Case Report

Development of a Facility-Level Second Victim Syndrome Peer-Mentor Program: Program Design and Future Directions

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Abstract

Background
Despite efforts to prevent errors, studies show that iatrogenic, or health care-related, errors continue to occur. Understandably, these errors, which can range in severity from near-misses to serious harm, can be devastating for the health care professionals involved, creating a potential second set of victims, in addition to the patient(s) that were harmed directly. Studies show that individuals struggling with second-victim syndrome (SVS) can be at increased risk for depression, burnout, and poor work performance. However, programs designed to develop peer mentors to support individuals struggling with SVS are poorly described.

Methods
Following a review of the literature, our team designed a program that involved training for leaders to serve as mentors and provide ongoing emotional support to their staff. Mentorship training included a 90 to 120-minute training, involvement in monthly mentoring meetings, and materials and training on potential support modalities, such as journaling, aromatherapy, walking paths, and other stress relief activities.

Results
Thirty SVS peer mentors at our facility completed the training, with plans to expand to 50 SVS peer mentors by the end of 2025. Plans to expand the program to other facilities, add additional metrics, and evaluate both mentor and staff outcomes are underway.

Conclusion
The mentor training program was designed to support health care professionals experiencing SVS and build support for colleagues through the development of mentors to help with psychological support. Additional research on the short- and long-term outcomes for facilities implementing similar SVS peer-mentoring programs is needed.

Keywords
second-victim syndrome; SVS, medical errors; counseling; health personnel; mental health; psychological stress; mentors

Introduction
In the course of their daily work, health care professionals can face intensely challenging situations. Depending on the setting and role, health care professionals are frequently required to navigate complex clinical situations, often with limited time, support, and resources, while simultaneously managing sorrow, grief, and other difficult emotions related to their patients.[1] In some cases, these feelings can be related to involvement in a medical error or patient safety event.[2,3] Despite efforts to prevent medical errors, studies show health care-related errors continue to occur.[4-6]

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These errors, which can range in severity from near-misses and minor mistakes to serious, potentially life-threatening events, can produce powerful emotions for the health care staff involved, some of which have the potential to permanently alter the course of their personal and professional lives.

While medical errors pose a clear risk to patient safety, there is a growing recognition that errors can pose risks to the health care professionals involved in them as well.[3] More than 20 years ago, in his now seminal 2000 publication, "Medical Error: The Second Victim," Dr. Albert Wu introduced the concept of health care providers as potential second victims of medical errors.[7] In the years that followed, the concept of health care providers as potential "second victims" was expanded to include not only the trauma staff experienced following involvement in medical errors, but also patient injuries, suicides, and other unanticipated adverse patient events.[8,9] Recently, a group of international experts proposed a definition that further expanded the definition of second victims to include "...any health care worker, directly or indirectly involved in an unanticipated adverse patient event, unintentional health care error, or patient injury...who becomes...negatively impacted...," emphasizing that the negative impact to health care providers can be multi-dimensional, and not just limited to clinical staff.[10]

The incidence of second victim syndrome (SVS) is not well-defined, but recent studies suggest that 10% to 40% or more of staff may experience signs of SVS after involvement in an error or serious patient event, reporting feelings of guilt, anxiety, depression, intrusive thoughts, isolation, and sleep disturbance, to name a few.[11] These feelings, in turn, can lead to disruption to personal and professional relationships, loss of confidence, and changes to well-being.[11,12] In addition, while the long-term consequences of SVS are not well-defined, there is evidence that without appropriate support, some health care providers experiencing SVS can spiral into severe depression, with some even contemplating, or choosing to take their own lives.[13]

Because of the risks that SVS can pose to health care professionals, identifying signs of SVS quickly is key.[6] In particular, experts suggest it may be important for health care facilities to monitor colleagues for signs of SVS at a unit- or department-level and "...provide an immediate intervention with one-on-one support, trigger debriefings, and access to other organizational resources, such as patient safety or risk management leaders."[14] However, implementing effective SVS programs requires resources, support, and in some instances, a shift in the underlying culture of a facility or health system.[15]

Over the last 2 decades, various SVS support programs have been developed and implemented,[15] with some reporting favorable outcomes.[16,17] However, the impact of SVS programs is still being evaluated.[18,19] In addition, while many SVS programs have a similar focus conceptually, in practice, many SVS programs focus on different triggers for SVS, use different assessment tools,[20] and measure different outcomes.[19] However, a feature that has been relatively consistent across SVS programs is the use of peer-supporters both as a means for building capacity within the organization and for engaging health care providers, who may be reluctant to engage with traditional employee mental health support mechanisms, such as employee assistance programs.[21]

With this in mind, the purpose of this article is to describe the context and design of a facility-based program aimed at developing peer mentors capable of identifying and providing support to health care providers at risk for or suffering from SVS. Specifically, in the manuscript, we describe the structure of our program, which is being piloted now, outline goals and proposed metrics, and finish by discussing the planned next steps.

Methods

Program Setting

The setting for this program was an approximately 400-bed acute-care hospital located in a large urban center in the southern part of the continental United States. The hospital is a Level II trauma center, a Joint Commission-accredited comprehensive stroke center, an accredited chest pain center, and a Level III neonatal intensive-care unit. The facility is also designated as a Pathway to Excellence® and Magnet®-accredited hospital.

Program Context

Clinically, the context for the development of our facility's SVS and support program was rooted in several experiences, described below.

Initially, one of the triggers for the program came in the aftermath of a child who arrived at our emergency room in need of cardiopulmonary resuscitation. Despite the staff's efforts, the cardiopulmonary resuscitation ultimately proved unsuccessful. Adding to the difficulty, one of the staff members involved in the resuscitation effort was pregnant, days from her planned due date. While all were experienced staff, the overweighing nature of the situation, with some staff forced to recoil at the sight of the child covered in a white sheet on a stretcher, was simply too much to bear for some. Adding to the collective trauma, within days of this event, the staff had to intervene on another small child who had drowned. As is common for emergency room staff in many locations, over the following weeks, staff were faced with additional distressing incidents, creating multiple second victims in need of support.

A second trigger for the development of our SVS peer-support program involved a case where a physician met with facility leadership and the patient safety team to discuss a patient who had unexpectedly died. During the meeting, the physician repeatedly replayed the events, struggling to come to terms with the difficult situation. Unbeknown to the physician, he was experiencing the effects of being a second victim.

In addition, the need for a second-victim surveillance and support program was brought to light by our staff's involvement in the COVID-19 global pandemic. The staff caring for patients with COVID-19 witnessed patients who ultimately died from COVID-19 or complications from the disease. Like thousands of other nurses and health care providers worldwide, despite their best efforts, many of our nursing staff questioned why patients were still dying. One physician explained that we, the staff, were the ones who were providing them with empathy and compassion and their best chances of survival. The work being done during the pandemic was more than medical care; it was emotional and spiritual support for the patient and their families. Caring for a dying patient can be stressful and psychologically taxing on the health care provider, but the impact on the patient and family is immeasurable.

Collectively, these situations, as well as the larger psychological and emotional backdrop of the COVID-19 global pandemic, highlighted the need in our hospital for a formal program to identify and help support staff struggling with SVS. In particular, these situations underscored the need to provide leaders with training on how to recognize staff at risk for SVS, as well as strategies for supporting staff who may be struggling with their involvement in an error or traumatic care-related experience.

Program Goals

In response to these challenges, the Patient Safety team at our facility set out to develop an SVS surveillance and support program, with a focus on identifying and developing mentors. The program, (which we called "Plus Let Us Support Staff" (PLUSS), had 2 aims. First, the PLUSS program was designed to build our facility's capacity to support colleagues struggling with SVS by providing peer mentors with the education and tools needed to help them effectively identify and assist health care professionals following involvement in an adverse event or in need of support. Second, the program aimed to identify and support the health care professionals experiencing SVS directly by offering resources, counseling, and direct interventions.

Program Design and Elements

Mentor Selection: The selection of potential SVS mentors for the program used the following process. Initially, the program was advertised at our twice-monthly facility Zero Harm Council meetings, which are attended by multidisciplinary leaders from both clinical (eg, nursing, quality, patient safety, infection prevention) and non-clinical (eg, security, laboratory, operations) teams from within the facility, as well as additional leaders relevant to the topics being discussed. Leaders attending those meetings were invited to serve as the initial cohort of SVS peer mentors for our program.

To qualify, mentors had to indicate a desire to help people, agree to complete the training (described below), and agree to share insights, perspectives, and learnings from their time as

an SVS mentor at a monthly PLUSS Program Committee meeting. The PLUSS Program Committee was created by the Assistant Chief Nursing Officer and the Patient Safety Director to help ensure the long-term stability of the program by sharing ideas and supporting members. As a part of their role, each mentor was required to present something they had done to further the program.

During the pilot program, all those that volunteered to serve as mentors were facility leaders. However, being a leader did not automatically translate to acceptance into the program. Some leaders chose not to participate in the PLUSS mentor program, and their decision was respected. No informal leaders expressed a desire to be a mentor, but our pilot program allowed for informal leader involvement with executive sponsorship. Although our executive leadership team had the final say in selecting mentors for the program, there was an understanding that only employees in a charge position or higher and in good standing would be selected. This eliminated graduate nurses and new employees because they lacked the clinical experience and understanding of hospital system processes.

Mentor Training

Format and Learning Objectives: As with most existing SVS programs, our peer-mentor training program utilized an interactive, live format.[22] Sessions were approximately 90 to 120 minutes in length, depending on the level of participation, questions, and quality of discussions, and were guided by a PowerPoint presentation. During the initial part of the training program, attendees were shown a video describing a case of a nurse who took their own life following their involvement in a medical error. In addition, interactive exercises allowed attendees to become familiar with the tools provided and to share previous experiences. The majority of attendees had some personal experience with SVS or knew someone who had.

Learning outcomes for peer mentors attending the training were for them to be able to (1) concisely describe the ”second victim” phenomenon to a colleague in 1 sentence, (2) verbalize resources that could support fellow health care providers traumatized by a negative patient care experience, and (3) identify strategies for raising awareness among clinicians and leaders about the importance of second victim identification and support. During the training, potential SVS mentors also received didactic information on SVS definitions, triggers, relevant statistics, potential signs and symptoms, and potential recovery trajectory. They also were introduced to an algorithm for assessing and providing support to staff in distress. Potential mentors received guidance about how to assess colleagues’ emotional and psychological states relative to a stressful event (resigning, surviving, or thriving). Potential SVS mentors also received a participant guide that included relevant crisis support information and telephone numbers, practices for recovering and recharging, breathing exercises, and potential signs and symptoms of compassion fatigue. Upon completion of the training, SVS peer mentors received a certificate and tools for supporting staff, including (1) a packet of organizational and community resources, (2) a participant guide, with stress relief tips and mentor contact information, (3) a journal/doodle book, (4) an adult coloring book, (5) a Zen walking path, (6) a stress ball, and (7) essential oils.

Being a mentor involves ongoing support, not just a one-time intervention. It is about being present and helping employees navigate their emotions and stress over time. Most of the leaders in our program had an office where meetings could be secure and confidential; however, meetings could take place anywhere that met the participant’s needs. For example, if the participant felt more comfortable walking and talking, then the mentor could walk alongside the participant as they talked. Some participants preferred to talk while exercising on the track outside the hospital, while others preferred to meet over lunch at a picnic table. The hospital also provided a relaxation therapy room where they could meet privately. The mentor and participant could choose meeting frequency, location, and duration. Together with the participant, mentors could tailor the meetings as the participant progressed or regressed. Mentors agreed to attend regular committee meetings (PLUSS Program Committee) where they shared learning ideas, successes, and disappointments. These monthly meetings also helped keep mentors accountable for their program engagement.

Preliminary Outcomes and Planned Program Endpoints and Metrics

At the time this article was written, 30 multidisciplinary peer-support mentors (including both clinical and non-clinical leaders) had undergone training on how to recognize and provide SVS support to staff using our PLUSS program. As the program gains momentum, we plan to expand the number of trained mentors at the facility to more than 50, which equates to approximately 3% of the 1500 current total staff members. In addition, we plan to expand the pilot to an additional facility by the end of 2025, develop an anonymous survey to better understand staff satisfaction with support mentoring, and evaluate participant longevity and participation in the program.[19] Longer-term, the goal is for the PLUSS program to be made available to all regional hospitals within our health system.

Discussion

While our project is still in the pilot stage at the time of writing, this article adds to a growing body of literature describing efforts to raise awareness and provide health care staff the skills needed to identify colleagues who may be showing signs of SVS following their involvement in an unintentional health care error, injury, or unanticipated adverse patient event.[10] As noted in the introduction, despite having access to a range of evidence-based, emotional support resources in our facility, following a series of events, it became evident that an understanding of SVS was lacking. Therefore, we concluded both staff and leaders could benefit from specific training on how to not only identify those at risk for SVS but also provide them with appropriate support. This realization led us to take the initial step toward what we hope will grow into an all-inclusive SVS program to support our staff and physicians.

The Agency for Healthcare Research and Quality (AHRQ) and other organizations provide information on the stages physicians and staff go through after a medical error or adverse event.[14] These, and other evidence-based resources, are valuable, but when we contemplated first steps, we realized we needed a complete program that included development and training for leaders. Recognizing this gap, we developed the PLUSS program, which provides initial and ongoing education and training for mentors.

One of the considerations for our program was the length of the initial training. Currently, the initial training for our program is 60 to 120-minutes in length, somewhat shorter than other published accounts.[16,22] It is unclear the role that training length plays in the SVS mentors' confidence and competence. Anecdotally, our team has some concerns about the length of training sessions as it can be emotionally taxing, especially for leaders who have direct experience with SVS. During our pilot, we found that shorter training still allowed the mentor to gain an understanding of the overall concepts, access the materials, and have time to strategize their approach. However, given the need for mentor development, we ensured that mentors are committed to ongoing learning through the PLUSS Program Committee, which meets monthly. As noted earlier, these monthly meetings provided our mentors with a safe place for continued learning and a place to share ideas and experiences. In addition, as part of our program, we required mentors to present at least once during the year, which allows for at least 12 hours of ongoing annual education.

As with other SVS programs, ensuring the confidentiality of the health care providers who were receiving peer support from mentors was a vital aspect of the pilot program.[19] Studies show that in addition to the shame many health care providers feel following involvement in an adverse patient event, many second victims suffer in silence, and they are unsure of whom they can confide in. Frequently, second victims may fear judgment from their colleagues, supervisors, and others, and worry about legal implications that can result from involvement in an adverse event. Our facility belongs to a Patient Safety Organization (PSO), which affords the highest level of legal protection and requires strict confidentiality of all discussions, deliberations, and records to improve patient safety, health care quality, and health care outcomes.

During program development, we also carefully considered the types of resources and tools we could provide to help the staff members in different stages of SVS. During the pilot, we opted to provide a range of options, designed

to meet staff where they are. For example, mentors were given journals, which they could offer to staff to use to document and organize their thoughts during challenging times. The journals included intermittent doodling pages for those who found drawing therapeutic. Mentors were also taught to create a walking path (inside and outside the hospital) designed to help participants take a break from the stressors on the unit. When using the walking path, the staff can quickly walk by the nursery, chapel, scenic gardens, and serenity rooms while concentrating on breathing and stress relief. We also provided mentors with a roll-on tube of lavender essential oil, which, with the staff member's permission, was applied to the participant's wrist or uniform to help provide immediate stress relief in situations where the staff member was not able to walk away. Anecdotally, we found these approaches helpful, but additional research is needed to determine the degree to which these tools can assist our mentors in supporting staff experiencing SVS.

Strengths and Limitations

While our hope is for this paper to add to the literature on this topic area, the program was only recently implemented; therefore, outcomes for both the mentors and participants are unknown. It is also important to note that the program focuses on the development of mentors and not the recipient of the mentoring. This limits the understanding of how impactful the program is for participants with SVS. Because the program focuses on mentor and mentor training, we anticipate that the program will be sustainable. However, due to their heavy involvement, it is possible that mentors may become overwhelmed with emotional burdens or have trouble with consistent participation. More research is needed to determine program sustainability. In addition, health care professionals experiencing psychological stress may not seek support; they are more likely to isolate from others. Mentors are trained to identify health care professionals in need of emotional support; therefore, they can identify individuals in need of emotional support and intervene as appropriate. In addition, despite data suggesting the significant number of health care providers who have been involved in a safety event that resulted in effects consistent with SVS, definitions of SVS vary, making it difficult to identify all second victims. Therefore, it is important to have enough mentors trained to proactively reach out to all clinicians whether or not support appears necessary.[3]

Conclusion

In summary, our facility-based SVS program PLUSS was designed to support health care professionals experiencing SVS by offering resources, counseling, and direct interventions. The PLUSS program was also designed to build our facility's capacity to support colleagues struggling with SVS by developing mentors. Mentor development includes education and training to identify staff experiencing SVS and how to effectively intervene with psychological support. Long term, our hope is that this approach ensures emotional and psychological support of staff and physicians and helps the facility cultivate a healthier and more resilient workplace.

Conflicts of Interest

The authors declare they have no conflicts of interest.

Ms Trammell is an employee of HCA Houston Healthcare, a hospital affiliated with the journal's publisher.

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