

Second Victim Support: Critical Incident Stress Management for Healthcare Workers

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Date for publication: April 14, 2015

Background:

Health care providers work in complex systems where critical incidents (CIs) are unavoidable. CIs include major incidents such as pandemics or radiologic emergencies, mass casualties, violence to colleagues, suicide or self-harm by a patient or staff member, unanticipated deaths or “near miss” incidents such as medication errors or other unanticipated errors.

There are often thought to be three victims that result from these critical incidents. The “first victim” is the patient that suffered the initial adverse event. The “second victim”, as defined by Scott et al, “is a health care provider involved in an unanticipated adverse patient event, medical error and/or a patient-related injury who becomes victimized in the sense that the provider is traumatized by the event. Frequently, the second victim feels personally responsible for the unexpected patient outcomes and feel as though they have failed their patients, second-guessing their clinical skills and knowledge base.”¹ The “third victim” is the subsequent patient cared for by the affected health care provider. A perioperative catastrophe may adversely affect the ability of a provider to care for his subsequent patients.²

Within the frame of guilt, blame, and shame that may embody hospital culture, coping with critical incident stress becomes even more difficult for these providers. The providers may feel a sense of responsibility that can lead to a fear of harming other patients and make coping with critical incident stress even more difficult. Untreated CI stress may affect cognitive function and therefore reduce patient safety. Caregivers may be traumatized in the long term when one or more of the following criteria are present: feelings of helplessness/powerlessness, feelings of personal guilt, a high degree of identification with the patient, threat to life and health, or incidents involving children. They may manifest symptoms, which may include: anxiety, depression, aggression, impaired sleep, difficulty making decisions, difficulty concentrating, and feelings of being over-challenged or helplessness, that may lead to suicide in the second victim.

Critical incident stress management (CISM) is a comprehensive peer support program used originally to stabilize psychological function of firefighters, paramedics, police officers and soldiers following exposure to CIs.³ CISM programs have been extended to airline pilots, air traffic controllers, and to health care workers in recent years.^{4,5} Evidence supports that the implementation of a CISM program helps employees recovery more quickly from the incident, resume tasks sooner, decrease the probability of subsequent disorders, improve resilience, and save the organization further costs, such as, absence from work, and retaining experienced workers, thus saving the cost of training new staff. While adaptation of a CISM program in hospitals may take time, it may serve as a mechanism of changing professional culture and improving patient safety.^{4,5}

While a CISM program may be beneficial for employees, it can be costly and time-consuming for a health care organization to provide and maintain supportive interventions for its second victims. By measuring outcomes, organizations can identify beneficial programs and direct resources appropriately. The purpose of this study was to develop and validate the Second Victim Experience and Support Tool (SVEST) as a survey tool to assist health care organizations track and improve the support for second victims.

Results:

This study was conducted over a year at a pediatric hospital that specialized in treating children with catastrophic illness. The authors developed a final 30-item questionnaire that examined 7 dimensions of second victim response and support including psychological distress, physical distress, colleague support, supervisor support, institutional support, non-work related support and professional self-efficacy. Their measured outcomes variables were absenteeism and staff turnover intention. Items were measured on a 5-point likert scale (1= “strongly disagree” to 5 = “strongly agree”). Data was collected regarding staff position, years of service, age, and gender. Support options were also examined including use of a peer counselor, outside counselor, coworker or supervisor in the CISM program. The survey tool was assessed for content validity and construct validity. Fit indices used to evaluate the model included χ^2 test, comparative fit index, and root mean square error of approximation.

Of 281 participants, the three largest groups represented were nurses (44%), physicians (8.5 %) and pharmacists (8.5%). Only 1% of respondents felt colleague support was poor. 10.3% of respondents suffered physical distress. 9.6% of respondents disclosed victim-related turnover intentions and 7.1% had victim-related absenteeism.

This study validated the use of the SVEST tool by health care leaders to guide their implementation of new second victim resources and assess their existing programs. SVEST could be used to evaluate future CISM programs before their inception and as well as track the performance of these programs over time. This tool could also assist hospital administrations in pinpointing areas of improvement, justifying the need to invest resources, and investigating opportunities that exist for improving care in their organizations. Furthermore, by providing an assessment of nurses and physicians after CIs, SVEST may also be used to identify other factors that improve patient care after CIs. Providing a positive and supportive environment may lead to increased vigilance, improved safety practices and positive patient outcomes.

References

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