Just Culture and the Second Victim

By Tammy Young, Pharm.D.

July 30, 2020

I have no relevant financial disclosures.
No one else in a position to control content has any financial relationships to disclose.

Objectives

- Describe the differences between human error, at-risk behavior, and reckless behavior.
- Identify the reasons people drift from procedural compliance.
- List the six predictable phases of the second victim recovery process.
- Describe the three tiers of support for second victims.

History of Patient Safety

- Up to the mid 1990's
  - Healthcare workers were solely responsible for errors
  - System processes were not reviewed
  - Management punished those responsible for the error
  - Perfect performance expected

History of Patient Safety

- Why didn't this work?
  - Healthcare workers were afraid to report errors
  - Many errors were driven underground
  - System process were not changed to prevent errors
  - Humans make mistakes

History of Patient Safety

- Around the mid 1990’s – culture shift
  - Blame-free response to errors
  - Acknowledged that everyone makes mistakes
  - Recognized weaknesses in the system processes
  - No benefit to punishment for human errors

History of Patient Safety

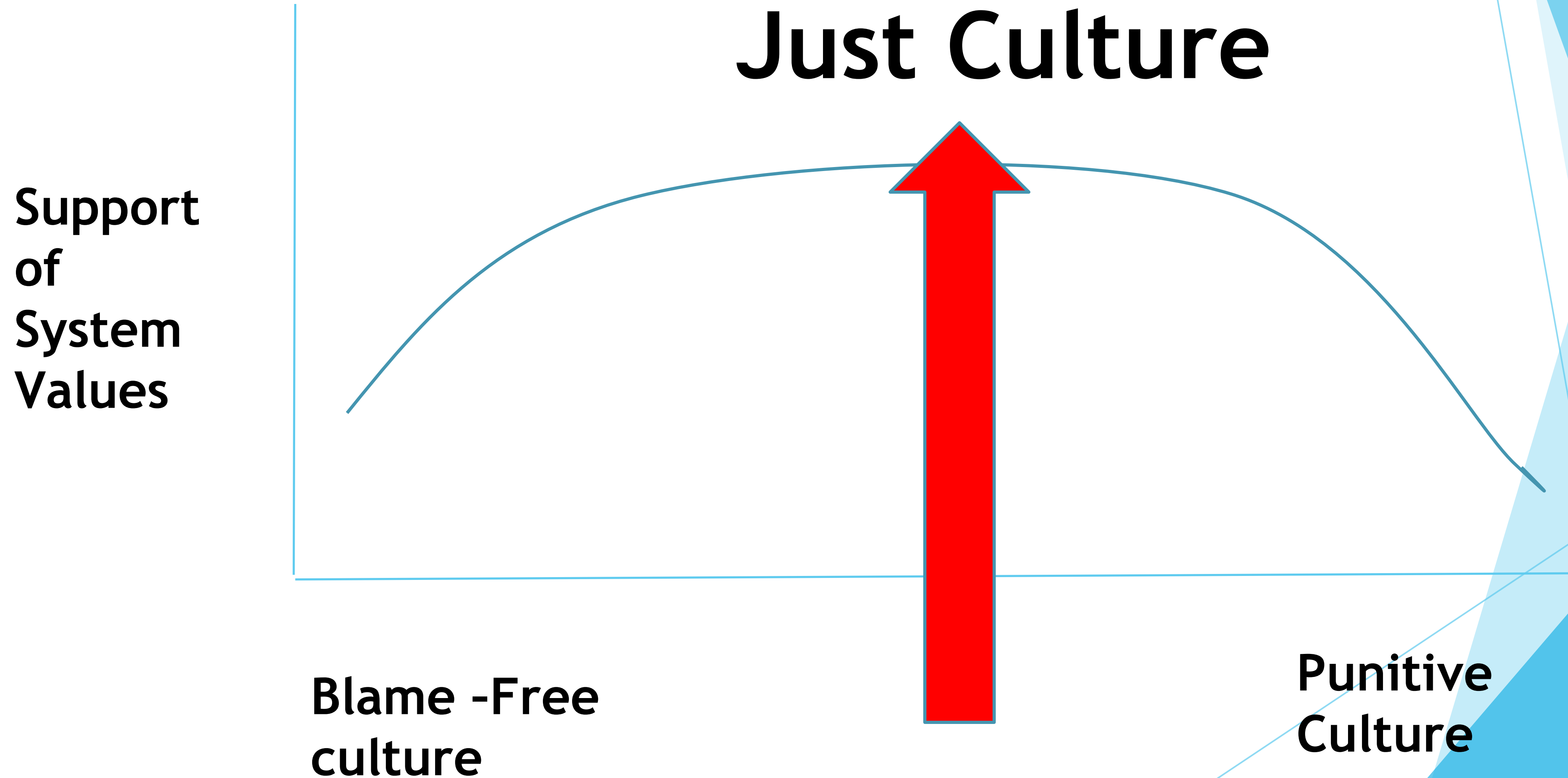
- Why didn't this work?

  Does not account for individuals

  that **knowingly** make unsafe

  behavioral choices

Where we are going…



Just Culture

- Good system design <u>and</u> good behavioral choices by staff produce good results
  - Safety is valued in the organization
  - Staff feel comfortable reporting errors
  - Staff look for risks in the system
  - Leadership held accountable for improving system design

Just Culture

- Three types of behavior associated with Just Culture
  - Human error
  - At –risk behavior
  - Reckless behavior

Just Culture

- **Human error**
  - Unintentional and unpredictable behavior
  - Action was not intended
  - Mental slip, lapse, or mistake
  - As humans, we are prone to errors
    - Examples:
      - Forgetting to dilute a medication
      - Miscalculating a dose
      - Transposing an incorrect dose while ordering

Human Error

- Why do human errors occur?

Endogenous	Exogenous
• Anxiety • Stress • Fatigue • Distractibility • Internal issues	• Lighting • Interruptions • Physical distractions • Staffing patterns • Technology glitches • Absence of job aids (calculator)

Human Error

Response to Staff

- Console
- Support

Response to System

- Exam system process
- Implement changes (if possible) to decrease risk of errors

Human Error

- Management of human errors (system)

Effectiveness	Strategies
Most Effective Hardest to Implement	• Forcing Functions • Barriers and fail-safes • Automation and computerization
Moderately Effective	• Standardization and protocols • Redundancies • Warnings, alerts, reminders, checklists
Least Effective Easiest to Implement	• Rules and policies • Educational programs • Suggestions to “be more careful”

At-Risk Behavior

- Behavioral choices that are made in the mistaken belief that the risk is insignificant or justified
- People tend to drift into unsafe behaviors
- Not choosing to put people in harm’s way
  - Drifting becomes habitual
  - Lost perception of risk
  - Rewards more immediate (ex: time saved)

At-Risk Behavior

Reasons to follow speed limit

* Obey the law
* Avoid ticket

* Avoid future accident

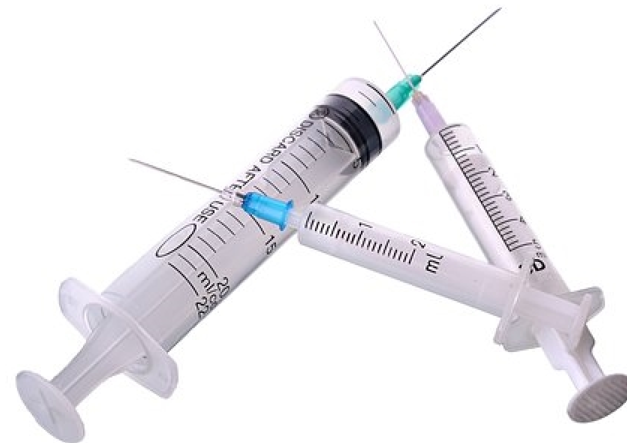
Justifications to go 5-10 mph over speed limit

* Save time
* Everyone else is speeding

* No consequences/ minimal risk

At-Risk Behavior

- Scanning the barcode on the first container several times when multiple containers will be dispensed
- Technology work-arounds
- Carrying medications in pockets
- Borrowing medications from another patient's drawer
- Not labeling syringes (drawn up at bedside, but not used immediately)
- Using estimated weights



At-Risk Behavior

- Management of at-risk behavior

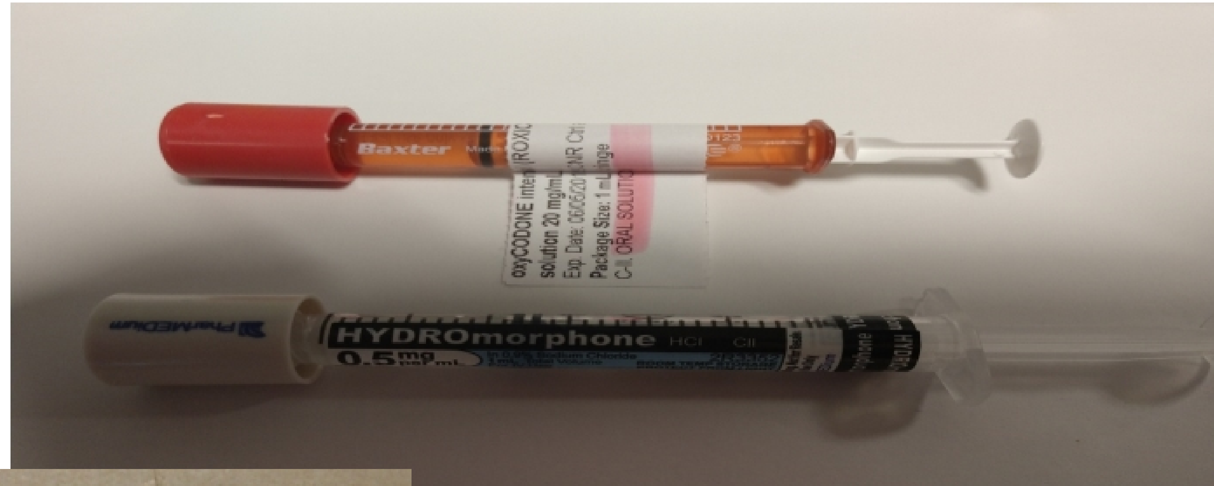
Response to Staff
- Coach/Support
- Mentor all staff on area of risk and expectation

Response to System
- Exam system process
- Implement changes (if possible) to remove the barriers

Drifting

- Human nature to drift
  - Saves time
  - Over time risk fades and culture more accepting of risk
- Positive reinforcement
  - Rewarded for being “fast” rather than being “safe”
- System failures
  - Work-arounds due to systems not working (ex: barcode not scanning)
- Subconscious reasoning
  - Subconscious mind makes most of the decisions
  - Only see what the brain wants us to see

Confirmation Bias



Change Blindness

- Inability of the visual system to detect changes to something in plain view.
  - Study by Simons, DJ and Levin, DT
    - Random people on the street were asked directions
    - During conversation, person asking for directions switched to another person
    - 50% didn't notice the change
  - Invisible Gorilla study (www.theinvisiblegorillaexperiment.com)
    - Asked to count number of passes of a ball
    - Many people missed the gorilla that walked around the gym

Reckless Behavior

- Conscious choice to disregard what is known to be a substantial and unjustifiable risk
  - Behavior is not the norm
  - Cannot justify the behavior
  - May not intend harm, but know there is a risk
  - Examples:
    - Driving 100 mph in a 55 mph zone
    - Drug diversion
    - Driving or direct patient care under the influence of drugs or alcohol

Reckless Behavior

- Management of reckless behavior

Response to Staff

* Remedial Action
* Disciplinary Action

At-Risk vs Reckless Behavior

At-Risk Behavior	Reckless Behavior
Does not see the risk or believes the risk is justified	Always perceives the risk and understands the risk is not justified
Behavior is the norm within groups	Behavior is not the norm within groups
Mistakenly believes the choice is safe	Knows the choice is not safe
Choice puts other people first	Choice is self-centered

Question

- Which of the following is human error?
  - A) Technology work-arounds
  - B) Making a math error while calculating the patient's dose of medication
  - C) Borrowing medications from another patient
  - D) Not labeling a syringe that will not be used immediately
  - E) Overriding a computer alert without fully considering its importance

Question

Scenerio 1

- *A driver decides not stop at a particular stop sign as there is normally very little traffic.*

Scenario 2

- *A driver performs a "rolling stop" at a stop sign as the driver doesn't want to be late for work.*

Scenario 3

- A driver does not stop at a stop sign. The stop sign is mostly hidden behind a bush and the driver did not see the stop sign.

Just Culture

- Human errors
  - Management is to console/support (not punish)
  - Human errors are inevitable
  - Actual severity of the error outcome should not matter (even if harm occurred)

- Examples:
  - Dave's Subs*
  - Hospital case

* Marx, David. *Dave's Subs*. Plano, Tx: By Your Side Studios, 2015.

Ohio State Board of Pharmacy

- **OAC 4729:1-4-02 Duty to report**
- (H) An error in dispensing shall not be required to be reported pursuant to paragraph (C) of this rule except when the error is the result of reckless behavior or unprofessional conduct ***and*** meets any of the following per the national coordinating council for "Medication Error Reporting and Prevention's Index for Categorizing Medication Errors" (2/20/2001):
  - (1) An error occurred that may have contributed to or resulted in temporary harm to the patient and required intervention;
  - (2) An error occurred that may have contributed to or resulted in temporary harm to the patient and required initial or prolonged hospitalization;
  - (3) An error occurred that may have contributed to or resulted in permanent patient harm;
  - (4) An error occurred that required intervention necessary to sustain life; or
  - (5) An error occurred that may have contributed to or resulted in the patient's death.

Second Victim

- Definition

"Second victims are health care providers who are involved in an unanticipated adverse patient event, in a medical error and/or a patient related injury and became 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."

Second Victim

- Second Victim
  - **Term coined in 2000 by Dr. Albert Wu**
    - professor of health policy and management at the Johns Hopkins School of Public Health
  - **Disagreement in the literature about the term**
    - not about the support needed
  - **Healthcare provider can feel traumatized**
    - Feels personally responsible
    - Second guessing clinical skills and knowledge base
  - **Post-event investigation often shows**
    - Complex clinical condition
    - Poorly designed processes
    - Sub-optimal communication patterns

Second Victim

“The first few days after the patient died, honestly, were terrible. I was flooded with thoughts and emotions that I could hardly even identify at the time. I felt incredibly sad. I was anxious. I was scared of being sued. I felt alone. I couldn’t understand why I wasn’t able to use my thinking to take control of my emotions. I wasn’t sure what to say or do. Others tried to say helpful things but no words helped, especially words that tried to convince me I shouldn’t feel so bad.”

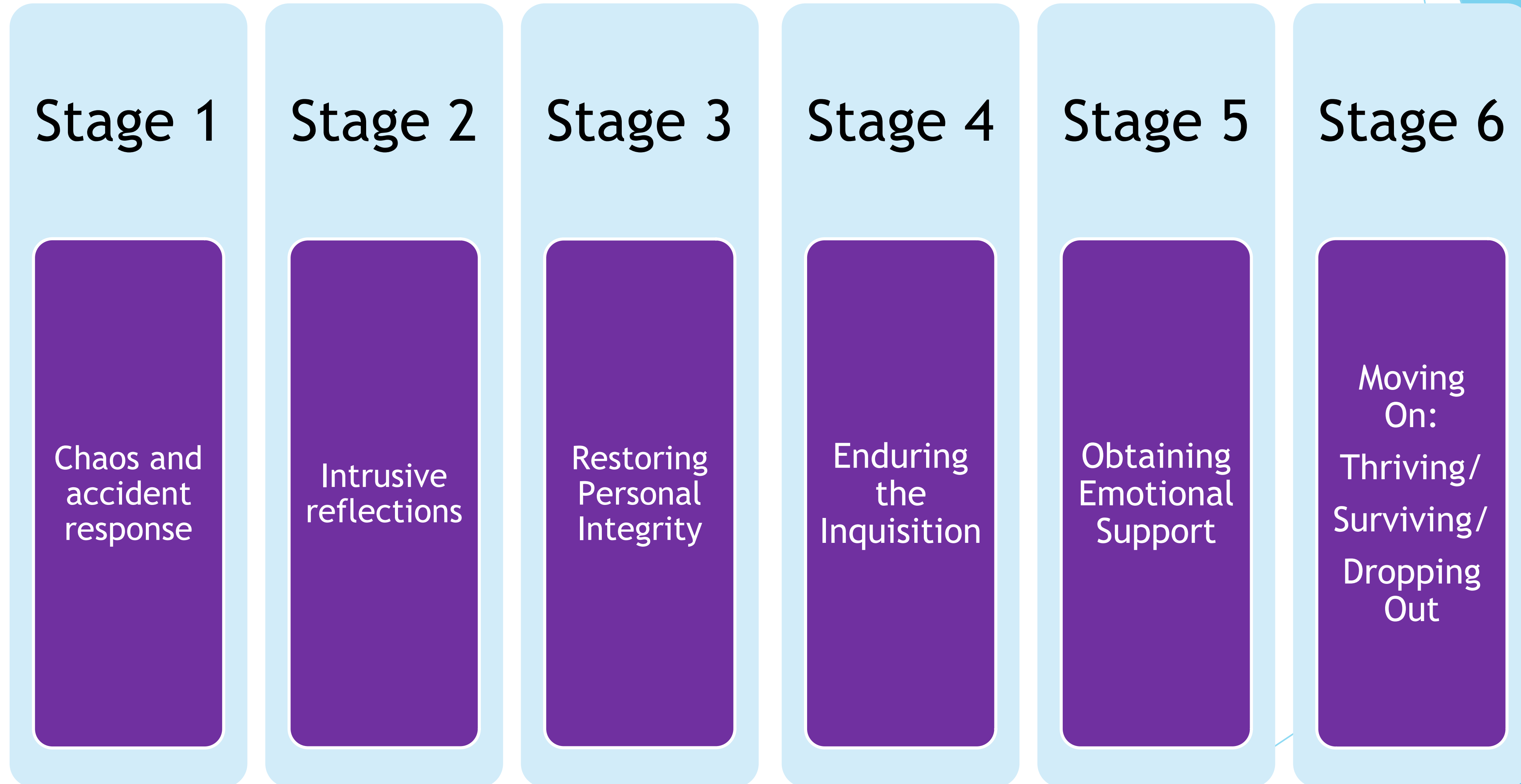
Gary Deroo RPh, Pharmacy Clinical Practice Leader, Chatham-Kent Health Alliance, Chatham, ON

Second Victim

- Nearly 50% of healthcare providers could experience the impact as a second victim at least once in their careers.

- Psychological impact
  - Post-traumatic stress disorder
  - Higher suicide rate among healthcare providers

Second Victim Trajectory



Scott SD, et al. The natural history of recovery for the health care provider “second victim” after adverse patient events. Qual Saf Health Care. 2009; 18:325-330.

Stage 1

Chaos and accident response

- Flood of internal and external emotions
- Asks self “How and why did this happen”?
- May be unable to complete shift
  - Physician – may need help with patient
  - Battles guilt and self-doubt

Stage 2

Intrusive reflections

- Self-reflection
- Re-enactment of the scenario
- Periods of isolation
- Internal questioning
- Doubt ability to be a competent clinician
- Daily work and patient care – challenge
- Asks self "How did I miss this?" and "Could this have been prevented?"

Stage 3

Restoring personal integrity

- Need support from a trusted colleague
- Unsure where to find help
- Inability to move forward
- Asks self “what will others think?” and “Will I ever be trusted again?”

Stage 4

Enduring the Inquisition

- Focus on potential repercussions
  - Job security, licensure, future litigation
- “I might get fired”
- Worried of losing co-worker’s respect

Stage 5

Obtaining emotional support

- Seek emotional support
- Concerned about who is safe to confide
  - HIPPA issues
  - Asks “Can I tell a colleague or a family member?”

Stage 6

Moving on

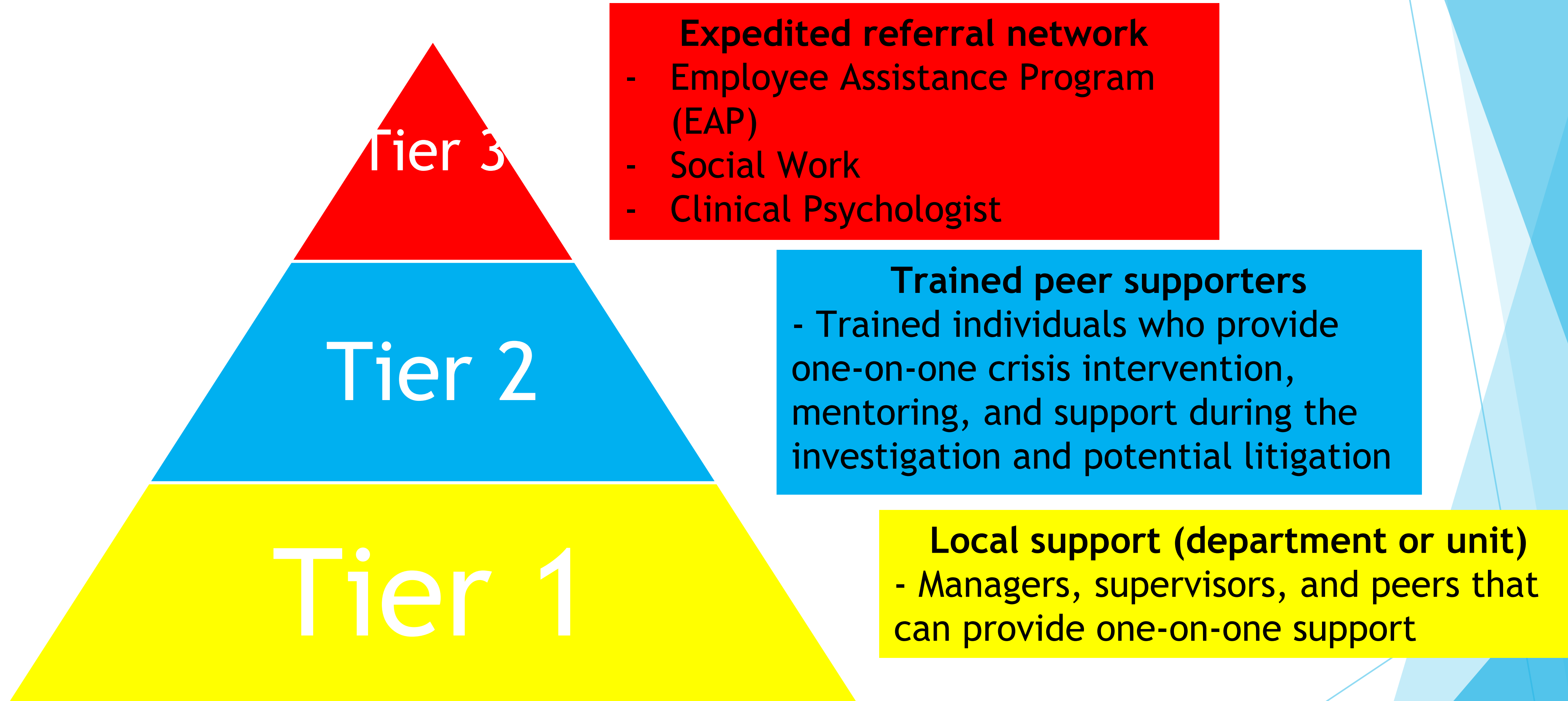
- Dropping out
  - Leave current work environment
  - Leave profession
- Surviving
  - Continue to work
  - Preoccupied by event

Stage 6

Moving on

- Thriving
  - Learn and grow from the event
  - Change practice patterns
  - Reliable support system

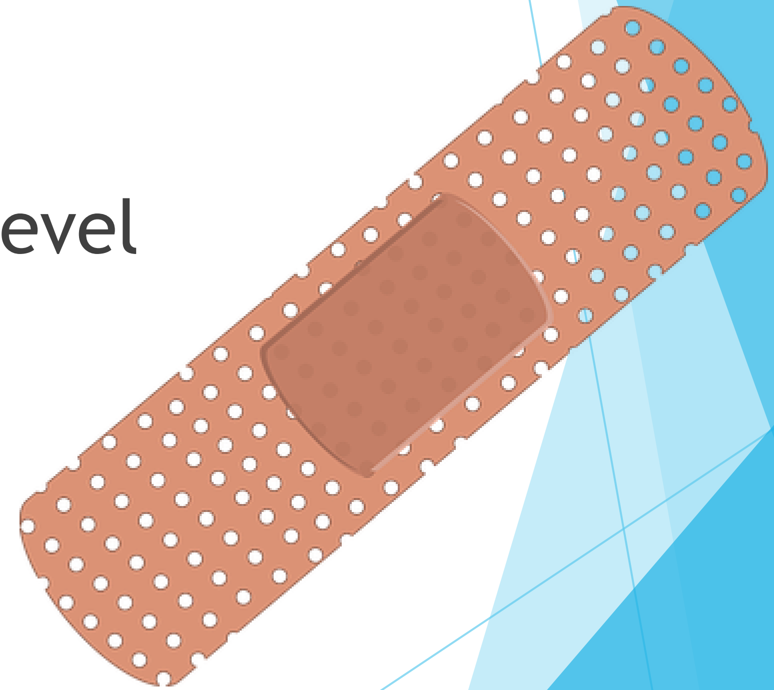
Scott Three -Tier Model of Support



Scott SD, et al. Caring for our own: deploying a systemwide second victim rapid response team. Jt Comm J Qual Patint Saf. 2010 May: 36(5): 233-40.

Local Support

- Immediate emotional first aid
- Basic care
- Organized at the local or department level
- Study by Scott et al.
  - 60% find this support sufficient



Scott SD, et al. Caring for our own: deploying a systemwide second victim rapid response team. Jt Comm J Qual Patint Saf. 2010 May: 36(5): 233-40.

Second Tier

- Specially trained peer supporters
- Provides guidance and nurturing
- One-on-one support
- Refer to other internal resources
  - Support during investigation of event / legal action
- Study by Scott et al.
  - 30% find this level of support sufficient

Scott SD, et al. Caring for our own: deploying a systemwide second victim rapid response team. Jt Comm J Qual Patint Saf. 2010 May: 36(5): 233-40.

Third Tier

- Professional counseling
  - Chaplains, EAP personnel, social workers, psychologists
- Study by Scott et al.
  - 10% require this level of support

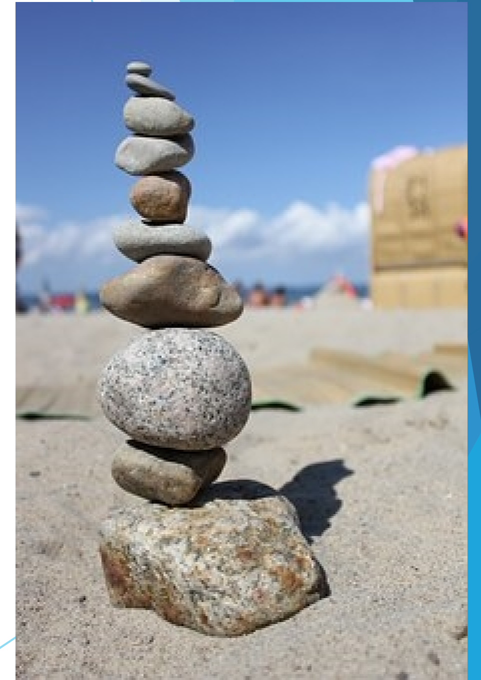
Scott SD, et al. Caring for our own: deploying a systemwide second victim rapid response team. Jt Comm J Qual Patint Saf. 2010 May: 36(5): 233-40.

OhioHealth "SAFER" Response

- Stabilize
- Acknowledge
- Facilitate
- Encourage
- Recovery or referral

Stabilize

- Department manager or director
  - Call appropriate resources
  - Meet associate's basic needs
    - Offer safe place for associate to be away from the area
    - Ask about present needs
    - Support decision to go home or return to work



Acknowledge

- Unit department manager/director
  - Offer emotional support
  - Validation of associate's feelings and reactions
  - Keep focus on the present moment

Facilitate

- Provided by Employee Assistance Program (EAP), Practitioner Health and Wellness (PHW), and/or Pastoral Care
- Wait 1-2 sleep cycles
  - Potential for re-traumatization
  - Debrief or process details of trauma
- Facilitate Understanding
  - Validation, normalization and emotional support
  - Education on common reactions to trauma

Encourage

- Provided by EAP, PHW, and/or Pastoral Care
- Encourage coping
  - Coping skills
  - Self-care practice
  - Identifying successful coping strategies

Recovery or Referral

- Provided by EAP, PHW, and/or Pastoral Care
- Education
  - Signs/symptoms of post traumatic stress
  - When to seek assistance
  - Resource information

Interventions

- Individual support
  - Speak individually with an EAP or PHW clinician or chaplain
  - On-site or virtual
- Group support
  - Group setting
  - Facilitated by EAP, PHW clinician or chaplain
  - Emotional support and psychoeducation
    - Common reactions
    - PTSD symptoms
    - Self-care strategies
- Group support and debriefing
  - Includes debriefing for those directly involved

Additional Leader Actions

- Normalize feelings and emotions
- Acknowledge the impact of the event
- Expressing feelings can be helpful or healing
- Open invitation to discuss concerns
- Acknowledge there may be unanswered questions
- Provide information on EAP, PHW, or Pastoral Care

Question

- Nearly 50% of healthcare providers could experience the impact as a second victim at least once in their careers.
    - True or False?

Question

- Listed below are the second victim recovery process stages except:

a) Chaos and accident response
b) Intrusive reflections
c) SAFER response
d) Enduring the inquisition
e) Obtaining emotional first aid
f) All the above

Conclusion

- **Just Culture**
  - Leadership held accountable for improving system design
  - Staff held accountable for behavioral choices
- **Response to an event**
  - Based on behavioral choices
  - Not outcome
- **High prevalence of second victims**
  - Require emotional support
  - OhioHealth responds to critical incidents (SAFER response)

Resources

1) Institute for Safe Medication Practices. *The differences between human error, at-risk behavior, and reckless behavior are key to a Just Culture.* ISMP Medication Safety Alert! June 18,2020.

2) Institute for Safe Medication Practices. *Our long journey towards a safety-minded Just Culture. Part 1: where we have been.* ISMP Medication Safety Alert! September 7, 2006.

3) Institute for Safe Medication Practices. *Our long journey towards a safety-minded Just Culture. Part 2: where we're going.* ISMP Medication Safety Alert! September 21, 2006.

4) Marx, David. *Dave's Subs*. Plano, Tx: By Your Side Studios, 2015.

5) Scott SD, Hirschinger LE, Cox KR, McCoig M et al. *The natural history of recovery for the health care provider "second victim" after adverse patient events*. Qual Saf Health Care. 2009;18:325-330.

6) Scott SD, Hirschinger LE, Cox KR, et al. *Caring for our own: deployment of a second victim response system*. Jt Comm J Qual Patient Saf. 2010;36:233-240.

Resources

7) Scott SD. *The second victim phenomenon: a harsh reality of health care professions.* Perspectives on Safety. Patient Safety Network. May 2011.
8) Seys D, et al. *Health care professionals as second victims after adverse events: A systematic review*. Evaluation & The Health Professions. 2012;36(2):135-162.
9) Institute for Safe Medication Practices Canada. *The second victim: sharing the journey toward healing*. ISMP Canada Safety Bulletin. October 31, 2017.
10) Simons DJ, Levin DT. *Failure to detect changes to people during a real-world interaction*. Psychonomic Bulletin & Review 1998; 5 (4):644-649.
11) Wu AW. *Medical error: the second victim. The doctor who makes the mistake needs help too*. BMJ 2000;320 (7237):726-7.
12) Ozeke O, Ozeke V, Coskun O, et al. *Second victims in health care: current perspectives*. Advances in Medical Education and Practice. 2019;10:593–603.
13) Images from https://pixabay.com

Questions?