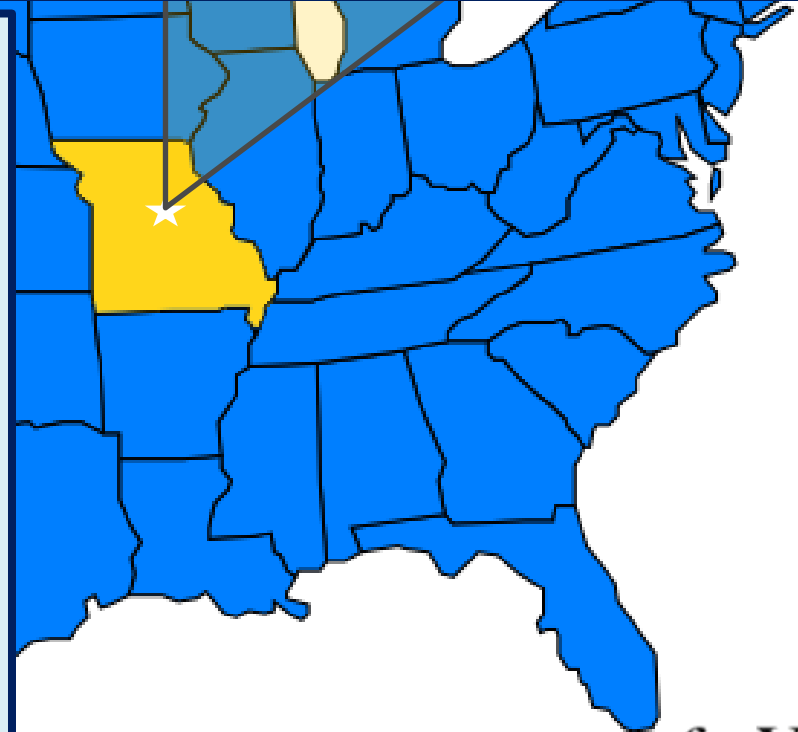




# Caring For The Caregiver After Adverse Clinical Effects

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University of Missouri Health Care System  
March 11, 2016

## University of Missouri Health Care

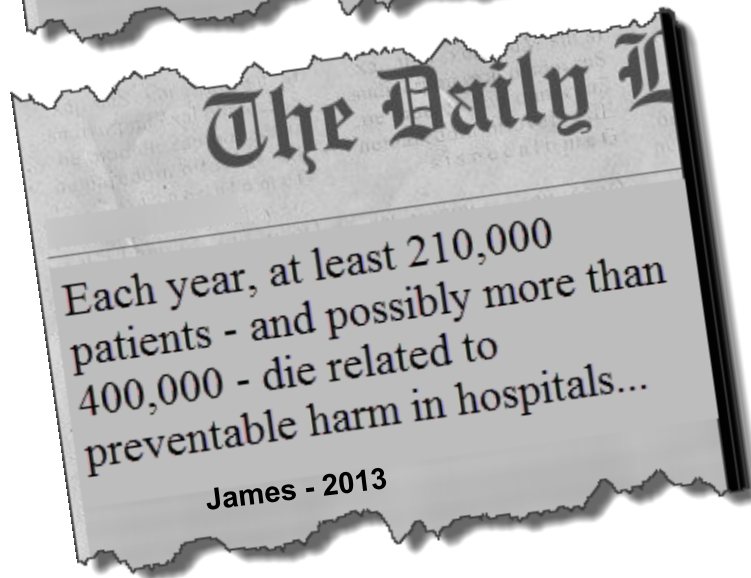
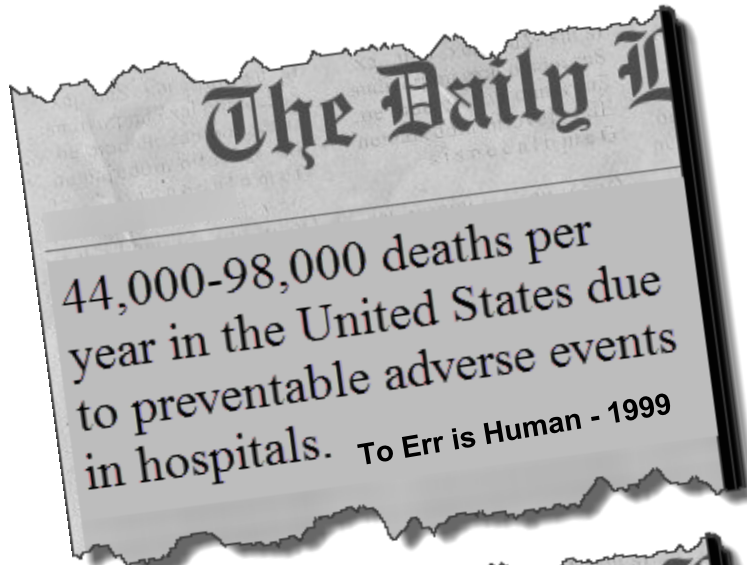


### • University of Missouri Health Care By The Numbers:

#### • Fiscal Year15

- Five Hospital System
- 54 Ambulatory Clinics
- Level One Trauma Center – 72,000  
Emergency and Trauma Visits
- 6,000 Staff
- 618 Physicians
- 615,000 Annual Clinic Visits
- 6 million pharmacy orders per year
- 1.7 million laboratory tests

# The Modern Patient Safety Movement



Good Clinicians + Faulty Systematic Processes =

Adverse Patient Event →

Adverse Staff Impact →

Predictable Responses/Behaviors

Scott et al., 2009



# History of the PROBLEM

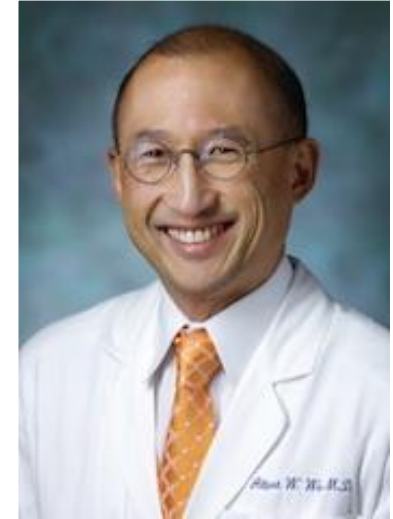


# Review of the Literature

## Medical error: the second victim

*The doctor who makes the mistake needs help too*

**Albert Wu, MD**



When I was a house officer another resident failed to identify the electrocardiographic signs of the pericardial tamponade that would rush the patient to the operating room late that night. The news spread rapidly, the case tried repeatedly before an incredulous jury of peers, who returned a summary judgment of incompetence. I was dismayed by the lack of sympathy and wondered secretly if I could

improvements that could decrease errors. Many errors are built into existing routines and devices, setting up the unwitting physician and patient for disaster. And, although patients are the first and obvious victims of medical mistakes, doctors are wounded by the same errors: they are the second victims.

Virtually every practitioner knows the sickening realization of making a bad mistake. You feel singled

*“Virtually every practitioner knows the sickening realization of making a bad mistake. You feel singled out and exposed..... You agonize about what to do..... Later, the event replays itself over and over in your mind”*

laboratory tests, and innovations that present daunting images of illness have in fact created an expectation of perfection. Patients, who have an understandable need to consider their doctors infallible, have colluded with doctors to deny the existence of error. Hospitals react to

every attentive to the patient or family, minimizing the failure to do so earlier and, if you haven't told them, wondering if they know.<sup>1-3</sup>

Sadly, the kind of unconditional sympathy and support that are really needed are rarely forthcoming.

# Second Victims Defined...

*“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.”*



Scott, S. D., et al., (2009).



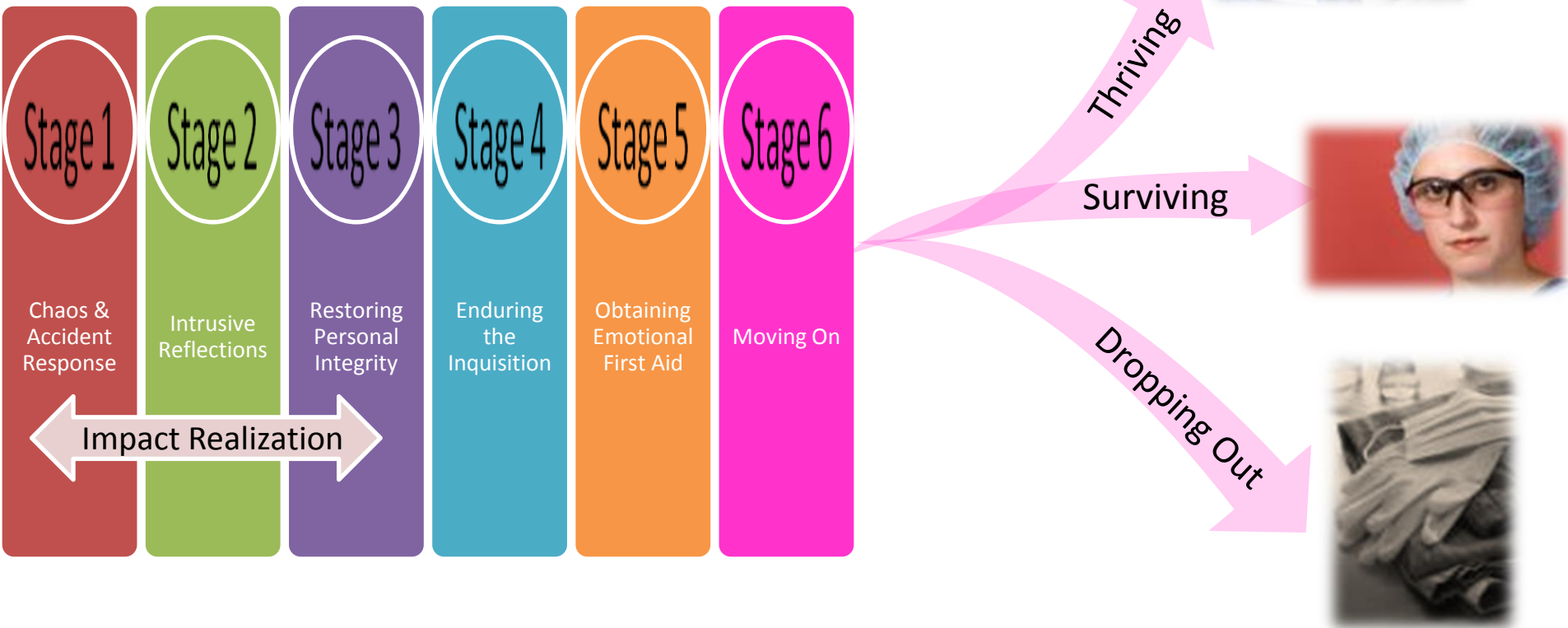
# High Risk Scenarios

- Patient 'connects' staff member to family
- Pediatric cases
- Medical errors
- Failure to rescue cases
- First death experience
- Unexpected patient demise



Scott, S. D., et al., (2010).

# Second Victim Recovery Trajectory





# Five Rights of the Second Victim

Following the event ensure that caregivers and staff receive the following support:

Treatment That Is Just

Respect

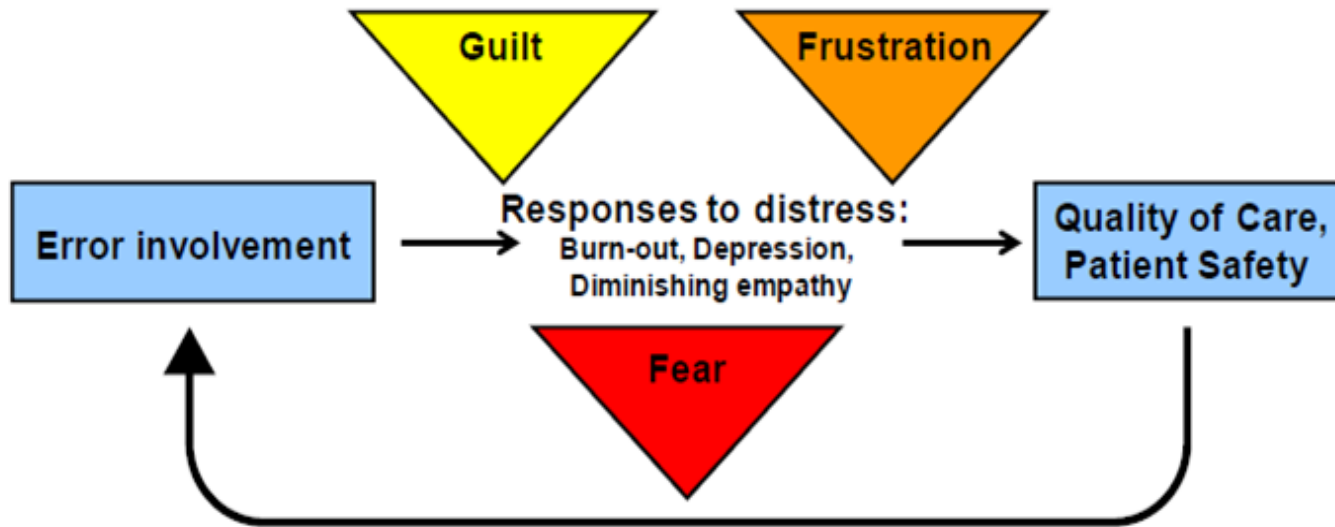
Understanding and Compassion

Supportive Care

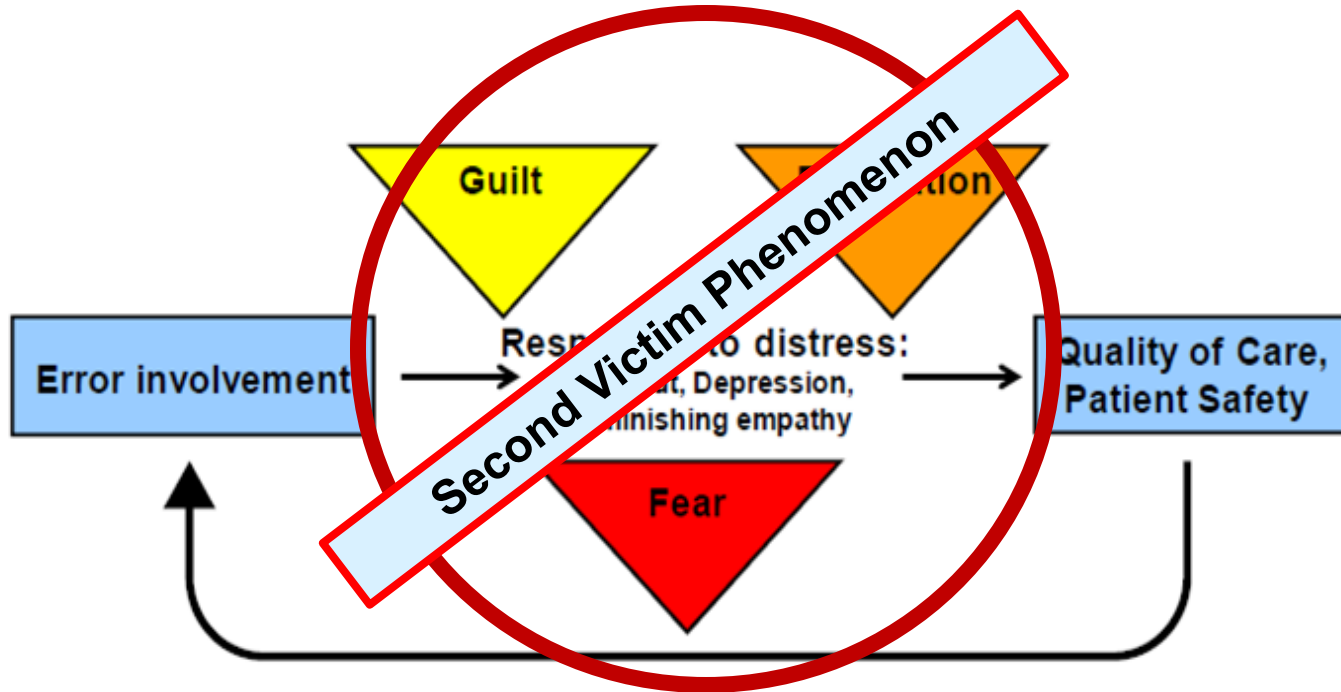
Transparency



# Reciprocal Cycle of Error



# Reciprocal Cycle of Error



Schwappach, D. L., & Boluarte, T. A. (2009).

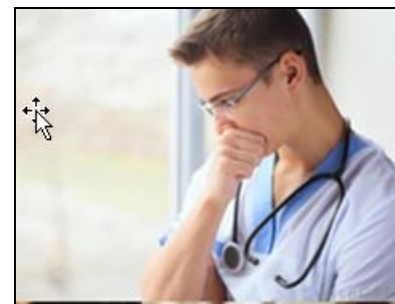




Everyone has a personal story.....

# Prevalence

- 83% of respondents personally involved in an adverse event during **career** (Harrison et al., 2015)
- 53% involved in a serious adverse patient event in the past year (Hu et al., 2011)
- 60% could recall an adverse event in which they were a second victim (Edrees et al, 2011)
- University of Missouri Health Care (2014 Culture Survey Results)
  - Overall 27% of respondents claimed second victim within past 12 months
  - Highest unit – 62% (Intensive Care Unit)



*“....(health care) providers are human. As such we make mistakes, and some of these mistakes lead to patient harm. Because of this very humanness, we also have strong emotional responses to the suffering and harm that occurs because of the mistakes we make.”* (Pratt, 2015)





# Second Victim Interventions

Second victims want to feel...

Appreciated

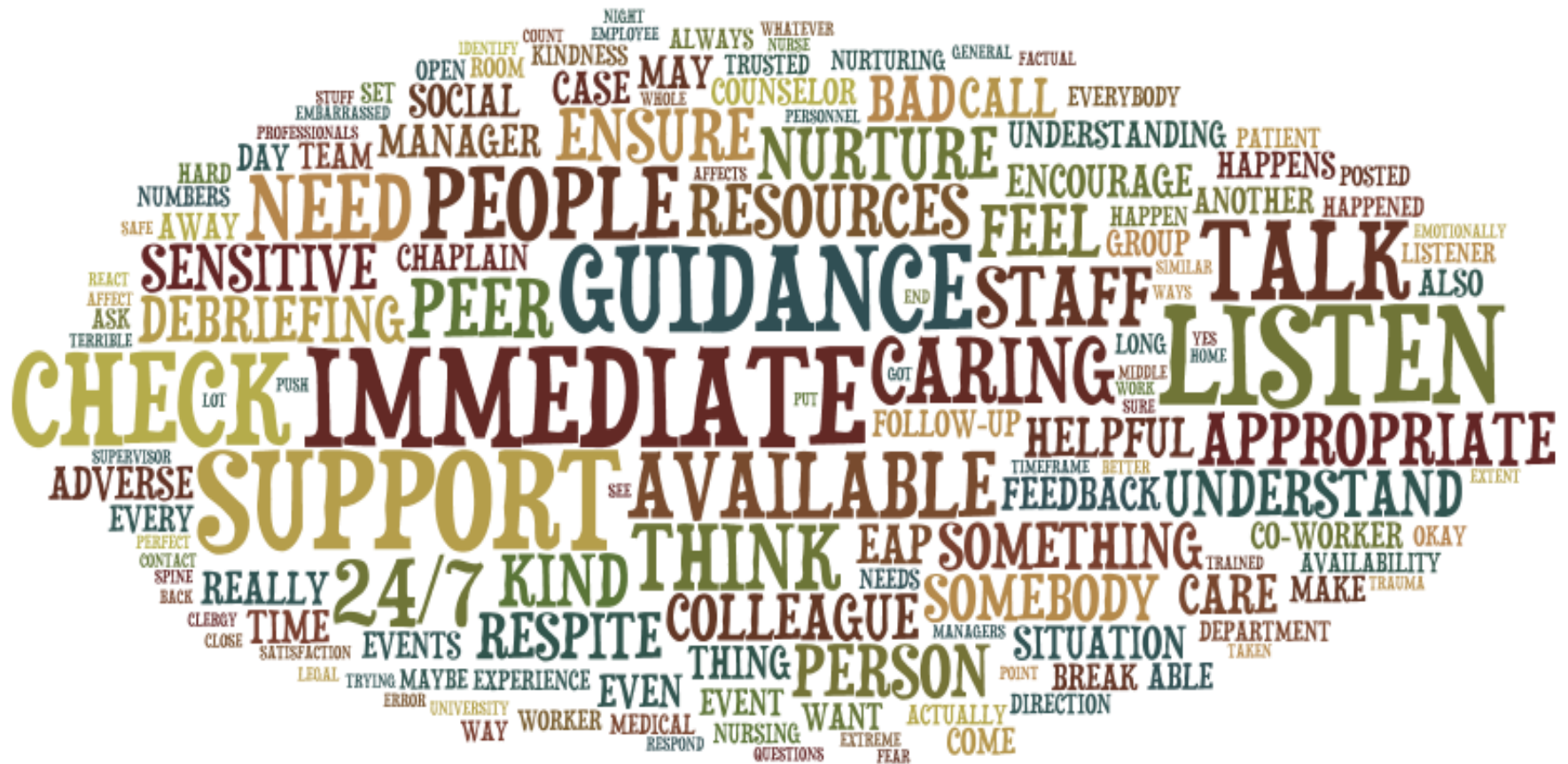
Valued

Respected

Understood

Last but not least....Remain a trusted member of the team!

# What Second Victims Desire...



# forYOU Team Innovation....

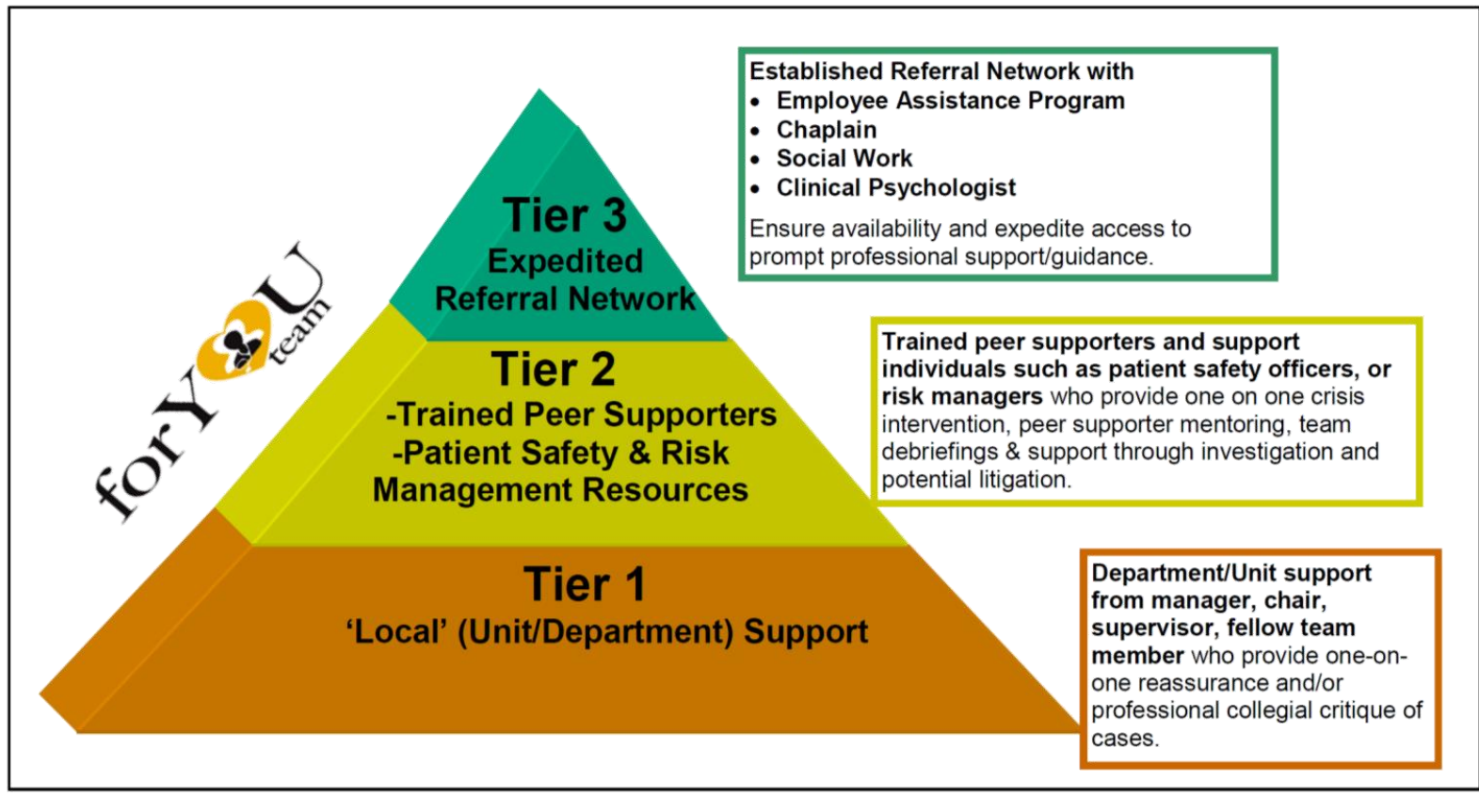
- **Minimize the human toll** when unanticipated adverse events occur.
- **Provide a 'safe zone'** for clinical faculty and staff to receive support to mitigate impact of the adverse event.
- Develop an internal rapid response infrastructure of **'emotional first aid'** for clinicians and personnel following an adverse event.



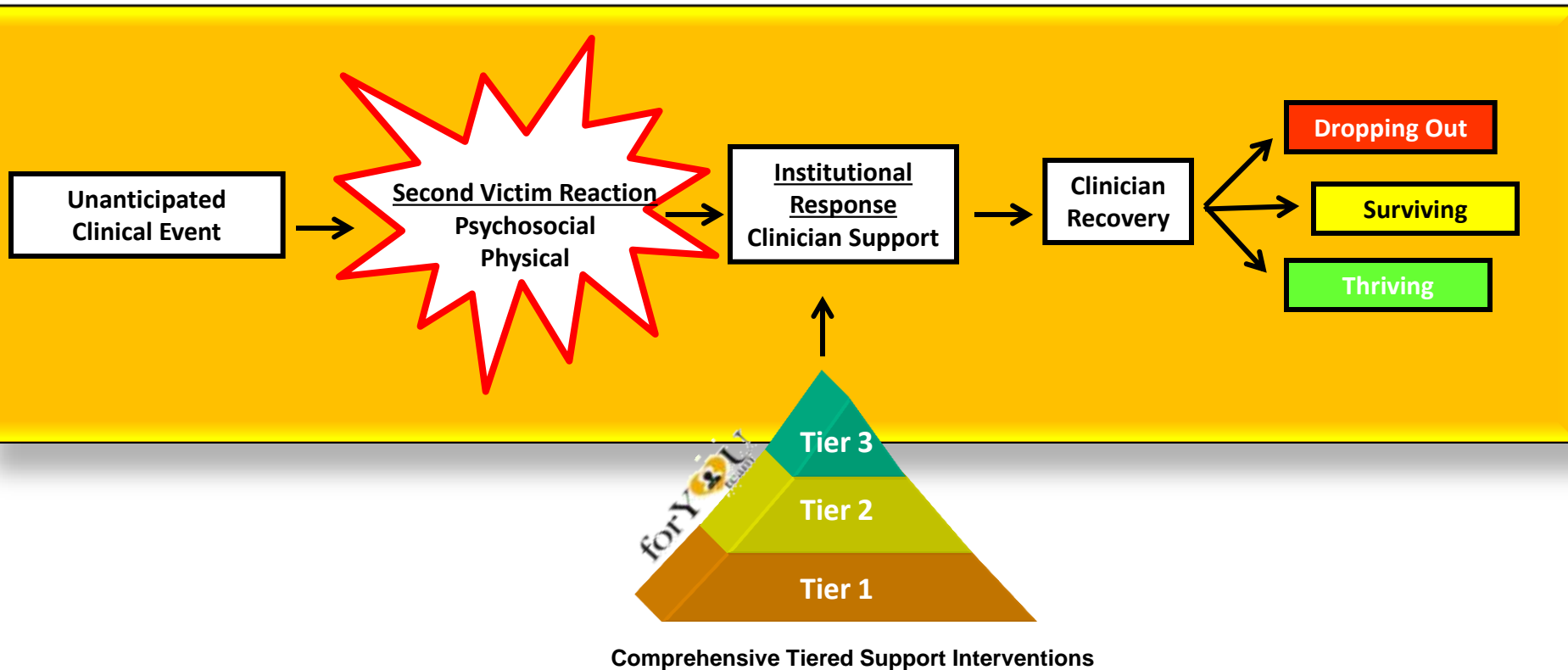


# Support Strategies Interventions

## The Scott Three-Tiered Interventional Model of Second Victim Support



# Second Victim Conceptual Model



# Considerations....

- Humans are fallible
  - Under normal conditions, humans make 5-7 errors/hour
  - Under stressful/emergency conditions, humans make 11-15 errors/hour  
(Doe; 2009 Department of Energy Center for Human Performance)
- Modern approach to patient safety is 'systems thinking' > > > Health care MUST design systems to offset the human fallibility factor
- Clinicians involved in medical errors are deeply affected by the experience





# A NEW Health Care New Paradigm

- Comprehensive plan in place to address the needs of the patient/family, care for health care providers, and investigation process to identify systems issues to address.
- Open discussions of event response plans BEFORE an event occurs
- Promoting an environment of psychological safety – actively surveillance for any potential defects
- Immediate, supportive care for patient/family members
- Active identification of second victims. Immediate interventional support. 'Safe Zones' for sharing concerns/feelings
- Clinician feedback to design stronger, less fallible systems of care



Conway, J. et al., (2009).

# A Closing Thought....



“Any is Too Many.....”

*“The longer we dwell on our misfortunes, the greater is their power to harm us.”* Voltaire

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