Second Victim Syndrome among Critical Care Professionals

دکتر شیما صفازاده

عضو هیئت علمی دانشکده پرستاری و مامایی دانشگاه علوم پزشکی اصفهان

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قوانین سفر

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- مشارکت در بحث و به اشتراک گذاری تجارب بسیار عالی است.
- گفتگو در مورد خطاها به صورت باز و آزادانه مورد حمایت قرار می گیرد.
- در مورد تجارب شخصی همکاران خود قضاوت نمی کنیم.
- به منظور یافتن راهکارهای عملیاتی و منطبق با فرهنگ خودمان بحث و گفتگو می کنیم.
- نظرات شما هم سفران:.....

اهداف اختصاصی

۱. با مفهوم سندرم قربانیان دست دوم آشنا شویم.
۲. نظام سلامت را از نظر بروز خطاها و واکنش های بعد از آن در بخش های مراقبت ویژه نقد کنیم.
۳. راهکارهای عملیاتی نحوه برخورد با کادر سلامت شاغل در بخش های مراقبت ویژه که مرتکب خطا در ارتباط با بیمار شده اند، را به اشتراک بگذاریم.
۴. برای آموزش مفهوم قربانیان دست دوم به سایر همکاران و دانشجویان خود انگیزه و علاقه داشته باشیم.
۵. به منظور تخفیف سندرم قربانیان دست دوم، از همکاران و دانشجویان خود در زمان وقوع خطا حمایت کنیم.

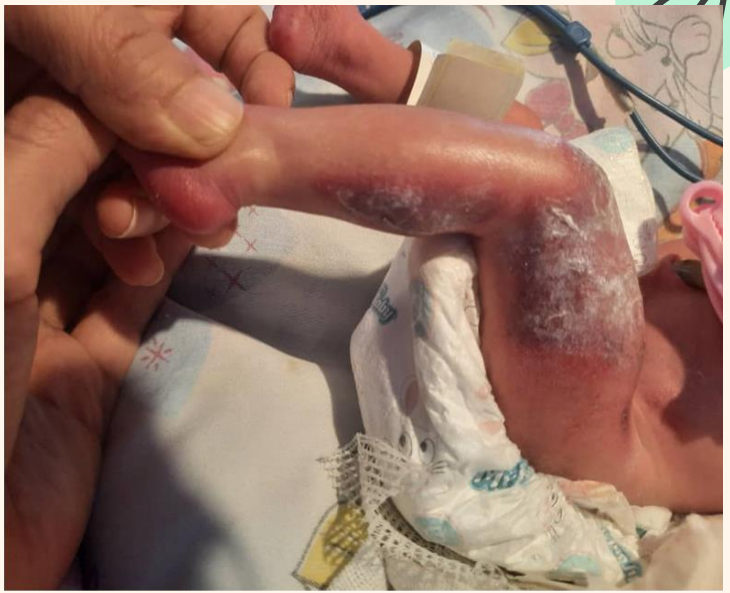
برداشت جامعه از خدماتی که ما ارایه می کنیم

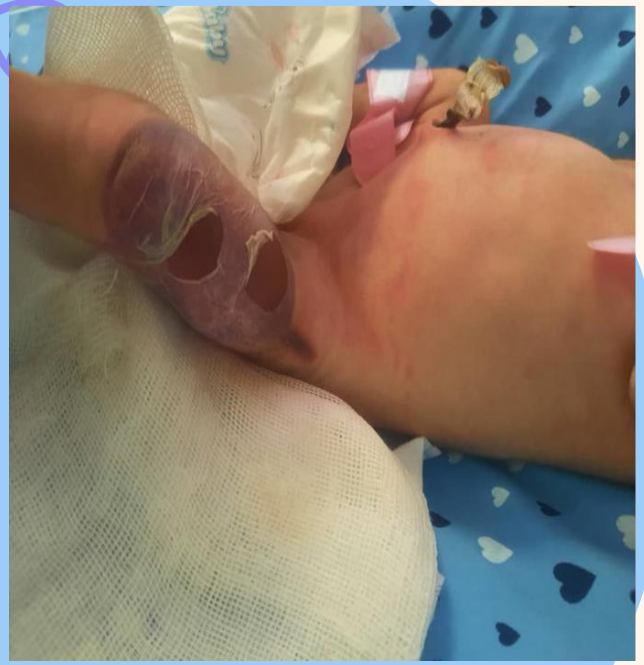
۴۷% مردم نگران خطاهای پزشکی در بیمارستانها هستند.

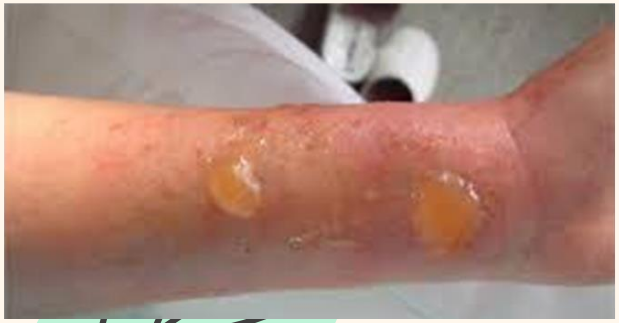
(Kaiser/AHRQ, 2000)

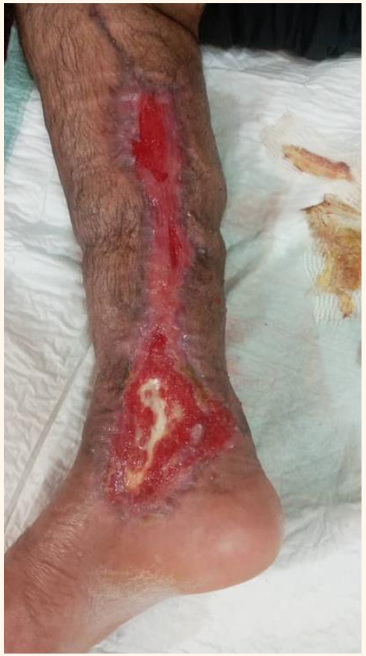
مهم ترین خطاهایی که تا کنون در زمان ارایه خدمات بهداشتی درمانی در بخش مراقبت ویژه انجام داده یا شاهد آن بوده یا شنیده اید را نام ببرید

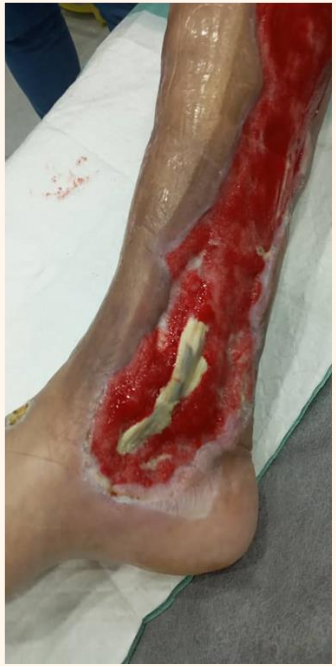
نمونه ای از خطاهای رخ داده

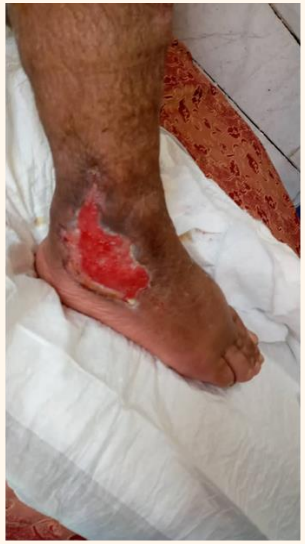


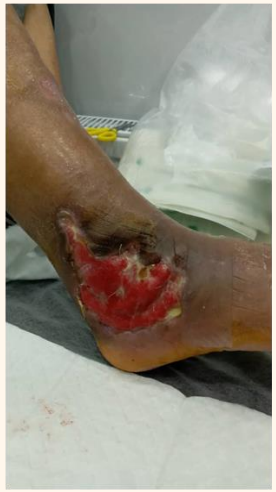


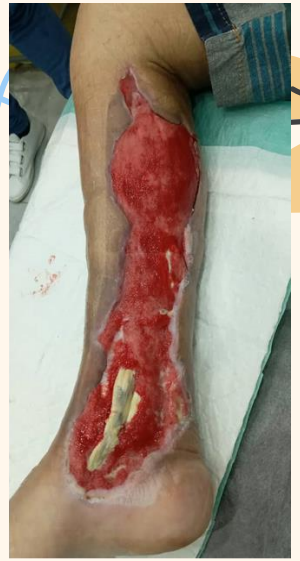






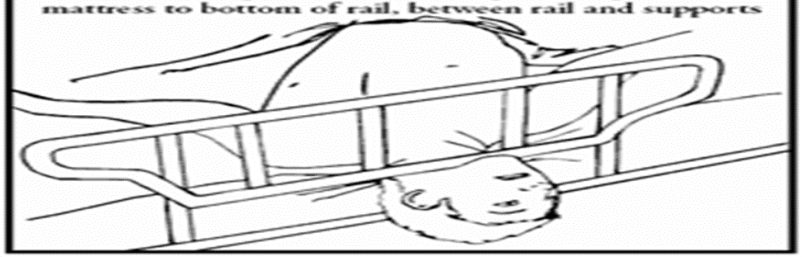






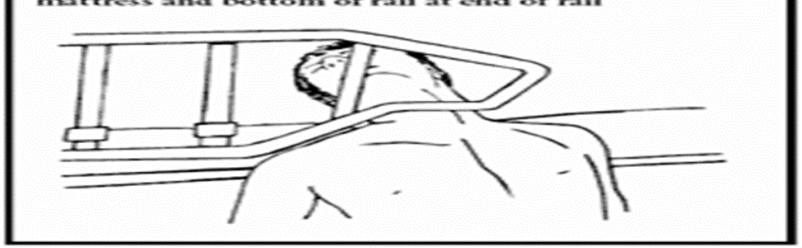
Zone 1 - Entrapment within rail

Zone 2 - Entrapment between top of compressed mattress to bottom of rail, between rail and supports



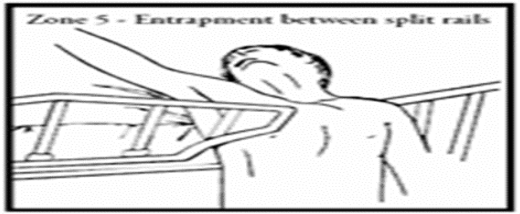
Zone 3 - Entrapment in horizontal space between rail and mattress

Zone 4 - Entrapment between top of compressed mattress and bottom of rail at end of rail

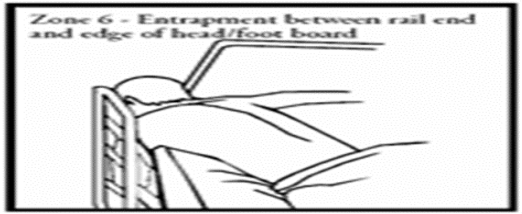


Zones 5, 6 and 7 are not measured zones. These are shown here only for reference for future reporting of entrapment incidents.

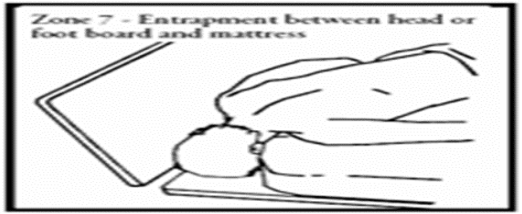
Zone 5 - Entrapment between split rails



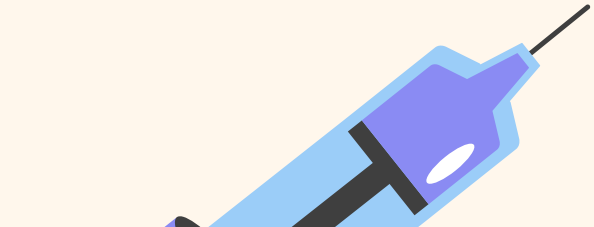
Zone 6 - Entrapment between rail end and edge of head/foot board



Zone 7 - Entrapment between head or foot board and mattress



Patient safety : The absence of preventable harm to a patient during the process of health care and reduction of risk of unnecessary harm associated with health care to an acceptable minimum

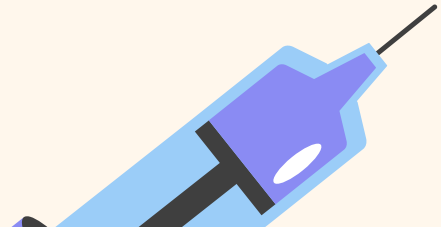


“…the reduction and mitigation of unsafe acts within
the healthcare **system**, as well as through the use
of **best practices** shown to lead to
optimal patient outcomes.”

The Canadian Patient Safety Dictionary, October 2003.

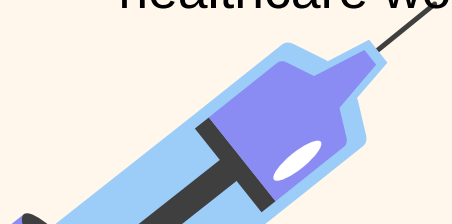
According to the World Health Organization (WHO), one in ten patients worldwide is harmed while receiving hospital care, with millions experiencing preventable adverse events annually.

Between 20% and 51% of critically ill patients experience an adverse event during their ICU stay, which is higher than an incidence of 10% in healthcare overall



The incidence of human error in the ICU is 31%, leading to fatal or permanent injury or prolonging the length of ICU stay.

More ICU healthcare workers may be involved in patient safety incidents, and the impact of these incidents on patients may be a major psychological burden for healthcare workers.



آمار خطا در ایران

میزان خطاهای پزشکی در بیمارستان‌های ایران: مرور نظام‌مند و متاآنالیز

علی محمد مصدق‌راد[1]، پروانه

دریافت: ۱۳۹۸/۱۲/۱۲ ویرایش: ۱۳۹۸/۱۲/۲۰ پذیرش: ۱۳۹۹/۰٤/۲٤ آنلاین: ۱۳۹۹/۰٤/۳۱

چکیده

بیشتر مطالعات با استفاده از فرم گزارش داوطلبانه خطا به محاسبه میزان خطاهای بیمارستانی پرداختند (۶۷٪). مطالعات انجام شده میزان خطاهای پزشکی در بیمارستانهای ایران را بین ۰/۰۶٪ و ۴۲٪ گزارش کردند. با انجام فراتحلیل، میزان خطاهای پزشکی در بیمارستانهای ایران بر اساس مدل تصادفی ۰/۰۱٪ با حدود اطمینان (۹۵٪) به دست آمد.

خطای پزشکی

خطای پزشکی (Medical error) عدم موفقیت یک اقدام برنامه ریزی شده بهداشتی و درمانی در رسیدن به اهداف تعیین شده (خطای اجرا) یا استفاده از یک برنامه اشتباه برای رسیدن به هدفی (خطای برنامه ریزی) است

عوارض ناخواسته ،(**Adverse events**) آسیب غیرعمد ناشی از خطاهای پزشکی است که به بیمار تحمیل می شود. عوارض ناخواسته آسیبی است که به خاطر خدمات پزشکی ارایه شده به بیمار روی دهد، نه به دلیل فرآیند بیماری یا شرایط بیمار اتفاق افتد. آسیب ناخواسته، آسیب و جراحتی است که به بیمار (طرف تقاضا) از طرف ارایه کننده خدمات سلامت (طرف عرضه) وارد می شود.

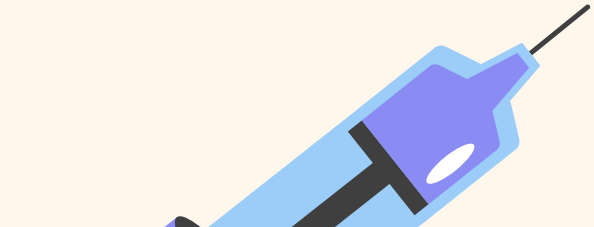
Healthcare professionals (HCPs) work in high-stakes environments where adverse events and medical errors are an unfortunate reality

While the immediate focus is often on patients and institutional accountability, the emotional and psychological toll on healthcare providers involved in such incidents is increasingly recognized as a critical issue

Second Victim Syndrome (SVS)

by Wu in 2000

The emotional distress, self-doubt, and psychological sequelae experienced by HCPs following adverse patient outcomes, unanticipated events, or clinical errors.



the second victim syndrome (SVS), characterized by psychological reactions such as anxiety and depression, as well as psychosomatic symptoms including headaches and sleep disturbances

Second Victim Syndrome (SVS), encompasses a wide array of psychological (shame, guilt, anxiety, sadness, and despair), cognitive (compassion, discontent, burnout, and secondary traumatic stress), and physical repercussions

In critically ill patients in the ICU, treatment is complex and high-risk, and the incidence of medical errors and adverse events is high, affecting patient outcomes

Intensive care units (ICUs) are particularly susceptible to patient safety incidents, which can place a significant psychological burden on healthcare workers and lead to a high prevalence or exacerbation of SVS

Global estimates suggest that almost 50% of healthcare providers experience SVS at least once in their career, and the prevalence ranges from 10.4% to 43.3%

Studies have reported an 18% prevalence of SVS among ICU healthcare workers

58% of ICU healthcare workers had SVS, which is higher than the incidence (10–43%) reported for healthcare workers in various healthcare settings (e.g., operating rooms, obstetrics, and internal medicine)

In a survey conducted among clinician members of the Society of Critical Care Medicine, surgeons and anesthesiologists exhibited higher negative responses following procedural errors, whereas internal medicine and emergency medicine practitioners showed higher negative responses after diagnostic errors.

SYMPTOMS OF SVS

Symptoms were broadly categorized into thoughts, psychological distress, physical distress, impact on behavior, and impact on sociability.

Frequent symptoms included guilt (12–68%), anxiety (38–63%), anger at self (25–58%), and lower self-confidence (7–57%).

Symptoms experienced by second victims in the ICU, such as guilt, anxiety, lower self-confidence, and re-living the event repeatedly.

Unwanted, upsetting memories and flashbacks are common after traumatic experiences

The recovery time from SVS

The recovery time from SVS varied among ICU healthcare workers, with

2–4% recovering in less than one day,

22–29% within one week,

20–40% within one month, 10–20% within one year,

1–11% after more than one year,

8–15% never recovering

Several individual and systemic factors can exacerbate SVS reactions.

These include complex patient cases, professional relationships, clinical experience levels, spiritual beliefs, and organizational support or lack thereof.

Victims often question situations of “What if”, leading to increased responsibility for adverse events, doubting their skills, experiencing psychological symptoms, considering career changes, taking sick leave, or even reporting turnover intention

Due to fear of lawsuits and the lack of transparent reporting procedures, SVS often remains silent

The healthcare system has typically failed to appropriately address secondary victims' psychological, social, spiritual, or occupational crises through appropriate communication or the establishment of supportive networks

The consequences extend beyond individual suffering, with exacerbated risks of increased burnout, absenteeism, staff turnover, and even compromised patient safety and quality of care

Healthcare institutions have developed various interventions to support affected professionals.

Notable programs such as the resilience in stressful events (RISE) initiative at Johns Hopkins Hospital and the forYOU program at the University of Missouri health care

Peer support, individual counseling, and structured debriefing.

Scott’s Three-Tiered Model of Support:

1. Immediate emotional first aid,
2. Peer support,
3. Access to professional counseling services,

Comprehensive system-wide support system for second victims

forYOU Team

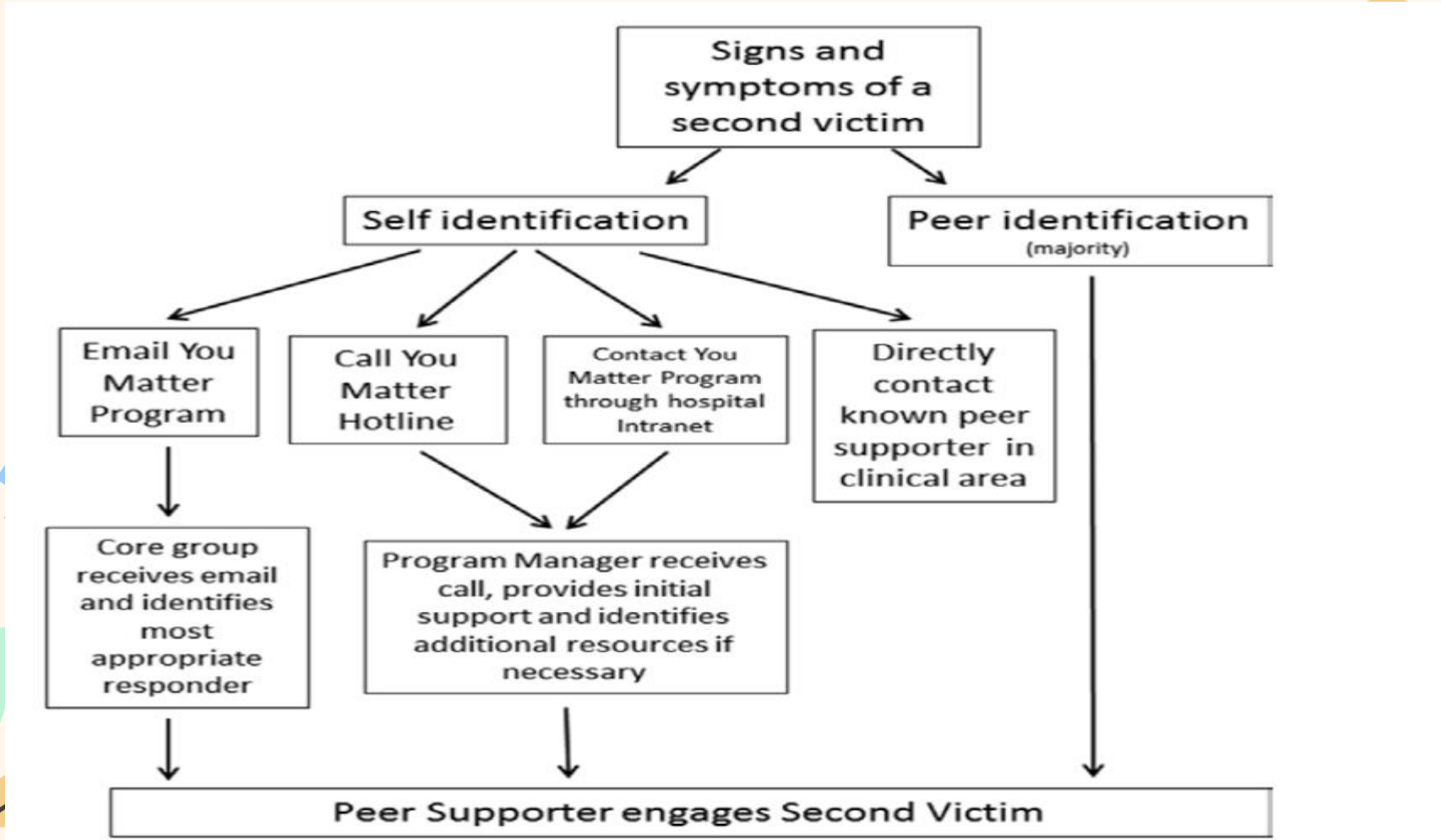
A system-wide support network at University of Missouri Health Care (MUHC) called the forYOU Team

The forYOU Team harnesses existing resources within health-care systems to address unmet needs of clinicians suffering as second victims

The six key components when initiating a second victim program.


Identify a core team
Find an executive sponsor
Develop unit base teams
Involve marketing
Educate and train
Track data
Building a second victim program

Peer support programs


Signs and symptoms of a second victim
Self identification
Peer identification (majority)
Email You Matter Program
Call You Matter Hotline
Contact You Matter Program through hospital Intranet
Directly contact known peer supporter in clinical area
Core group receives email and identifies most appropriate responder
Program Manager receives call, provides initial support and identifies additional resources if necessary
Peer Supporter engages Second Victim

Stress-coping models and theories of trauma recovery

Emphasize the need for structured, guided processing to achieve long-term resilience

The importance of institutional culture as a mediating factor—HCPs' perception of organizational support may influence not only engagement with interventions but also the trajectory of recovery.

Leadership Behaviors

Organizational norms encourage open discussions about emotional well-being.

Leadership training,

Trauma-informed supervision

Policies that normalize help-seeking behavior

Psychological safety is prioritized

European Researchers' Network Working on Second Victims (ERNST),

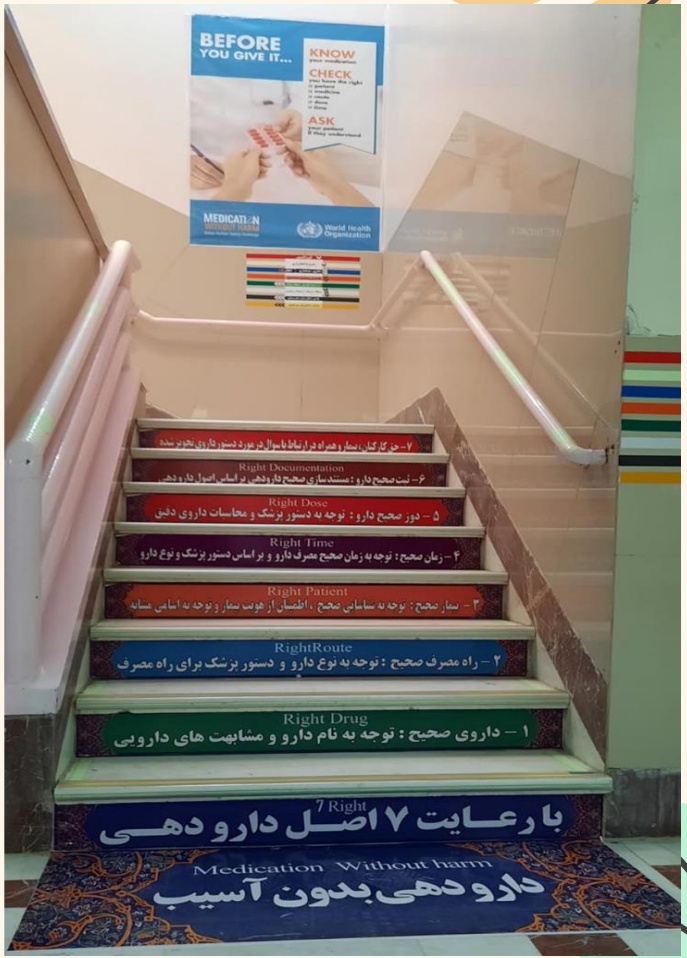
The importance of a comprehensive occupational health approach, strong organisational safety culture, allocating adequate resources for ongoing support, securing leadership commitment, and tailoring interventions to the unique sociocultural and legal contexts of each institution and country cannot be overemphasized

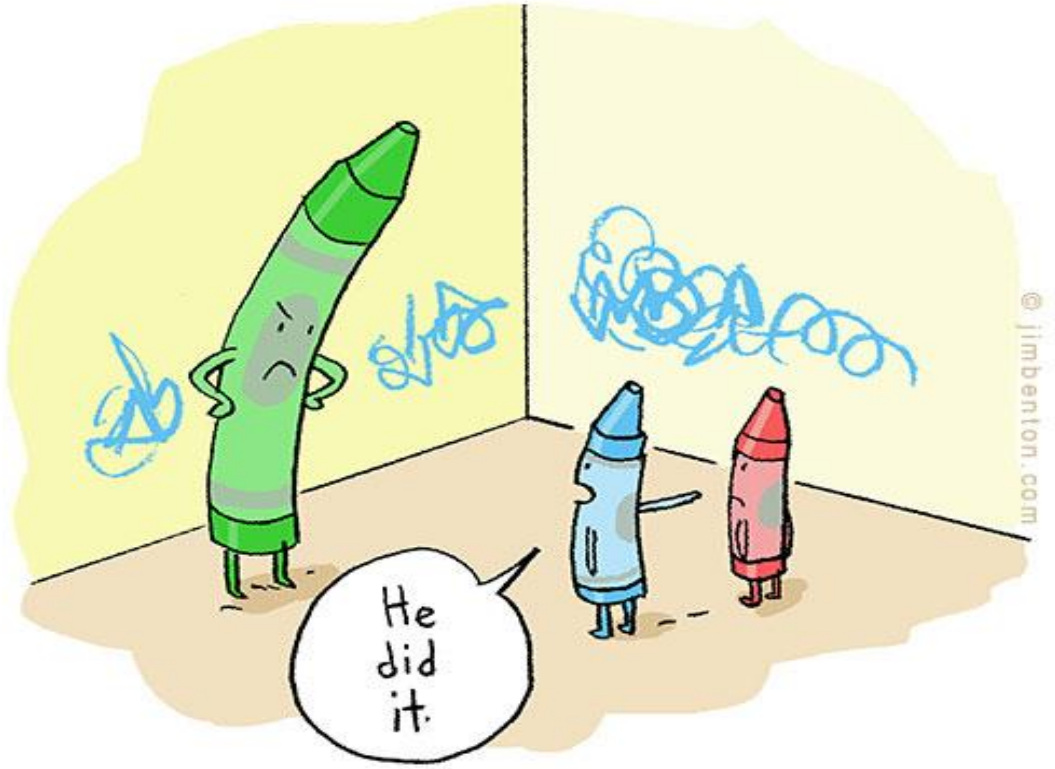
Mindfulness-Based Stress Reduction (MBSR) and resilience training programs

فرهنگ سازمانی مبتنی بر ایمنی

با ایمنی بیمار زندگی می کنیم

نقش یادآورها




He did it.
© jimbenton.com

فرهنگی باز و آزاد برای بیان نظرات پیرامون ایمنی بیمار

فرهنگ برابری و عدالت در سازمان

Second victims' perceptions of organizational and peer support are a part of ‘just culture’. Enhanced support for second victims may improve the quality of health care, strengthen the emotional support of the health care professionals, and build relationships between health care institutions and staff.

Self-compassion for Health Professionals

Self-compassion was defined as “being caring and compassionate towards oneself in the face of hardship or perceived inadequacy,”.

Three interrelated elements of self-compassion: self-kindness, common humanity, and mindfulness.

Formal indicators of Second Victim outcomes

Tools such as the SVEST to assess Second Victim interventions

“Physicians and nurses need to accept the notion that error is an inevitable accompaniment of the human condition, even among conscientious professionals with high standards.

Errors must be accepted as evidence of system flaws not character flaws.”

Leape, 1994

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سپاس بابت مشارکت و
همراهی شما
در پناه امن الهی باشید