NURSES AS SECOND VICTIMS – WHEN A MEDICAL ERROR HAPPENS

Brent LoCaste-Wilkens, MSW

Bonnie L. Magliaro, MS, RN, CS, CPHQ
LEARNING OBJECTIVES

- Define what constitutes a medical error
- Identify who the victims are
- Describe the impact on the “second victim”
- Discuss strategies to minimize the impact on second victims
- Analyze the level of support within an organization
- List actions you can take to support second victims
DEATHS RELATED TO ADVERSE MEDICAL EVENTS
WHAT CONSTITUTES A MEDICAL ERROR

Figure 2. HPI SEC Algorithm

Was there a deviation from generally accepted performance standards (GAPS)?

Yes

No

Did the deviation reach the patient?

Yes

No

Did the deviation cause moderate to severe harm or death?

Yes

Near Miss Safety Event

No

Serious Safety Event

Preceptor Safety Event

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## Grading of Medical Errors

<table>
<thead>
<tr>
<th>HPI SEC</th>
<th>Code</th>
<th>Level of Harm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serious Safety Event (SSE)</td>
<td>SSE 1</td>
<td>Death</td>
</tr>
<tr>
<td></td>
<td>SSE 2</td>
<td>Severe Permanent Harm</td>
</tr>
<tr>
<td></td>
<td>SSE 3</td>
<td>Moderate Permanent Harm</td>
</tr>
<tr>
<td></td>
<td>SSE 4</td>
<td>Severe Temporary Harm</td>
</tr>
<tr>
<td></td>
<td>SSE 5</td>
<td>Moderate Temporary Harm</td>
</tr>
<tr>
<td>Precursor Safety Event (PSE)</td>
<td>PSE 1</td>
<td>Minimal Permanent Harm</td>
</tr>
<tr>
<td></td>
<td>PSE 2</td>
<td>Minimal Temporary Harm</td>
</tr>
<tr>
<td></td>
<td>PSE 3</td>
<td>No Detectable Harm</td>
</tr>
<tr>
<td></td>
<td>PSE 4</td>
<td>No Harm</td>
</tr>
<tr>
<td>Near Miss Safety Event (NME)</td>
<td>NME 1</td>
<td>Unplanned Catch</td>
</tr>
<tr>
<td></td>
<td>NME 2</td>
<td>Last Strong Barrier Catch</td>
</tr>
<tr>
<td></td>
<td>NME 3</td>
<td>Early Barrier Catch</td>
</tr>
</tbody>
</table>
WHO ARE THE VICTIMS WHEN ERRORS OCCUR?

1st  2nd  3rd
Supportive patient safety cultures may reduce second victim–related trauma. (Quillivan 2016)
THE SECOND VICTIM EXPERIENCE
1817 TRIPLE TRAGEDY

Princess Charlotte of Wales

- Only heir to the British throne
- Gave Birth to still born son after 50 hours of labor
- Died of post-partum hemorrhage
- Royal Physician, Sir Richard Croft committed suicide 3 months later
KIMBERLY HIATT

- RN
- Seattle, 2010
- Medical Error
- Child 5 y./patient dies
- Dismissed from job
- Commits suicide
ERIC CROPP

- Pharmacist
- Ohio, 2009
- System Failure
- Child 2 yo/patient dies
- Criminal Charges: Involuntary Manslaughter
- Partners with the Emily Jerry Foundation
JULIE THAO

- Labor & Delivery RN
- Wisconsin, 2006
- System Failure
- Mom 16 yo/patient died
- Criminal Charges
MULTIPLE SECOND VICTIM TRAUMAS

(1) Adverse Event

(2) Peer Response

(3) Investigation

(4) Litigation
POTENTIAL CYCLE OF ERRORS
CONCERNS

• About the patient
  • Is the patient/family okay?

• About me
  • Will I be fired?
  • Will I be sued?
  • Will I lose my license?

• About peers
  • What will my colleagues think?
  • Will I ever be trusted again?

• About the next steps
  • What happens next?
SYMPTOMS

- Extreme fatigue
- Sleep disturbances
- Rapid heart rate
- Increased blood pressure
- Muscle tension
- Rapid breathing

- Frustration
- Difficulty concentrating
- Flashbacks
- Loss of confidence
- Depression
- Grief/remorse
- Post Traumatic Stress
TANDEM SUPPORT TEAM COMPONENTS

- Staff trained in PFA and Grief
- Sustainability Committee
- Webpage, Identifiers & Marketing Materials
- Newsletter, Huddles & Practice Sessions
- SPÖK – Text Notification System
- Reporting
PSYCHOLOGICAL FIRST AID (PFA)

• Practical support which does not intrude
• Assesses needs and concerns
• Helps address basic needs
• Listens
• Provides comfort and calming atmosphere
• Connects people to information or services
• Protects individuals from harm
PFA IS NOT

• Limited to something only professionals can do
• Incident debriefing or analysis
• Professional counseling
• Mandated
PEOPLE WHO MAY NEED IMMEDIATE ADVANCED SUPPORT ARE THOSE WHO ARE

• Injured themselves and need medical care
• Unable to care for themselves or dependents
• Express intent to hurt themselves or others
TST 2016 DATA

- 16 Calls
- 20 individual
- 2 group
- 62 employees helped
THE RECOVERY TRAJECTORY

Stage 1: Chaos & Accident Response
Stage 2: Intrusive Reflections
Stage 3: Restoring Personal Integrity
Stage 4: Enduring the Inquisition
Stage 5: Obtaining Emotional First Aid
Stage 6: Moving On

Impact Realization

Thriving
Surviving
Dropping Out
PROVIDING PEER SUPPORT

Tier 3
EAP et. al.

Tier 2
Tandem Support Team

Tier 1
“Local” Unit/department support
CHALLENGES TO PROVIDING PEER SUPPORT

• Stigma to reaching out for help.
• High-acuity areas have little time to integrate what has happened.
• Intense fear of the unknown.
• Fear of compromising collegial relationships because of the event.
• Fear of future legal issues.
## Things to Say (and Not to Say) to a Colleague after an Adverse Event

**Things to say**
- Emotional support
  - Are you ok?
  - You've had a tough break.
  - Thank you for sharing with me.
  - What are you doing to cope?
  - Are you going to be ok?
  - Informational support
    - These things happen to all of us.
    - You did everything you could.
    - Let me tell you about something that happened to me.
    - You are still a good doctor/nurse.

**Things not to say**
- Didn't you realize what would happen?
- What were you thinking?
- I wouldn't have done that!
- You need to get over it.
- Nothing.
PEER SUPPORT INTERACTION
References:


