

Second Victim Support Unit Scoping Project

Final Report

Dr Ceri Jones, Cardiff University, Dr Noelle Robertson, Vanita Chamdal, Professor John Maltby, University of Leicester, Stefan Weger, University Hospitals of Leicester

East Midlands

**Patient
Safety
Collaborative**

Contents

Background	3
The second victim experience	4
Results	5
Second victim model	7
Peer supporter selection	9
Peer supporter workshop	9
Workshop feedback	10
Communication strategy	11
Follow up training	13
Evaluation	13
Results	13
Recommendations	15
Conclusions	17
References	18

Background

An adverse clinical event, patient safety incident or medical error can have a far-reaching impact not only for the patient and their families; the first victims, but also the healthcare professionals involved. These are sometimes referred to as 'second victims'. Often the opportunity to discuss the details of the event and share how this has affected them personally is lacking for healthcare professionals. Second victims have been defined as:

“Healthcare team members involved in an unanticipated patient event, a medical error and/or a patient related injury and become victimized in the sense that they are traumatized by the event. Frequently, these individuals feel personally responsible for the patient outcome. Many feel as though they have failed the patient, second guessing their clinical skills and knowledge base.” (Scott, et al., 2009).

This concept was first identified by Albert Wu in 2000 (Wu, 2000). Since then there have been several studies exploring the concept of second victim, across Europe, Canada, Australia, United Kingdom, and the United States. The facets of second victimhood can exhibit a wide variety of physical and psychosocial symptoms, such as; anxiety, anger, guilt, fear, depression, trouble sleeping, and social withdrawal, intrusive thoughts and doubt over clinical abilities lasting weeks, months, or years. It is estimated that the prevalence of second victims ranges between 10 to 43% amongst healthcare professionals. After an adverse event, second victims want to feel appreciated, respected, understood, and to remain a trusted member of their healthcare team as well as organisational support to help them cope with the error (Scott, et al., 2009). Healthcare professionals involved in adverse events experience emotional distress on both a personal and a professional level (Mants, 2015).

During the period of the incident, second victims can feel devastated, singled out, hesitant in having discussions with colleagues, have concerns around job security as well as competency around their job (Clancy, 2012, Wu, 2000). Outcomes of these experiences can vary where they can: Survive, Thrive, or Drop out; this is very much dependent on the individual's personal resilience, coping strategies as well as the support they receive (Sidney, 2013) (Scott, et al., 2009).

The University Hospitals of Leicester (UHL) and Nottingham University Hospitals (NUH) recognised that there is a need to support clinical staff who are involved in patient safety incidents. A serious incident that resulted in an avoidable child death, had far reaching consequences for both the family and staff involved and acted as the trigger to better understand what clinical and non-clinical staff experience when they are involved in an adverse event, and also how best to support them. Funded

by the East Midlands Patient Safety Collaborative (EMPSC) and supported by a team of academic and clinical psychologists at the University of Leicester (UoL) and Cardiff University (CU), in-depth semi-structured interviews were carried out with twenty-one staff across the Trusts who were purposefully sampled for their involvement in a historic patient safety incident. These were analysed and used to support the development of a pilot second victim support unit, in the Children's Hospital at UHL.

The second victim experience

In order to understand the concept of second victimhood, semi-structured interviews were conducted with clinical and non-clinical staff across the two Trusts. Participants were purposefully sampled as frontline staff who had been directly involved in a patient safety incident, adverse event or medical error. The selected participants were a cross-section of healthcare professionals across two different clinical units in the two Trusts. Twenty-one participants were interviewed in total. Six male, fourteen female, of these nine were medical, eight nursing, three support staff and one admin.

The interviews were semi-structured and aimed to explore the experience of being involved in an incident and any changes at the 1) organisational, 2) team, or 3) individual level the health professional may experience. These subsections explored:

- **Organisational** - the response from the organisation, any support offered, how they felt about the organisation after the incident
- **Team** - any relationship changes with colleagues during the time of the incident and how they felt on the support they received
- **Individual** - addressing emotional changes and other trauma related symptoms such as psychological and physical and symptoms, cognitions and changes in perceptions, as well as their ability to separate professional and personal life

Interviews were transcribed verbatim and subject to template analysis. Template analysis was selected an appropriate method of thematic analysis as it has been used previously in healthcare to explore the experiences of healthcare professionals (Mulluish & Bassey, 2012; Perry, Barkham, & Evans, 2013). Template analysis allows the hierarchical coding of large volumes of data, whilst creating a degree of structure, through the generation of a priori codes based on pre-existing data and research (King, Brooks, McCluskey, & Turley, 2015).

Results

There were six priority themes that emerged from the analysis, these were victimisation, self-blame, cognitions, heightened emotionality, coping behaviour, organisational support, patient safety and culture.

Victimisation/self-blame – participants felt lack of control, vulnerable, not being heard, fear, guilt and feeling responsible for the patient and their families.

“It really just makes you feel so vulnerable” (Nurse)

“Can’t get my voice listened to?...who do I need to get my voice listened to. If nobody’s listening to mewhat’s the point of me?” (Play therapist)

“when it actually happens that immediate when you realise you’ve made a mistake, you feel a huge amount of guilt. You feel hard on yourself that you’ve actually made that mistake. You feel a bit sick to be honest, it depends how big it is” (Nurse)

Cognitions – Following the event, participants reported a lack of confidence and doubt in their own abilities and their ability to carry out their job leading to reduced professional self-efficacy, double checking, intrusive thoughts, flash backs and rumination.

“confidence loss after that email, I thought I was the worst doctor in the world (laughs) that’s partly why I didn’t want to go back that evening” (Consultant)

“sitting at home with a cup of tea then all the thoughts bubbling into my head and I’m all right when I’m surrounded by people but at night when a child passes or something, that’s when I get down when I’m on my own” (Nurse)

Heightened emotionality – Participants reported feeling very high emotions after the event, many felt very angry at the situation, the decisions made, and the response from others including the organisation. They were highly anxious, sad, upset, irritable, depressed and traumatised.

“at times I was really upset and I was quite depressed but in other times I was furious with the situation” (Nurse)

“slightly anxious on edge and afterwards I was quite anxious that morning erm yeh so I changed shifts so I wasn’t doing anything important really” (Nurse)

“Upset, it destroyed me really as a person” (HCA)

“it’s emotional trauma that’s acute and I think if it had sort of effected me to the point that I felt like my mood was slow and I was feeling sort of depressed” (Consultant)

Coping behaviour – Many demonstrated a physical response such difficulty sleeping. Some demonstrated negative coping behaviours such as increased alcohol use, others used more positive coping behaviours such as exercise, seeking support from others (colleagues and family) or avoidant behaviours such as avoiding work, the ward where the incident occurred or patient and their families.

“I avoiding being on call this weekend and I was avoiding seeing patients as much as I could, new patients because I didn’t want to be the one that made the mistake or I got my registrar who confirm that it’s the right thing to do a felt a bit avoidant this weekend” (Consultant)

“So I have done that, I have rang in....say I’ve done the night shift and then I’ve woken up, I have rang in to see how that patient is. Cos you do, it is on your mind” (Nurse)

Organisational support – participants described the support participants received during the incident and the support they wished they had. Many participants felt supported by their team and colleagues but wished they received more support from the management and organisation leading to a lack of faith in the organisation and a lack of commitment to the organisation.

“I would have liked more support from my line manager. Um, I would have expected her, I know she would do now, she would have withdrawn me from duty, given me an opportunity to talk through, so she could establish how I was feeling, whether I was actually fit to carry on either that day or the following day”. (Nurse)

“you’re a human being and everyone makes mistakes don’t they there’s just no support and you’re just made to feel like a failure” (HCA)

Patient safety and culture – Many reported being frustrated by response of the organisation during the investigation, they felt they were being blamed and not treated fairly with many fearing repercussions this would bring.

“I think, it has a very bad approach to medical error. Um, they have a blame based culture, they have a retribution based culture, they don’t look at any learning from incidents and they waste the opportunity” (Consultant)

“particular Dr who deals with it wasn’t supportive it felt like a trial... upsetting that this has happened to somebody erm I didn’t feel personally responsible to the actual mistake that was made but I still felt responsible for the patient” (Senior Nurse)

Resilience/post traumatic growth - Some participants demonstrated adaptive capacity, new growth from the situation and resilience, new ways of working, increased confidence, creating more of a learning culture and a supportive team.

“I’m proud to work with the team that I work with because everybody just does their job to the best of their ability and I know that everybody’s doing their best when they come here. I’m proud of how we all look after each other on here” (Nurse)

“Because if I got emotionally involved with every patient that was like that, I’d be a bag of nerves. So, yeah, that one incident has kind of wised me up if you like to not being so involved with parents on a personal level” (Nurse)

“it probably increased it because it gave that chance to do the investigation, make changes, make sure it doesn’t happen again so a negative thing ended up well” (Consultant)

The results demonstrate that, staff involved in a patient safety incident, medical error or adverse event, experience a strong emotional response, including victimization and self-blame. They doubt their professional abilities and without the appropriate support from the organisation, lose faith in the organisation and their commitment to it, with many considering taking time off or leaving. Conversely, if the incident is handled fairly and staff feel supported by their colleagues and the organisation, then there is growth from the situation, building resilience and adaptive capacity, through a supportive culture, new ways of doing things, and the learning from the incident.

Second victim model

A fairly recent development in supporting the wellbeing of staff, a number of healthcare organisations such as the Kaiser Permanente, Johns Hopkins and Missouri Healthcare System developed and implemented ‘second victim support units’. These programmes or units are based on recommendations to treat post-traumatic stress disorders (PTSD) (NICE, 2005). These include recommendations for Psychological First Aid (PFA) as an early intervention for all survivors of potentially traumatic events (Forbes, et al., 2010). Within this, a phased model trains staff to offer peer support with no pre-existing expert knowledge or clinical expertise.

These second victim support programmes are predominantly in the USA and there is a need to understand if these models could be translated to a UK Healthcare context. On reviewing the existing models of second victim support one well established model (Scott, et al., 2010) developed over the last seven years was identified as a good fit for the UK Healthcare context. In 2010, Dr Sue Scott led a multidisciplinary research team at University of Missouri Health Care (MUHC) and developed a model to support and provide a rapid response team for clinician support following an adverse event.

The clinician rapid response system, staffed by trained colleagues/peers, provided a safe zone of support within the natural working environment of the suffering clinician and ideally occurs immediately after the clinical event.

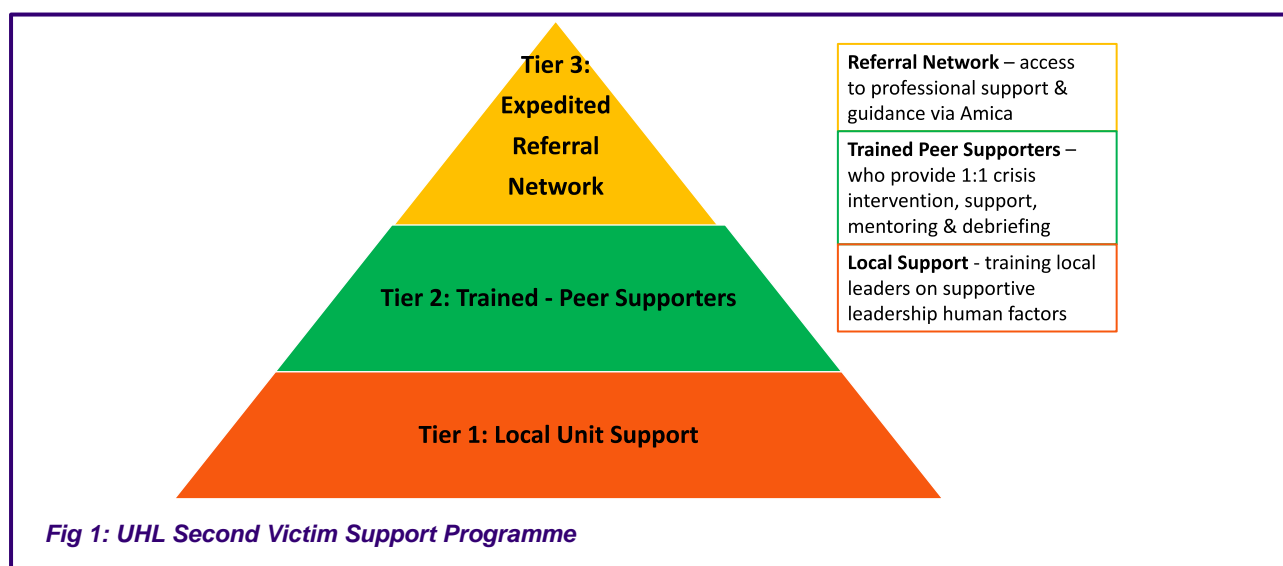
The second victim support programme and associated training programme developed by the team at UoL and CU is adapted from the Scott Model (2010). This was piloted from October 2016 in the Children's Hospital at UHL.

The second victim support programme (fig 1) comprised of 3 tiers:

Tier 1: Local training in the chosen clinical area, on basic supportive leadership and human factors.

Tier 2: Selection and training of peer and self-nominated multidisciplinary healthcare professionals who can provide peer support to those who are involved in a patient safety incident. The team of academic and clinical psychologists at UoL and CU developed a 1 day training programme for those providing peer support to enable them to have those difficult conversations and recognise when to signpost individuals for more professional support and guidance.

Tier 3: Setting up of a referral network to provide further psychological and structural support for peer supporters through AMICA, the internal counselling service.



Peer supporter selection

An internal communication plan was put in place to disseminate information throughout the Trust on how to become a peer supporter. Information was circulated using the following methods: promotional boxes on UHL's intranet, e-mail communications, and information provided in the monthly CEO's briefing on the second victim model. This resulted in a high volume of interest and thirty-one completed applications. Interested applicants had to fill in a pre-screening application detailing previous experience and motivation to become a peer supporter.

Peer supporter workshop

A one day workshop was held at the University of Leicester in October 2016. Sixteen attended from UHL's Women's and Children's department and ranged from play therapists and nurses, to matrons and consultants. The day involved introducing the concept of a second victim and reflecting on personal experiences. Organisational culture was addressed, particularly in regards to human factors and blame culture which was highlighted during the interviews. The last part of the day was focused on establishing the role of the peer supporter including confidentiality, what is expected, what skills are required, including those to self-care. The process for referral was provided (fig 2) and attendees were able to put into practice the skills and techniques they had learned during scenarios and role plays.

All attendees were provided with certificates of competence and the authorisation to act as a peer supporter in the Trust. All peer supports were given peer supporter badges (fig 4) and lanyards so they are easily identifiable. They were also provided with other support materials including a prompt sheet and evaluation sheet to fill out after each peer support interaction. Regular sessions were also set up for peer supporters with the Head of Amica (UHL's internal counselling service) to discuss progress and any concerns or specific cases in a safe environment.

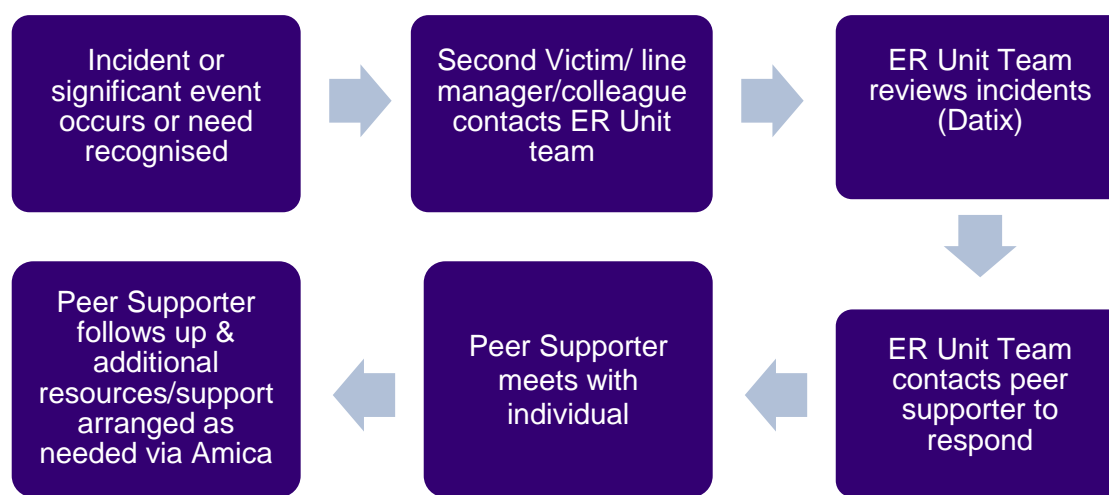


Fig 2 Referral Process

Workshop feedback

Participants found the workshop very valuable, they were keen to put into practice what they had learned as peer supporters. Illustrative feedback from the workshops:

“Very valuable; we needed peer support for years!! Thank you”

“Thought the day was very thought provoking looking forward to next step”

“Excellent, any additional training to develop further skills as peer support would be very helpful”

“Felt a comfortable group and that there will be a good support network for trainees. Lots of scope for personal development”

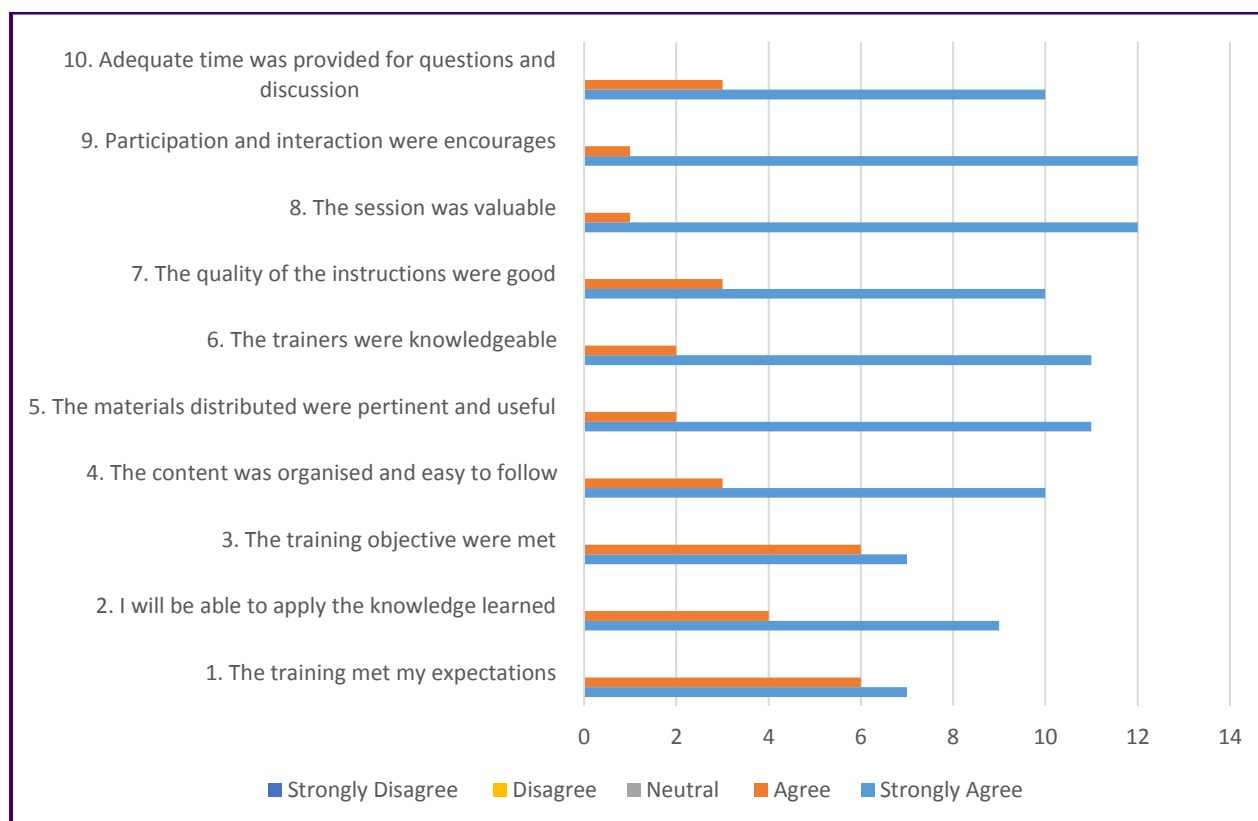


Fig 3: Peer Support Workshop Feedback

Communication strategy

The peer supporter programme was communicated to staff through a number of channels;

- A video was created to explain the concept of a second victim in a 'talking heads' interview with a consultant at UHL who had experience of being a [second victim](#).
- An internal intranet page detailing the peer support programme and how to access it.
- All peer supporters were given peer supporter badges (Fig 4) and lanyards to be easily identifiable



Fig 4: Peer Supporter Badge

- A poster displayed in the wards on how to access the programme (fig 5). Posters were put up in areas where staff may go to unwind following an incident such as common rooms and kitchens.

Peer Supporter

University Hospitals of Leicester NHS Trust
Caring at its best

Do you work in Women's and Children's?

Have you been involved in a patient safety incident, which has led you to feeling personally responsible, doubting your abilities and double checking your work?

Are you suffering from psychological effects such as anxiety, trouble concentrating and sleeping, or feeling stressed and burnt out? Have you considered leaving the profession?

Did you know?

You can receive impartial emotional support from trained peers immediately following a significant work-related event. Trained peers can be easily identified by the green lanyard and 'Peer supporter' badges in your area.

What do Peer Supporters offer?

Peer Supporters create a confidential and safe place to help provide you with 'emotional first aid' immediately or soon after a difficult work-related event.

- Listening
- Intervention
- Stabilising
- Exploring
- Providing information

Here to help 'Care' for you.

To find out more speak to a Peer Supporter in your area or contact:

Stefan Weger on
stefan.weger@uhl-tr.nhs.uk
or
Tee Taylor on
theresa.taylor@uhl-tr.nhs.uk

UNIVERSITY OF LEICESTER
CARDIFF UNIVERSITY
PRIFYSGOL CAERDYDD

All information is confidential.

Fig 5: Peer Support Poster

- A clinical champion from the trained peer support group was identified as a 'go to' person to act as a liaison between the staff, ward managers and wider programme team.

Follow up training

A half-day follow up training session was held at UoL six months after the initial peer supporter workshop. Eight attended the training. The session covered feedback from the peer supporters and progress so far, the peer supporter programme vision, updates on marketing, processes and evaluation. Peer supporters had the opportunity to refresh their skills using scenario triads and role play exercises where a real-world scenario was simulated by an actor. This was recorded and is being developed for use in further training programmes.

Evaluation

Individuals who used the peer support service were contacted for follow up interviews on their experiences of the service. The interviews explored their experience of the peer support programme and what led them to access the programme. Symptoms were explored including how stressed they felt before and after using the programme. Participants were asked for their experiences of speaking to a trained peer, the support offered, and whether this helped them stay at work.

Results

Valuable service

Interviewees found the opportunity to speak about their experience of a patient safety incident within a short space of time of the incident occurring as invaluable. Many stated, the peer supporter being aware of the incident and disclosing their personal experiences of previous incidents reassured the individual.

“I found her very helpful at the time. So, her being there was great” (Nurse)

“It was very beneficial, it was very good. I was just given that free space to just talk very openly. And because she was also my manager and had an understanding about the incident as well, that obviously helped I think. I felt it was managed really well, I was given the support and offered time to actually go home on that shift, which

is what I needed. I was then in a much better head space to be at work. I felt much better about being in work” (Senior Nurse)

“I did have that afternoon off after that chat, but I’ve worked better and I felt confident again, and felt happy to be in work again, without it I would have found it difficult to go back into work” (Nurse)

Recommend the service

All interviewees stated that not only would they use the service again, but they have introduced the service to other colleagues. This was for various reasons including to provide additional, structured support to individuals involved in a direct or indirect incident, as well as, making others aware of the programme across the ward as many did not know the service was available to them.

“I would definitely recommend the peer support to anyone, at first I didn’t even know we could have this kind of support” (Nurse)

‘I told my colleague to get some support when I saw she was struggling to manage her emotions with an incident’ (Nurse)

Utilising the service

Many stated, now they were aware of the service and what it offers, they would use it again as and when they need it. This knowledge provided somewhat of a safety net, through awareness of when and where the healthcare professional can utilise the service during times of adversity.

“I can contact her at any point, and probably I will use a bit more that allowed me to put a lot of my tensions on her really, because she was here every day with me she always had time to ask me every daily, how I’m doing today.” (Nurse)

Trained peers

Interviewees stated they felt assured that members of their own team were trained with the correct skills to support someone during times of critical incidents. Many stated the comfort in having someone already aware of the ward and the dynamics can provide better support than an external body. Thus, strengthening the relationship between peers.

“I think there should be more people trained into it, and maybe not only managers I would believe that you should have a mixture of people.” (Nurse)

“the fact that she came to me, the fact that she made the time. She even contacted me I remember at home, you know, saying how I’m doing. And that was really good. I really enjoyed that, and I think we should have more supporters like her.” (Nurse)

Comfort

Interviewees described the aftermath of the support meeting as a support system which they could feel comfortable using. Rather than taking time off work, the health professionals felt at ease to continue working in the hospital, given a change of environment and were able to ease themselves back into the ward.

“Because that allowed me to stay in the hospital environment, instead of going off sick. It gave me a break from the labour ward. And that was the point when she contacted me and she came over to talk to me here. So, it was not in the other hospital, it was quite nice. She came over in her own time.” (Nurse)

Understanding

The peer support meetings normalised many of the reactions of the health professionals utilising the service. As described above, the interviewees found themselves feeling less alone with their emotions and reactions when the peer supporter disclosed they too have had a similar experience.

“She made me realise that everyone makes mistakes, cos we’re humans and to hear from her that she’s also experienced something like that as well. really reassuring.” (Nurse)

“I actually wanted to talk about it. And, yeah, I was able to talk to her. What helped me the most was probably the fact that she said that she also makes mistakes” (Nurse)

“I think really having that space to talk and really just let everything out was just so beneficial because, you know, she’s a trained peer supporter and she’s a manager, and could really understand.” (Nurse)

Recommendations

Recommendation 1:

Staff Need Support after a Patient Safety Incident

This scoping project explored the experiences of health professionals in two clinical units in two large Acute Trusts. The findings not only supported existing literature but illustrated the ways in which critical incidents can impact the healthcare professional over a long period of time. The implication of this are that health professionals are susceptible and vulnerable to errors and these can have detrimental consequences at both the individual and organisational levels. However if staff feel supported by their colleagues and the organisation, this can led to positive outcomes, increased organisational and individual resilience and adaptive capacity, new ways of working developed from a supportive and learning culture to ensure those errors are not made again.

Recommendation 2:

Scale and Spread of the Second Victim Support Programme

The pilot second victim support programme and the training of a network of peer supporters was seen as valuable by staff, and helped support those that accessed it. The expansion of this programme in other areas and other Trusts may provide healthcare professionals with the skills and services required to help reduce the facets of second victimhood, and help staff feel supported and remain at work.

Recommendation 3:

Wide Dissemination and Communication of Second Victim Support Programmes

Second victim support programmes need to be widely communicated and disseminated, through a structured and ongoing communication strategy. The internal team at UHL worked closely with the communications department to ensure that the programme was communication through a number of different channels, the staff intranet, CEO briefings, videos and posters. The purpose of this was to both recruit peer supporters and staff to access the programme for support. There can be a stigma associated with seeking help so communications were carefully ‘messed’ to normalise this, with examples of personal experiences.

Recommendation 4:

Peer Supporters Need Structured Support and On-going Training

Structured support for peers was a key component of the second victim support programme. Regular meeting were set up with Amica, UHL’s internal counselling service, this provided peers with an opportunity to discuss with each other or the head of the counselling service any issues they are having or difficult cases and how to deal with these. In addition, ongoing refresher training and opportunities to reflect and practice are an important element and should be built into any peer support programmes.

Conclusions

This scoping pilot investigated healthcare professional's experience of the concept of second victimhood. Personal accounts of experiences of being involved in patient incidents, were explored, highlighting staff can suffer a number of negative psychical and psychological effects. These findings demonstrate that staff do need support after being involved in a patient safety incident. If staff are supported then there can be positive development and growth from the incident both at an individual and organisational level. These findings helped shape the development of a second victim support programme using the established 'Scott Model of Second Victim Support', which involved training peer supporter to provide emotional first aid to colleagues in the immediate aftermath of an incident. The response from the health professionals utilising the service was positive, helping them normalise the situation, feel supported and remain in work. Recommendations from the pilot are that these programmes needed to be widely communicated to ensure recruitment of peers to be trained and uptake of the service. Peer supporters themselves need to be offered opportunities to reflect and further develop skills, through clinical supervision and ongoing training. Further research and piloting of the model is also recommended, to expand on the support available to second victims in the UK healthcare system.

References

- Clancy , C. M. (2012). Alleviating "second victim" syndrome: how we should handle patient harm. *Journal of Nursing Care Quality* , 27(1), 1-5.
- Forbes, D., Creamer, M., Bisson, J. I., Cohen, J. A., Crow, B. E., & Foa, E. B. (2010). A guide to guidelines for the treatment of PTSD and related conditions. *Journal of Traumatic Stress*, 23(5), 537-552.
- King, N., Brooks, J., McCluskey, S., & Turley, E. (2015). The Utility of Template Analysis in Qualitative Psychology Research. *Journal of Qualitative Research in Psychology*, 12(2), 202-222.
- Mants, T. (2015, 04 29). *Health care professionals' experiences after making errors in practice: an integrative review of the literature*. Retrieved from UVicSpace: <http://hdl.handle.net/1828/6063>
- Mulluish, S., & Bassey, S. (2012). Cultural competence in the experiences of IAPT therapists newly trained to deliver cognitive-behavioural therapy: A template analysis focus study. *Counselling Psychology Quarterly* , 25(3), 223-238.
- NICE. (2005, March). *Post-traumatic stress disorder: management* . Retrieved from NICE: National Institute for Health and Care Excellence: <https://www.nice.org.uk/guidance/cg26>
- Perry, T., Barkham, M., & Evans, C. (2013). The CORE-OM and CORE-OM (SV) in secure settings: a template analysis of the experiences of male patients and their staff. *The Journal of Forensic Practice*, 15(1), 32-43.
- Scott, S. D., Hirschinger, L. E., Cox, K. R., McCoig, M., Brandt, J., & Hall, W. L. (2009). The natural history of recovery for the healthcare provider "second victim" after adverse patient events. *BMJ Quality & Safety* , 18(5), 325-330.
- Scott, S. D., Hirschinger, L. E., Cox, K. R., McCoig, M., Hahn-Cover, K., Epperly, K. M., Phillips, E. C., & Hall, L. W. (2010). Caring for our own: Developing a systemwide second victim rapid response team. *The Joint Commission Journal on Quality and Patient Safety*, 36(5), 233-240.
- Sidney, D. (2013). *Second Victim: Error, Guilt, Trauma, and Resilience*. Boca Raton : CRC Press .
- Wu, A. (2000). Medical error: the second victim. The doctor who makes the mistake needs help too. *BMJ*, 320(7237), 726-727.

Contact us

Dr Cheryl Crocker

Regional Lead: Patient Safety Programme

East Midlands Health Science Network

Honorary Associate Professor, University of Nottingham

**C Floor, Institute of Mental Health, University of Nottingham Innovation Park,
Triumph Road, Nottingham, NG7 2TU**

Phone: 07772353064

Email: cheryl.crocker@nottingham.ac.uk

With thanks to



East Midlands

**Patient
Safety
Collaborative**