Implementing a Peer Responder Program for Second Victims

Abstract

Objective: This clinical project served to educate hospital staff about the second victim phenomenon (SVP), existing organizational support mechanisms available after patient-related stressful events, and a newly developed peer responder support program.

Methods: The SVP Awareness campaign with its associated education session was implemented for the staff of the Neonatal and Women’s Divisions. All staff were invited via email to anonymously participate in a custom web-based 14-item survey before and after the education sessions to evaluate the effectiveness of the education sessions.

Results: Of the 225 staff members invited to participate, 72 (32%) responded to the pre-education and 79 (35%) responded to the post-education surveys. No statistical associations were found between the pre- and post-education nominal data despite a post-education increase awareness of SVP (68%) as well as an increased awareness of the hospital resources available to them after an adverse event (76%). 68% of the post-education respondents identified as SVs during their career. The staff participants reported that they had feelings of guilt and other SVP symptoms due to patient-related events, yet less than half of them were aware of that this was a known problem for healthcare providers. Tragically, 28 (35%) of the post-education survey respondents identified as SVs within the past year (eight in the past month, nine in the past six months, and 11 in the past year) at this medical center. Lastly, the survey uncovered potential implications for staff turnover due to SV experiences: 33% of the
pre-education and 39% the of post-education survey respondents reported wanting to leave the healthcare profession due to an adverse patient-related event.

**Conclusion:** This clinical project demonstrated the importance of providing SVP education to healthcare staff since less than half of them were aware of that SVP was a known problem for healthcare providers. Also, the survey uncovered a knowledge gap regarding the existing support programs available to staff after a stressful patient-related event. The organization will use this information to develop resources to support staff after patient safety events occur to promote a greater wellbeing for caregivers, and facilitate a healthy environment for staff, patients, and the organization.