עדכוני המערך לבטיחות הטיפול

ינואר 2021

תופעת 'הנפגע השלישי'

הנפגע הראשון מאירוע חריג, הוא כמובן המטופל ומשפחתו. הנפגע השני בעקבות אירוע חריג הוא איש הצוות אשר היה מעורב ישירות בטיפול, עת ארע האירוע החריג. הנפגע השני עלול לחוות את האירוע החריג כטראומטי, במישור המקצועי ובמישור האישי.
לתמיכה אותה מקבל (או לא מקבל) הנפגע השני מסביבת העבודה שלו, השלכות ארוכות טווח על השפעת האירוע החריג על מצבו הרגשי של הנפגע השני, המוטיבציה, תפיסת התפקיד שלו, נכונותו לקחת אחריות, להתקדם במקום העבודה ועוד.

עו"ד אלונה סיגלר-הרכבי תיארה את תופעת **הנפגע השלישי** (The third circle of victims): לצד אנשי הצוות המעורבים ישירות באירוע החריג, שהם המעגל השני שנפגע, יש את המעגל השלישי שהם אנשי צוות אחרים שהיו נוכחים במשמרת, חברי צוות שהיו אמורים להיות במקום ונעדרו, חברי הנהלה שלא נכחו במוסד וצוותים מיחידות אחרות שחוששים שאירוע כזה, יכול לקרות גם להם.

לאירועים חריגים ברפואה יש השפעה רחבה ונמשכת הרבה יותר ממה שנהוג לחשוב. אנשי המעגל השלישי (למרות שלא היה להם חלק באירוע החריג) בוחנים את האירוע החריג ואת ההתנהלות שלאחריו, ומסיקים מסקנות אישיות באשר להתנהלות המקצועית שלהם. למסקנות אלו יש השפעה מכרעת על תפיסת התפקיד, יכולת העבודה בצוות, הנכונות לקחת אחריות, המוטיבציה להכניס טכנולוגיות חדשות ולעיתים הרהורים על העתיד המקצועי שלהם.

הלך הרוח של המעגל השלישי, המוטיבציה והערכים הם אלה שיבנו את עבודת הצוות, את הלמידה מאירועים חריגים ואת מניעת הישנותם.

עבודת הנהלה עם תמיכה, שקיפות והבנה שלא כל אירוע חריג הוא תוצאה של רשלנות או שניתן מראש למניעה, פידבק חיובי ומסר, שרוצים את הצוות בהמשך, תסייע לשמירת צוות מקצועי שהושקע רבות בהכשרתו.

מומלץ להכניס להכשרות כלים להתמודדות עם אירוע חריג, על מנת להפוך את ההתמודדות עם הנושא לאפקטיבית יותר, לצמצם השפעה שלילית על אנשי המעגל השלישי ועל המוסד הרפואי כולו.

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Quality and Patient Safety Executive Division
P.O.B 1176 Jerusalem 91010
Tel: 02-5080313 **Fax**: 02-5655962

אגף בכיר לאיכות ובטיחות הטיפול
ת.ד.1176 ירושלים 91010
טל: 02-5080313 **פקס**: 02-5655962

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[Opinion]

THE THIRD CIRCLE OF VICTIMS, FOLLOWING A SENTINEL EVENT-THE RIPPLE EFFECT

Alona Sigler-Harcavi

Abstract

As an attorney with extensive experience in risk management, patient safety and quality assurance, I also represent, for the State of Israel, medical staff ("second victims") before inquiry boards, following sentinel events. Thanks to attorney-client privilege and the anxiety regarding the inquiry, staff members are very open with me, often baring their emotions, pains and fears to me with respect to the mood and tone existing in their ward, even weeks and months after the sentinel event. Consequently, I witness the ongoing injury caused by sentinel events, not only to the patient and to the second victims, but also to the entire staff of the ward (sometimes of the entire institution). These are the members of the third circle of victims ("third victims"). When management doesn't take care of the second victims, the third victims also get hurt, dreading the possibility of being involved in a similar event and not getting the care they need from their employers. These apprehensions harmfully affect the solidarity of the ward and the whole institute's corporate culture, resulting in an "every man for himself" mentality. Therefore, taking care of the second victims should be an integral part of risk management, not only for the benefit of the second victims, but for a far larger and wider interest: preserving morale, motivation, role perception, teamwork, etc. of the third circle. It has been my experience that post-sentinel-event risk management that does not include second victim care, is like a half-built bridge: going nowhere, very low ROI.

Key Words: Risk management, sentinel event, second victim, inquiry, transparency, learning organization.

First example –A mix up in the IVF unit:

I want to tell you the story, of a sentinel event, that took place, not so long ago, in an IVF unit, at one of the general hospitals, in Israel:

- The embryos of patient A were accidentally implanted in the uterus of another patient, patient B.
- This was the result of an accumulation of mistakes, made by doctors, nurses, lab technicians, and a Secretary – just like in the Swiss cheese model.
- Fortunately, a few minutes later, a lab technician discovered the mistake – by sheer luck.
- The incident was reported immediately, and the senior staff talked with both patients: the owner of the embryos and the patient who received them, by mistake.
- The patient who received the embryos agreed to pregnancy prevention procedures and the embryos were lost.

The consequences of the incident:

- Both patients did not receive their embryos that day;
- One patient lost precious embryos;
- The other patient suffered a critical loss of trust, in medical staff – and refrained from having any more fertility treatments;
- A malpractice lawsuit was filed against the hospital;
- The incident was widely reported in Israel, through national media and social networks.

Risk management actions:

- Following the incident, the hospital performed some risk management activities: a debriefing was conducted, and protocols were refreshed and renewed;
- The Israeli Health Ministry conducted an inquiry of its own.

Meanwhile, new problems emerged:

- The incident impacted harshly on staff morale and motivation, their ability to work as a team, the ability to rely on each other, their perception of their roles, and more;
- Allegations were exchanged between staff members of different disciplines and between the management and the staff;
- Staff members who reported and revealed systemic problems, as the cause of the incident, were perceived as troublemakers.
- One staff member decided to leave the unit, blaming a hostile work environment as the cause for leaving. Later she was asked to come back – and so she did – but the problems remained;
- The incident impacted badly on staff performance and the overall mood of the unit for some time.

Representing medical staff:

- As an attorney with extensive experience in risk management, patient safety and quality assurance, I also represent, for the State of Israel, medical staff that were involved in sentinel events (sometimes known as "second victims") before inquiry boards.
- Thanks to attorney-client privilege and the anxiety regarding the inquiry, staff members are very open with me, often baring their emotions, pains and fears, with respect to the mood and tone existing in their unit, even weeks and months after the sentinel event.
- Consequently, I witness the ongoing injury caused by sentinel events, not only to the patient and to the second victims, but also to the entire staff of the unit, members of the management and sometimes the staff of the entire institution, which I shall refer to as the "third circle of victims".

Multiple points of view:

- I can tell you the story of the sentinel event in the IVF unit –
  - From the patients' point of view;
  - From the point of view of the second victims;
  - Or from the point of view of the management;
  - But this article will focus on the Third Circle's point of view: their needs and feelings, their resolutions, decisions and more.

The Second Victims:

Because we are dealing with a ripple effect, in order to fully understand the implications on the third circle, a few observations regarding the second victims are necessary:

- Often, as a result of being involved in a sentinel event, the staff members experience trauma. Many staff members define such an event – and the time period following such an event – as the most difficult period of their career or even their lives.
- Those staff members feel guilty for failing the patient and doubting their aptitude for their position or profession.

- Some of the second victims take all the responsibility upon themselves – and ignore the system's role in the event.
- While others: Blame everybody else for the event, in order to feel better about themselves – which, in its turn, generates a sequence of new problems in the unit, especially regarding teamwork and trust.
- Left to their own devices, the length of the second victims recovery period and the outcome of this recovery is totally based on the individual`s strength and resources

What do Second Victims need?

- To know they are not alone, when facing their conscience, the patient, their colleagues, the media, the Ministry of Health etc. (Some of the Second Victims even have to face backlash from inside their own home).
- They need to know they still have a professional future.
- Second victims feel relieved when the patient or the patients' family is being looked after and that their pain is being alleviated.
- Second victims feel better when actions take place in order to prevent similar events from occurring again in the future, since this means: 1.There is a smaller chance for a similar event to happen to them again in the future; 2.Something good came out of the event – therefore the pain was not entirely in vain.

The Second Victims – What is the reality I see in Israel?

- The Israeli Ministry of Health repeatedly declares that it expects the institutions to support the second victims.
- However, there are big differences between the medical institutions as to how to handle this issue.
- The second victim is sometimes lost between the cracks, resulting in negative consequences such as: A decline in the motivation to take responsibility and the motivation to advance, or even leaving the healthcare system entirely, which means that years of training and experience go down the drain.
- Of course, a culture of blame and shame does not go hand in hand with supporting the second victims. A culture of learning and forward-facing risk management depends on supporting the second victims.

The Third Circle of Potential Victims

- Many of those Staff members think to themselves: "something similar could have happened to me too, and what will become of me if it does"?
- Other staff members may think it will be better for them to keep their distance from the second victims, since they prefer to be identified with the group of staff members so called: "those who never make mistakes".
- When management does not take care of the second victims, and does not send a clear appropriate message across the institution, the third circle also gets hurt: They fear the danger of being involved in a similar event, and they assume that if so, they too won`t get the support they will need, neither from their employers, nor their colleagues. These apprehensions harmfully affect the solidarity of the unit and the whole institute's corporate culture, going as far as an "every man for himself" mentality.

The main Take home message:

- Following the occurrence of a sentinel event, caring for the second and third circle of victims is an integral part of forward-facing risk management.
- Not only for the benefit of the second victims, but for a far larger and wider interest: preserving morale, motivation, role perception, teamwork, etc. of the entire third circle.
- It has been my experience that post sentinel-event risk management that does not include second victims care, is like a half-built bridge: going nowhere, very low ROI.

Second Example – Suicide in an oncology ward

- A patient with suicidal tendencies, well known to the staff, was hospitalized in an oncology ward. He committed suicide there, by jumping out the window.
- The incident happened when the nurse, who was in charge of the suicide watch, stepped out of the room briefly, to bring the patient his medication, which he urgently needed.
- The ward's staff had no previous experience in dealing with mental or suicidal patients.
- The event was traumatic for the entire staff, including the arrival of the police at the scene.
- In this case, the hospital's chief nurse and her deputy immediately arrived at the scene.

- The chief nurse supported the staff, helped with handling the patient's family and the authorities.
- In the weeks to follow, a lot of resources were invested in drawing conclusions, making the required changes and supporting the staff.
- The main messages to the entire staff were:
  - The nurse involved was not the only one responsible for the event;
  - Systemic lessons must be learned;
  - The most important issue is to prevent future events;
  - Work must go on, while giving support to those who need it.
- Despite all the difficulties, the ward managed to keep a positive and functional atmosphere, good teamwork and to give mutual support.
- The health ministry inquiry board, which took place months later, was very impressed with the work that was done by the chief nurse and the entire hospital.

So what to do? – My Model (in a nutshell)

1. Principles and Values:

1.1. The third circle's state of mind, motivation and values are what make or break the team work. Without team work we cannot do anything, especially to prevent sentinel events and learn from them, when they do happen.

1.2. We should raise the awareness of mid and upper-level management to the reality that any response or lack of it, following a sentinel event has an immense, lasting impact on the entire staff of the unit and their overall disposition.

1.3. Management of all levels must commit to a consistent and pre-established policy, regarding sentinel events, reports of events and near misses, supporting the staff, adopting a systemic approach and so on.

1.4. A fixed set of rights: as others I also suggest predetermining a fixed set of rights for second victims – this way everything is known in advance.

1.5. Dealing with a sentinel event, one must always remember that not all such events are the result of negligence or preventable.

1.6. Avoid the misconception that punishment, by itself, is sufficient to prevent future mistakes. Punishment does not inspire motivation, quite the opposite.

2. After the event

2.1. Regarding The Second Victims

2.1.1. The first question management should ask themselves - regarding each and every staff member, who was involved in a sentinel event - is:
Do we want to retain them?
Usually, management intuitively knows the answer to this question, especially when the event was caused by an inadvertent mistake, contributed by a systemic or an infrastructure deficit.

2.1.2. Credibility and Transparency are other significant considerations, for retaining the staff member, since this is exactly the kind of behavior we want to encourage.

2.1.3. Clear Messages and Consistent Actions:
When management decides to keep the staff member, management's actions need to be consistent in this matter, such as: making sure that the staff member gets emotional support when needed, and has legal counsel – generally this is already covered by insurance. Telling the staff member explicitly: according to what we know today and as far as this is up to us, we want you with us going forward. We understand that a systemic problem or an infrastructure challenge also contributed to the mistake, and we will do everything in our power to improve them, in order to reduce the chance of a similar event occurring in the future.
And last but not least: Don't forget to give positive feedback, such as - we appreciate the way you acted after the event – when such feedback is due.

2.2. Regarding The third circle - Clear messages to the entire unit and institution These messages need to be explicitly spread to the entire staff of the unit, in order to prevent negative atmosphere and trust issues.

3. On a day-to-day Basis – Regarding the Entire Staff of the Institution

3.1. Since sentinel events and mistakes, are an inseparable part of any system, every training and every protocol should include references as to how to cope with them when they do happen, sooner or later, including: everybody needs to be transparent, cooperative, and do whatever they can to lessen the damage while supporting each other. This will help us to learn how to prevent similar mistakes in the future.

3.2. Each and every member of the organization needs to ask themselves every day
- What can I do today?
  - With what I have in hand now
  - From my position;

- In order to:
  - Prevent sentinel events
  - Improve team work, morale, motivation, etc.
- To benefit:
  - Myself, and other staff members, patients and the entire organization.

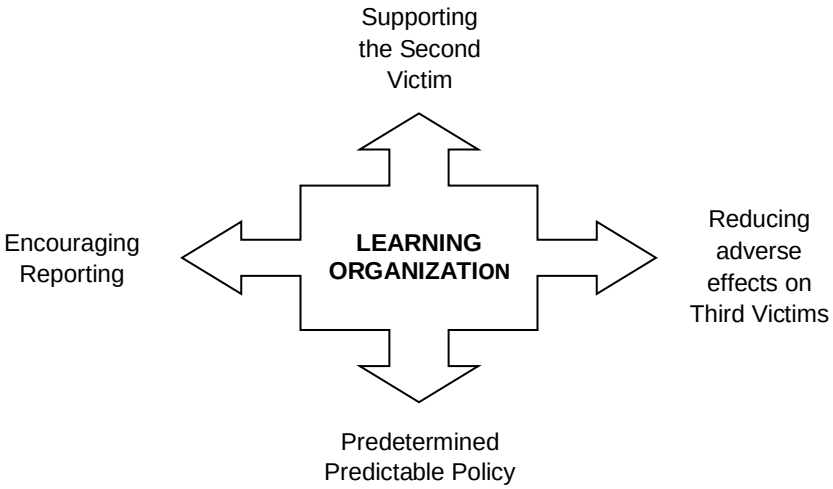
3.3 In my experience, each and every one of us, can contribute to these goals, even an independent legal counsel, such as myself.

In conclusion:

In order to be a learning organization, which we all want to be, we should remember the ripple effect that sentinel events have throughout the medical institution.

Therefore we must make sure that our culture includes supporting the Second and third circle of victims.

Risk management that does not include second victims care, is like a half-built bridge: going nowhere, very low ROI.



Contact to the Author:
Alona Sigler-Harcavi, Esq., LL.B., LL.M.
E-mail: alona@hlaw.co.il