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CENTER FOR PATIENT SAFETY: WHITEPAPER

Center for Patient Safety

Improving Patient Safety: The Intersection of Safety Culture, Clinician and Staff Support, and Patient Safety Organizations

Rebecca G. Miller, MHA, FACHE, CPHQ, CPPS; Susan D. Scott, RN, PhD, CPPS; Laura E. Hirschinger, RN, MSN, AHN-BC

Contributors:
Staci Walters, RN, MSN, CNL, CPPS; Nancy Schanz, RN, MA, MHA, MBA; Celeste Mayer, RN, PhD

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Abstract

Lessons from high reliability industries such as nuclear power and aviation are being adopted in healthcare. A key component of a high reliability organization is a culture of safety that relies upon trust, report and improvement. (Reason and Hobbs, 2003).

One initiative gaining considerable recognition in promoting trust and providing clinician support is a Second Victim Intervention Program. This kind of intervention offers peer support to individual healthcare workers and professionals who are involved in, or victimized and traumatized by, an unanticipated adverse patient event, medical error, or a patient related injury. (MU Health forYOU Team).

Second Victim Intervention Programs demonstrate respect of healthcare workers and an appreciation of the complexity and risk inherent in the healthcare work environment. Additionally, Second Victim Intervention Programs compliment patient safety program activities that assess culture, identify and report adverse events, disclose errors, support patients and families, and take action to reduce repeated errors.

As pioneers of the Second Victim movement, MU Health patient safety researchers established the forYOU Team in 2007. Through a structured system of training, support, documentation and integration with the patient safety program, a dedicated team of frontline peer supporters serve as rapid responders who identify and support second victims. Having supported more than 1,360 second victims, the forYOU Team's success continues building on trust that enables staff to seek help and healing.

Confidentiality, a critical success factor for a Second Victim Intervention Program, must be ensured for peer supporters and second victims. An organization establishing a program and participating in a federally-designated Patient Safety Organization (PSO) can define the program within its Patient Safety Evaluation System (PSES). It can also define program documentation as Patient Safety Work Product (PSWP) to obtain federal level confidentiality protections available through the Patient Safety and Quality Improvement Act of 2005 (PSQIA).

Opportunities to implement and integrate a Second Victim Intervention Program within an organization's PSES through PSO participation (and next steps) are discussed within this paper.

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High Reliability Organizations (HROs)

Historically, the concept of a safety culture arose from high risk and complex industries such as nuclear power and aviation; industries where the safety of the public and workers depends upon implementing highly reliable processes to reduce and eliminate error. Such industries forged the way for the growth and understanding of the importance of a safety culture in healthcare and its adoption of high reliability processes. (Hines, Lofthus, et al. April 2008).

HROs operate in unforgiving social and political environments; where technologies are risky and present potential for error; the scale of possible consequence from mistakes can preclude learning through experimentation; and lastly they require complex processes to manage complex technologies and complex work to avoid failure. (Wikipedia).

Certainly, healthcare meets this definition: It involves extremely complex regulations; increasing complexity of diagnosis, disease management and treatment; and increasing complexity of human interactions in high stress situations.

A culture of safety that supports high reliability has three central attributes: trust, report, and improve. (Reason and Hobbs, 2003).

- Workers exhibit enough trust in their peers and the organization that they routinely recognize and report errors and unsafe conditions.
- Trust is established when the organization eliminates intimidating behavior that suppresses reporting, acts in a timely way to fix the problems, communicates improvements to those who reported the problems and supports staff.
- When all three attributes of a safety culture are working well, they reinforce one another and produce a stable organizational culture sustaining high reliability. (Chassin and Loeb 2014).

A Safety Culture

Safety culture is the foundation for quality and performance improvement wherever healthcare is provided. Safety culture is:

> *"...the product of individual and group values, attitudes, perceptions, competencies and patterns of behavior that determine the commitment to, and the style and proficiency of, an organization's health and safety management. Organizations with a positive safety culture are characterized by communications founded on mutual trust, by shared perceptions of the importance of safety, and by confidence in the efficacy of preventative measures." (Health and Safety Commission of Great Britain, 1993).*

Culture is palpable--from leadership through every level of the organization and to patients, families and anyone entering the healthcare setting. As a component of highly reliable care, the importance of measuring, evaluating and improving the safety culture gains increasing importance, particularly since culture impacts financial strength, patient and staff satisfaction, quality and safety processes, staff turnover and outcomes. (Hughes, March 2008), (Wolosin, 2008), (Weaver, Lubomski, et al., March 2015).

Most hospitals assess the safety culture using a variety of survey tools; the most widely used being the Agency for Healthcare Research and Quality's (AHRQ) Survey on Patient Safety Culture (SOPS), a validated tool allowing for comparisons and national benchmarking on key safety culture domains. (AHRQ, 2014 User Comparative Database Report. March 2014).

The national SOPS database ($n > 400,000$) and Center for Patient Safety SOPS surveys ($n > 26,000$) identify consistently low scores on key safety culture aspects that impact individual staff; these include teamwork, communication and, importantly, a non-punitive response to error. Table 1.

A non-punitive response to error is the extent to which staff are not blamed when a patient is harmed, are treated fairly when they make mistakes, and feel safe reporting mistakes. A non-punitive response to error is critical to the success of a Second Victim Intervention Program.

Table 1. National SOPS Database, CPS Database, Hospital Results

HOSPITAL DIMENSION	CPS 2012 POSITIVE RESULTS	CPS 2014 POSITIVE RESULTS	POSITIVE RESPONSE TREND	AHRQ 50TH PERCENTILE	AHRQ 90TH PERCENTILE
Handoffs & Transitions	**32.2%**	**37.2%**	**+5.%**	*46%*	*63%*
Nonpunitive Response to Error	**34.8%**	**41.4%**	**+6.6%**	*43%*	*56%*
Teamwork Across Units	51.7%	**49.3%**	**--2.5%**	*59%*	*75%*
Staffing	**51.7%**	52.9%	**+1.2%**	*55%*	*68%*
Management Support for Patient Safety	65.7%	57.4%	**--8.3%**	*72%*	*84%*
Overall Perceptions of Patient Safety	62.5%	59.8%	**--2.7%**	*66%*	*77%*
Communication Openness	59.2%	60.0%	**+.8%**	*62%*	*71%*
Organizational Learning—Continuous Improvement	**69.9%**	61.4%	**--8.5%**	*73%*	*82%*
Feedback & Communication About Error	62.4%	62.5%	**+.1%**	*66%*	*78%*
Frequency of Events Reported	62.6%	**63.8%**	**+1.2%**	*65%*	*76%*
Supervisor/Manager Expectations & Actions Promoting Patient Safety	**72.9%**	**74.1%**	**+1.2%**	*76%*	*84%*
Teamwork within Units	**82.4%**	**76.0%**	**--6.3%**	*81%*	*88%*

Results in **green** indicate areas of most success. Results in **red** are lowest results, identifying priority areas for improvement.

Assessment tools are also available for nursing homes, medical offices, ambulatory surgery centers and pharmacies. Similar safety culture concerns are identified in nursing homes that show low percentage positive ratings for a non-punitive response to error, in medical offices showing concern about work pressure and communication openness and in pharmacies that also show concern about work pressure as well as response to mistakes. These are all settings in which individual clinicians and staff members are impacted by unanticipated outcomes. (AHRQ, Surveys on Patient Safety Culture, April 2015).

As discussed by Reason and Hobbs, high reliability organizations have a culture of safety with attributes of trust, report and improvement. Trust among staff, managers and leaders is imperative for a culture of safety. It promotes reporting and communication about safety issues and concerns, as well as mutual support for caregivers, patients and families. Second Victim Intervention Programs fill a gap in support by providing individual support to caregivers who work in a highly stressful and complex environment—caregivers whose actions and decisions affect co-workers, patients and their families, as well as their own family members.

The Second Victim Phenomenon

In today's complex healthcare settings, clinicians face a multitude of demands requiring personal resiliency that relies on emotional defenses to carry them through the workday, "to get the job done." Sometimes an unexpected patient outcome intensifies the emotional aftershock (or stress reaction) making it impossible for the clinician to focus on the task at hand. If not addressed, the emotional suffering may be prolonged, resulting in self-doubt regarding their future as a healthcare professional. This emotional response has been described as the second victim phenomenon. (Wu, 2000).

MU Health patient safety and risk management experts in Columbia, Missouri have been studying the impact of unanticipated clinical events on clinicians since 2007. The team defined second victims as:

> *"healthcare 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. Frequently, these individuals feel personally responsible for the patient outcome. Many feel as though they have failed the patient, second guessing their clinical skills and knowledge base." (Scott et al., 2009, pg. 326).*

Even though individuals respond to unexpected clinical events in a wide variety of ways, there is a predictable pattern of recovery. This recovery trajectory is delineated into five specific stages and an outcome period. (Scott et al., 2009).

1. chaos and accident response
2. intrusive reflections
3. restoring personal integrity
4. enduring the inquisition
5. obtaining emotional first aid.

The sixth outcome period is known as "moving on." There are three potential pathways in this period: thriving, surviving, and dropping out.

As the clinician recovers in the aftermath of the unexpected clinical event, it is quite common for clinicians to experience a variety of reactions, including physical and psychosocial symptoms.

Table 2 provides an overview of commonly reported symptoms. These responses are normal reactions to an abnormal and unanticipated patient event or outcome. Signs and symptoms of the second victim experience may last a few days, a few weeks, a few months, or longer.

Analysis of 1,075 peer support events at MU Health Care revealed specific clinical situations that evoke a second victim reaction. (Hirschinger, Scott, & Hahn-Cover, 2015).

The top six risk factors include:

1. pediatric cases
2. multiple patients with bad outcomes
3. unexpected patient demise
4. young adult healthy patient
5. patient known to the staff
6. first death on "their watch."

Understanding staff vulnerabilities and having a proactive surveillance plan for these patient types will contribute to prompt identification of potential second victim reactions.

Clinician Support

Although individual clinicians have unique second victim support needs they all desire similar structures of basic emotional support. Based on qualitative interviews of thirty-one identified second victims it became apparent that clinicians desired specific supportive response from their respective healthcare institution (Scott et al., 2010) (Scott et al., 2009).

Table 2. Commonly Reported Second Victim Symptoms

Physical Symptoms	Psychosocial Symptoms
Diarrhea	Anger and Irritability
Difficulty Concentrating	Depression
Eating Disturbances	Extreme sadness
Fatigue	Fear
Headache	Feeling Numb
Muscle Tension	Flashbacks
Nausea/Vomiting	Frustration
Rapid Breathing	Isolation
Rapid Heart Rate	Self-Doubt
Sleep Disturbances	Uncomfortable returning to work

Prior to a safety event, clinicians expressed a strong desire to understand the processes related to adverse clinical event investigations as well as institutionally sanctioned support networks. After a safety event, clinicians desired supportive peers who would provide compassion and understanding in a confidential manner within the context of the clinical work environment. They also desired predictable internal support be available at all times.

In some situations there is also a recognized need for a brief respite allowing the provider to regroup and compose self. The clinicians also desired a safe and just culture approach during a systematic review of the clinical event promoting an objective, complete review of case with the opportunity for clinician feedback and reflection on care delivered.

To provide predictable and comprehensive clinician support in the aftermath of an adverse clinical event, MU Health patient safety researchers designed an innovative evidence-based approach, known as the forYOU Team. This peer-based method uses a second victim caring moment to mitigate individual clinician suffering. (Hirschinger, Scott, & Hahn-Cover, 2015).

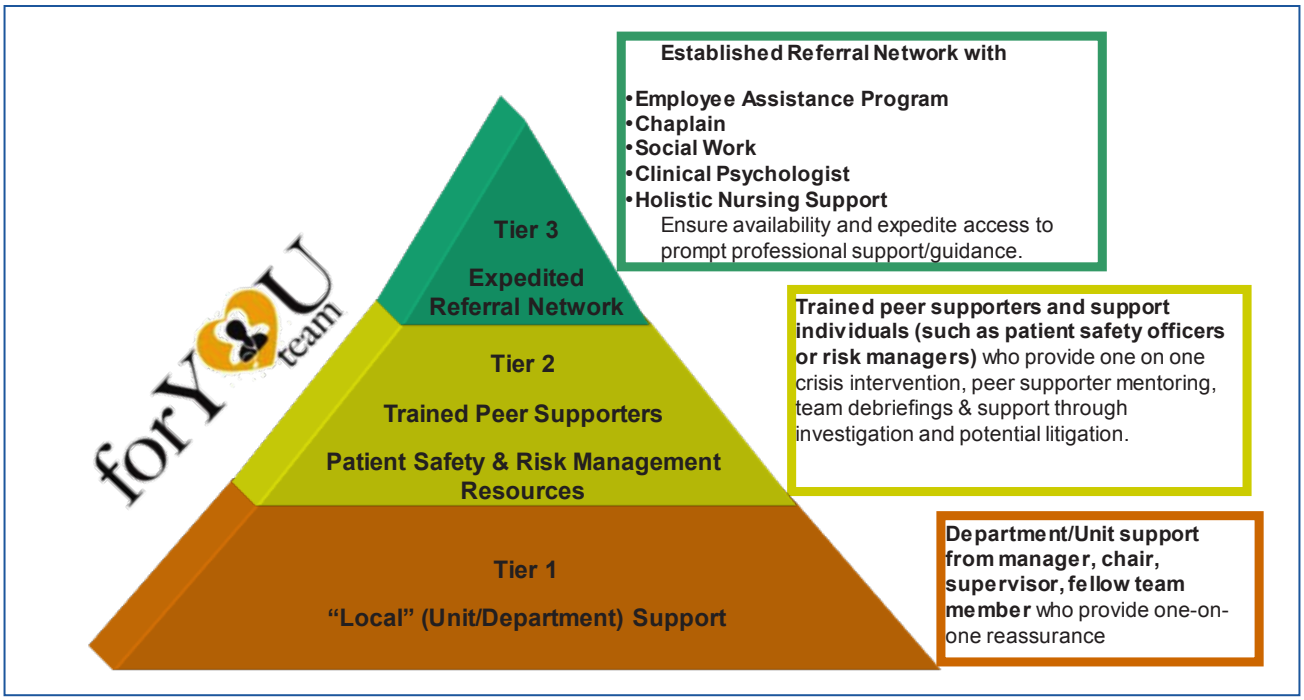
The caring moment integrates provision of comfort measures, promotion of well-being and healing techniques using a comprehensive three-tiered approach. (Scott et al., 2010). Figure 1.

The model entails continuous surveillance during high-risk clinical events by clinical leaders and colleagues or peers trained in the second victim phenomenon. It also involves instant deployment of supportive techniques once a potential second victim is identified. The forYOU Team members are peers who are familiar with the second victim phenomenon, with the aim of ensuring that the interaction contributes to clinician recovery with prompt access to professional counseling resources if warranted.

The vast majority of peer support occurs during the team member's daily work routine. Peer supporters are responsible for identification of possible second victims and have been trained to provide one on one support. In the event that a second victim requires more intense assistance or additional support, the peer supporter can refer to a cadre of counseling resources.

One-on-one support is the interaction between the trained peer supporter and the second victim. This interaction typically takes place within hours of the event or it may occur day(s) after the event. The first interaction allows the second victim to discuss feelings and reactions with the goal of reducing overall stress as well as facilitating an understanding

Figure 1. Scott's Three Tier Interventional Model of Second Victim Support



of the typical response the second victim may experience. Peer support may consist of one to three contacts with the second victim. Each contact may last 15 minutes to 30 minutes, depending on the severity of the event. This discussion is confidential and is conducted without judgment. The focus is on the second victim's personal response to the situation not the specific clinical details of the event. If the second victim would like to discuss clinical improvement aspects, this request is directed to the forYOU team leader for immediate referral to Patient Safety/Risk Management.

In addition to one-on-one support, occasionally an entire care team is adversely affected by an event. In these situations, emotional group debriefings are offered by the forYOU Team. They are facilitated by individuals who have further training in group crisis intervention. The debriefing is not a critique of an incident or performance, but a brief conversation about the event just experienced and the emotional impact that the care team may be experiencing. Confidentiality is assured and maintained during these discussions.

To monitor forYOU Team performance, a generic data collection tool was designed with guidance from General Counsel. (Hirschinger, Scott, & Hahn-Cover, 2015).

The purpose of this document is to capture second victim risk factors and insights into interventional measures in a de-identified manner. Specific "supportive interventional" information is documented by the peer supporter. No event specific notes are recorded–only basic information impacting peer support. Figure 2 is an example of a completed peer encounter form.

Figure 2. Example, Completed forYOU Peer Encounter Form

forYOU team

INTERACTIONS **Peer Supporter:**

Health Care
University of Missouri Health System

Activation: ☒ New ☐ Mentoring (No direct support provided) **Date of Interaction:** 6/25/15 **Length of Interaction:** 40min

Professional Type: ☐ MD/DO ☒ RN/LPN ☐ Respiratory Therapy ☐ Pharmacist ☐ EMT-P/EMT ☐ Other

Event Type: ☐ Unanticipated Patient Outcome ☐ Adverse Event (Medical Error) ☐ Personal/Professional Crisis ☐ Other

Event Outcome	Risk Factors	
☐ No Harm	☒ Community high profile	☐ Palliative Care
☐ Temporary Harm	☐ Death of a staff member or their spouse	☐ Patient known to staff members
☐ Permanent Harm	☐ Failure to Rescue	☐ Patient that reminds staff of their family
☒ Death	☐ First death under their "watch"	☐ Patient victim of violence
☐ Other	☐ Litigation	☒ Pediatric case (21 years & younger)
	☒ Long term patient	☐ Unexpected patient demise
	☐ Medical error	☐ Young adult patients
	☐ Multiple patients with poor outcomes	☐ Other
	☐ Organ donation	

Referrals	Peer Reflections (No Specific Case Detail)
☒ No Referral Made	Reviewed feelings - √ coping mechanisms
☐ Chaplain	
☐ Clinical health Psychologist	
☐ Employee Assistance Program (EAP)	
☐ Personal Counselor	
☐ Risk Management/Patient Safety Team	

☒ Follow-Up #1 **Date of Interaction:** 6/27/15 **Length of Interaction:** 15 min

Referrals	Peer Reflections (No Specific Case Detail)
☒ Not Needed	
☐ Chaplain	
☐ Clinical Health Psychologist	
☐ Employee Assistance Program (EAP)	
☐ Personal Counselor	
☐ Risk Management	

☐ Follow-Up #2 **Date of Interaction:** **Length of Interaction:**

Referrals	Peer Reflections (No Specific Case Detail)
☐ Not Needed	
☐ Chaplain	
☐ Clinical Health Psychologist	
☐ Employee Assistance Program (EAP)	
☐ Personal Counselor	
☐ Risk Management	

Example

Information contained in this document is privileged and confidential and may be shared only with individuals defined as the "workforce" of University of Missouri Health Care within our facility's Patient Safety Evaluation System (PSES).

Integrating Second Victims and Safety Culture Assessment

Historically, second victim research has focused primarily on the experience and effects, both short and long term, on the individual clinician. An MU Health study focused on the relationship of second victim support (or lack thereof) and the impact on clinician perceptions of the patient safety culture. (Scott, 2015).

The research, representing the first quantitative study addressing the impact of clinician support on a healthcare organization, was a longitudinal study. Its goal was to gain insight into how patient safety attitudes and perceptions at the unit and system level were influenced by second victims who received support and those who did not.

Data obtained using the AHRQ SOPS assessed the patient safety culture of the healthcare system by analyzing differences between clinician groups. To identify the clinician groups, two additional questions were added to the AHRQ Hospital SOPS survey:

1. *"In the last 12 months, were there any patient safety events that caused you personal problems such as anxiety, depression or concerns about your ability to do your job?"*
2. If the clinician responded "yes" to this question, they were considered a second victim. A subsequent question was then asked to determine perceived levels of institutional support, *"Did you receive support from anyone within the MUHC system?"*

The initial survey period (2007) served as baseline data prior to deployment of the forYOU Team. Three subsequent surveys (2009, 2012 and 2013) assessed clinicians' overall perceptions of patient safety. The surveys used the 12 safety dimensions and the overall patient safety grade as the outcome variables with non-victims, second victims with support, and second victims without support serving as the independent variable.

Results for individual dimensions and overall safety grade were analyzed across time. Mean scores for non-victims and supported second victims were similar across each of the measured dimensions. They were also higher than non-supported second victims' scores in all 12 dimensions, including the overall safety grade (statistically significant difference, $p<.001$, was noted in all 12 dimensions).

The four survey period results also demonstrated clear differences in the dimension scores of supported second victims over time as the forYOU Team matured and grew in size of peer supporters. Table 3.

The study underscores the significance of clinician support in the aftermath of unanticipated clinical events. It shows the significance of the MU Health patient safety initiative by revealing a direct relationship between clinician support and future perceptions/attitudes within the context of the local work environment up to and including the organizational level. The forYOU Team peer interactions and discussions have been pivotal to the evolution of MU Health's patient safety transformation and considered a valuable component of its Patient Safety Evaluation System.

Patient Safety Organization (PSO) Support for Second Victim Intervention Programs

The Patient Safety and Quality Improvement Act (PSQIA) is intended to support a culture of safety by encouraging reporting of and learning from adverse events, near misses, unsafe conditions and other related patient safety activities. A key aspect of the PSQIA is the provision of federal-level confidentiality and legal protections that encourage such reporting, learning and sharing among healthcare providers and professionals participating in a PSO. PSOs certify with the AHRQ by performing "required patient safety activities," defined within the PSQIA to support quality and patient safety improvement. These activities include collecting and analyzing Patient Safety Work Product (PSWP) submitted by PSO participants, developing and disseminating learning gained from the review and evaluation of PSWP and maintaining confidentiality of the PSWP.

PSO participating organizations define their own Patient Safety Evaluation System (PSES) to delineate patient safety activities that produce PSWP with the intent of reporting to a PSO. PSWP refers to information related to patient safety activities assembled for reporting to a PSO. The PSES can include a variety of patient safety and quality improvement activities; for example, findings from

adverse event analysis, meeting minutes that include discussion of patient safety and quality data and, sharing of learning about the structure and process for providing Second Victim support. (Patient Safety and Quality Improvement Act of 2005, Pub. L. 109-41, 42 U.S.C.), (Patient Safety Rule, 42 CFR Part 3).

PSOs not only establish a culture that encourages reporting and sharing of safety events and learning; they also support open communication and transparency about errors within and across organizations, an opportunity not otherwise available to proactively prevent medical errors. (Kendig, Miller 2012).

Table 3. MU Health Culture Survey Mean Scores, Aggregated Across Four Survey Periods (n=4,228), representing nursing and allied healh professionals

Dimension	Dimension Title	Mean Scores *[Range 1-5]*		
		Second Victim Support YES (SV +)	**Second Victim Support NO (SV-)**	**Nonvictim**
1	Teamwork within units	4.14	3.42 +*	4.01
2	Supervisor/Manager Expectations & Actions Promoting Patient Safety	3.93	3.07 +*	3.87
3	Management Support for Patient Safety	3.67	2.82 +*	3.61
4	Organizational Learning - Continuous Improvement	3.84	3.10 +*	3.73
5	Overall Perceptions of Patient Safety	3.53	2.71 +*	3.62
6	Feedback & Communication About Error	3.50	2.85 +*	3.61
7	Frequency of Events Reported	3.26	2.87	3.53
8	Communication Openness	3.73	2.98 +*	3.67
9	Teamwork Across Units	3.31	2.72 +*	3.36
10	Staffing	3.28	2.61 +*	3.38
11	Handoffs & Transitions	3.01	2.61+*	3.14
12	Nonpunitive Response to Errors	3.33	2.43 +*	3.17
Overall Safety Grade	'Give your work area/unit an overall grade on patient safety.'	3.58	3.01+*	2.94

+ Statistical difference <.0001 [SV+ to SV- Support]
*Clinically meaningful – mean score difference >0.40 [SV + to SV–]

Supporting Second Victims through PSO Participation – An Example

The University of North Carolina Medical Center developed a Second Victim Intervention Program modeled from the MU Health forYOU Team program in 2014. Although volunteers indicated during the first training that they were willing to risk the potential of a future subpoena for the higher good of supporting a peer, concern was expressed about the confidentiality of the peer-to-peer conversations, given that peer conversations were likely to include information about the event that occurred and other personal information. Volunteers felt if they were the person needing support, confidentiality and protection of the conversation were important and it could influence their decision to seek or not seek healing support.

This sentiment was observed in reality when two professionals who were offered support declined, specifically because of fear of discoverability of the conversation. Leaders of the UNC Second Victim Intervention Program sought consultation from the NC Quality Center Patient Safety Organization and national PSQIA experts, resulting in knowledge that Second Victim supportive conversations could be maintained confidentially and protected under the PSQIA as a patient safety activity. Given that Second Victim Intervention Programs are new in healthcare, sharing how PSOs can support them contributes to further implementation and enhanced national patient safety improvement. Best practices to integrate Second Victim Intervention Programs with PSO participation involve having policies in place that describe the organization's PSES and the organization's Second Victim Intervention Program as a patient safety activity along with what will be reported to the PSO. See Exhibit 1 - UNC Health Care Peer Support Convening Policy.

Exhibit 1 - UNC Health Care Peer Support Convening Policy

Sample - UNC Health Care Peer Support Convening Policy

Second victims are caregivers closely associated with a serious adverse patient event who may experience emotional trauma that may also affect their ability to provide safe patient care in the future as a direct result of the emotional distress experienced. These individuals may benefit from Peer Support.

This protocol defines the process for Peer Support Convening Sessions to meet this need.

Convening refers to established guidelines for assembly of a Peer Support Volunteer Patient Safety Evaluation System (PSES) workforce* and a healthcare professional for the purpose of supporting the healthcare professional to become resilient and learn from the incident to become a better clinician. The program is designed to hold confidential discussions that are intended to improve the quality of patient care and development of best practice recommendations related to the support of second victims in the workplace. Members of the UNC Peer Support Volunteers PSES Workforce will complete a survey following convening sessions to evaluate the structure and process of convening for continuous quality improvement and for the purpose of reporting a summary of the evaluation to the North Carolina Quality Center Patient Safety Organization (NCQC PSO).

1. **Education of Second Victim Program Participants:** Training on the Confidentiality Provisions of the Patient Safety Quality Improvement Act (PSQIA) for all UNC Peer Support Volunteers PSES Workforce shall occur at the time of initial Second Victim Program training and for the healthcare professional receiving support, shall be provided at the beginning of the first convening session.
2. **Conduct of Convening Session:** Convening sessions shall occur within the UNC's PSES. The convening must begin with education on the confidentiality protections for the discussions. No documentation of the meeting or conversation shall be developed. All communications are Patient Safety Work Product (PSWP).
3. **Reporting to the PSO:** Periodically, a summary of the Peer Support program evaluation survey will be reported to the North Carolina Quality Center Patient Safety Organization (NCQC PSO).

* Reference the Peer Support Volunteer Patient Safety Evaluation System (PSES) workforce in the organizational PSES policy.

Strategies to Implement a Second Victim Intervention Program

Any individual in any healthcare setting can be impacted by unanticipated adverse events. Healthcare is a high impact, complex, high intensity profession. How can organizations develop and benefit from a Second Victim Intervention Program, integrate the program within their patient safety program and ensure confidentiality and privileged protection for second victims and peer supporters?

Characteristics of a Successful Second Victim Program

- √ An understanding of the organization's safety culture strengths and weaknesses.
- √ Leadership commitment and support for peer supporters and second victims, including support of training and other time and resources required for peer supporters and second victims to be successful.
- √ Strong program leadership and team commitment by individuals serving as peer supporters.
- √ Safety and confidentiality for second victims seeking support through the program for sharing of issues, concerns and vulnerabilities.
- √ Ability to hard-wire the program within the organization and grow the program to meet ongoing needs of second victims.

Implementation Strategies

- Assess the culture for patient safety within the organization, ideally at the department and unit level. Consider including questions about staff perceptions of support when they are impacted by unanticipated events and, if a Second Victim Intervention Program is in place, evaluate the impact of the program over time.
- If participating with a PSO, consider how the Second Victim Intervention Program can be integrated within the organization's PSES to further support confidentiality, learning and healing. If not participating in a PSO, consider the benefits of participation especially the ability to create a "safe environment" for both the second victim and peer supporter.
- Train leaders and peer supporter team. Identify a leader and team to implement the program and obtain training for them. Toolkits and articles are available on Second Victim Intervention Programs to assist in implementation and understanding. Attendance at periodic train-the-trainer sessions is encouraged and participation in webinars and in-person presentations is beneficial. (MU Health forYOU Team), (Center for Patient Safety Website), (Medically Induced Trauma Support Services Website).
- Establish policies, processes and documentation requirements for the program, defining how the program integrates with the organization's patient safety program and within its PSES, as applicable. This may include a policy, similar to the UNC Health Care Peer Support Convening Policy, to establish guidelines to assemble a peer support workforce to work with healthcare professionals through confidential discussions to improve the quality of care and develop best practices to support second victims in the workplace.
- Establish a structure for the program including defining characteristics and attributes of peer supporters, seek volunteers to serve as peer supporters and acknowledge and recognize their work in the program.
- Promote the program within the organization to ensure all workers are aware of and have easy access to the program and the support that is available for them.
- Use a Plan-Do-Study-Act or other performance improvement cycle to evaluate the program on an ongoing basis and identify improvement, expansion and enhancement opportunities for victim support and healing.
- Consider program expansion through integrated networks for other providers including ambulatory, ancillary, home care, skilled care and other settings.

Tying Safety Culture, Second Victims and PSO Processes Together

Regardless of efforts undertaken to implement highly reliable processes, healthcare will always have a human component and the potential for error. Healthcare will also always involve highly complex and unique situations and circumstances, as well as emotions on the part of individuals receiving care, their loved ones and clinicians and staff who work with patients. How can support be provided for all of these individuals to improve safety processes, outcomes and well-being of patients and staff?

This paper has explored the concepts of high reliability organizations relating to healthcare, the importance of evaluating and improving the safety culture for patients and staff, elements of a successful program supporting caregivers involved in unanticipated events and how the PSQIA establishes a federal structure supporting safety process and outcome improvement.

How do these elements tie together?

- √ A high reliability organization must have a laser target on continuously improving the culture of safety.
- √ Safety culture must be measured and action taken to address vulnerabilities.
- √ Staff must feel safe and supported in order to believe in and support improvement in the safety culture.
- √ To feel safe and supported individuals must be comfortable with reporting and talking about their role in and personal impact of unanticipated events.
- √ Learning and healing from unanticipated events is dependent upon the willingness of individuals and organizations to safely and openly report and evaluate events.
- √ PSOs further support a safety culture allowing for reporting and sharing of safety concerns, including the personal impact and potential for individual healing of those involved in and impacted by adverse events and other unanticipated clinical outcomes.
- √ PSOs are intended to not only work with participating organizations to report adverse events, but also to support programs that increase learning, improve quality and patient safety and reduce errors, programs like Second Victims.

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