ways with patient harm incidents, do not wish to be labeled as victims - finding the term disempowering. Describing the provider as a victim in patient safety incidents can also be seen as minimizing the impact on patients and disempowering healthcare providers. Sidney Dekker (2013) has also acknowledged the term to be somewhat problematic indicating a ranking of health providers as secondary victims, as "coming after and less important than" others. The use of the word victim for patients and providers does however heighten the gravity of the issue of patient safety incidents. The impact on providers includes various psychological, physical, behavioural, cognitive and possible long-term effects. As mentioned previously post-traumatic stress disorder and health

provider suicide in rare incidences has been reported. Seys et al (2012) comprised a helpful composite of the range of responses as well as defensive and constructive coping reported by providers in their systematic review of 41 research papers – see table 2 and 3 below for details.

Table 2 - Symptoms mentioned in a systematic review of 41 articles on health care professionals as second victims after adverse events.

Psychological Symptoms	Physical Symptoms	Behavioural Symptoms	Cognitive Symptoms	Possible Long-Term Effects
Feelings of guilt (n=19) Anger (n=14) Irritation (n=13) Psychological distress, fear (n=12) Depressed mood, feeling of embarrassment, humiliation, uncomfortable (n=8) Feelings of shame, Inadequacy, regret, grief, sadness, self-doubt, disappointment (n=7) Frustration, anxiety (n=6) Loss of self confidence (n=4) Feelings of remorse, repetitive intrusive memories, anxiety, horrified (n=3) Sadness, nervousness, anguish, self-blame (n=2) Indifference, devastation, believe actions were reasonable, depression, loss of temper, hyper vigilance, disbelief, spiritual distress, panicky, confusion, vulnerability, feelings of betrayal of others, discouragement, sorrow, excessive excitability, upset, dysphonic feelings, intense feelings of agony and anguish, desperation (n=1)	Sleeping disturbance (n=2) Uncontrollable crying, shaking, increased blood pressure, exhaustion, abdominal discomfort, nausea or vomiting or diarrhoea, muscle tension, headaches, eating disorder (n=1)	Insomnia (n=4) Seeking solace in alcohol or drugs, isolation (n=2)	Disturbance in concentration (n=1)	Burnout (n=4) Decreased quality of life (n=3) Possible PTSD, concentration difficulty (n=2) Affected memory, easy loss of nerves, anxiety (n=1)
Note. PTSD = posttraumatic stress disorder (Seys, D., et al, 2012)				

Table 3 - Defensive and constructive coping reported by providers in a systematic review on health care professionals as second victims after adverse events.

Defensive Coping/Change in Practice	Constructive Coping/Change in Practice
More likely to keep error to themselves Avoidance of similar patients Feeling less confident with patient/family, getting more worried, less trusting of others' capability Avoid further contact with patient/family, thought about leaving practice, change in doctor–patient relationship, ordering more tests, afraid of making another error	Asking a colleague what they would have done in similar situation Seeking more advice, paying more attention to detail Reading more carefully, learning/ making changes in practice to reduce future errors Increasing education, confirming data personally, trusting others' judgment less, keeping better documentation of patient records, do more observations on patient Asking for references, listening to patient more closely, following policies and procedures more closely, slowing down more, increasing attention to self-care and self-pacing, using more evidence-based medicine, changing organization of data, allowing colleagues to learn from mistakes, learning whether colleagues would have made the same judgment and decision, improving respondent's practice or department, improving routines related to drug administration, increasing vigilance, reviewing of medication, prevention, double checking of subject's work, checking on each other, medication prior to dispensing or administration (Seys, D., et al, 2012)

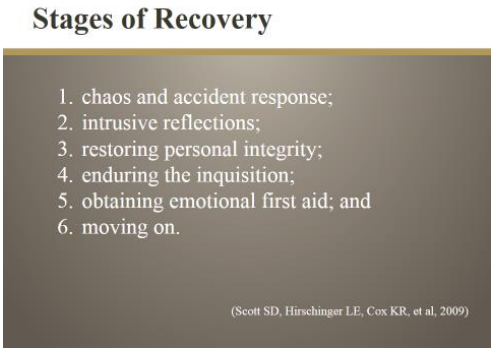
The recent focus of provider experience of patient safety incidents has been directed toward the negative outcomes of this experience for the professionals. The literature provides apt descriptions of the detrimental effects of harmful patient care errors on clinicians and depicts the high cost of these events, which may include burnout (Lewis, Baernholdt, Yan & Guerbock; 2015), depression, leaving practice, suicidal ideation and ultimately suicide (Christensen, Levinson & Dunn, 1992; Cramer, Foraita & Habermann, 2012; Jones & Treiber, 2012).

Less attention has been paid to a positive impact. Sidney Dekker (2013), a research psychologist with a background in aviation safety and one of the leading safety specialists, who has studied and taught extensively about provider experience with patient

safety incidents in varied industries cautions “legitimate emotions such as anger and guilt may be unnecessarily pathologized into psychological or somatic illness that need clinical intervention and perhaps medication” (Dekker, 2013). Dekker highlights that a less negative approach to the issue will allow for the processing of normal reactions to negative outcomes. He shares that most importantly an acute sense of the unique needs and lived experience for the “second victim” can, and should, be honoured within supportive peer relationships as well as within the social structures of an organizational response to preventable patient harm incidents. Compassion, understanding and a personalized approach to support are essential. Standardized Employee Assistance Programs have a place however organizations are deploying other best practices to fully support healthcare professionals.

Stages of recovery

Slide 9



Scott SD, Hirschinger LE, Cox KR, et al (2009) from the University of Missouri defined a six step process of recovery for the second victim:

1. Chaos and accident response;
2. Intrusive reflections;
3. Restoring personal integrity;
4. Enduring the inquisition;
5. Obtaining emotional first aid; and
6. Moving on.

Table 4 below outlines these steps and includes, questions often asked and suggested organizational responses. Important findings within this body of work and other studies (Engel, Rosenthal & Sutcliffe, 2006; Ullstrom, Hansson, Overtveit & Brommels, 2014) highlight the cognitive and emotional response of physicians, nurses and other healthcare providers following a patient safety incident. It is important to note how each healthcare professional navigates incidents is highly individualistic, however we know the more serious the patient harm the more profound the challenge will be for the provider (van Gerven et al., 2016).

Table 4 – Six Stages of the Process of Recovery for the Second Victim

(Scott SD, Hirschinger LE, Cox KR, et al, 2009)

Staging	Stage Characteristics	Common Questions	Proposed Institutional Actions
Stage 1 **Chaos & Accident Response**	Error realized/ event recognized. Tell someone ⇨ get help Stabilize/treat patient May not be able to continue care of patient Distracted Experience a wave of emotions	How did that happen? Why did that happen?	Identify second victims Assess staff member(s) ability to continue shift Activate" ForYOU Team" support as needed
Stage 2 **Intrusive Reflections**	Re-evaluate scenario Self isolate Haunted re-enactments of event Feelings of internal inadequacy	What did I miss? Could this have been prevented?	Ensure "ForYOU Team" Response Observe for presence of lingering physical and/or psychosocial symptoms
Stage 3 **Restoring Personal Integrity**	Acceptance among work/social structure Managing gossip/grapevine Fear is prevalent	What will others think? Will I ever be trusted again? How much trouble am I in? How come I can't concentrate?	Provide management oversight of event. Ensure incident report completion. Manage unit/team's overall response-"rumor control" esp. Evaluate if event debrief is indicated
(Stages 1-3 may occur individually or simultaneously)			
Stage 4 **Enduring the Inquisition**	Realization of level of seriousness Reiterate case scenario Respond to multiple "why's" about the event Interact with many different 'event' responders Understanding event disclosure to patient/family Litigation concerns emerge	How do I document? What happens next? Who can I talk to? Will I lose my job/license? How much trouble am I in?	Identify key individuals involved in event Interview key individuals Develop understanding of what happened Begin answering 'why' did it happen
Stage 5 **Obtaining Emotional First Aid**	Seek personal/professional support Getting/receiving help/support	Why did I respond in this manner? What is wrong with me? Do I need help? Where can I turn for help?	Ensure emotional response plan in progress if needed. Ensure Patient Safety/Risk Management representatives are known to staff and available as needed.
Stage 6 **Moving On** (One of Three Trajectories Chosen)	**Dropping Out** Transfer to a different unit or facility Consider quitting Feelings of inadequacy	Is this the profession I should be in? Can I handle this kind of work?	Provide ongoing support of the second victim. Support second victim in search for alternative employment options within institution.
	Surviving Coping, but still have intrusive thoughts Persistent sadness, trying to learn from event	How could I have prevented this from happening? Why do I still feel so badly/guilty?	Provide ongoing support Maintain open dialogue
	Thriving Maintain life/work balance Gain insight/perspective Does not base practice/work on one event Advocates for patient safety initiatives	What can I do to improve our patient safety? What can I learn from this?	Provide ongoing support Support second victim in 'making a difference' for future. Encourage participation in case reviews involving event Encourage staff feedback on practice modifications.

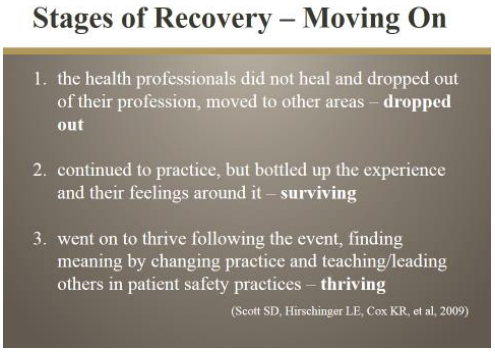
Throughout all stages individuals may experience physical and/or psychosocial symptoms.
Triggering of symptoms and repetitive thoughts regarding the event can occur anytime during stages 2-6.

The University of Leuven's Institute for Health Care Policy studied the individual, situational and organizational aspects which influence psychological impact and recovery of a patient safety incident on physicians, midwives and nurses in Belgian hospitals. They found the psychological impact is higher when the degree of harm for the patient is more severe, when health professionals feel responsible for the incident, and more prevalently, among female healthcare professionals. They found individual characteristics of optimism and extroversion might be protective. Interestingly, those who use active coping and planned problem solving experience a higher psychological impact (van Gerven et al., 2016). This may be because these active problem solvers feel a loss of control over their immediate situation.

The growth and learning aspects for those second victims who have been able to move on has also surfaced in a smaller body of more recent research (Plews-Ogan, May, et. al., 2016). It would seem that important components of personal and professional growth in these instances includes making meaning or making sense of the incident within one's own belief systems, rebuilding threatened personal and professional integrity and sharing learnings with others (Aasland et. al, 2005; Engel et al, 2006; Meurier, Vincent & Parmer, 1997; May & Plews-Ogan, 2012; Scott et al, 2009).

Open and transparent conversations with patients and families through disclosure, discussion and analysis of processes and clinical decision making with the healthcare team, and others such as quality and safety professionals is a critical early step toward processing and finding meaning. Some healthcare providers when able to talk about their experience go on to use their stories to teach others, which can be a powerful meaning-making endeavor. Meaning-making in this sense allows providers to try to have some good come from a bad experience.

Slide 10



In the final stage of recovery named "Moving On" three outcomes played out for the participants in the study. These three stages are:

1) the health professionals did not heal and dropped out of their profession, moved to other areas – dropped out;

2) continued to practice, but bottled up the experience and their feelings around it – surviving; and
3) went on to thrive following the event, finding meaning and "made something good come out of the event" by changing practice and teaching/leading others in patient safety practices – thriving.

The thriving healthcare provider changed how they practiced and/or became involved in practice change. Health professionals who have reported positive adaptation to these incidents report the vivid memories of their experience and subsequent regret remains in parallel with growth aspects. However, those who do experience growth emerge over time with a sense of endurance, feelings of increased strength and capacity, openness and a willingness to engage in and teach others about safety issues to prevent reoccurrences (Pratt & Jachna, 2015).

There is a need to approach healthcare professional and organizational cultural barriers which stigmatize second victim experiences as taboo, to build peer supports and programs that compassionately aide people to negotiate the recovery process, and move on and thrive following a devastating professional experience of unintended patient harm. It is important to initiate formal and informal structures to address this issue (Hirschinger, Scott & Hahn-Cover (2015).

Management of Patient Safety Incidents: Health Provider Experience

How organizations treat providers who experience patient safety incidents directly influences the organizational patient safety culture, for better or worse. The research in this area consistently notes providers are rarely offered structured institutional supports following significant patient safety incidents (Seys, et. al., 2012). As well, post-event investigations do not standardly incorporate the clinician's needs surrounding emotional impact, coping and recovery. The magnitude of the impact on the health professional is inversely related to the organization's response to the event. The impact of patient safety incidents on providers is long-lasting. Without support and feedback, emotional closure is very difficult. Coupled with a sense that nothing will change as a result of reporting events (Espin et al., 2006) and perhaps their jobs may be at risk (Hall & Scott, 2012), healthcare providers can dwell in a type of fatalism or as Charles Vincent describes a "learned helplessness" when it comes to healthcare system failures choosing to "pick up and carry on" as best they can when things have gone wrong. Sydney Dekker notes providers may become victims to systemic failures and closed loop learning virtually ensuring ongoing process problems are not addressed. All too often system failures are interpreted as an individual failing by those directly involved. Sometimes managers who are under time, financial, performance target, and public relations pressures can be already predisposed to blame care givers; feel the limitations of inadequate resources to deal with safety problems and choose to implement quick but ineffective fixes

(Catchpole, 2009). Many healthcare team members have little to no training or exposure to the concepts of human factors, systems failure and high reliability which could positively impact the incident management process. For more information on these concepts refer to PSEP – Canada Modules: 2 – Human Factors, 5 - Organization and Culture: Essential to Patient Safety, and 6 - Technology: Impact on Patient Safety. It is important that senior leadership and quality and patient safety professionals who are responsible for providing structural and leadership support to teams undergoing patient safety incident management convey just culture principles which are based in safety science, best evidence and blame avoidance.

Patient Safety Incident Management Plan

Slide 11

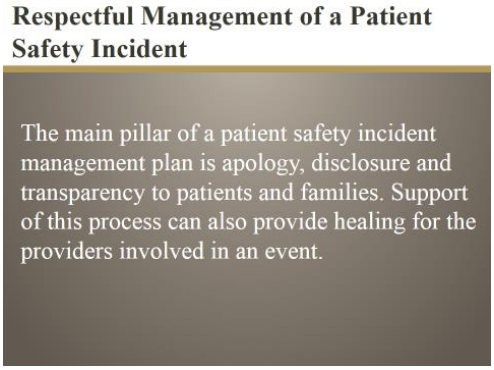
An Institute of Health Improvement (IHI) whitepaper (2011) on the respectful management of serious clinical adverse events highlights the experience of the first (the patient and family), second (the health providers) and third victim (the healthcare leadership and organization itself). The authors suggest every organization should have a crisis management plan for patient safety incidents ready before they use it. Organizations should also provide an approach to integrating their safety plan into the organization with a particular focus on the patient and family as well as a fair, just and compassionate treatment for staff. Concise, practical tools should be available for professionals responsible for executing the crisis management plan and ongoing support to patients, families and providers.

All too often providers are silent on their experience. In light of this, it is important that organizations have plans in place to meet the needs of their teams. Providers may not know who to turn to for guidance and in many cases they will turn to their colleagues to make sense of events or for support. Sometimes these informal supports are compassionate and well-intended; however, when uninformed they may be harmful. For example, some second victims have reported that in the immediate aftermath of their experience, colleagues have essentially downplayed the severity of the impact, noting

that complications do arise in complex processes of care and the best thing to do is to carry on and get right back into clinical practice. On other occasions, peers may make insensitive comments, avoid contact, or avoid conversation about the matter altogether; simply not knowing how to navigate the situation and perpetuating the myth of perfection. Currently, many frontline professionals are not sure how to support their peers through the personal and professional aftermath of the sensitive topic of mistake making and fallibility. It's important to remember however that peer support seems to be a significant need for second victims. Who can understand how one feels any more than a peer who recognizes that they may be in your shoes one day? How can we better equip all health professionals to strengthen self -care and peer support following patient safety incidents? Where are the opportunities to build upon the comradeship and collegiality of teams so that professionals who care deeply about each other can also support each other?

Disclosure - Respectful Management of a Patient Safety Incident

Slide 12



The main pillar of a patient safety incident management plan is apology, disclosure and transparency to patients and families. Support of this process can also provide healing for the providers involved in an event.

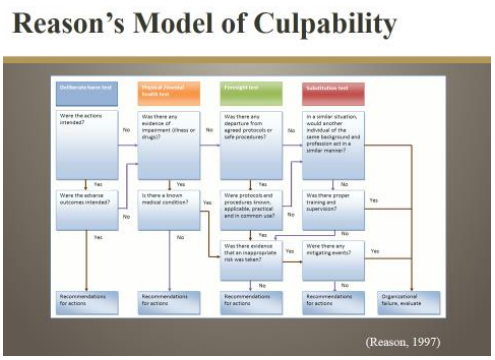
Dr. Rick VanPelt is an American anesthesiologist who has been an active advocate for patient safety, specifically on disclosure and transparency and active engagement with patients and families to improve prevention and incident response. Dr. VanPelt was involved in a serious patient safety incident, injecting a local anesthetic systemically during an operative procedure. Linda Kenney was the patient who was seriously affected, initially having a cardiac arrest in response to this injection. Dr. VanPelt reached out to Kenny following the incident when she had sufficiently recovered and together they have inspired thousands with their work in the area of apology, disclosure and provider support as well as patient involvement in system improvement. Not all patients, families and/or providers are in a place to achieve these comparable gains, with healing taking time. The Medically Induced Trauma Support Services (MITSS) Program founded by Dr. VanPelt

and Linda Kenny serves as an exemplar in this area. The Canadian Patient Safety Institute's Disclosure Guideline is a valuable resource for organizations and clinicians offering information for clinical teams on the important components of disclosure and how to disclose information on preventable harm incidents with compassion and competence.

Mrs. Margaret Murphy is another inspirational and compassionate patient safety advocate who lost her son to a serious patient safety event. Mrs. Murphy also speaks to the experience of clinicians in patient safety incidents and says that unless we build formal support structures which allow clinicians' to overcome stigma and shame, too many lessons will remain unleveraged, unsafe processes unchanged and many clinicians will carry these incidents silently throughout their careers.

Fear of Litigation, Regulatory Reprimand

Slide 13

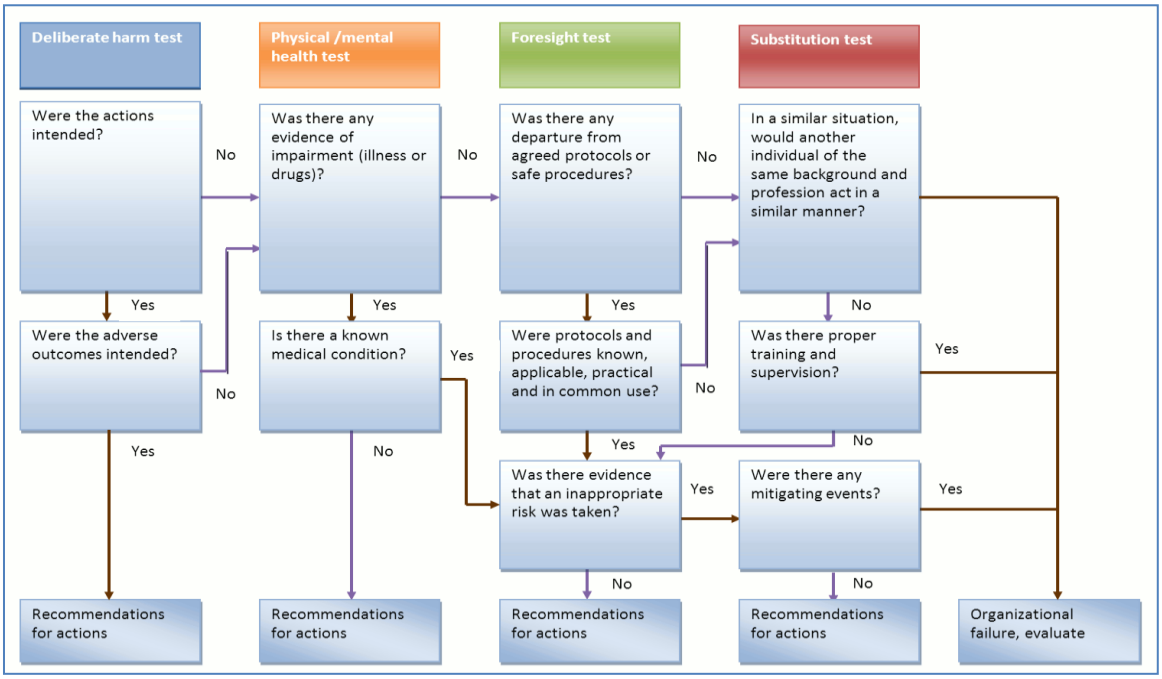


The principles of fair and just culture as an approach to system failure in high-risk industry is outlined in the PSEP – Canada Module 5 – Organization and Culture: Essential to Patient Safety. As well, James Reason's Model of Culpability, noted in Figure 1 below, walks through an algorithm that offers a decision support mechanism for the investigation of patient safety incidents. The incident decision tree seen below can aid quality and patient safety professionals as well as those leading and supporting the investigation of patient safety incidents. While simply a tool that may not fit all contexts, this decision aide addresses the need to balance and understand individual competence concerns along with system failure principles.

Health professionals are required to maintain skilled and competent care and the varied health profession regulatory, accrediting and certifying bodies are accountable to ensure this competence within its membership. No health professional should be engaged in a practice, skill or care scenario they are not professionally prepared to undertake. Professionals are accountable to speak up when feeling their care provision may be unsafe or underprepared. And like others, healthcare professionals suffer from substance

dependency and mental health crises which may impair safe practice. However, no health professional should ever be held accountable for a systemic failure. The Canadian Medical Protective Association and the Canadian Nurses Protective Society offer learning tools and supports for healthcare professionals involved in legal or regulatory investigations. Varied professional organizations such as the Canadian Medical Association, The Royal College of Physicians and Surgeons and the Canadian Nurses Association also offer resources for health professional wellness and problematic substance abuse.

Figure 1- Reason's Model of Culpability



Developing an Organizational Support Program

A few organizations have developed formal organizational support programs to help healthcare providers cope with their emotional distress following incidents by seeking timely support in a non-judgmental way. To date most of this work has been done in the United States. As noted earlier, a team from the University of Leuven in Belgium led by Dr. Vanhaecht and Dr. van Gerven is also developing proactive approaches to the second victim experience and have initiated an international research group to continue to more fully understand the best practices needed for support.

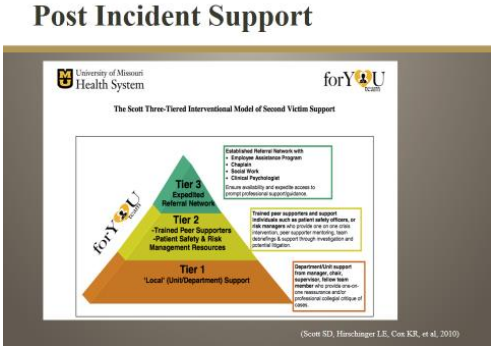
Examples of leading-edge, innovative programs are: Medically Induced Trauma Support Services (MITTS) noted above, and hospitals such as the University of Missouri Health Care's forYOU Team, Brigham's Women's Hospital, Boston Children's Hospital, Kaiser Permanente and Johns Hopkins Hospital. Some of these programs have been in place

long enough to have collated trending data on incidence, prevalence, program use and outcomes and are very willing to share results.

It is important to note that these support programs noted above have, on most occasions, been incorporated into or aligned with each organization's overall response to patient safety incidents. For example, most organizations who have been responsive to the second victim experience have existing Crisis Intervention Support teams and are using existing infrastructure to enhance clinician support post safety incident. This approach offers a fiscally and logistically sound integration by placing an emphasis on incorporating provider experience within overall patient safety incident management. In other words, pragmatic building of needed program principles are incorporated into existing infrastructures. Responding teams undergo enhanced preparation and have the license and resources from leadership to create new response systems that recognize and respond actively to the provider experience -- not just lip service, but real action.

Most programs foundationally rely on peer support as an integral component of the overall approach. Although the research evidence is limited in this area, the identification of the importance of peer support is emerging as a critical touch point for healthcare providers who are navigating the personal and professional after effects of a patient safety incident (Plew-Ogan, May, Owens, Ardelt, Shapiro & Bell, 2016; Seys et. al, 2012). Providers are frequently reluctant to seek Employee Assistance Programs. The one-to-one contact with a colleague can offer reassurance and a professional, collegial critique of the case, as well as an understanding ear from one who truly appreciates the complexities of front-line clinical care. These exchanges open opportunities for deep learning. If done well, peer support may help to shift the initial provider response of fear, guilt and feelings of personal failing to an opportunity for learning and affecting system change. All too frequently colleagues do not know how to reach out to a team member who has been involved in a patient safety incident. Sensing embarrassment and confusion, they often refrain from mentioning the incident at all, limiting healing, sharing and learning.

Slide 14



The forYOU program at the University of Missouri is built upon a three-tiered approach:

- Department support from unit managers, administrators or chiefs;
- Support from formally trained peer support members, safety officers, risk managers; and
- Expedited Referral Support from professional mental health clinicians such as employee assistance programs, clinical psychologists, social worker, holistic nurses or chaplains.

Trained peer support members from varied professions undergo a two-day workshop and an on-call system allows a peer support-trained colleague to be available for just-in-time connection on a 24/7 basis. Peers are matched professionally, for example, allowing a nurse to speak with a compassionate nurse peer with training in second victim concepts and best practices. Quality and safety professionals working in the organization deploy the forYOU program. An integral communication and dissemination plan for the program is a key component of success - building awareness of the service, but also communicating the importance that reporting, sharing and learning from patient safety incidents is foundational to supportive, open, evolving and growing organizations.

Plews, Ogan et al, (2016) used a posttraumatic growth and wisdom development framework to explore positive adaptation after serious patient safety incidents. They emphasize that a wise clinician, in the case of incidents, is one who can comprehend the deeper meaning of interpersonal and intrapersonal aspects of life, tolerate ambiguity and uncertainty and understand the limits of his or her knowledge. Outcome themes from the study describe preventing reoccurrence and improving teamwork, dealing with imperfection and helping others through teaching.

It is clear the difficult experience of being involved in incidents and causing harm while providing patient care, system failure or not, is one which influences health providers deeply. Silences and treating the healthcare provider's post incident experience as a natural rite of passage that needs to be endured and "stepped over" on the push for production will limit progress within our healthcare system. Tacitly accepting these incidents as a reasonable cost of providing care is no longer acceptable (Brenner, 2009). A shifting paradigm is underway for healthcare professionals - one that accepts fallibility with humility and accountability, as well as action toward learning. In order to advance patient care outcomes this shift must be nurtured. Second victim provider support will play an incredibly important role in this shift.

Educational initiatives focusing on communication after unintended harm incidents should also target health professional teachers, students and trainees.

While many health professional curricula are now embedding quality and patient safety principles, the emotional, personal and professional experience of being involved in a serious patient safety incident is difficult to comprehend for most novice healthcare providers. Simulated case scenarios may be one approach to opening the discussion and allowing trainees and students access to the sense of profound confusion and challenge

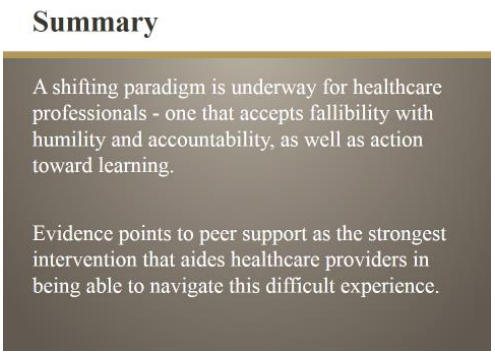
that this type of experience may evoke. Through this type of training exposure, resilience in the face of a real-life experience may be enhanced.

PSEP – Canada's Module 17: How to Build and Embed Patient Safety and Quality Content into Curricula/Education Programs offers educators examples of ways to embed patient safety and quality improvement into established curricula.

Reflective practice, self-forgiveness and reframing perfection within a just culture at the clinical point of care are essential ingredients to successful navigation of a patient safety incident experience for healthcare providers. An unintended patient harm experience may be difficult to live through, but also holds the potential to contribute to deeper clinical wisdom and personal growth. Disclosure, apology and patient/family engagement in system improvement are core actions that are imperative for an improving healthcare system. Second victim peer support programs must integrate these actionable strategies as part of healing for patients and families as well as providers.

Summary

Slide 15

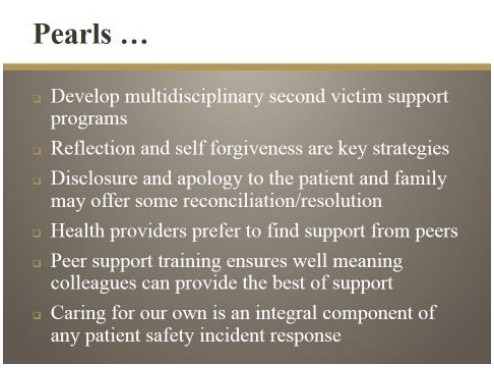


Unintended patient injuries or complications resulting in death, disability or prolonged care arising from health care management is unacceptable to any healthcare provider. This PSEP – Canada module has discussed the issue of the second victim in relation to improving quality and patient safety outcomes in healthcare systems. Influencing conditions such as system complexity, health professional cultures, psychological safety, safety culture, just culture and lack of awareness were highlighted. The impact of patient safety incidents on the health provider as well as the stages of recovery or response were outlined along with organizational structures needed to respond to the provider experience. Finally, an overview of best practice second victim support programs and principles was offered. Dr. Don Berwick, ex-president of the Institute for Healthcare Improvement and a well-respected international health improvement advocate notes, "We have begun to learn not to blame doctors and nurses (healthcare providers). They are doing their best. These are highly stressful jobs and people feel battered."

Being involved in these kinds of incidents is devastating for all concerned - patient, family and those who have been caring for them. The incidence of a serious second victim experience may be as high as 50-80% in the course of a health professional's career. The degree of emotional impact for providers can create severe distress and have negative life-altering outcomes. However, health providers who experience patient safety incidents and adapt through their experience may well emerge as the most deeply motivated and committed safety advocates and teachers (Plews-Ogan et al., 2016). Provider experience with patient safety incidents is becoming increasingly recognized as an important aspect of patient safety, but there is much to do. For the sake of patients, families and healthcare providers, the call to action is a moral one. How might your leadership on this issue make a difference for your colleagues and the patients and families they care for?

Pearls

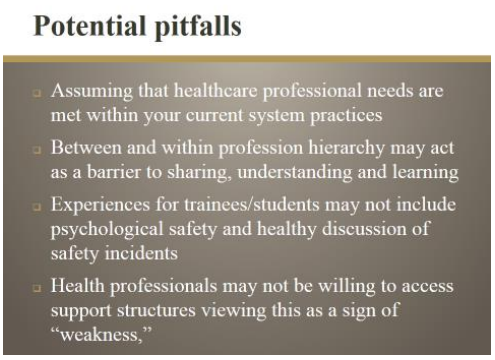
Slide 16



1. Developing multidisciplinary second victim support programs that align with existing organizational infrastructure can maximize second victims coping and resilience;
2. Reflection and self-forgiveness are key strategies to healing and thriving through a second victim experience;
3. In some cases disclosure and apology to the patient and family may offer some reconciliation/resolution for health providers involved in patient safety incidents;
4. Health providers prefer to find support from peers in these instances;
5. Peer support training ensures well-meaning colleagues can provider the best of support; and
6. Caring for our own is an integral component of any patient safety incident response.

Potential pitfalls

Slide 17



1. Assuming that healthcare professional needs are met within your current system practices;
2. Between and within profession hierarchy may act as a barrier to sharing, understanding and learning from patient safety incident experiences;
3. Experiences for trainees/students may not include psychological safety and health discussion of safety incidents; and
4. Health professionals may not be willing to access support structures viewing this as a sign of "weakness," preferring to handle things on their own.

Resources

- Trigger tape from PSEP – Canada Module 5: Organization and Culture: Essential to Patient Safety – Dr. Van Pelt candidly discusses his experience with a serious incident. He highlights the discomfort felt by his colleagues in being able to discuss the event.

- The story of an anesthetist's journey following a patient safety incident and the formation of the Medically Induced Trauma Support http://www.youtube.com/user/MITSSUtube - p/a/u/0/__vfmakmmE4

- Video of Mrs. Margaret Murphy, mother of Kevin Murphy, and patient safety family member advocate (WHO). Mrs. Murphy lost her son Kevin to a patient safety incident and addresses a cohort of physiotherapy students in Ireland. Mrs. Murphy speaks of the importance of not ignoring the health provider experience as a key catalyst for system change. (51minutes) https://www.youtube.com/watch?v=7BhGyMP_gGE

- Video Clip of Surgeon Dr. Peter Pisters describing his role in a patient safety incident and learning from this experience (7 minutes) http://www.patientsafetyinstitute.ca/en/toolsResources/HealthcareProviderStories/Pages/Surgical-error-inspires-doctor-to-champion-the-safety-of-all-patients-2016-10.aspx

- Video clip of Emergency Room nurse Nadine Glenn describing her role in a serious medication error incident (7 minutes – good trigger tape for mini lecture and engagement) https://www.youtube.com/watch?v=p44wxk7BL20&t=331s

- Video clip of Dr. Francois de Wet describing his role in a patient safety incident where breakdown in communication during a patient intubation led to unintended patient harm https://www.youtube.com/watch?v=WrnURmas8_Y

- Medical Errors: The Silent Killer in Medicine | Carol Gunn TED Talk. Dr Gunn passionately talks of her experience of system failure when her sister as a patient was harmed by a patient safety incident. Addresses the taboo of health professional fallibility. https://www.youtube.com/watch?v=Lu-HcylvuU8

- Dr. Brian Goldman Canadian physician TED talk (19 min long). Canadian physician and radio show host talks about errors and mistakes in providing care and the challenge of facing one's fallibility. He also describes the cumulative emotional toll of cases that do not go well. https://www.ted.com/talks/brian_goldman_doctors_make_mistakes_can_we_talk_about_that

- Glucometer malfunction RN Annie's story (5 minutes long- good trigger tape for systems discussion/reflection) Nurse initially disciplined for an equipment malfunction- glucometer. Was not treated fairly by leadership or her manager on initial investigation of a critically low blood sugar result. Eventually discipline sanctions were dropped when investigation revealed a systems issue. Human factors approach, systems approach. https://www.youtube.com/watch?v=zeldVu-3DpM

- Lessons from Nursing – How professional hierarchies and bullying atmospheres contribute to compound unsafe patient care and lack of peer support- Kathleen Bartholomew (Nurse Manager) (21 minutes) https://www.youtube.com/watch?v=Qh4HW3yx00w

- Medically Induced Trauma Support Services (MITSS)
  Founded by patient Linda Kenney, Just In Time Support for Peers, many useful links including referral service from MITTS as well as a comprehensive toolkit

for clinicians and those who are setting up support programs
http://www.mitsstools.org/

- RISE Resilience In Stressful Events – Johns Hopkins
http://www.ihi.org/education/ihiopenschool/resources/Documents/Forum 2013 Storyboards/Forum 2013_Hanan Edrees.pdf

- RISE Toolkit – Program Implementation. Link to an excellent resource on how to implement a peer support program for second victims. Roadmap outlined, beginning with an organizational needs assessment to recruitment and training for peer support team members and engagement strategies as well as success metrics. http://www.comp-ocpm.ca/download.php?id=823

- University of Missouri Health Care System's forYOU Program
http://www.muhealth.org/foryou

- Agency for Healthcare Research and Quality (AHRQ) CANDOR Toolkit. The Communication and Optimal Resolution (CANDOR) toolkit outlines a comprehensive process that health care institutions can use to respond in a timely, thorough, and just way when unexpected events cause patient harm. The care for the caregiver module provides insights into formalizing institutional support and has numerous videos to aid in education.
https://www.ahrq.gov/professionals/quality-patient-safety/patient-safety-resources/resources/candor/introduction.html

- Conway J, Federico F, Stewart K, Campbell MJ. Respectful Management of Serious Clinical Adverse Events (Second Edition). IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2011
http://www.ihi.org/resources/Pages/IHIWhitePapers/RespectfulManagementSeriousClinicalAEsWhitePaper.aspx

- Canadian Medical Protective Association – Responding to Adverse Events and Stress post incident – Good Practices Guide
https://www.cmpa-acpm.ca/serve/docs/ela/goodpracticesguide/pages/key_concepts/key_concepts-e.html?open=adverse_events&to=managing_stress

- Canadian Nurses Protective Society - Canadian Nurses own legal support system, a not for profit society created by nurses for nurses, tailored to meet the needs of registered nurses in all nursing roles http://www.cnps.ca

- Canadian Patient Safety Institute and Alberta Health Services -- Helping Healers Heal webinar and power point (2015)
  http://www.patientsafetyinstitute.ca/en/toolsResources/Presentations/2015Webinars/Documents/2015-04-27%20-%20Second%20Victim/CPSI%20-%20National%20Call%20-%20Helping%20Helpers%20Heal%20-%202015-04-27.pdf

- Patient Safety and Incident Management Toolkit, Canadian Patient Safety Institute.
  http://www.patientsafetyinstitute.ca/en/toolsResources/PatientSafetyIncidentManagementToolkit/Pages/default.aspx

- Clarion Clinic – Power point presentation on Second Victim principles with 3 case studies
  https://www.carilionclinic.org/sites/default/files/Healing%20Our%20Own%20Presentation.pdf

- International Society for Health Care Quality (ISQua) - Phil Hassen, an ISQua Fellowship Forum moderator and known international health care improvement expert and advocate discusses support for the second victim in a blog page, announcing a focus on second victim experience for ISQua 2017
  http://www.isqua.org/education/programme-content/fellowship-forum/january-2017-patient-safety-support-for-the-second-victim

- Kaiser Permanente – Power point presentation on Second Victim Support Principles
  http://e4enterprise.com/charm/Care%20for%20Caregivers%20PowerPoint%2050%20Minutes.pdf

- University of Leuven -- power point presentation by international expert on second victim phenomenon for ISQua by Dr. Kris vanhaecht (2017) Includes discussion of the 3rd victim (organization, CEO, healthcare boards)
  http://www.isqua.org/docs/default-source/education-/isqua-webinar_march-2017_kris-vanhaecht.pdf?sfvrsn=0

- Frequently cited, devastating case story of Kim Hiatt, a 24- year veteran, exemplary neonatal ICU nurse who gave a patient 10 times the dose of calcium required. The patient died and Kim committed suicide seven months later.
  https://www.vox.com/2016/3/15/11157552/medical-errors-stories-mistakes

References

Aasland, I.J., Jones, B., & Gupta, T.S. (2004). Reactions to adverse events among Australian and Norwegian doctors. Australian Family Physician, 33, 1045-1046.

Aasland, G. & Førde, R. (2005). Impact of feeling responsible for adverse events on doctors' personal and professional lives: the importance of being open to criticism from colleagues, Quality and Safety Health Care, (14), 13–17.

Brenner, M. (2009). Collateral damage. Journal American Medical Association, 16, 1637-1638.

Christensen, J. F., Levinson, W. & Dunn, P.M. (1992). The heart of darkness: the impact of perceived mistakes on physicians. Journal of General Internal Medicine, 7, 424-431. doi: 10.1007/BF02599161

Clancy, C. (2012) Alleviating "Second Victim" Syndrome How We Should Handle Patient Harm Journal of Nursing Care Quality, (27) 1, 1–5.

Cramer, H., Foraita, R. & Habermann, M. (2012). Nursing errors and the consequences: results of a survey of nurses from inpatient care institutions. Pflege, 25(4), 245-259. doi:10.1024/1012- 5302/a000213

Denham, C.R. (2007). TRUST: The five rights of the second victim. Journal of Patient Safety, 3(2), 107-119.

Edrees, H. & Federico, F. (2015). Supporting clinicians after medical error. British Medical Journal, 350. doi: 10.1136/bmj.h1982

Engel, K., Rosenthal, M. & Sutcliffe, K. (2006). Residents' responses to medical error: Coping, learning, and change, Academic Medicine, 81(1), 86-93.

Hall, L. & Scott. S. (2012). The second victim of adverse health care events, Nursing Clinics North America, (47), 383–393.

Hirschinger, L.E., Scott, S.D, and Hahn-Cover, K. (2015). Clinician support: Five years of lessons learned. Patient Safety & Quality Healthcare.12 (2), 26-31.

Jones, H., & Treiber, L. (2012). When nurses become the second victim. Nursing Forum, 47(4), 286-291.

Lewis, E., Baernholdt, M. Yan, G., & Guerbock, T. (2015). Relationship of adverse events and support to RN burnout. Journal of Nursing Care Quality, 30(2), 144-152. doi: 10.1097/NCQ.0000000000000084

May, N. & Plews-Ogan, M. (2012). The role of talking (and keeping silent) in physician coping with medical error: A qualitative study. Patient Education and Counseling, (88), 449–454.

Newman, M. C. (1996). The emotional impact of mistakes on family physicians. Archives of Family Medicine, 5(2), 71-75. doi: 10.1001/archfami.5.2.71

O'Beirne, M., Sterling, P., Palacios-Derflingher, L., Hohman, S. & Zwicker, K. (2012). Emotional impact of patient safety incidents on family physicians and their office staff. Journal of the American Board of Family Medicine, 25(2), 177-183.

Paparella, S. (2011). Caring for the caregiver: moving beyond the finger pointing after an adverse event. Journal of Emergency Nursing, 37(3), 263–265.

Plew-Ogan, M. May, N., Owens, J. Ardelt, M. Shpiro, J. & Bell, S. (2016). Wisdom in medicine: What helps physicians after medical error? Academic Medicine, 91(2), 233-241.

Quillivan, R., Burlison, J., Browne, E., Scott, S. & Hoffman, J. (2016). Patient safety culture and the second victim phenomenon: Connecting culture to staff distress in nurses. The Joint Commission Journal on Quality and Patient Safety, 42(8), 377-383.

Reason JT. Managing the Risks of Organizational Accidents. Aldershot, Hampshire, England: Ashgate Publishing Ltd, 1997

Scott, S. D., Hirschinger, L.E., Cox, K.R., McCoig, M., Brandt, J., & Hall, L.W. (2009). The natural history of recovery for the healthcare provider "second victim" after adverse patient events. Quality and Safety in Health Care, (18), 325-330.

Scott, S. D., Hirschinger, L. E., Cox, K. R., McCoig, M., Hahn-Cover, K., Epperly, K.M. & Hall,L.W. (2010). Caring for our own: Deploying a system wide second victim rapid response team. The Joint Commission Journal on Quality and Patient Safety, 36, 233–240.

Scott, S. & McCoig, M. (2016). Care at the point of impact: Insights into the second-victim experience. Journal of Healthcare Risk Management of the American Hospital Association, 35(2), 6-13.

Seys, D., Wu, A. W., Van Gerven, E., Vleugels, A., Euwema, M., Panella, M., Scott, S., Conway, J., Serneus, W., Vanhaecht, K. (2012). Health care professionals as second victims after adverse events: A systematic review. Evaluation and the Health Professions, 36(2), 135-162.

Seys, D., Scott, S., Wu, A., Van Gerven, E.,Vleugel, A., Euwema, M., M., Panella, M., Conway, J., Sermeus, W. & Vanhaecht, K. (2012). Supporting involved health care professionals (second victims) following an adverse health event: A literature review. International Journal of Nursing Studies, (50), 678–687.

Sirriyeh, R., Lawton, R. & Gardner, P. (2010) Coping with medical error: a systematic review of papers to assess the effects of involvement in medical errors on health-care professionals' well being. Quality and Safety in Health Care, (19), 1-8.

Smetzer, J. (2012). Don't abandon the "second victims" of medical errors. Nursing, 42(2), 54-58. doi:10.1097/01.NURSE.0000410310.38734.e0

Tapper-Spears, P. (2002). The stories nurses tell of patient care errors. (Unpublished Doctoral dissertation). University of Tennessee. Tennessee, USA.

Ullstrom, S., Hansson, J. Overtveit, J. & Brommels, M. (2014). Suffering in Silence: a qualitative study of second victims of adverse events. British Medical Journal of Quality & Safety, (23), 325-331.

Van Gerven, E., Bruyneel, L., Panella, M., Euwema, M. Sermeus, W. & Vanhaecht, K. (2016). Psychological impact and recovery after involvement in a patient safety incident: a repeated measures analysis. British Medical Journal Open Access, 6, doi: 10.1136/bmjopen-2016-011403.

Van Pelt, F. (2008). Peer support: healthcare professionals supporting each other after adverse medical events. Quality and Safety Health Care, 17, 249–252.

Waterman, A. D., Garbutt, J., Hazel, E., Dunagan, W. C., Levinson, W., Fraser, V. J., & Gallagher, T. H. (2007). The emotional impact of medical errors on practicing physicians in the United States and Canada. Joint Commission Journal on Quality & Patient Safety, 33(8), 467-476.

Wears, R. L., & Wu, A. (2002). Dealing with failure: the aftermath of errors and adverse events. Annals of Emergency Medicine, 39(3), 344-346. doi: 10.1067/mem.2002.121996.

Wu, A. W. (2000) Medical error: The second victim. The doctor who makes the mistake needs help too. British Medical Journal, 320, 726-727.

Wu, A., Sexton, J., & Pham, J. Health Care Providers: The Second Victims of Medical Error (chapter 47). In Croskerry, P., Cosby, K., Schenkel, S. & Wears, R. (Eds). (2009). Patient Safety in Emergency Medicine. Philadelphia, PA: Lippincott Williams & Wilkins.

Module 19 Trainer's Notes

Principal message

The single most important message your audience should come away with is that *a shifting paradigm is underway for healthcare professionals - one that accepts fallibility with humility and accountability, as well as action toward learning after a patient safety incident.*

Module overview

This module provides content on the health provider experience of patient safety incidents (PSIs), as well as exemplars on successful and innovative provider support programs. Strategies that organizations can use to support healthcare professionals during and after patient safety incidents have also been outlined.

Preparing for a presentation

1. Assess the needs of your audience

Choose from the material provided in the module according to the needs of your expected participants. It is better for participants to come away with a few new pieces of information, well learned, than to come away with a deluge of information from which they can remember little or nothing.

2. Presentation timing

The suggested timing for this module is:

Introduction	2-3 minutes
Trigger tape & discussion	5-7 minutes
Presentation	30 minutes
Summary	2-3 minutes
Total	45 minutes

3. Number of slides: 17

4. Preparing your presentation

The text in the module was not designed to be used as a prepared speech. Instead, the text provides material you may want to use. The slides have been designed to trigger your

presentation. Although the slides closely follow the text of the module, they do not contain all of the content. Their use presumes that you have mastered the content.

You may want to make notes on the slide summary pages to help you prepare your talk in more detail and provide you with notes to follow during your presentation.

Remember that you can adjust the slides to suit your presentation content, your style, and to make it feel fully familiar and your own.

Practice your presentation using the slides you have chosen, and speaking to yourself in the kind of language you expect to use, until it is smooth and interesting and takes the right amount of time. The most accomplished presenters and teachers still practice prior to a presentation; don't miss this step.

5. Preparing a handout for participants

The module text and slides were designed to be reproduced and provided to participants as a handout. Take the portion you need; they can be used in their entirety, module by module, or for just one specific topic. Please ensure to acknowledge the source of the material, the PSEP – Canada Acknowledgment Page at the front of the module provides the formal citation.

6. Equipment needs

- Screen, computer and projector
- Flipchart and markers for recording discussion points

Test your equipment beforehand to ensure that it works.

Review your video to assess which portions you would like to use.

Have a back-up plan so that if there is any equipment failure you can move without panic to your back-up plan. For instance, have in mind that:

- if the video fails, you can read the vignette of the trigger tape story;
- if the slides cannot be shown, you can refer to the hand out slides; and
- if the markers do not work, you can have participants list items on their hand outs that you would have written up for all to see.

Making the presentation

1. Introduce yourself

If you have not already done so, introduce yourself. Include your name, title, and the organization(s) you work for. Briefly describe your professional experience related to the information you will be presenting.

2. Introduce the topic

Show the title slide for the module. To establish the context for the session, make a few broad statements about the importance of topic as a patient safety matter. Tell participants the format and time you will take to present the session. Identify the teaching styles that you intend to use.

3. Review the session objectives

Show the slide with the session objectives listed. Read each objective and indicate those that you are planning to emphasize.

4. Show the trigger tape

After reviewing the objectives for the session, show a trigger tape. The trigger tape should engage the audience and provide appropriate context for the session. The trigger tape does not need to demonstrate an ideal interaction, but to "trigger" discussion.

A teachable moment: discussion after the trigger tape

After the trigger tape, ask the participants for their comments about the issues and the interaction they have just seen. To affirm what they contribute, consider recording the important points on a flipchart or white board.

Use the discussion to set the stage for the material to follow. Do not let the discussion focus on a critique of the technical quality of the video or how "real" the players seemed. If the participants do not like something that was said or done in the video, acknowledge that there is always room for improvement and ask them how they would do it themselves.

Setting limits to discussion time

It is usually best to limit discussion of the video to no more than five minutes, then move on to the presentation. To help move on if the discussion is very engaged, try saying something like:

- let's hear two last points before we move on, and
- now that you have raised many of the tough questions, let's see how many practical answers we can find.

For the more advanced facilitator who is confident of both the patient safety material and his or her pedagogic skills, it is possible to use the trigger tape as a form of case-based teaching and to facilitate the discussion to draw out the teaching points of the module. If this approach is used, it is essential to write up the points on a flip chart as they arise, to fill in any gaps and to summarize at the end. The hazard of this approach is that the discussion will not yield the desired teaching points. Return to the slides if this happens.

5. Present the material

Recommended style: interactive lecture

An interactive lecture will permit you to engage your audience yet cover your chosen material within the time.

Clinical Case Vignette

The following case can be used to generate discussion in small or large group format:

An emergency room (ER) nurse and clinical care leader work in a busy community hospital. The ER team was caring for a seriously ill man presenting to the ER with a life-threatening gastrointestinal bleed (GI bleed). The man was homeless and had been found bleeding, having difficulty breathing and deteriorating quickly in an alley in the city. Paramedics had called ahead to the ER to alert the receiving team to the man's condition and potential treatment needs. The nurse describes her memory of the details surrounding the incident vividly, a common experience for second victims.

The nurse described the scene in the ER at the time as chaotic, many team members were at the patient's bedside in a resuscitation scenario that required multiple complex interventions to be executed simultaneously - from central line insertion and fluid resuscitation to blood transfusion, intubation and instant consultation with specialists on call.

The team decided to try a novel treatment in an attempt to save the patient's life. As a last chance approach, a medication that may stop the serious haemorrhage, but would be used "off formulary," would be tried. The nurse as the clinical lead RN took on the task of sourcing the medication directly from the pharmacy and getting it sent up ASAP. No reference materials were on hand. The nurse attempted to look up the drug for dosing and mixing details but couldn't find references regarding the intended use for the GI bleeding. The pharmacist was not sure either.

The nurse checked in to the chaotic bedside to alert the attending ER physician that she was working on trying to figure out how to mix the drug, the senior physician noted to her, "he is deteriorating so fast" and said firmly… "JUST GIVE IT ALL." So she did. She pushed the full vial intravenously. Moments later the pharmacist called to the ER and said "whatever you do don't give the full vial, I have found some details on dosing for this condition." It was too late; the full vial had been given. The nurse describes her heart sinking. She was filled with fear and confusion.

Reflection

How has the level of complexity of this case contributed to this potentially lethal medication error?

Consider the principles of just culture as you reflect on the nurse's actions and response; was she "to blame" for the medication error?

Clinical Case Progression

As a thriver, the nurse navigated her experience with reflection and action. She went on to join the Canadian Patient Safety Institute as a project manager and was involved in educating others on patient safety. She shared her story at an international webinar conference and made the following commitment to her patient who had died:

- I promise to stop the line
- I promise to speak up
- I promise to facilitate my own and others learning from mistakes
- I promise to help build a strong safety net of practices for patients and healthcare providers

The nurse's story is available on a video clip; the link is noted in the resource section of this module. As you listen to the emotion in the nurse's voice as she recounts her story, you will note the emotional toll she carries with her of the event. Commonly, most providers involved in serious incidents will carry the emotional burden of the event throughout their careers. Breaking the taboo of silence around such events will contribute to eliminating feelings of being alone and peer support in these instances can "hold the experience" for the second victim, allowing for a working through of emotions at a very vulnerable time.

Reflection

How might the members of the nurse's team learn from the circumstances of this incident and if they did, how might the learning be shared?

What are the reporting and learning systems like in your organization? How might your organization respond to this event?

How might a peer support post serious incident have aided the nurse in her working through this experience?

6. Key take-home points

1. Develop multidisciplinary second victim support programs
2. Reflection and self forgiveness are key strategies for second victims
3. Disclosure and apology to the patient and family may offer some reconciliation/resolution
4. Health providers prefer to find support from peers
5. Peer support training ensures well meaning colleagues can provide the best of support
6. Caring for our own is an integral component of any patient safety incident response.

7. Summarize the discussion

Briefly, review each part of the presentation. Recap two or three of the most important points that were discussed.