QI Boxset: Second Victims – Supporting your teams Pam

Laura Playforth and Pam Mosedale

RCVS Knowledge:

Welcome to the Quality Improvement Boxset by RCVS Knowledge, a series of webinars, podcasts, and video interviews for practices and practitioners.

Pam Mosedale:

Hi everyone, today I'm going to talk to Laura Playforth. Laura is Group QI Director at IVC Evidencia and I'm going to talk to her about Second Victim Syndrome. Hi Laura.

Laura Playforth:

Hi Pam.

Pam Mosedale:

I've heard this term 'second victim syndrome' quite a lot when I've been looking in, particularly in human health care information. What does it mean really? Who is this second victim? I'm not quite sure what it means.

Laura Playforth:

A second victim can be any member of the veterinary team who's emotionally impacted by an adverse event. When we say adverse event, that can be anything like a medical error, an unexpected patient death, or even conflicts with a client. And these incidents can have quite a significant impact on the team members who've been involved in that patient's care, as well as obviously what we might consider the first victim, which would be the patient and potentially the client in that as well.

It can be a bit of a contentious term, I mean victim in itself can be a bit of a contentious term, not everybody who's adversely impacted by life events wishes to consider themselves a victim, sometimes people see that as taking away some of their own ability to advocate for themselves. It doesn't seem... it seems like a passive way of describing somebody rather than an active participant in life, so victim itself can be contentious but there is or can be further contention around being a second victim and whether that is taking anything away from the primary victims, which obviously it isn't intended to at all.

There can be different terms used, so people adversely impacted can be used as a term on its own, but essentially they all mean the same thing, that something not good happened and the emotional impact extended further than just the patients and the client into the team.

Pam Mosedale:

I suppose in a veterinary setting you could almost call it third victim couldn't you, because there's the patient as the first victim and the owner or the carer for the animal or the client is the second victim. We're maybe the third victim.

Laura Playforth:

Yep, absolutely. They definitely do talk about that in human health care as well around impacts on friends and family. Because when adverse events happen, the extent of the repercussions can be quite far reaching, especially a very significant event like an unexpected death or significant victim harm. That in fact impacts a lot of different people.

Pam Mosedale:

Yeah, and definitely I can relate to that having been... actually, having made lots of mistakes and actually another contentious term, one of the mistakes I made was actually leaving an instrument in animal which is called a never event in human health care. I think personally, I think that's a contentious term too, because it makes you feel like you're so bad, you've done something that should never ever happen.

Laura Playforth:

Yeah, absolutely. And I think that term is definitely falling out of favour for that reason, because in itself it implies a degree of blame, like that should never have happened, so why did it happen to you? Whereas we know things like retained instruments, retained swabs, they still happen, they happen in human healthcare, they happen in veterinary healthcare, despite everybody's best efforts. So yeah, again, that's a term that very much we try to avoid these days.

Pam Mosedale:

Getting back to the second victims then, if that's what we're going to call them, what can we do to help? When something like this happens within our own team and somebody obviously has been really badly impacted by something that's gone wrong, what can we do as a team to help them?

Laura Playforth:

I think in an ideal world, it's best to have a team culture prepared in advance before a significant event happens. Obviously, if a significant event has happened and we haven't been able to do that groundwork, then we can deal with that separately. But I think developing that real culture of psychological safety for the team is incredibly important. When something bad does happen, the team know that everybody's got their back.

Not that we are not going to take responsibility for anything that we might have done that was wrong, but that we won't get blamed for having made a genuine innocent mistake. And I think psychological safety can be driven by how we behave, how we talk as a team to each other, how we talk to ourselves, how we behave towards each other. So always treating other people with compassion, looking to understand what's happened when something's gone wrong, even something very minor.

If we treat all minor incidents the same way that we would treat a major incident with psychological safety, we can build up that team culture and build up that team resilience and that spirit of we're all in this together, we're all trying to do the right thing, we all want the best for the patients, therefore anything that's gone wrong has been unintentional and an accident. And yes, merits investigation and yes, probably merits doing things different in the future, but it doesn't merit berating individuals or blaming them or any of those other really negative adverse behaviours. I think leading by example with a psychologically safe culture is incredibly important, but also being really explicit about it and talking to the team about it very openly.

What does that mean? What does that look like for us as a team? How do we identify behaviours that are consistent with that behaviours that are not consistent with that? And how do we challenge behaviours that are not consistent with the culture that we want to have as a team?

I think it's the underpinning value of the culture is absolutely can't be understated. But if we're in a situation where we haven't had the time for whatever reason to prepare that culture, then it's definitely listening to the individual without judgment, letting them offload their emotions, letting them talk about what happened, making it very clear that you're not judging them and letting them express their emotions, making it okay to talk about how you feel emotionally and not minimising them.

So not saying things like, it's okay, or you don't need to feel bad about it, because we do feel bad about these things and something's gone wrong and harmed a patient, everybody's going to feel bad about it that's involved. And that's a normal and natural emotion that people should be allowed to express. And if they can express it safely without fear of judgement, that can be part of the process in moving on because when second victimhood can become a real issue is when we're not able to or allowed to process these emotions effectively we can then get caught up in a lot of unwanted side effects moving on from that.

Pam Mosedale:

Yeah, again, I can really empathise with that because having once been involved in an error where nobody did talk about it and we didn't have a chance to debrief about it or express anything really and it was all kind of, it wasn't blamed, but it was kind of ignored as if it was shameful almost. I think you're so right there. But what about if people themselves, that person involved themselves doesn't want to talk about it? What would you do then?

Laura Playforth:

Yeah, I think that can be very challenging and there can be a lot of shame around medical mistakes. We're there as a veterinary team to care for patients and first do no harm is kind of the principle that we all live by. So, when harm occurs, it can be very difficult. And if somebody doesn't want to talk about it, then that is their prerogative. Not to talk about their emotional side of things, particularly.

I think it's good to signpost people to external help or to encourage them to speak to friends and family, speak to people outside the team, if they've got a mentor relationship, speaking to some like Vetlife or maybe the Samaritans if they are really struggling.

If you feel shame and can't get it out to the team, then I would always encourage people to speak about how they feel about it to somebody outside the team. And that can be equally effective and sometimes takes away some of those feelings of shame, and also that fear of being judged by team members as well.

There's some evidence that they did some studies in human health care with medical residents. And when an event had happened, one of the things that the medical residents worried about the most was how their fellow professionals would feel about it and whether they would still trust them to work together in a team environment.

Because obviously there needs to be a lot of trust between team members when you're delegating things, you're asking people to do things, you're doing a procedure together, somebody else is monitoring your anaesthetics, somebody else is doing a surgery, you have to be able to trust that the other person is competent and that was one of the things they worried about the most.

In terms of thinking about unpicking an incident after it's happened, there are some parts of it that obviously will need to be talked about at some point because we need to understand how an incident has happened. But that part of it can come later. The most important part of it is making sure everybody's OK and the damage is mitigated as much as it can be for the patient, for the owners and for the team member that everybody's emotional needs are met as best they can be through talking things through and having somebody listen with empathy and understanding. And then we can move on to the root cause analysis. And hopefully by that time, some of the weight will be taken out of it so they can just talk about it practically.

But I think it's that repeated understanding and support, you know, we're here for you, we understand these things happen, we're looking to prevent it happening again in the future and that can make a huge difference to people just hearing those things stated out loud. And I would identify with your experiences as well.

I've made some medical and surgical errors in the past and it just didn't get talked about and so you were just left with this horrible unresolved guilt and upset and concern of what do people think about me now.

I can remember a surgery that I did very early on in my career of doing a perineal urethrostomy that didn't go to plan and just feeling very stressed about it and having really intrusive thoughts about it throughout the day and struggling to sleep and just not knowing where to turn or who to offload that to and just feeling because of the shame that I just really didn't want to talk about it. But I think if somebody had approached me and talked about it in a supportive way, I think it would have been much easier to get over some of those negative emotions much more rapidly.

Pam Mosedale:

Yeah, and I think it's really important, as you say, to separate the two things, to do that initial talking to people if they want to talk about it, giving them support. But then we are tempted to get into the why did it happen and start looking at all the little details. But that's for later, isn't it? That's for a cold debrief. It's for later. And it needs doing, as you say. But one thing I think is nice for people is that when other people say, yeah, that happened to me.

And that I think that makes people feel quite a lot better, doesn't it, to know that they're not the only person in the world this has happened to. But what would the after effects be if people are not supported, if they are just left with their intrusive thoughts and not helped? What sort of after effects are we going to see?

Laura Playforth:

I think it can depend very much on the individual, can depend on what else is going on with them at the time, it can depend on how severe the incident was, but it can range from, you know, people can sometimes manage to work through these feelings themselves and move on. Some people are able to do that, particularly if they are not struggling in any other way and it's been a more minor incident, sometimes people can manage through that on their own. It's not ideal, but it can come out the other side okay. If it's much more significant impact on the patient and or if the person has got other things going on with them personally, then it really can escalate into something incredibly serious. It can have a very detrimental effect on people's mental health. It can lead to depression. It can lead to issues with post-traumatic stress type symptoms. You know, as we've talked about intrusive thoughts.

And it can lead to self doubt in terms of your professional or role capabilities. Like if this has happened, should I be doing surgery anymore? Should I be giving medication because I can't do it? What if it happens again? And this can lead to anxiety, which ironically can then lead to a reduction in performance and much more likelihood of mistakes happening again. If somebody is very anxious, double, triple checking things, it can lead to delays in care, getting administered. It can lead to other errors happening because they're so focused on not having this one thing happen again. Other things then get neglected and other errors can happen. So, it can be a really horrible, self-fulfilling prophecy if these emotions are not dealt with.

Pam Mosedale:

And I guess it can lead to burnout and definitely lead to loss from the profession. You might have people just deciding they're not going to do surgery anymore and they're going to stick to consulting, but you might also have people thinking, I'm not OK as a vet anymore. I'm not competent and capable of doing this job anymore.

Laura Playforth:

Yeah, absolutely. And particularly if you do get into that sort of that downward spiral of getting very anxious and focused on one thing and then something else happens and you think, you look at it as more evidence of I can't do this. Whereas all that needs to happen is processing these emotions and moving on from this incident. And then that person can go back to being perfectly capable and competent as they always were. Mistakes happen to everybody. It doesn't matter how capable, competent, experienced, how many qualifications you've got, how many surgeries you've done.

These things will happen to everybody at some point. And I think you're right, having that open discussion of mistakes that have happened to you or to people you know in the past, it can be really helpful to put things into context. And I think social media, although it can be both a blessing and a curse in these senses, I've definitely seen lots of threads of somebody saying, gosh, I've done this awful thing and I feel terrible. And then in a really big group, you'll see dozens of people go on and go, I've done that. Yeah, that happened to me. That happened to somebody I know. And it doesn't minimize the impact of what happened on the patient, but it puts it in context of this is a mistake that people make. So, you feel like it's, it's more of a, yeah, it's more accepted that that mistake can happen rather than it's just something wrong with you. That is why it happened.

Pam Mosedale:

And if those kinds of mistakes, a particular type of mistake is happening often, it gives a chance for it to look later in the cold lighter day, you say, at the systems involved and see if there's something that could help, you know, what would you say to a practice then?

If they want to start thinking about this, what's the first thing they should do to try and prepare themselves for this happening?

Laura Playforth:

I think having discussions about significant events early before they happen can be really helpful in setting that sort of culture and getting processes ironed out for what happens if, well, if when a significant event happens, because it will at some point. You can set out that process for people and talk about mistakes that have happened in the past proactively. So, things that you've done, particularly for practice leaders and team leaders that can be really powerful to talk very early on about, I made this mistake in my career. Here's what happened. Here's how I dealt with it. Sometimes here's how I would have dealt with it if I'd known more about how to process these emotions and how to go through the root cause analysis process. And I think that can really set the tone for the entire team that they understand that people make mistakes and that when they make a mistake, this is what the process is going to involve.

And it's important, like you say, to focus on the emotional processing in the first instance, and then look towards the root cause analysis process. And having that root cause analysis in place quite often really helps people, because the thing that they really want to happen is for this not to happen again, not to them and not to anybody else. And knowing that the root cause analysis process is in place and how it works and how it's thorough and how it puts changes in place to prevent things happening again, or at least reduce the incidence as much as it can do.

That can be really, really helpful to people. So, I think getting things set up before something happens is always the ideal. And I think talking a lot about having a growth mindset as well, that adverse events happen, and we focus on learning from them, and we review mistakes as a team as an opportunity for growth that is all part of our quality improvement ethos and our culture of psychological safety where we look after each other and we support each other even when things go wrong.

I would say that's probably the best basis if you're thinking about how to get set up for these things is that really open communication, the leaders setting that example and talking very openly about things that have happened to them and getting that process ready and doing debriefs and going through maybe a mock scenario to test out your process or perhaps picking something like a near miss event.

They can be fantastic because there's much less emotion associated with a near miss event because it didn't actually happen. Although some near miss events can have an impact on some people. If it was a very risky incident, a lot of them are quite low risk and no harm actually happened. So, it can take the emotion out of the situation of sort of practicing and going through the process to see how it would work. And then when something does happen, everybody's familiar with how it works and what happens. And they know the kind of conversations that will be had and they know the culture and they know what's coming. And again, that can take a lot of that fear of what's going to happen. Am I going to get fired? Is the team going to refuse to work with me? It takes that out of the equation because they know that's not going to be the case.

Pam Mosedale:

Yeah, I think that's really important. Everything's a learning opportunity, isn't it? Everything that happens, even the bad things that happen in practice, are learning opportunities. And for anyone who might be listening to this and think, well, how do you start doing this root cause analysis stuff, et cetera, we've got loads of resources at RCVS Knowledge. We've got some more podcasts like this. We've got webinars.

We've got all sorts of resources you can look at. And you can even use some of our case examples of things you could discuss as a team as if, yeah, what would we do if that happened to us?

Laura Playforth:

Yeah, absolutely. And I think it can sound, if you're not familiar with the process, it can sound like something really complex and scary, but the resources on there will just walk you through it from start to finish.

And it can be really quite straightforward. You just need to follow through the process and it's about not jumping to conclusions of, it was this one thing that was the thing that caused everything to happen. It's looking at it more broadly and looking at what other factors were involved because healthcare is complex. Life is complex.

And these incidents will always be complex. Multiple people are usually involved. There's lots of different processes. There'll be patient factors going on. They might have comorbidities. There might be client factors of what the client wants. And all these things contribute to errors happening. So, it's about looking at the situation more broadly and unpicking all the different pieces and then looking at what you can put in place to try and reduce risk in the future.

I think it's such a powerful thing to do together as a team and it can really bring the team together because they're focused on solving a problem, not on criticising a person.

Pam Mosedale:

I think that's the real take home of this isn't it? It's not about blaming people, it's looking at what went wrong, not who went wrong, but supporting the person involved.

Laura Playforth:

Yeah, absolutely. I think supporting the whole team as well, there's a team behind every act of care that takes place. The clients and the patient will have come into contact with multiple people, even in an outpatient consultation scenario. And it's again, not forgetting about the rest of the team as well.

So, even though it may be a clinical person who has the sort of final touch on a mistake, there could be other contributory factors involving other people. It's thinking about them as well and how they feel and not just focusing on, the vet did this. But, you know, did the receptionist have a party in that case? How do they feel about it? And I think, you know, when we're very focused on ourselves, if something's happened to us, you can sometimes forget about the wider team and they can be equally impacted. And sometimes not, you know, if something clinical has happened and they're a non-clinical member of the team, they maybe haven't got as full an understanding.

And it's worth going through things with them as well so that everybody knows and understands what's happened and that what their role in it may or may not have been.

Pam Mosedale:

An activity for the whole team really.

Laura Playforth:

Yeah, yeah, absolutely. And it can be just such a positive experience and bring teams together and that's what it should be.

Pam Mosedale:

Thank you, Laura. think that's your final sentence there was absolutely got it all in a nutshell. So, thank you very much for your time today and hope this is useful to anybody. Bye.

Laura Playforth:

Thank you.

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