Nurses as Second Victims: Peers Supporting Peers

According to a 2013 report from the Lucian Leape Institute at the National Patient Safety Foundation, in order to provide the safest and most effective care of patients, the healthcare provider must 1) feel safe from physical and psychological harm and 2) be able to find joy and meaning in their practice. While creating this culture is challenging at best, nothing is more detrimental to a healthcare provider than an adverse event, especially one that leads to litigation or a board complaint. In 2000, Wu contended that while a patient may be harmed with a medical error, the doctor is also wounded by the same error; they are the second victim. It is at this time in a person’s career that it becomes difficult to even function, let alone find any joy or meaning in one’s career. Most often, second victims experience feelings of shame, fear, anger, guilt, self-doubt, and isolation. These feelings can lead to emotional incapacity, depression, burnout, impaired clinical care, drug or alcohol use, and even suicide.

In cases of serious adverse events, the long-term consequences can even mirror post-traumatic stress disorder (Edrees, Paine, Feroli, & Wu, 2011).

In a survey of 3,100 physicians, 81% of those who had been involved in a clinical incident experienced some degree of emotional distress (Pratt & Jachna, 2015). This research led Pratt and Jachna to further define second victim as “any clinician who experiences significant emotional distress due to the course of clinical events” (p. 56). While much of the early research on second victim focused on physician colleagues, it was also found that nurses have a high risk for second victim-related harm because of the amount of time spent caring for patients and the number of medications administered (Quillivan, Burlison, Browne, Scott, & Hoffman, 2016). Medication errors are one instance of second victim-related harm experienced by nurses. Most authors agree that healthcare systems have a responsibility to care for second victims and that there are few structured emotional support services for care providers.

Early pioneers addressing second victim, such as Kaiser Permanente, found that the stigma attached to accessing Employee Assistance Programs and mental health services prevented care providers from utilizing those services (Van Pelt, 2008). Fears regarding poor performance appraisal, possible litigation, or a report to the licensing board may also prevent victims from seeking emotional support. Victims often did not know who it was safe to talk to and what they could discuss. Recognizing the needs and the barriers, health care organizations began creating innovative support systems for caregivers such as the Brigham and Women’s Hospital, where they formalized a Peer Support Team to pair second victims with a trained peer support person with a common clinical background (Van Pelt, 2008).

Stages of Recovery After an Adverse Patient Event

University of Missouri Health Care added two items to their internal patient safety culture survey to discover the needs of their organization in relation to second victim. It was found that 175 out of 1,160 respondents had experienced a patient safety event that caused personal distress. This was described as “anxiety, depression, or concerns about one’s ability to perform one’s job” (Scott, Hirschinger, Cox, McCoig, Brandt, & Hall, 2009, p. 325). In addition, 68% reported they did not receive institutional support with this stress. In follow-up qualitative interviews with nurses, doctors, and other caregivers, six stages of recovery were delineated after an adverse patient event (see Table 1).

Intervening

Early training for the Peer Support Teams was based on critical incident response and psychological first aid (Van Pelt, 2008). The team was taught to listen, assess, and when necessary, refer to the next level of care. Psychological first aid potentially decreases the risk of error through nervous system re-regulation after an unforeseen event. In addition, the ongoing peer support after a bad outcome, claim, litigation, or board complaint provides a confidential means to verbally process the event and its effects. Both support the provider’s inherent resilience (Trent et al., 2016).

More resources continue to become available. In 2011, the World Health Organization published Psychological First Aid: Guide for Field Workers. In 2014, the American Association of Nurse Anesthetists published recommendations and resources for a critical incident stress management program that allows for support during and more importantly, for as long as necessary, after a critical adverse event. For those organizations wanting to create their own primary and secondary victim support program, Medically Induced Trauma Support Services has a toolkit that can be accessed at www.MITSS.org.

Evaluating the Effectiveness of Peer Support Teams

In 2016, Trent and colleagues published a qualitative study highlighting the benefits support participants received from the peer support program, “SWADDLE,” in the Baylor Scott and White healthcare system. In that study, the term health care adversity was coined and is defined as “difficult disclosures, depositions, claims, lawsuits, and licensing board/agency complaints” (Trent et al., 2016, p. 28).
Participants found it most useful to talk to respected peers with similar training who could really understand and give perspective to the experience of the event. The participants also reported it was useful to have preemptive education regarding risk management and the legal processes. Bad outcomes, with or without medical error, are open to litigation. Due to how the SWADDLE volunteers are selected and trained, the participants appreciated the fact that the communication is truly confidential peer support without records. The study also identified a need for further research in the area of board complaints and the effects on providers, particularly in those states that have seen a sharp increase in board complaint numbers since tort reform.

Supporting Each Other

While a formal peer support team is ideal, not all healthcare providers have access to a formal program. Most authors agree that the first response would be to genuinely express care and concern by asking the person, “How are you?” Peers should be taught how unhelpful and insensitive comments can inflict further harm. Nurses frequently give each other psychological first aid. They talk to each other in the medication room, the break room, and in the parking lot, offering encouragement and support to each other. Simple, more effective communication tools can be taught through in-services and onboarding. Proper tools can improve the effectiveness of how nurses support each other through the stressful and emotional minefield that is today’s medical-surgical nursing unit. It is equally important to educate on “second victim” and provide numbers and resources available should emotional distress be encountered. Root cause analysis can also be used as an opportunity to identify potential second victims who might need attention.

Building on What We Learned

Tragic and unexpected outcomes are part of health care. Scott (2015) encourages organizations to create formal support programs to prevent the long-term personal suffering that may cause some nurses to leave the profession. Most work being done on second victim focuses on traumatic, life-changing events; however, work is also being done on the personal distress that builds up over time and leads to burnout. One study (Lewis, Baehmoldt, Guofen, & Guterbock, 2015) found a relationship between RN involvement in adverse events and burnout, including burnout domains of emotional exhaustion and depersonalization. In addition, the same study found that giving support to RNs could be beneficial in preventing the emotional exhaustion and depersonalization. In another study of 358 nurses, Quillivan and colleagues (2016) found that a non-punitive response to error was significantly associated with reductions in several dimensions of second victim distress. The authors suggest that reducing punitive response to error and encouraging supportive interactions could lessen the severity of the second victim experience. A culture that looks at errors as learning experiences and provides supportive peer and management relationships could more adequately prepare and preserve the integrity of the nursing workforce. While most state boards and organizations require documentation of errors, the conversation could be supportive and one that focuses on learning and professional growth, reducing the adverse effects of shame and guilt. Additionally, resilience training can improve the ability to bounce back after stressful or adverse events are encountered in health care. Building resilience will be discussed in the next “Healthy Practice Environments” column.

Table 1.
Stages of Recovery Following Adverse Patient Events

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
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<tr>
<td>Stage 1: Chaos and accident response</td>
<td>In this stage, the victim may feel unable to think coherently and need peer support.</td>
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<td>Stage 2: Intrusive reflections</td>
<td>In this stage, the victim’s mind plagues them with re-enactments, “what if” questions, and feelings of inadequacy.</td>
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<td>Stage 3: Restoring personal integrity</td>
<td>In this stage, support is sought out.</td>
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<td>Stage 4: Enduring the inquisition</td>
<td>In this stage, there is fear about job security, license repercussions, and fear of future litigation. The person is still struggling with trust and what others think about them. This stage can be complicated with negative gossip.</td>
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<td>Stage 5: Obtaining emotional first aid</td>
<td>Anxieties at this stage are about who is a safe person to confide in. Many felt that “where to go and what could be said” were never clear.</td>
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<tr>
<td>Stage 6: Moving on</td>
<td>Three pathways to moving on were identified: dropping out, surviving, and thriving. Dropping out is defined as changing either professional role or location or leaving the profession all together. Surviving is defined as doing alright, but still being plagued by the event. Thriving is when victims have had insights and feel they have become better people as a result of the incident.</td>
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Source: Adapted from Scott, Hirschinger, Cox, McCoig, Brandt, & Hall, 2009.

References


Coming soon in...

Medsurg Matters™

- Triad Team Nursing – An Overview Of a Pilot Hybrid Staffing Model
- Nursing Students Having a Voice in Medical-Surgical Units
- Fighting the Flames of Nursing Burnout
- The Importance of Certification: Cost as a Barrier
- End-of-Life Care in a Medical-Surgical Setting

Building Bridges from Theory to Practice

continued from page 1

patient about keeping the wound clean and dry. The nurse instructs the patient to breathe deeply, cough, and turn to prevent complications of pneumonia. The nurse assists the patient to the chair while making the patient’s bed. The nurse develops a plan with the patient that the patient will participate in the dressing change and move ‘from bed to chair’ on Post-Op Day 2. Which nursing theory can you think of that would support the nurse’s activities and patient interactions? This is a demonstration of Dorothy Orem’s Self-Care Deficit Theory. The nurse is moving the patient from a stance of dependence to one of more independence along the health continuum.

Scenario 2:

A couple is vacationing at the beach with their 10-year-old daughter when she is attacked by a shark. Unfortunately, the girl loses her left arm in the encounter, but she survives a nearly fatal event. Surgical repair is required for the remaining bud of the limb. After several days of recovery, despite a traumatic event, the youth has a positive attitude and desires to begin ambulation by walking up and down the halls of the pediatric unit. The nurse recognizes that the patient’s balance may be altered and offers to accompany her. The patient ambulates very well without any instability of gait and ventures into the teen room to obtain some books to read. Which nursing theory would capture the overall patient scenario? Sister Callista Roy’s Adaptation Theory can be applied to this patient scenario. Roy’s theory stated that in order for a person to respond positively to environmental changes or challenges, adaptation must occur (Roy, 1984). The girl demonstrated positive adaptation to a life-changing event – the loss of a limb.

Scenario 3:

An older adult is diagnosed with stage 4 liver carcinoma. The family is in the room, and the atmosphere is solemn. The nurse comes into the patient’s room to see if anything is needed. The nurse feels that she would like to do something to change the energy in the room and thinks to herself, “What could that be?” She shares with the family that she can bring several recent comedy DVDs into the room for the patient and family if they would like to watch movies. The patient perks up and states that he would like to see some movies. Suddenly, the room feels like a cloud has been lifted; the energy has changed. When talking about energy, Martha Roger’s Science of Unitary Human Beings may come to mind. Everything has a pattern, and interactions are patterns in and of themselves. Through the nurse’s interaction, the environmental pattern changed to a more positive one (Newman, 1999).

As exemplified in these scenarios, nursing theory does indeed weave into the activities of everyday nursing practice. The question that remains is: How can we bring the awareness of the underpinnings of nursing theory to the forefront so that bedside nurses can become inspired and build upon the theoretical knowledge of the nursing theorists?