



WINTER 2015 – RESILIENCE IN STRESSFUL EVENTS

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One thing health care professionals have in common, across our many disciplines, is that we chose our careers to help patients find a pathway to health or improved quality of life.

We enter our professions with the vague awareness that we will also see patient tragedies, traumas and loss of life, but many of us don't fully appreciate the personal impact and emotional turmoil these unfortunate events can produce — not just on our patients, but also on us. When unanticipated medical errors result in harm to a patient, the event also shakes health care professionals to their core. Sometimes their lives, like the lives of their patients, are forever changed.

An emotional response to adverse clinical events is referred to as a “second victim” phenomenon in the literature. This phrase was coined a decade ago by Wu, a professor of health policy and management at the Johns Hopkins Bloomberg School of Public Health. It's meant to describe the twin casualties caused by a serious medical mistake. The first victim is the patient, the person hurt or killed by a preventable error. The second victim is the person who has to live with the aftermath of making that error.¹

Scott defines a second victim as a “...health care provider involved in an unanticipated adverse patient event, medical error and/or patient injury who becomes victimized in the sense that the provider is traumatized by the event. Frequently, second victims feel personally responsible for the patient outcomes and feel as though they have failed their patients, second guessing their clinical skills and knowledge base.”² In this definition, a health care provider is anyone who provides patient services. Nurses, advanced practice nurses, physicians, allied health clinicians, support service personnel, students, and volunteers can all be second victims.

Do you know of any health care providers you believe are second victims? I'm guessing you personally know of colleagues who have endured the pain of being involved in a medical error that resulted in patient harm. Have you ever felt like a second victim? For those of us who have made errors in the course of our careers, we can relate to the personal stress that they cause, whether or not harm to the patient is the outcome.

I can remember, as clear as if it happened yesterday, a time when I administered an incorrect dose of a medication. As soon as I realized what I had done, I froze in the hall outside the patient's room, paralyzed as I thought through the situation and grappled with the fact that I made the mistake. I felt the heat of panic rise in me

and an immediate wave of nausea wash over me. Running back to the patient's bedside, I stood there processing the fact that I could not reverse my error. I stood by my patient, assessing his vital signs and looking for changes in status. Then the questions began: How could this have happened? Will my error cause harm to the patient? Will I lose my job? Will my license be in jeopardy? Will my colleagues trust me again with patient care? Will I trust myself? Do I need to reveal what I did? Finally, I felt the shame of making a mistake that could potentially harm a patient. And all of this occurred in the first few minutes after I made the error.

Over the course of my career in many hospitals, when the topic of medical errors is discussed, I haven't encountered any colleagues who have said they have not made an error in patient care. I'm not talking about huge errors that cause permanent patient harm, although some colleagues have been involved in these events, but rather small errors that don't result in harm. One of the things I believe is that it is impossible to judge how these events will affect the health care provider; the perception is truly an individual experience. I have been repeatedly struck by the realization that many health care providers benefit from care and compassion offered to them by their colleagues during and after a medical error. Health care, as a profession, has implemented a thorough process to help patients and family members through these events. We have not done as well to provide immediate empathy to the health care provider, and this can be accomplished through a structured approach called Resilience in Stressful Events (RISE).

The RISE Program was developed by our colleagues at Johns Hopkins to provide timely peer support to any staff member who encounters a stressful, clinically related event, in order to facilitate staff resilience and recovery. The objectives of RISE are to:

- ▶ increase awareness of the second victim phenomenon;
- ▶ provide interdisciplinary peer support in a non-judgmental environment;
- ▶ equip managers and employees with healthy coping strategies to promote well-being; and,
- ▶ reassure and guide employees to continue thriving in their professional roles.

In 2011 and 2013, **Ingrid Connerney**, DrPH, MPH, RN, CPPS; **Badia Faddoul**, DNP, RN, CCRN; and **Lyn Murphy**, PhD, MBA, MS, RN, were awarded a UMNursing seed grant to conduct a survey and qualitative study related to the impact of patient-related events among health care professionals at the Medical Center. They found that, after an adverse event, study participants experienced:

- ▶ increased or new onset of anxiety and/or depression;
- ▶ nightmares and changes in sleep patterns;
- ▶ an inability to adequately perform their jobs;
- ▶ the feeling of being shunned by colleagues;
- ▶ desire to leave the medical profession as a whole; and,
- ▶ inadequate support following the adverse event.

continued on page 2.

See Figure 1 below for expected signs and symptoms of distress of second victims.



Figure 1

The hoped-for benefits of RISE are that, through peer support, second victims will experience less “drop out” and less “surviving” and rather more “thriving.” Scott² defines these terms as follows: “Dropping out” means the individual is frequently absent from work, or changes professions, or moves to a different practice location, or sadly, commits suicide. “Surviving” means the individual performs at the expected performance levels with possible residual pessimism or negative attitudes and appears to do “okay” but has interfering thoughts of the event. “Thriving” means the individual can transform and transcend the unfortunate experience to a reframed self-story with new knowledge and wisdom and a continued zest for the profession.

The foundation of RISE is that it provides immediate peer-to-peer support for health care givers who have experienced a stressful patient-related event. This peer support is non-judgmental and confidential and is targeted to the early stages of recovery from stressful events using the concept of psychological first aid (PFA). First used in disaster situations to promote support and stabilization, PFA is an evidence-based modular approach to assist people in the immediate aftermath of a significantly stressful event, to reduce initial distress and to foster short and long-term adaptive functioning. In this model, the aid is not provided by mental health experts, but often by other peers and even volunteers who do receive training to respond in these situations. PFA emphasizes strengths, coping, and connecting strategies. It includes non-intrusive pragmatic care and assesses the immediate needs for coping and daily functioning. PFA does not necessarily involve discussion of the traumatic event. See the PFA components in RISE in Figure 2 below.



Figure 2

As we move forward to implement RISE at UMMC for the support of all health care workers, we are putting out a call for individuals interested in serving as Peer Responders. We have established criteria for Peer Responders (see Figure 3 below) and an application process. We will offer in-depth training. If you are interested, please go to the Nursing and Patient Care Services homepage at <http://intra.umms.org/ummc/nursing> and look for the announcement “Recruitment: Resiliency in Stressful Events” under News.

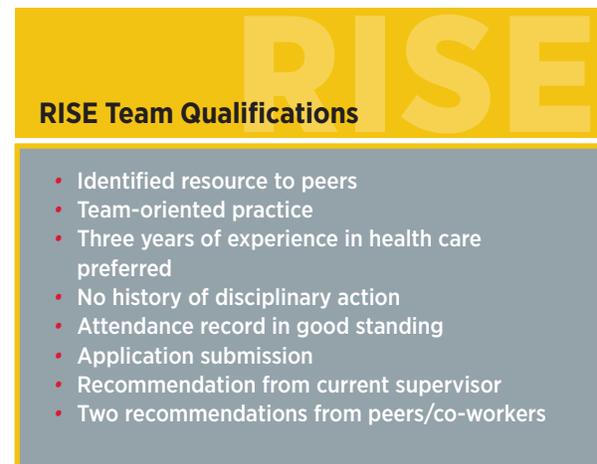


Figure 3

The need for peer-to-peer support is real and important. Think of Kimberly Hiatt, a nurse who made an unintentional error by giving a fragile baby a 1.4 gram dose of calcium chloride instead of the correct dose of 140 milligrams. While it is unclear whether the death of the 8-month-old patient was due to this medication error, it was clear to all involved that Hiatt, a nurse with 24 years of experience, was devastated by the event. It is public record that Hiatt was terminated from her job, that a Washington State nursing commission investigation ensued, and that, ultimately, Hiatt committed suicide. Hiatt’s dismissal and her death raise larger issues and questions about the impact of errors on health care workers, the second victims of medical mistakes.

Donald Berwick, former president and chief executive officer of the Institute for Healthcare Improvement, stated “Health care workers, who get wrapped up in error and injury, as almost all someday will, get seriously hurt too. And if we’re really healers, then we have a job of healing them too. That’s part of the job. It’s not an elective issue, it’s an ethical issue.”³

We believe this is an ethical imperative and demonstrates our support of each other in many ways, with the implementation of RISE being our next venture.

References

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3. Denham, C.R. (2007). TRUST: The 5 rights of the second victim. *Journal of Patient Safety* 3(2), 107-119.