Second Victim Response Teams: Institutional Design Strategies to Care for Our Own

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Background

When patients suffer unexpected clinical events, care providers are at risk of suffering as a result of the unanticipated outcome and become "second victims"[1-7]. Suffering care-givers feel as though they have failed the patient and frequently second guess their clinical skills, knowledge base and career choice[8]. It is critical that health care institutions plan for the needs of potential second victims [9] and design supportive interventions that sustain a healthy recovery during this vulnerable period.

Purpose

To solicit feedback from members of our large healthcare system regarding personal experience with the second-victim phenomenon in terms of prevalence, past support they received, and desired restorative interventions that would have made a difference for professionals in crisis.

Methods

Between March 10 and 31, 2009, a 10-item semi-structured web-based survey was constructed and distributed via survey monkey technique to approximately 5,300 faculty and staff at University of Missouri Health System (UMHS) . Solicitation for participation was by email to internal list serves, newsletters, and chief of staff mailing. Beyond basic demographics, the survey items focused on actual and desired support structures for health care clinicians. Simple counts and proportions were used for demographic items. Narratives were categorized into location, level and specific characteristics of emotional support. Chi-square analyses were used to compare professional groups and experience levels on three support variables.

Results

Across six facilities and corporate leadership at MUHS (Figure 1), 897 surveys were returned with an overall response rate of 17% (Table 1). Nursing comprised 40% of respondents (Figure 2). While 5% did not respond (n=48), 39% (n=351) reported that, within the past twelve months, they had been involved in a patient safety event that caused personal problems such as anxiety, depression or concerns about their ability to do their job. Less than 1/3 reported they had received emotional support (Figure 3). When support was received, colleagues/peers or managers/supervisors provided most of the support (Figure 4). Thirty-six percent of respondents offered narratives describing desired restorative interventions. More than 8 in 10 believed support should be formalized within the institution, while only three persons stated support wasn't needed (Figure 5). Six support levels were derived from narratives, but most wanted one or more of three types of internal support (Table 2). Narratives with specific characteristics of support were categorized into any of eight types (Table 3). There were no statistical differences by professional group or years of experience regarding support location, levels, or specific characteristics.

Conclusions and Implications

The high response rate was surprising and may provide insight into the amount of second victim suffering. Regardless of professional group or years of experience, respondents reported formal support should be provided within the institution, specifically at the department/unit level as well as from clinicians whose daily job duties involve supportive interventions. From these results, a pyramid illustrating three tiers of internal support was developed (Figure 6). We now believe that synchronizing and structuring internal resources according to these three tiers would provide 24/7 emotional support for potential second victims.

Figure 1: Participation by Facility

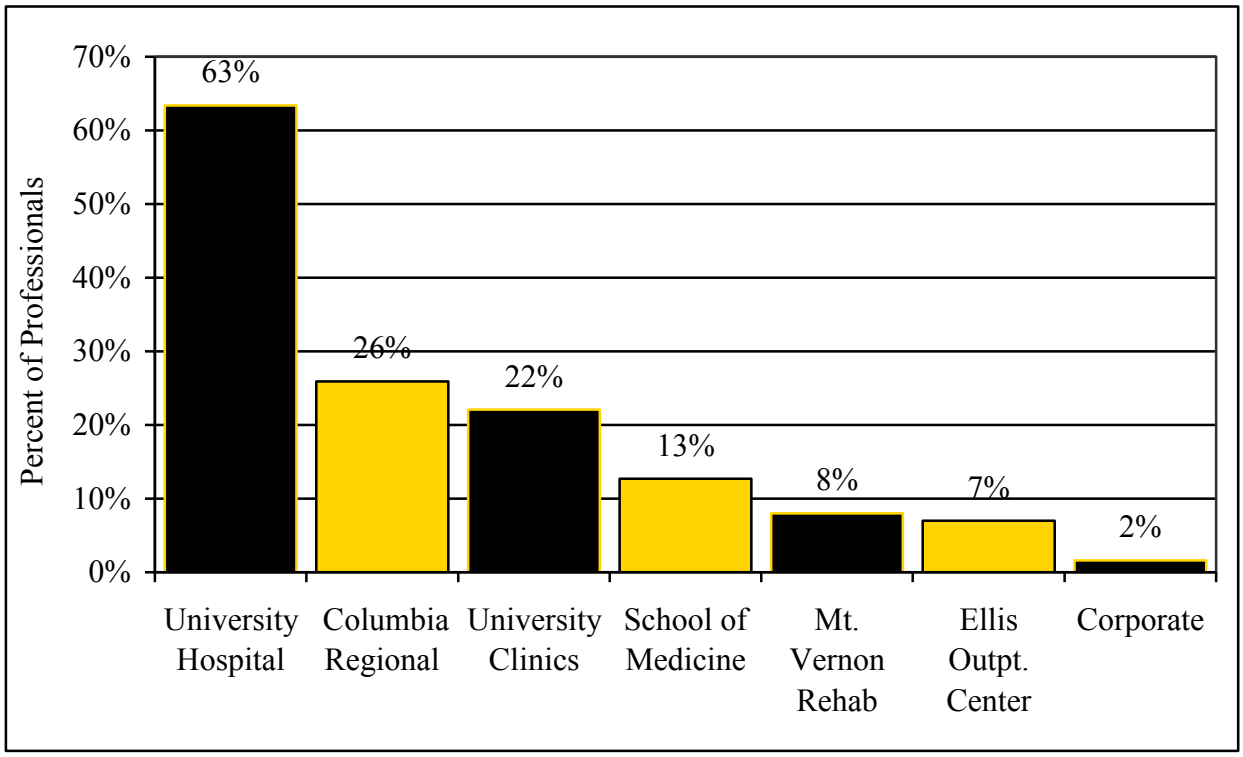


Table 1: Survey Response Rate

Professional Type	Professional Type Estimated Count*	Returned Surveys	Response Rate
MD's (Attending, Fellow, Resident)	814	184	23%
Medical Students (M3's and 4's)	192	65	34%
RN's/LPN's	1466	362	25%
Allied Health	2827	286	10%
Totals	5299	897	17%

*Estimated from UMHS Human Resource Database for Spring 2009

Figure 2: Participants by Professional Type (n=897)

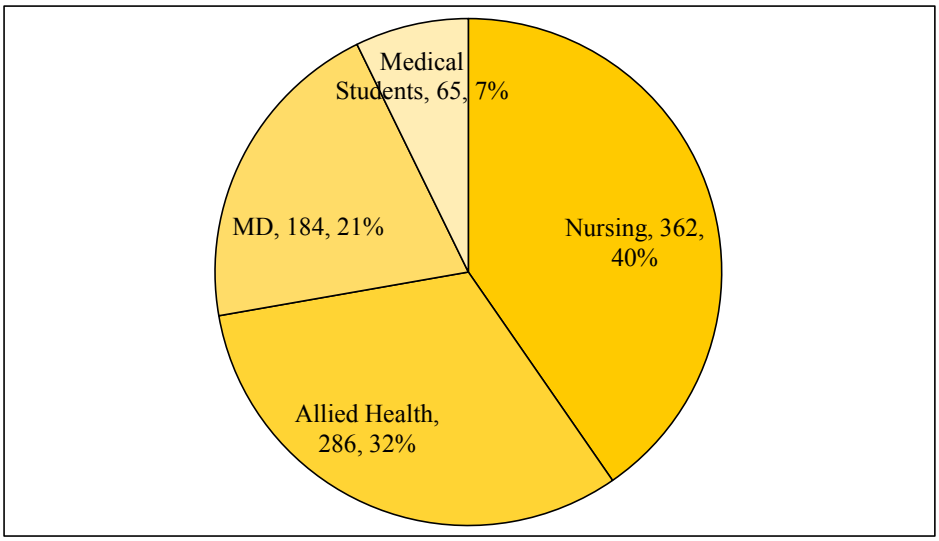


Figure 3: Rate of Emotional Support Received For Participants Agreed A Clinical Event Had Caused Personal Problems Within The Past 12 Months (n=351)

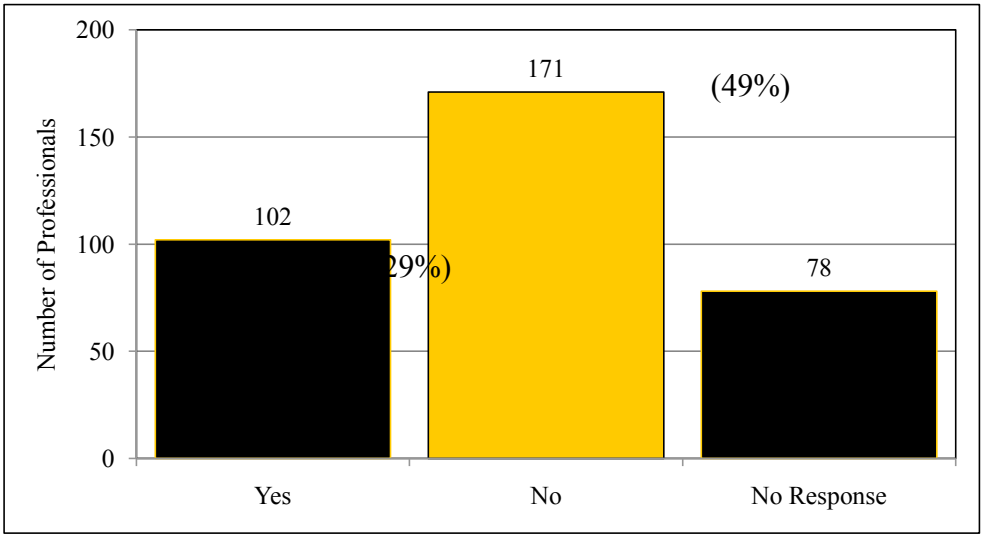


Figure 4: Source Of Emotional Support After a Clinical Event

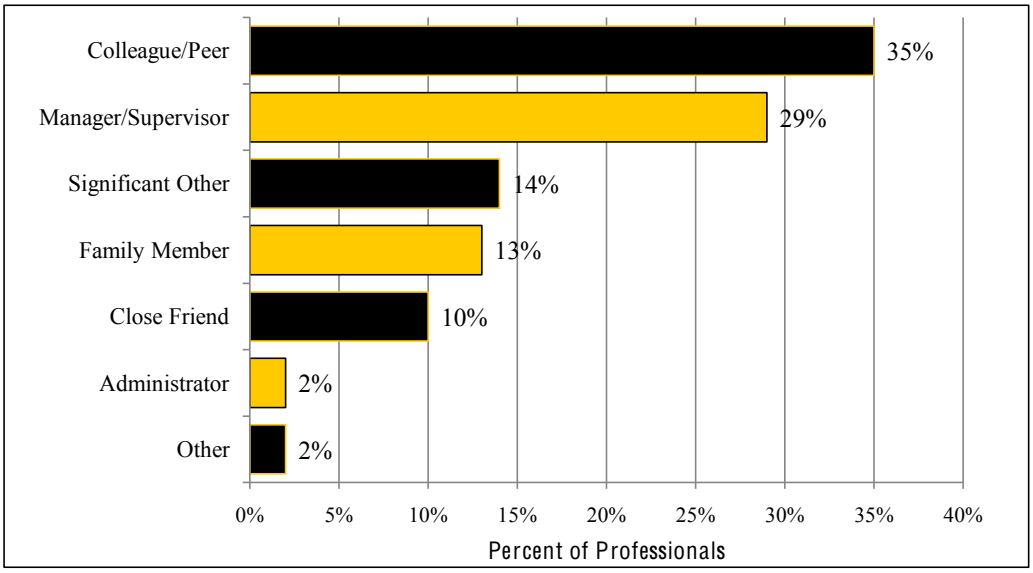


Figure 5: Recommended Locations For Second Victim Support
(322 Respondents with 451 recommendations for support location)

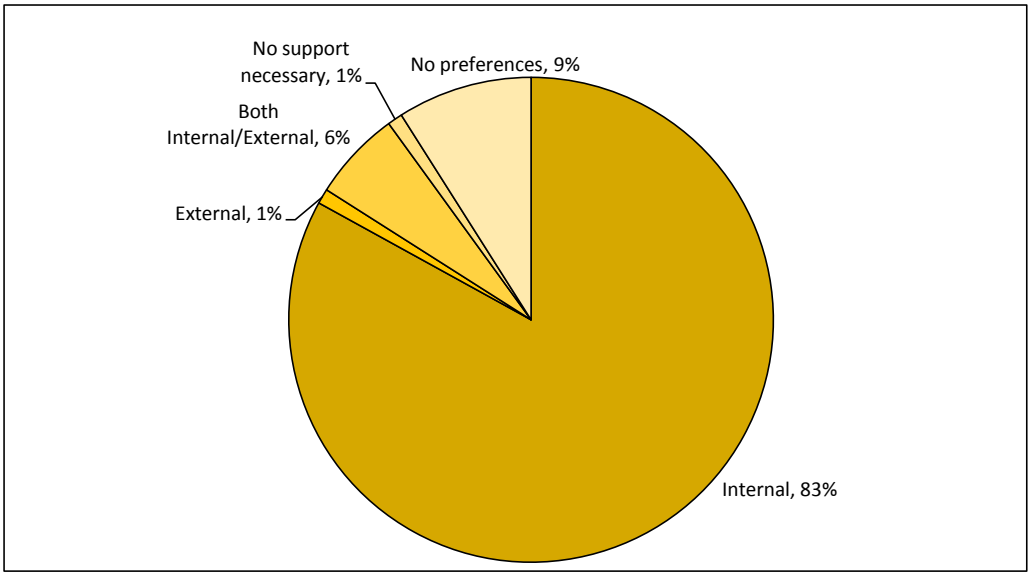


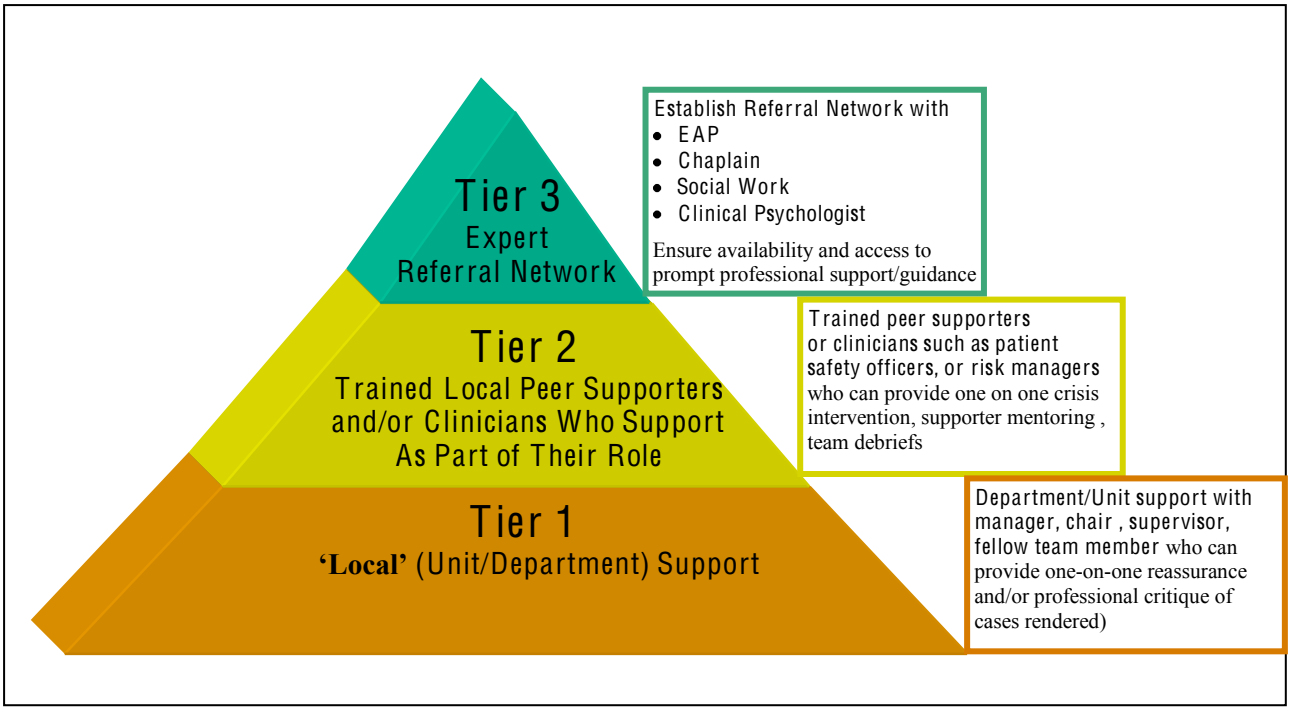
Table 2: Support Levels Identified from Narratives (n=478)

Narrative Descriptions Of Various Levels of Internal And External Support	Narratives Provided	Percentage of Total Narratives Provided
No support necessary.	3	<1%
Internal Support: Departmental/Unit support with Manager/Chair/Supervisor/Team Members; One on One Reassurance; Professional Review of Case Events with feedback	217	45%
Internal Support: Institutional Support Outside the Department/Unit Level; Trained Peer Support Network – special training in Crisis Intervention; Patient Safety and Risk Management Referrals; Team Debriefings	161	34%
Internal Support: Formalized Referral Network; Trained personal counselors such as Employee Assistance Program, Chaplains, Social Workers, or Clinical Health Psychologists	75	16%
External Support: Support provided by family/friends without internal support/guidance.	3	<1%
External Support: Support provided by personal counselor	19	4%

Table 3: Characteristics of a Support Network as Requested by Respondents (n=143)

Specific Support Characteristics	Narratives Provided	Percentage of Total Narratives Provided
Provide time away or a brief respite from the clinical area to allow staff member to re-group/collect thoughts and compose self	31	22%
Ensure a safe and just culture approach with a no-blame mentality	29	20%
Provide education and knowledge about adverse clinical event investigations; knowledge about second victims; knowledge about sanctioned support networks within the institution	22	15%
Ensure a systematic review of the clinical event to ensure an objective, complete review of case is conducted	18	13%
Ensure that internal support team is available 24 hours per day/ 7 days a week	14	10%
Follow-Up with Second victim following the immediate aftermath of a clinical event should be expected and anticipated	14	10%
Services provided should be strictly confidential	12	8%
Services provided should be individualized based on the unique needs of the staff member	3	2%

Figure 6: Recommendations for Establishing Three Levels or Tiers of Institutional Support



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