AACN d Critical Care
Volume 28, Number 4, pp. 366-374

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Creating Healthy Work Environments for Second Victims of Adverse Events

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ABSTRACT

Adverse events may cause a patient serious harm or death; the patient becomes the first victim of these events. The health care providers who become traumatized by the events are the second victims. These second victims experience feelings such as guilt, shame, sadness, and grief, which can lead to profound personal and professional consequences. An organizational culture of blame and a lack of support can intensify the provider's suffering. Second victims, as they move through predictable stages of recovery, can be positively influenced by a supportive organizational culture and the compassionate actions of peers, managers, advanced practice nurses, educators, and senior leaders. The American Association of Critical-Care Nurses Healthy Work Environment standards provide a framework for specific actions health care professionals should take to support colleagues during their recovery from adverse events.
Keywords: adverse event, medical error, second victim, healthy work environment

Any nurse can become involved in an adverse patient event—a "safety event that results in harm to a patient"[1(pSE-4)]—irrespective of the nurse's role, clinical practice area, or level of expertise. Because of the nature of critical care nursing practice, including the care of vulnerable patient populations, management of rapidly changing conditions, and use of high-risk therapies, critical care nurses may be more exposed to conditions that increase the risk for adverse events. These events can lead to serious patient outcomes and traumatize the health care provider, who may experience a myriad of distressing symptoms with potentially devastating personal and professional consequences.[2,3] The provider's recovery from these events is influenced by multiple elements of the work environment, including formal and informal support from peers, leaders, and the health care organization.[2-4]

The American Association of Critical-Care Nurses (AACN) Standards for Establishing and Sustaining Healthy Work Environments[5] provides an evidence-based framework that can address the needs of health care providers suffering after adverse events.

The purpose of this article is to provide critical care nurses and organizational leaders with specific actions to create a healthy work environment (HWE) that supports colleagues after adverse events. Health care provider experiences and the support needed after an event are reviewed. Evidence-based, supportive interventions provided by staff nurses, managers, advanced practice nurses, educators, and senior leaders are presented within the framework of AACN's HWE standards.

Incidence and Nature of Adverse Events

The Institute of Medicine's seminal report, *To Err Is Human: Building a Safer Health System*,[6] revealed that 44 000 to 98 000 deaths occur as a result of preventable medical errors in the United States annually. The US Department of Health and Human Services Office of Inspector General studied the incidences of adverse events in hospitalized Medicare beneficiaries and determined that 27% of patients suffered serious outcomes or

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The author declares no conflict of interest.

DOI: https://doi.org/10.4037/aacnacc2017996

temporary harm from these occurrences.[7] Serious adverse events were experienced by 13.5% of the patients studied, resulting in 1 or more of the following: prolonged hospital stay, permanent harm, the need for life-sustaining interventions, or death.[7] These serious events were related to medication (31%), patient care (28%), surgery or other procedures (26%), and infection (15%).[7] The study also found an additional 13.5% of beneficiaries experienced adverse events causing temporary harm requiring medical interventions. A review of all events concluded that 44% were preventable.[7]

As patients are being hospitalized with more complicated health problems and the health care system is becoming more complex, the potential for error and patient harm is increasing.[8] The types of errors occurring in health care are varied (Table 1)[9] and often result from a combination of human characteristics, nature of the work, physical environment, human-system interfaces, organizational or social environment, management, and external factors.[10] Adverse events signify the presence of system defects; however, a common response to these events is to blame the individuals involved.[10]

Table 1: Medical Errors[9]

Error	Example
Medication	Dosage miscalculations Look-alike, sound-alike medications
Surgical/ procedural	Retained foreign bodies Wrong patient, wrong site, wrong procedure
Diagnostic	Mislabeled specimen Incorrect interpretation
Person–machine interface	Adapting device for unintended use Alarm failure Device programming error Improper connection between patient and device
Transition and handoff	Incomplete report during change in level of care Medications not reconciled
Teamwork and communication	Conflicting orders from different providers Critical results not reported Insufficient information about change in patient status
Nosocomial conditions	Falls Infections Pressure injuries

Second Victim Phenomenon

Wu[11] first used the term *second victim* in conjunction with heath care providers in 2000 to describe the subsequent emotional distress experienced by physicians involved in adverse events.[11] Wu discussed a medical error involving one of his colleagues and the culture of blame that followed leading to the emotional distress. He identified the patient as the first victim of the event and the health care provider as the second victim. Wu laments the lack of sympathy and support needed from colleagues to help providers heal after the trauma and advocates for changes in how organizations respond to adverse events, stressing the need for peer support, disclosure of the event to the patient or family, and an institution-level approach to preventing future recurrence.[11]

A team at the University of Missouri Health Care defined *second victims* as "healthcare providers who are involved in an unanticipated adverse patient event, in a medical error and/or a patient related injury and become victimized in the sense that the provider is traumatized by the event."[2(p326)] The National Quality Forum estimates that 1 million health care workers, including clinical, support, and administrative staff, have been directly or indirectly involved in events that caused patient harm.[12] However, the number of health care providers who suffer because of these events is unclear.

Numerous events in which providers, including nurses, pharmacists, and physicians, suffered from a culture of blame and the absence of support after they were involved in errors are found in the literature,[13-15] including a letter from a nurse responding to an article on support for second victims.[14] The nurse, who was involved in a medication error that led to a patient's respiratory arrest, describes feelings of embarrassment and fear and having to plead with the employer for psychiatric support services. Because of the error, the nurse's employment was terminated. Although 6 years had passed since the event and the patient survived, the nurse "still [has] nightmares and [worries] about the patient."[14(p8)]

In some instances, punitive actions taken against the provider are more serious than termination. Denham[13] details the events surrounding the death of an obstetrical patient after an epidural medication was inadvertently

Table 2: Symptoms of Second Victim Experience

Physical	Emotional	Psychological	Professional
Exhaustion/fatigue	Anger	Anxiety	Burnout
Gastrointestinal distress	Disbelief	Depression	Decreased job satisfaction
Increased heart rate, blood pressure, respiratory rate	Embarrassment	Difficulty concentrating	Fear of disciplinary action, loss of employment, litigation
Muscle tension	Frustration	Flashbacks	Feelings of incompetency/inadequacy
Disturbed sleep	Grief	Repetitive memories	Lack of engagement
	Guilt		Loss of confidence
	Remorse		Self-doubt
	Sadness		Questioning career choice
	Shame		

administered through an intravenous line. Even though a series of system failures occurred in combination with human error, a nurse was criminally charged with the patient's death.[13]

Second Victim Suffering

Second victim care givers are known to suffer physically, emotionally, psychologically, and professionally.[2,3,11,14,16,17] Table 2 outlines specific symptoms second victims may experience as a result of internal self-criticism or the external judgments and actions of others, including the patient, patient's family, the provider's colleagues, or employer.[2,3,11,14,16,17] Symptoms such as sleep disturbances, difficulty concentrating, loss of confidence, and lack of engagement can threaten the well-being and safety of the providers and their patients and lead to additional errors.[16,18,19] Health care providers report the impact of distress lasts months to years; some never fully recover.[2,3] In the aftermath of adverse events, some second victims change jobs, leave their profession, or even consider suicide.[2,15]

Recovery Pattern

Scott et al[2] identified 6 stages of a predictable recovery pattern for second victims. Stage 1, chaos and accident response, is when the event is recognized, efforts are made to stabilize the patient, and the provider begins to realize the magnitude of the event. During stage 2, intrusive reflections, the second victim repeatedly reflects on the event, experiences self-doubt, and may lose confidence in professional skills. Stage 3, restoring personal integrity, is characterized by a search for acceptance and the need to regain trust from colleagues. In stage 4, enduring the inquisition, the individual recounts the event multiple times during the organization's investigation process and has a heightened sense of apprehension about future employment and career. Second victims seek emotional support during stage 5, obtaining emotional first aid, but are uncertain as to where to find this support or whom they can trust. Stage 6, moving on, has 3 potential outcomes: (1) dropping out (eg, transferring to a different practice environment, changing roles, or leaving the profession), (2) surviving (eg, continuing to work but still suffering from the event), or (3) thriving (eg, learning from the event and contributing to safety improvements).[2]

The degree of the event's impact on the second victim is determined by the response of colleagues and the culture of the organization.[3,18,20] Second victims need to talk about the incident and receive emotional support from their peers.[3,21] Second victims identify the importance of being supported by their manager and receiving assistance through a structured organizational support program.[2,3,19,21,22] Denham[13] proposed 5 rights of second victims: (1) treatment that is just, (2) respect, (3) understanding and compassion, (4) supportive care, and (5) transparency with the opportunity to contribute to future error prevention.

Promoting Support Programs

In response to the growing body of research that identifies the type of support needed by second victims, professional organizations and regulatory agencies have established guidelines encouraging the implementation of formal support systems in health care organizations. The National Quality Forum, which has outlined safe practices to reduce errors and patient

harm, specifies that after adverse events, caregivers should receive timely and systematic care that aligns with Denham's 5 rights of second victims.[12]

The Joint Commission encourages a transparent and nonpunitive method of addressing adverse events.[23] Hospitals are expected to have support systems available for second victims, and these providers should be offered the opportunity to participate in the organization's activities to prevent error recurrence.[1,24]

Beginning in 2018, hospitals participating in The Leapfrog Group's survey of safety, quality, and efficiency will be scored on the presence of protocols supporting caregivers involved in never events and on processes for making all caregivers aware of the hospital's support protocols.[25]

Professional nursing organizations embrace practices that support health care providers in these difficult situations. The American Nurses Association Code of Ethics for Nurses with Interpretive Statements,[26] which describes nurses' duties to patients and society, contains a provision that emphasizes a nurse's duty to self. This includes the "responsibility to promote [one's own] health and safety, preserve wholeness of character and integrity…"[26(p73)] Another provision addresses the nurse's responsibility to foster a moral work environment through respectful and supportive interactions with colleagues.[26]

These ethical responsibilities are consistent with the AACN's HWE standards[5]: (1) skilled communication, (2) true collaboration, (3) effective decision making, (4) appropriate staffing, (5) meaningful recognition, and (6) authentic leadership. These standards were developed to enhance patient safety, achieve optimal outcomes, and improve nurse satisfaction in the workplace. For each standard, AACN identifies critical elements that are evidence-based behaviors vital to creating an HWE. Interventions for second victim support based on all 6 HWE standards are discussed in this article.

Organizational Support Programs

Despite the recommendations for second victim support, evidence shows that formal programs supporting second victims remain limited.[2,3,27] In a Midwest academic health care system, 68% of survey participants involved in a patient safety event that caused personal distress reported not receiving organizational support.[2] Researchers in Sweden noted similar findings, where most second victims expressed a need for, but did not receive, systematic organizational support.[3] Joesten et al[27] examined surveys from 120 second victims in a community teaching hospital where some support services were available; only 32% of survey respondents felt adequately supported by the organization, less than one-third of respondents reported support services were offered to them, and the perception of 30% to 60% of respondents was that various support services were not available.[27]

In a national survey of risk managers from 575 health care facilities, 73.6% reported their facility provided emotional support to second victims; however, programs among these organizations varied with regard to scope, personnel, administration, efficacy, and maintenance.[28] The barriers to creating or maintaining support programs included funding, lack of clinical leaders to serve as peer support personnel, lack of buy-in by executive leadership, uncertainty about best practices, and uncertainty about how to initiate or organize a program.[28]

Health care providers can be hesitant to use support services, compounding their suffering. A stigma surrounding the need for mental health care causes some second victims to fear losing respect, being judged, or suffering a damaged reputation.[3,19,27,28] Others are concerned about confidentiality or fear the possibility that their need for psychological services will become a part of their employee record.[4,28] From a legal perspective, it is not clear whether communication occurring during the support process is protected information or if it could be considered admissible evidence against the second victim for possible malpractice litigation.[29]

Few organizations publish descriptions of formal second victim support programs.[21,30,31] One of the first to do so was University of Missouri Health Care, which created a 24/7 rapid response team for providers called the forYOU Team. The university developed the Scott Three-Tiered Interventional Model of Second Victim Support based on recommendations from second victims.[21] Tier 1 provides unit-based, individual support from peers and unit leaders immediately after the event, giving 60% of second victims sufficient support. Tier 2 supports the needs of approximately 30% of affected providers and involves assistance

from colleagues who are trained to provide individual emotional support, conduct group debriefings, assess second victims for signs that a higher level of support may be needed, and make appropriate referrals. Ten percent of second victims may benefit from support at tier 3, which assures rapid access to professional counseling services.[21]

Evaluations of second victim programs, although limited, provide information on the use of support services.[21,30,31] In the initial 10 months of the forYOU Team's program there were 49 tier 2 activations averaging 30 minutes each, 6 team debriefings averaging 77 minutes each, and 13 referrals for tier 3 professional support.[21]

The Resilience in Stressful Events (RISE) program at Johns Hopkins Hospital was studied over a 52-month period.[31] During that time, RISE provided trained peer support in response to 119 calls.[31] Researchers identified the most significant challenge for RISE was the second victims' lack of awareness of the program and uncertainty about how to access support.[31] This research is one of the few studies measuring efficacy of support programs. The RISE program was assessed from the perspective of peer support personnel and 87.8% believed they met the caller's needs.[31]

Efficacy was also reported in a Belgian study of 913 second victims in 33 hospitals. This study found no relationship between the hospitals' having a support team or protocol in place and the second victim's psychological impact and recovery from a patient safety incident.[20] Details of services offered by the hospitals were not examined and it is not known if providers were aware of support program availability.[20]

Actions for Creating a Healthy Work Environment

After an adverse event, the health care providers' needs should be thought of as a psychological emergency, with support provided on immediate and long term bases.[2,12,13,19] Health care professionals at all levels of an organization have essential roles in creating an HWE that supports second victims, eases their suffering, and fosters their recovery. Interventions for providing this support should be based on AACN's HWE standards.[5] Table 3 summarizes actions for second victim support using the framework of AACN's HWE standards.[3-5,8,10,12,13,19,21-24,32]

Healthy Work Environment Standards

The AACN HWE standard 1, skilled communication, is an essential competency for all members of the organization. This standard addresses continuously developing one's own communication skills, demonstrating mutual respect, promoting consensus building, protecting collaborative relationships, and assuring alignment between words and actions.[5]

Standard 2, true collaboration, recognizes that every team member makes valuable contributions to patient care. Critical elements of this standard include supporting the development of collaboration skills, respecting the opinions of others, working toward common goals, demonstrating accountability for one's actions, and holding others accountable for their actions.[5]

Standard 3, effective decision-making, asserts that all team members, including patients and their families, must be full partners in making decisions that affect patient care and the work environment. Effective decisions should be evidence based and data driven.[5]

Standard 4, appropriate staffing, assures that nurse competencies effectively meet patient needs.[5] Staffing decisions should take into consideration patient acuity, nurses' skills, and various work environment factors such as those affecting a nurse's ability to focus on patient care.[5]

Standard 5, meaningful recognition, is a process that acknowledges a nurse's contributions to the profession and the organization in ways that are meaningful to the individual.[5]

Standard 6, authentic leadership, outlines the role leaders have in creating a HWE. Critical elements include designing systems and engaging staff in implementing the HWE standards, modeling behaviors that are essential to maintaining the standards, and provision of the organizational resources necessary to achieve and sustain this goal.[5]

Staff Nurse Contributions

Contributions to second victim HWE by staff nurses are centered on skilled communication, true collaboration, and meaningful recognition. Peer support is important for second victims; when that support fails, second victims experience increased difficulty coping, self-doubt, and lack of confidence.[2,3] In 1 study,

Table 3: Healthy Work Environment Standards[5] for Second Victim Support

Skilled Communication	True Collaboration	Effective Decision-Making	Appropriate Staffing	Meaningful Recognition	Authentic Leadership
Encourage second victim to talk about event	Involve interdisciplinary stakeholders in program planning	Assess those involved in adverse events for symptoms of distress and need for support	Allocate additional staff to help stabilize patient during event	Assure second victims they are valued team members	Provide resources to create and sustain second victim support program
Listen actively, empathetically	Assure surveillance and support provided to all team members	Conduct periodic literature reviews for new evidence; maintain best practices for second victim support	Relieve staff from bedside care immediately after event to allow to compose themselves	Demonstrate trust in second victim's clinical practice	Model behaviors that uphold rights of second victims
Refer second victim to appropriate resources	Provide interdisciplinary team debriefing	Evaluate effectiveness of support program, make improvements	Evaluate staff for readiness to return to work	Encourage second victim participation in actions to reduce error recurrence and enhance safety practices	Address disrespectful behavior (eg, gossip, blame, incivility) toward second victims
Prepare provider for investigative process and provide follow-up on findings	Demonstrate respect for all second victims and hold others accountable for same	Include patients and/or families in decisions regarding safety improvements			Assure transparency between providers, patient and/or family, organization
Communicate to providers information on second victim phenomenon, organization's support program, and peer support					Foster culture that promotes system changes, avoids individual blame
					Build culture of safety that encourages reporting of errors, near misses

one-third of second victims reported a negative impact on relationships with coworkers after an adverse event, manifesting in forms of tension, judgmental comments, and open conflict.[3] Conversely, second victims have described peer support as a positive influence on their healing journey.[3,22] Second victims prefer to receive support from colleagues within their internal work environment rather than from external resources[21] and also may benefit from talking with colleagues who have experienced and recovered from adverse events.[4,11]

The communication skills that critical care nurses commonly use with patients and families are the same skills that empower them to provide support for their peers. Being present, actively listening, asking open-ended questions, demonstrating respect, avoiding judgment, and focusing on the emotions rather than on the details of the event are effective, caring interventions.[19,31] Verbally reassuring second victims about their professional competence is a form of meaningful recognition. Validating words with actions, such as asking a nurse to cover one's patients during a meal break, demonstrates trust and can help restore the provider's shaken confidence. Colleagues should understand that providers may need an extended period to recover and if second victim symptoms are recognized, peers can help the provider identify additional support resources through unit leaders.[2,3]

Responsibilities for contributing to a healthy work environment extend beyond an individual nurse's interactions with the affected providers. Colleagues from all disciplines must hold each other accountable for establishing and maintaining a workplace culture that is free from gossip, blame, ostracism, and other disrespectful behaviors toward second victims.[5]

Manager, Advanced Practice Nurse, and Educator Contributions

Second victims need their unit leaders' support in addition to peer support.[3,21,22] Unit-based leaders are responsible for creating an HWE through implementation of all 6 standards. During the event, an advanced

practice nurse can assist with stabilizing the patient; whereas, the manager can provide appropriate staffing by directing additional staff to the patient's bedside as needed. The primary need of the affected providers at this point is to have time away from patient care to compose themselves.[21]

Unit leaders should identify all direct and indirect care providers who may be affected by the event, including ancillary personnel, students, and volunteers.[4,21,32] Collaboration with department leaders will help assure all providers receive the emotional first aid they require. Unit leaders can plan for a formal team debriefing.

The manager, advanced practice nurse, and educator must be aware that staff members will often look to them to determine how second victims should be treated. By modeling respectful, compassionate, and blame-free interactions, these unit leaders provide authentic leadership that visibly sets the standard for an HWE.

Unit leaders should monitor for and control gossip or any forms of incivility.[4] To help restore a second victim's confidence and integrity, clinical leaders can provide meaningful recognition by identifying the provider's contributions to the unit and expressing trust in their clinical skills.[19] Establishing a surveillance process to frequently monitor providers for second victim symptoms will facilitate effective decision-making and identify the need for increasing levels of support in the weeks and months after the event.[3,4,21]

The incident analysis that takes place after an adverse event often intensifies and prolongs the second victim's distress.[2] Second victims are uncertain about the investigative process; many reported not receiving follow-up information on the outcome of the inquiry or notification that the case had been closed.[3] Unit managers can collaborate with the hospital risk manager to address these concerns. Using skilled communication to provide information, guidance, and periodic updates on the process enables the unit manager to offer the second victim additional support.

Unit-based advanced practice nurses and clinical nurse educators can communicate information proactively to staff on the second victim phenomenon, sources of organizational support, and team members' roles in creating an HWE. After an adverse event, second victims need to learn from the incident and identify the conditions that contributed to it.[3] This can be accomplished through conversations with advanced practice nurses or nurse educators. Group educational presentations, such as morbidity and mortality conferences that focus on learning from errors nonpunitively, can promote understanding of the event, enhance the quality of nursing practice, and contribute to a culture of safety through future error prevention.[33]

Educators in the academic setting should include second victim information in undergraduate and graduate curricula.[32] A standardized program for educating students about the second victim phenomenon has yet to be developed, however, Daniels and McCorkle[34] have proposed an evidence-based curriculum for nurse anesthetists. An expert panel validated this educational content, which consists of 6 domains: (1) define and describe the second victim, (2) risks for nurse anesthetists, (3) barriers for second victims, (4) consequences of second victims, (5) evidence-based understanding and interventions frameworks, and (6) support systems.[34]

Senior Leader Contributions

Skilled communication and authentic leadership are the primary standards through which senior leaders contribute to an HWE. Second victims have identified a need for support from their organization[2,3,19,22] and the support available depends on the influence and direction provided by the organization's senior leaders. The senior leader's role in establishing an HWE for second victims is twofold. First, senior leaders are responsible for designing systems that protect care providers and defend the rights of second victims.[12,13] Second, senior leaders are responsible for creating a culture that upholds the values, expectations, and behaviors of the organization.[13]

A comprehensive system for providing second victims organizational support requires commitment from senior leaders and allocation of appropriate resources.[12,13,19] The system should encompass department-level and professional support, and it should provide a rapid response 24 hours a day.[4,19,21]

Resources are available to assist organizations to develop and implement a support system (Table 4). The Clinician Support Toolkit for Healthcare consists of an organization-readiness assessment checklist and 10 modules

for creating multidisciplinary advisory groups, developing policies and procedures, determining operational details, and evaluating program outcomes.[35] A system for educating all care providers on the second victim phenomenon, the needs of second victims, and steps for accessing the organization's support resources is an essential key to program success.[2,31] Once established, a support program's outcome data should be evaluated and improvements made to assure second victims' needs are being met.[35]

Senior leaders must actively support the rights of second victims and model behaviors that make this support visible throughout the organization.[12,13] Examples of this behavior include publicly requesting respectful treatment of second victims after an event, personally demonstrating compassion, assuring that second victims receive timely and appropriate care, and providing caregivers with the healing opportunity to participate in nonpunitive event analysis and organizational safety enhancement.[12,13]

Senior leaders must foster a safe and just culture that uses a systems approach for identifying factors that contribute to adverse events and for improving defective processes.[10,12] Nurses who perceive their organizational culture as supportive, respectful, and nonpunitive report less second victim distress after patient safety incidents, whereas those who see their organizational safety culture as one of blame experience a higher level of distress.[18,20] Health care organizations that achieve high levels of safety have developed a culture where providers feel safe when reporting errors, near misses, and unsafe conditions.[8] This component of an HWE enables organizations to understand how and why errors occur, which leads them to create a safer system.[36] Preventing adverse events will reduce the number of health care providers who become second victims in the future.

Conclusion

Adverse events resulting in patient harm affect health care providers in a variety of ways; the damaging effects may be substantial and long lasting. Predictable stages of recovery for second victims and additional studies offer guidance on how to support traumatized caregivers. Additional research is needed to evaluate outcomes of support programs and identify effective interventions.

Table 4: Second Victim Resources

International Critical Incident Stress Foundation, Inc
https://www.icisf.org

Institute for Healthcare Improvement: Respectful Management of Serious Clinical Adverse Events
http://www.ihi.org/resources/Pages/IHIWhitePapers/RespectfulManagementSeriousClinicalAEsWhitePaper.aspx

Johns Hopkins University and Health System: Resilience in Stressful Events (RISE)
http://www.safeathopkins.org/resources/johns-hopkins/rise/

Medically Induced Trauma Support Services: Clinician Support Tool Kit for Healthcare
http://www.mitsstools.org/tool-kit-for-staff-support-for-healthcare-organizations.html

University of Missouri Health Care: forYOU Team
https://www.muhealth.org/about-us/quality-care-patient-safety/office-of-clinical-effectiveness/foryou

Helping second victims heal and thrive after an adverse event is the responsibility of every member of the health care team, from bedside providers to the organization's senior leaders. The AACN's HWE standards provide a valuable framework for creating second victim support systems that can transform the work environment into a place that is "safe, healing, and humane."[5(p1)]

ACKNOWLEDGMENTS

The data in this article was presented in part at the American Association of Critical-Care Nurses National Teaching Institute; Houston, Texas; May 21-25, 2017.

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CE Evaluation Instructions

This article has been designated for CE contact hour(s). The evaluation demonstrates your knowledge of the following objectives:

1. Describe the second victim phenomenon and the suffering health care providers may experience after an adverse event.
2. Delineate the essential components of a second victim support program.
3. Contribute to creating a healthy work environment that supports second victims.

Contact hour: **1.0**
CERP contact hour: **1.0**
Synergy CERP Category: C

To complete evaluation for CE contact hour(s) for this article #ACC7342, visit www.aacnacconline.org and click the "CE Articles" button. No CE evaluation fee for AACN members. This expires on October 1, 2020.

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