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ABSTRACT

Background: Second victims (SVs) are health care workers traumatized by unanticipated, adverse patient events. These experiences can have personal and professional effects on SVs. Research indicates that SVs experience inadequate support following adverse events.

Purpose: To determine the prevalence of nurses who identified as SVs and their awareness and use of supportive resources.

Methods: A convenience sample of nurses was surveyed, and SV responses were compared with those who did not identify as a SV. Responses were analyzed using nonparametric methods.

Results: One hundred fifty-nine (44.3%) of 359 participants identified as SVs. There was a significant relationship between work tenure and SVs ($P = .009$). A relationship was found between SVs and awareness and use of support resources, with debriefing being the preferred method after an event.

Conclusions: Adverse events trigger emotional trauma in SVs who require administrative awareness, support, and follow-up to minimize psychological trauma in the clinical nurse.

Keywords: adverse event, medical error, nurses, second victim, supportive resources

Second victims are nurses, physicians, and other health care workers involved in an unanticipated adverse event, a medical error or patient-related injury.[1] They become victimized and traumatized by an event and can feel personally responsible for patient outcomes.[1] Identifying and recognizing second victims can be challenging, as many suppress their feelings due to the perceived stigma of seeking help from peers and others.[2] A health care organization that identifies and shares preventive strategies with members of its workforce could help nurses minimize the psychological trauma, cope more effectively, and return to clinical duties with a feeling of support and confidence following an adverse patient event. To provide quality patient care, nurses need to know that they too are cared for.

The purposes of this study were to (1) determine the prevalence of nurses who see themselves as second victims; (2) identify whether the support provided in the workplace following an adverse event was helpful; and (3) determine whether nurses were aware of available resources to help them cope following an event.

REVIEW OF THE LITERATURE

The second victim phenomenon is defined as health care workers' emotional response to adverse patient events that are unanticipated.[1]

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Adverse events can incur accidental harm or even death to patients by way of medical error. Given the unpredictable and sometimes chaotic nature of acute care settings, nurses can at some point in their career be affected by a traumatic patient event. Second victims experience emotional, physical, and professional suffering that can range from increased stress to intent to leave the profession.[2-4] Adverse events in clinical settings are unavoidable and unpredictable. Experiencing these adverse events can often leave nurses feeling as if they have no one to confide in and no resources available to cope with the outcome of the event. Unfortunately, the results of being a second victim can have a lasting impact both personally and professionally. Consequences include nurses changing jobs, leaving the profession, or dying by suicide.[2] Therefore, following an adverse event, it is imperative that health care systems identify effective support services for second victims.[5-7]

Prior research has established that clinical error has contributed greatly to sentinel events among the patient population. These errors are undoubtedly costly ones that contribute to public concern for patient safety while costing health care systems millions of dollars annually.[8] Contributing factors include legal proceedings and settlements as well as costs related to employee suffering, high turnover, and absenteeism.[9] Psychological stress in the aftermath of unanticipated adverse patient events can potentially lead to nurse burnout[10] and substance abuse among the second victims themselves.[11] Unfortunately, many nurses will be affected for years by an adverse event in the form of self-doubt, posttraumatic stress responses, perceived inadequate support by peers and management, and fear of disclosure.[7,9,12] These triggers can cause major emotional distress, occasionally lasting up to 2 years or more following an event.[7]

Adverse patient events have the potential to lead to profound emotional trauma, affecting nurses' professional and personal lives.[4] Although awareness of the second victim phenomenon is present, the culture of health care perpetuates victims to be isolated from necessary support, potentially worsening the effects of the event itself.[13] Suffering can be mitigated among clinical nurses, especially those who perceive being at fault for the error.

Nurses comprise more than half of the typical hospital workforce. Therefore, institutions that are poised to provide effective support services will benefit from maintaining the health and well-being of their nurses.

Theoretical model

The theoretical model that supported this study is Watson's theory of human caring. In this model, nursing is defined by caring, which helps nursing to embrace the positive energy that flows from an integration of mind, body, and spirit.[14] Her theory focuses on the centrality of human caring and provides a framework for nurses to practice. The art of caring involves compassion to ease patients' and families' suffering, promotes healing and dignity, and expands the nurse's own self-actualization.[14] Watson's theory supports both the "one who is caring and the one who is being cared for."[15]

This hospital's philosophy of nursing is centered on a culture of caring, with a focus on reducing avoidable and unavoidable suffering for patients and nurses. Inherent in the philosophy is teamwork, collaboration, effective communication, innovation, and professional development. Describing the prevalence of nurses who see themselves as second victims and assessing their awareness and value of available resources can help to enhance the care of nurses and minimize their suffering. This ensures they will be able to care for the patients, each other, and themselves.

METHODS

This descriptive study was completed in an 877-bed, tertiary quaternary academic hospital located in the Midwest. A survey was emailed to a convenience sample of approximately 1100 full- and part-time nurses working in inpatient units, interventional radiology, catheterization laboratory, emergency, and surgery departments. Staff were surveyed over a 3-month period. The survey was in English and divided into 4 sections: demographics, organizational assessment, experiences of the second victim using the Second Victim Experience Support Tool (SVEST), and postevent support resources. The demographic and organizational assessment tools were designed by the investigators for this study. Demographic data include participants' self-reported age, gender, general or specialty unit, years as a nurse, years as a nurse at the

current hospital, highest level of education, professional certification, and clinical or nonclinical role designation. The organizational assessment provided an opportunity for participants to report on awareness and use of organizational resources available for second victims. Participants who self-identified as second victims completed the SVEST and answered several additional questions about their preferences and use of postevent support resources.

Second Victim Experience Support Tool

The SVEST uses 5-point Likert scale response options to measure health care provider second victim experiences and perceptions of organizational support following involvement in adverse patient events. The survey has a reported a Cronbach α reliability score ranging from 0.61 to 0.89 and a 78% interrater agreement for content validity.[9] The SVEST consists of 29 items representing 7 dimensions of second victim experiences: psychological distress, physical distress, colleague support, supervisor support, institutional support, non-work-related support, and professional self-efficacy. In addition, the SVEST measured participants' perspective of 2 outcome variables: retention and absenteeism.

Procedures

Permission to use the tool was granted from the SVEST authors and the study was approved by the health system's institutional review board. To promote awareness and participation in the study, a survey link was sent to all nurses' hospital email address, along with an informational letter defining the second victim concept and the purposes of the study. Participants were informed that their responses would be confidential, anonymous, and free from identifiers. Due to anonymity, email and survey responses were not able to be tracked for completion.

The staff were asked to respond to the survey questions, as it related to their tenure with the current organization. Participation was voluntary and completion of the survey via an electronic link implied consent and agreement to be part of the study. The survey required approximately 20 minutes to complete. To encourage participation in the study, announcements were made at nurse-leader meetings and posted on unit-based electronic huddle boards. Periodic reminders were sent throughout the survey timeframe.

Data analysis

χ^2 tests were used to analyze the prevalence of nurses who self-identified as second victims as compared to those who did not, including their responses to questions related to their awareness and helpfulness of organizational postevent support resources. The 2 continuous variables, years of experience as a nurse and years as a hospital employee, were analyzed using Student's t test. The SVEST responses were analyzed using nonparametric methods, Wilcoxon or Kruskal-Wallis, which examined the relationship between SVEST responses and the demographic data. The significance threshold was set at an α of .05.

RESULTS

Demographics

Three-hundred fifty-nine nurses (32.6%, 359/1100) completed the demographic and organizational assessment section of the survey although not all questions were answered by all participants. Only the second victims (n = 160) were asked several additional questions at the end of the SVEST related to their support preferences following an adverse event. The majority of second victims were between the ages of 18 and 37 years (54.7%, n = 87) and female (91.8%, n = 146). Male second victims comprised 8.2% of the second victim group (n = 13). One respondent did not select gender.

When comparing non-second victims with second victims, the years of employment at the hospital and the variable second victim were found to have a significant relationship (16.5 ± 12.8 vs 12.9 ±12.3 years, $P = .009$). However, total years employed as a nurse and identification as a second victim (18.7 ± 13.9 vs 18.7 ± 16.0 years, $P = .980$) were not significant. When years of employment at the study hospital was stratified by age, second victims in 2 age groups had significantly more tenure: 18 to 37 years of age, 8.3 ± 7.3 years' tenure, versus non-second victims in the same age group, 6.0 ± 6.8 years' tenure ($P = .027$), and 38 to 53 years of age, 23.5 ± 9.8 years' tenure, versus non-second victims in the same age group, 17.9 ± 11.5 years' tenure ($P = .009$). None of the other demographic data representing all participants' age, gender, patient care area, certification, education, or role reached a level of significance (see Supplemental Digital Content Table 1, available at: http://links.lww.com/JNCQ/A912).

Table 1. Use of Postevent Support Resources[a]

Awareness and Use of Resources	SV n = 160 n (%)	Non-SV n = 182 n (%)	*P* Value
Aware of employee assistance program	66 (41.3)	56 (30.8)	.044
Unaware of any available support resources	110 (68.8)	145 (79.7)	.021

Abbreviation: SV, second victim.

[a] *Some nurses skipped responses or selected more than 1 response, which is reflected in the counts for the variables.*

Organizational assessment responses

The organizational assessment questions were answered by all participants and focused on awareness and preferences of postevent support services, knowledge of how to access available inhospital support services and recall of previous efforts to contact support services for self or others. In comparison with non-second victims, a significant number of second victims reported they were unaware of the hospital's internal employee assistance program as a resource (41.3% vs 30.8%, $P = .044$). Additionally, second victims were more likely to indicate a lack of awareness of any hospital support resources overall (68.8% vs 79.7%, $P = .021$) (Table 1). Second victims who did reach out for support following an adverse patient event were more likely to utilize unit-specific debriefing processes as opposed to non-second victims requesting help for a colleague (10.3% vs 4.1%, $P = .032$). When second victims were asked for more detail about who they reached out to, the majority indicated they connected with a colleague on or off the unit (77.1%), a spouse or significant other (62.4%) or a friend (59.6%). None of the second victims reported contacting a manager or supervisor for support and only 1 respondent (1%) reported they had contacted risk management or a chaplain/clergy member following an adverse event. Others indicated they had connected with a counselor (9.2%).

Several significant results were found when second victim responses to the organizational assessment questions were stratified by demographic variables. These questions focused on awareness of support resources, knowledge of how to access resources, efforts made to connect with resources post-event, and offers for support that were made but declined. Notably, females were more likely to be unaware of any available resource. All nurses in the 18- to 37-year-old group, regardless of gender, were more likely to use unit-specific debriefing following an adverse event. Males indicated a heightened awareness of pastoral care as a resource. Females were more likely to be aware of and contact the hospital's employee assistance program or use unit-specific debriefing resources (Table 2).

SVEST responses

Responses to the 5-point Likert-formatted SVEST questions were scored and averaged. Overall, second victims agreed that they experienced greater psychological distress with fears of future occurrences (70.1%), feelings of embarrassment (62.2%), remorse (49.6%), and feeling miserable (36.2%). Following the adverse event physical distress was reported with symptoms of exhaustion (48%), loss of sleep (38.5%), feeling sick (33.9%), and loss of appetite (28.3%). Seventy-five percent of second victims felt supported by colleagues. Of those, 69.2% felt a colleague helped them to believe that they were still a good nurse, despite a mistake being made. Second victims agreed that supervisors considered the complexity of the situations (59.8%), were fair (62.9%), and did not place blame (91.4%). More second victims were neutral in their responses to the questions about taking a mental health day or taking time off after an adverse incident. The majority of second victims responded that they desired time away from the unit for a short time in a peaceful location following an adverse event. They also preferred to discuss the details of the incident with a peer, desired an employee assistance program with free counseling, an opportunity to discuss the event with a manager or colleague, an opportunity to schedule time with a counselor at the hospital and a confidential way to connect with someone 24-hours a day to discuss the impact of the experience (see Supplemental Digital Content Table 2, available at: http://links.lww.com/JNCQ/A913).

Table 2. Response Differences Between Nurses Who Identified as Second Victims as Compared With Nurses Who Did Not[a]

Variable	SV That Responded No, %	Non-SV that Responded Yes, %	*P* Value
Aware of pastoral care			
Male	16.7 (3/18)	50.0 (10/20)	.043
Female	54.2 (78/144)	43.3 (68/157)	.060
Aware of employee assistance program			
Male	36.4 (4/11)	33.3 (9/27)	1.000
Female	56.4 (62/110)	44.0 (84/191)	.038
Unaware of any support resources[b]			
Male	34.5 (10/29)	33.3 (3/9)	1.000
Female	44.4 (100/225)	60.5 (46/76)	.015
Contacted unit-specific debriefing for self or colleague following event, age category			
54-72	47.5 (19/40)	75.0 (3/4)	.607
38-53	42.1 (37/88)	50.0 (6/12)	.602
18-37	45.3 (73/161)	100 (6/6)	.010
Contacted unit-specific debriefing for self or colleague following event			
Male	37.5 (12/32)	(0/0)	. . .
Female	45.5 (117/257)	68.2 (15/22)	.041
Aware of postcrisis response team, certified			
No	52.0 (91/175)	32.4 (11/34)	.036
Yes	38.5 (42/109)	71.4 (15/21)	.005
Unaware of any resources[b]			
No	46.1 (71/154)	56.4 (31/55)	.191
Yes	38.8 (38/98)	59.4 (19/32)	.041
Contacted employee assistance program following event			
No	47.9 (80/167)	51.9 (14/27)	.085
Yes	38.9 (42/108)	80.0 (8/10)	
Offered but declined unit-specific debriefing			
No	51.6 (16/31)	50.0 (2/4)	.199
Yes	68.2 (15/22)	25.0 (2/8)	
Contacted unit-specific debriefing			
ADN	14.8 (23/155)	80.0 (4/5)	.032
Diploma	35.7 (5/14)	0 (0/1)	
BSN	45.3 (86/190)	73.3 (11/15)	
More than MSN	48.4 (15/31)	0 (0/1)	

Abbreviations: ADN, associate degree in nursing; BSN, bachelor of science in nursing; MSN, master of science in nursing; SV, second victim.

[a] *Some nurses skipped responses or selected multiple responses, which is reflected in the counts for the variables.*

[b] *No indicates they are aware of resources. Yes indicates they are not aware of resources.*

DISCUSSION

This study supports the centrality of human caring identified in Watson's theory, as this transpersonal caring relationship is a result from the trust built between the nurse and the patient. This trust allows the nurse to provide companionate care and allows the nurse to achieve self-actualization. However, nurses may

not be able to provide compassionate care and healing if they themselves are hurting. Nurses who are second victims suffer both physically and psychologically.[4,7] Addressing nurses' understanding of the second victim concept and assessing their awareness of available resources enhances care of nurses, helps to minimize their suffering, and aids in their ability to care for patients.

Identifying and recognizing second victims can be challenging. The literature indicates that given the unpredictable and sometimes chaotic nature of the acute care setting, nurses will at some point in their career be affected by a traumatic patient event.[2-4] These events can leave nurses feeling as if they have no one to confide in and no resources available to cope with the outcome of an event. Health care systems need to provide easily accessible, confidential, system-based supportive resources for second victims. As stated in the literature, second victims can experience posttraumatic stress responses due to perceived inadequate support by peers and management, and fear of disclosure. These responses may last up to 2 years following an event.[3,7,12] The current study supports the finding that second victims experience greater psychological distress than physical distress.

Results of this study found that a greater percentage of female second victim nurses were unaware of any hospital resources. Comparisons between second victims and those who did not identify as such demonstrated that a higher percentage of second victims preferred unit-specific debriefing following an adverse event. These results differ from other studies, where victims were less likely to talk to a friend and more likely to contact an organizational structure.[7,16] Male second victims were more aware of pastoral care, while female second victims more likely to contact unit-specific resources for self or colleague. In addition, second victims indicated that they prefer a confidential way to connect with someone to discuss their experience. Of interest is that second victims were less likely to be aware of the hospital-based employee assistance program as an internal resource and were likely to be unaware of any additional hospital resources following an adverse event. All second victims said they desired time away from the unit for a brief period.

Second victims in this study did not think their supervisors blamed them for the adverse event and agreed that the situation was evaluated by leadership in a manner that considered the complexity of the practice setting. This is contrary to what has been found in the literature, where lack of leadership support has been cited. Second victims felt that supervisors understood their need for support following an adverse event.[10,17] Organizations and leaders need to be aware that although staff might recognize they need help, they may be unaware of available resources.[6,7,18]

This study was conducted prior to the coronavirus disease-2019 (COVID-19) pandemic. Throughout the pandemic, the organization provided additional support to staff through facilitator-led, peer processing groups, increased support through the employee assistance program, and ongoing communication to health care professionals of available support resources. Resources were communicated at daily huddles and email messages from the organization and from the nursing leadership team. More recently a peer-to-peer support program was implemented for nursing. The program utilizes the concepts of respect, support, and transparency in assisting the nurse on their second victim recovery trajectory. Review of the current literature provides little information on the effect of the pandemic on the second victim concept. The participant responses in this study highlighted the need for increased awareness of available support resources for second victims. There is benefit to resurvey the staff to determine how their understanding of the second victim concept could have changed, as well as their awareness of available resources and the value found in the use of these resources since the pandemic.

Implications for practice include considering age, gender, and experience when providing support for second victims, as these factors can influence resources staff prefer to access post-adverse event. In addition, because the majority of second victims indicated that they were unaware of resources available post-adverse event, organizations need to focus on highlighting available post-adverse event resources for staff. More education regarding the second victim concept in general should be shared with nursing administration and all staff members. Further studies are needed to examine the effect that peer-to-peer support programs and peer processing groups have on the psychological health of nurses who are second victims.

Limitations

This study was based on a nonprobability, convenience sample where survey participation was dependent on staff reading their emails, being motivated to complete the survey, and trusting that their responses would be anonymous. Despite efforts to reassure participants, this may have limited the response rate. The results of this study are generalizable to nurses in acute care settings in tertiary and quaternary care hospitals. The majority of responses came from general medical or surgical units or intensive care areas, which limits generalizability to other specialty areas. Future studies may benefit from performing the study in ambulatory settings as well as specialty care area (eg, maternal child health, emergency department, and surgical services).

CONCLUSIONS

This study validates the presence of the second victim phenomenon in an acute care hospital setting and provides nursing leadership with data to support decision-making and allocation of resources for second victims. Additional education is needed to enhance understanding of what the second victim's needs are following an adverse event, including available resources for clinical nurses.

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