

## INTRODUCTION

❖ Healthcare providers experience physical and psychological distress after a clinical event. These symptoms categorize the providers as Second Victims. The purpose of this project was to pilot Tier 1 of Scott Three-Tiered Interventional Model of Second Victim Support in five adult Intensive Care Units (ICU) in an academic medical center (Scott et al., 2009).

### WHAT IS A SECOND VICTIM?

“Health care providers who are involved in an unanticipated adverse patient event, medical error and/or a patient related injury and become victimized in the sense that the provider is traumatized by the event” (Scott et al, 2009 p.326).

### BACKGROUND & SIGNIFICANCE

❑ A cross-sectional study of surgeons involved in intraoperative adverse events reported a combination of anxiety, guilt, sadness, shame/embarrassment, and fear of litigation (Han et al., 2017).

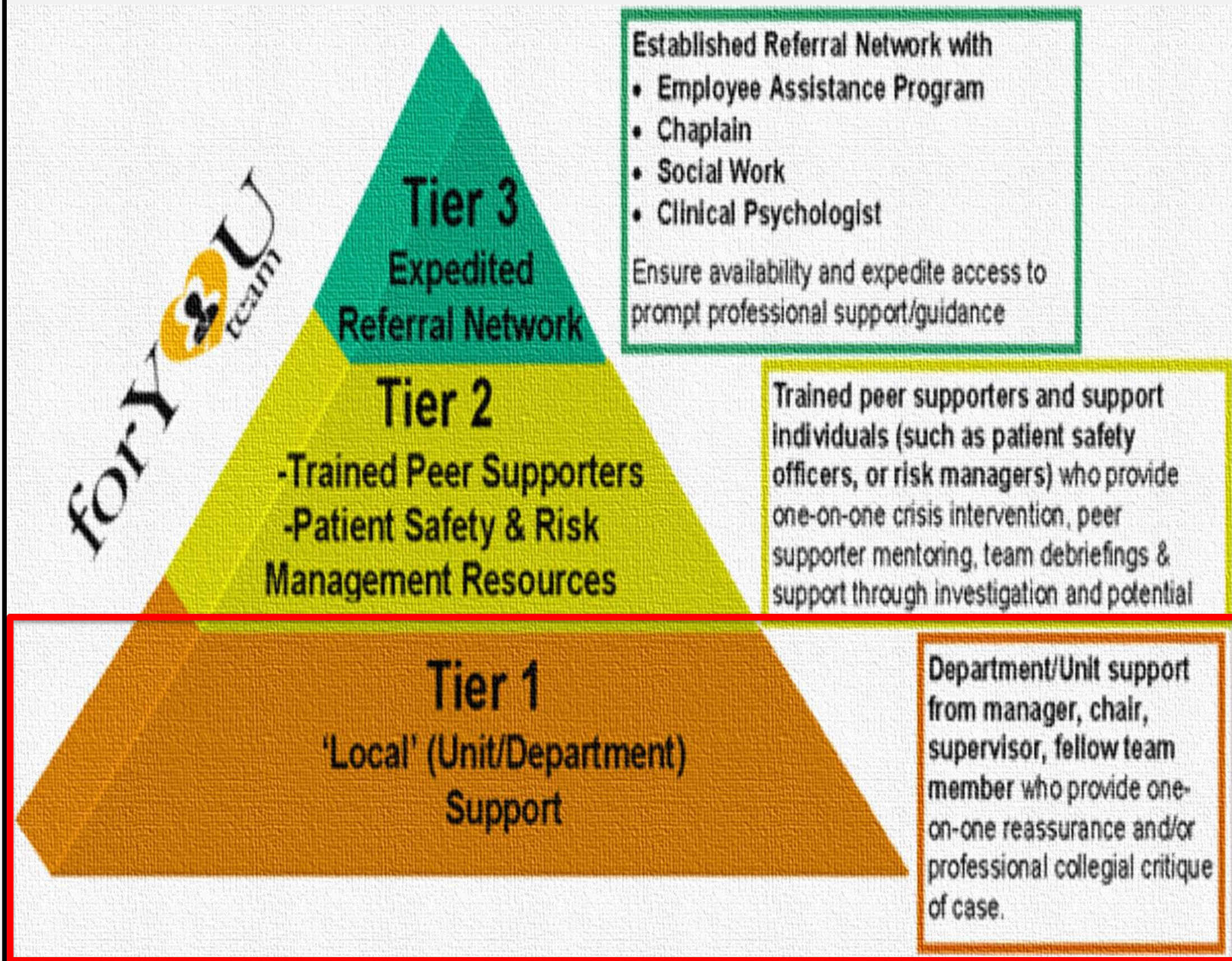
❑ Kimberly Hyatt was a Neonatal Intensive Care Unit nurse, in a Seattle hospital, whose pediatric patient received an incorrect dose of 1.4g of calcium chloride instead of the ordered 140mg. The infant died, and Nurse Hyatt was fired. She isolated herself, became depressed, and later committed suicide. Nurse Hyatt suffered in silence with no support program to turn to (Saavedra, 2017).

❑ The second victim phenomenon has a negative effect on staff retention, and absenteeism (Van Gerven et al., 2016).

❑ A second victim program is a critical element toward safeguarding the well-being of healthcare’s workforce.

## METHODOLOGY

- ❖ Quantitative design. Pilot project at an academic medical center- Level 1 trauma.
- ❖ Purposive convenience sample of 350 healthcare providers in five adult ICUs.
- ❖ Pre and post electronic distribution of the Second Victim Experience Survey Tool.
- ❖ Education to ICU staff/leadership and supporters.
- ❖ Implementation of Tier 1 Interventional Model of Second Victim Support.



- ❖ Data Analysis using SPSS V. 26.
- ❖ Percentage of survey responses and support options.
- ❖ Number and percentage of encounter interactions.

### CONTACT INFORMATION

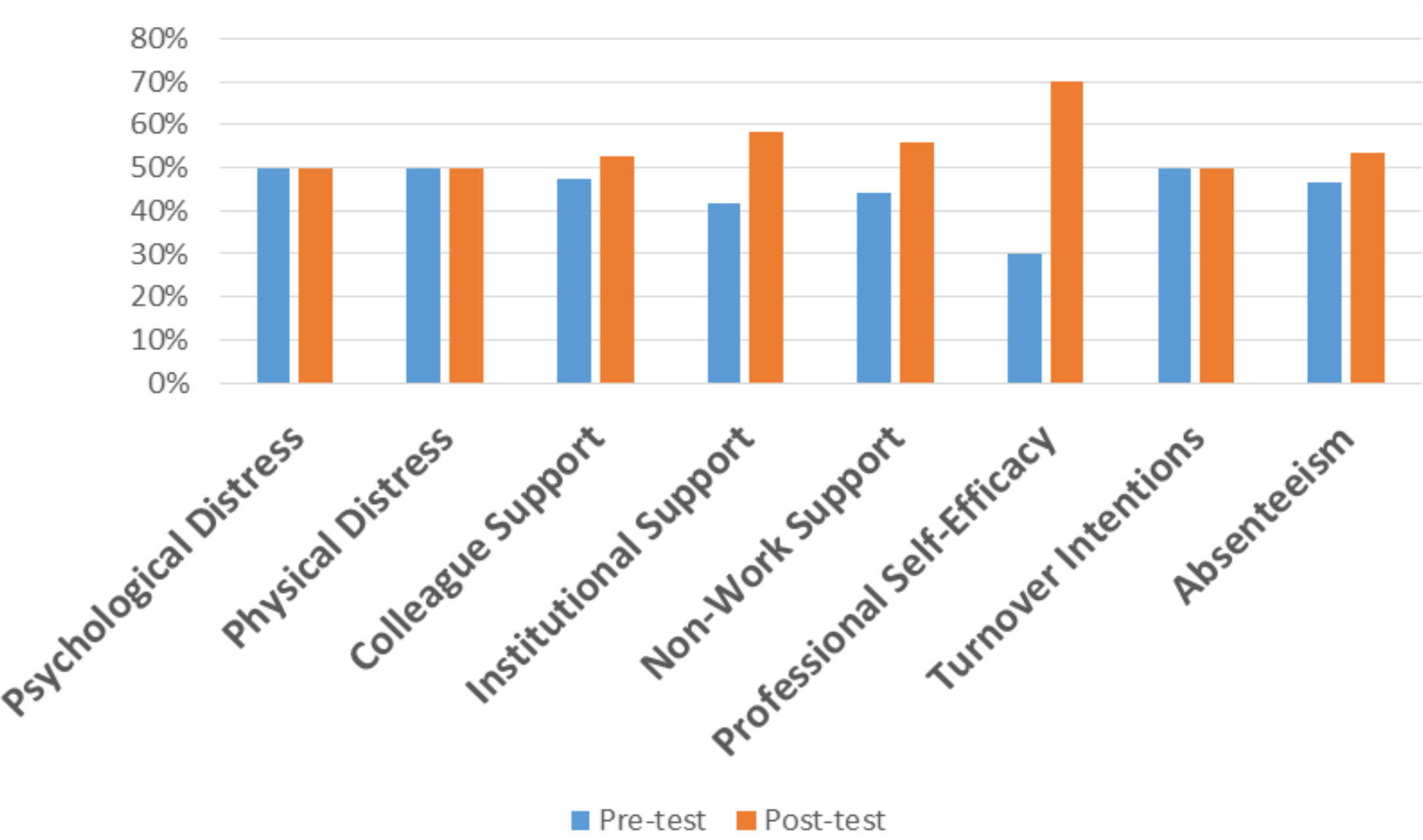
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## RESULTS/FINDINGS

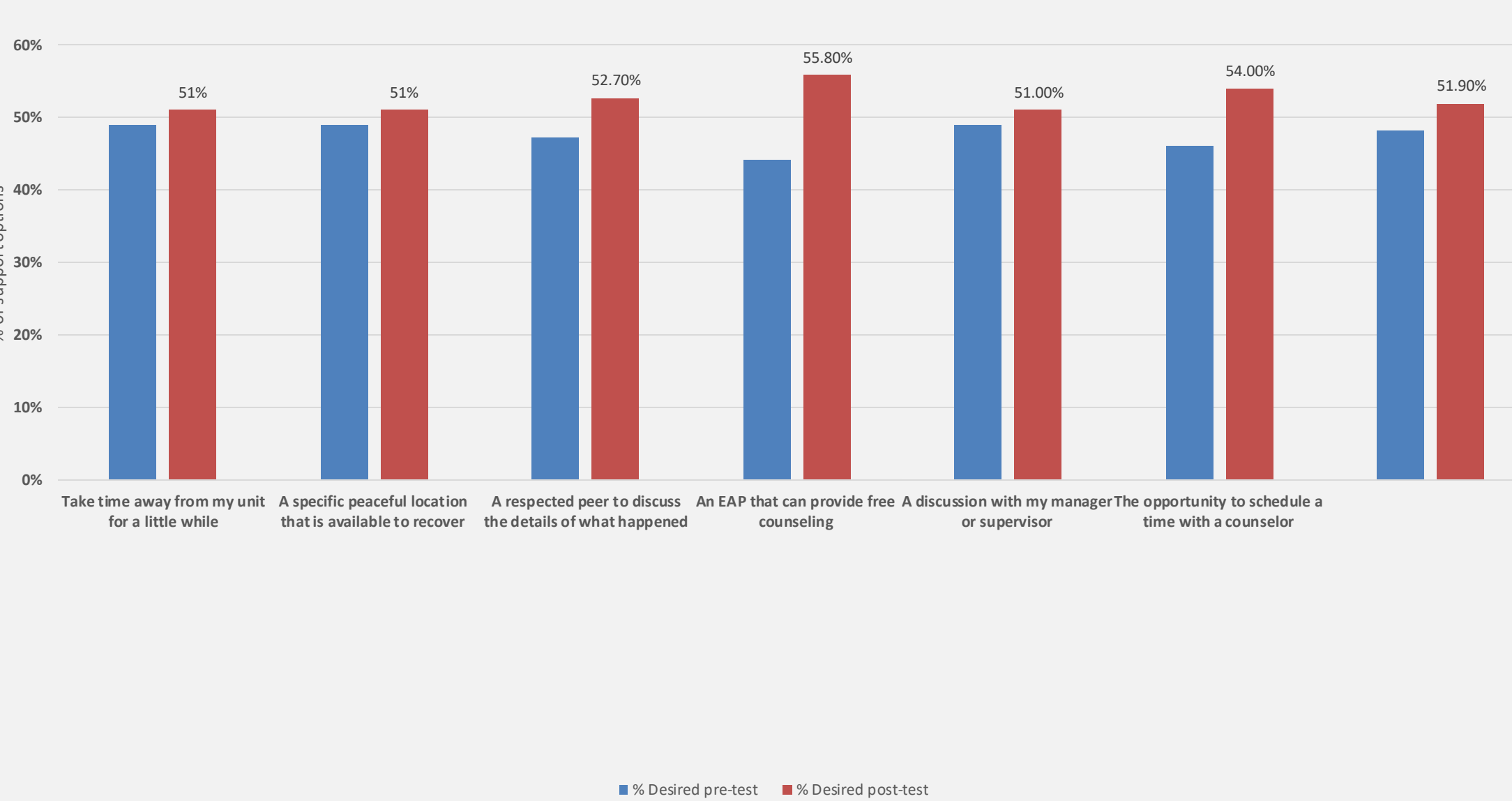
### SECOND VICTIM MEAN SCORES

Group	N	Mean	STD. Deviation	Std. Error Mean
Pretest	26	2.1393	.37184	.07292
Posttest	30	2.2540	.43650	.07969

### SURVEY RESPONSES



### PERCENTAGE OF SUPPORT OPTIONS



## DISCUSSION

- ❖ Demographics of 60 respondents: 73% females, 52% Registered Nurses and 59% > 10 years of service.
- ❖ Distribution of the perception scores revealed a non significant trend in the predicted direction (p=.298), likely due to small sample size.
- ❖ There was a small increase of survey responses and support options in the predicted direction. Not significant due to the small sample size.
- ❖ 23 Encounter Interactions recorded.

## IMPLICATIONS FOR PRACTICE

### Clinical Practice

- ❑ Nurses should assume a leadership role to promote trust, openness and support.
- ❑ Leadership should establish strategies to ensure that second victims survive the episode.

### Healthcare Policy

- ❑ Policy and Procedure to enforce and sustain an organizational support program.

### Quality and Safety

- ❑ A second victim program is an investment toward a just culture environment.

### Education

- ❑ Introduce the concept at the academic level. Provide education during orientation and onboarding.

### Financial

- ❑ Moran et al. (2017) predicted a net monetary benefit savings of \$22,576 per nurse who initiated a RISE call.
- ❑ Future research must examine the return on investment of second victim programs.

## CONCLUSION

The experiences of the second victims are real and can potentially harm the provider, the institution, and the patients.

The findings of this project support the need for specific staff interventions after these clinical events.

An organizational support program will help providers survive a second victim episode and maintain their careers.

This project should be expanded to Tier 2 with 24/7 peer supporters in the Emergency Department.

### REFERENCES AVAILABLE UPON REQUEST