A Case Study exercise - Manuel

The path of a healthcare professional in the aftermath of a patient safety incident

Key messages

- Patient safety incidents are the result of a chain of latent failures, predisposing conditions, and/or active failures. The healthcare worker is part of a team, and the team develops its activities in a system under specific conditions.

- A strong safety culture includes robust perceived psychological safety for the healthcare workers, enabling them to speak up by discussing safety concerns and to disclose any problem that could occur.

- Effective communication with patients and families is essential to avoid litigation, a situation that could represent significant suffering for all involved.

ERNST
The European Researchers' Network
Working on Second Victims

Executive summary

In a healthcare setting, when an incident occurs the staff involved could experience distress and suffering. Their mental health and capacity to take care of the subsequent patients could be affected, compromising patient safety. **This harmful experience of the healthcare professional in the aftermath of an incident is called the second victim phenomenon.**

This case study was made by the ERNST team – The European Researchers' Network Working on Second Victims. It is centred on the experience of healthcare workers - the second victims -, their feelings while coping with an unexpected situation, the importance of certain behaviours and choices, and finally the outcomes of the recovery process.

The case study starts with a story that was created by collecting several real situations that had happened in a hospital setting in Lisbon, Portugal but that could have happened in a hospital elsewhere. This case gives rise to a fictitious situation describing a series of failures when treating an elderly patient, resulting in serious harm and a litigation process. It is an opportunity to consider the implications of some specific issues regarding the second victim experience and patient safety in general.

It can be used for self-learning or integrated into lectures and discussions regarding the second victim phenomenon.

The next page presents an overview of the Case Study:

CASE STUDY OVERVIEW:

AIM: To understand the path of a healthcare worker in the aftermath of a situation that could cause a second victim experience.

Starting from:

Mr. Manuel's case

A serious adverse event after a wrong blood transfusion.

Considering crucial points for the experience of the healthcare workers in the aftermath of the event:

- Speaking up
- Incident report
- Institutional support
- Open disclosure

How have they influenced the results?

The second victim outcomes

and also the consequences to the:

- first victims
- third victim

that may also influence

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Mr. Manuel's Story

Mr. **Manuel Ferreira** was a 78-year-old retired engineer. He was widowed and he lived alone at his home; he had full autonomy in the activities of daily living. His son was a lawyer and, despite living abroad, he kept a close accompaniment of his father's life.

One day, Mr. Ferreira received a call from the lab where he had done a routine analysis prescribed by his family doctor/general practitioner (GP) to inform him that he had anaemia, unnoticed before. Mr. Ferreira immediately called his GP, but he found that he was on vacation, so he decided to go to the emergency service (ER) of the hospital nearby. His personal antecedents were diabetes, high blood pressure, and severe hearing loss.

At the ER, the clinical team found that Mr. Ferreira was suffering from tiredness for several weeks. There were no relevant changes in the objective examination. The doctor decided that he had to stay in the hospital because of the 7,5 g/dL value of haemoglobin, low Mean Corpuscular Volume (microcytic anaemia), and to facilitate the realization of further exams. Then, Mr. Ferreira was admitted to the Medicine Unit of the hospital, staying in a double-bed room with another patient who, by coincidence, was also named Manuel, although his last name was Pereira. Mr. Manuel Pereira suffered from dementia and occasionally had periods of time, space, and person disorientation.

During Mr. Ferreira's second night at the hospital, a nurse came by and called for his roommate, Mr. Manuel Pereira. Because of his hearing impairment, Mr. Ferreira thought that she was calling him and replied. Despite the existence of a transfusion protocol at the hospital, it wasn't properly followed. The nurse didn't confirm the patient's identification label on the wrist and started the transfusion of an erythrocytic concentrated unit saying to the patient that it was prescribed by his doctor. Mr. Ferreira wasn't expecting a transfusion, but he didn't have understood much of his doctor's explanations previously that afternoon, so he allowed the procedure without saying anything.

The nurse had to leave the bedroom just a few moments after the transfusion started because she had numerous tasks to do. The hospital was dealing with some human resources constraints, due to recent retirements, staff turnover, and vacations. The number of beds that each nurse was responsible for was at that time twice the normal.

About one hour later, she returned to Mr Ferreira's bedroom, and all seemed to be ok. Then, she finally got time to do the records on the electronic system and she noticed a big mistake: she had changed the patients' names, so the wrong patient was receiving a transfusion! She ran to the bedroom and stopped the procedure. She called the shift's nurse leader to report the situation and she also called the emergency doctor to give knowledge of what happened.

Maria, the nurse, felt absolutely devastated, but she continued her work. She started to fear what could happen next, so she didn't report the incident on the institution's report platform as her team leader asked.

The patient's blood types were not compatible, and Mr. Ferreira suffered a serious reaction to the transfusion and had to be admitted later that night to the intensive care unit.

The next day the assistant doctor gained knowledge of the situation and had to inform Mr. Ferreira's son, accompanied by the director of the service. They simply told them that something unexpected happened, with damaging consequences to the patient; clearly, they weren't interested in detailing too much of what had happened. The patient's son reacted with anger, and that was the beginning of a conflictual relationship, that culminated in a lawsuit where he asked for compensation for physical and moral damages.

Mr. Ferreira survived the incident and was discharged from the hospital a month later. However, he was very debilitated and became dependent on the activities of daily living.

Nurse Maria struggled to continue at the same hospital because she felt that all eyes were on her and that the team hadn't properly supported her. Nobody had talked to her about her feelings or expressed concern about her. Because the event hadn't reached the quality management team, no formal support had been offered. The cycle of tiredness, anxiety, guilt, and shame culminated with sick leave for several weeks.

Topics to consider

You might think that in your setting, this story wouldn't have happened. But remember that:

- The procedures and regulations are different between countries.
- Even when there are appropriate guidelines and protocols, sometimes real-life practices don't follow them. The professionals' behaviours could be influenced by, for example, work overload, insufficient staff, lack of experience, lack of appropriate knowledge, and internal factors (i.e., stress, demotivation, tiredness).

  Of course, there can be also careless behaviours that involve negligence, but these are minor causes of adverse events.

When something wrong happens, there is a chain of events that was responsible for or contributed to it.

In this story we can identify:

- A **first victim** – Mr. Manuel Ferreira, who was autonomous before and became dependent on the activities of daily living. His son is also a first victim.

- A **second victim** – nurse Maria. After struggling to remain in her work, she ended up drop-out.

- A **third victim** – the healthcare centre(hospital), suffering a lawsuit and loss of reputation.

Considering the following topics:

- **Speaking-up**
- **Incident report**
- **Institutional support**
- **Open disclosure**

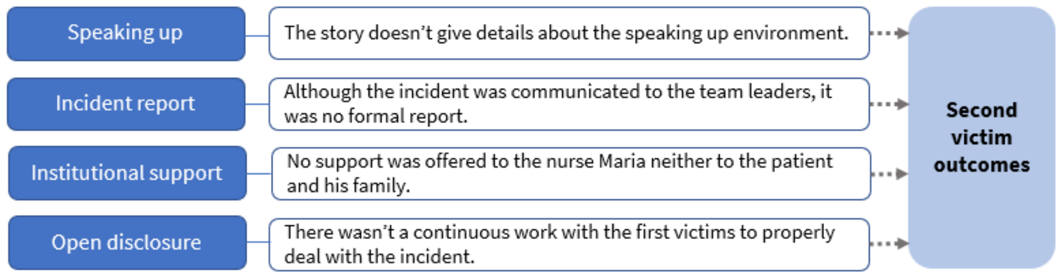
What should have been different in the situation presented regarding each aspect? Type below:

Speaking up	**Incident report**
Institutional support	**Open disclosure**

Considering what happened to the first and third victims, in which manner it can affect the second victim's experience and outcomes?

Type below:

Suggested topics



Speaking up

- We don't have information about the speaking up environment in the organization.
- If the patient identification procedures were frail, having the possibility to freely speak up, with no judgments, would help to identify the system failures, and probably prevent the incident/adverse event.
- Regarding the second victim, an environment that encourages speaking up behaviour will be recognized as a promoter of robust safety culture, with more perceived psychological safety at the workplace. Thus, that could be an aspect that favours the resilience of the healthcare worker and its call for help.

Reporting

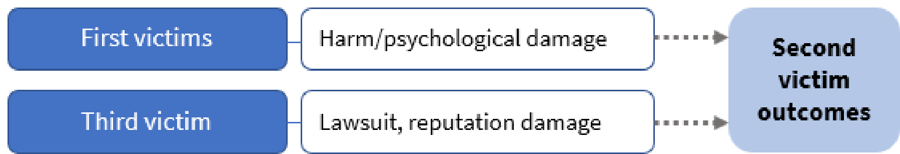
- The disclosure to the team staff is essential to minimize harm and other negative consequences in the short term.
- When there's a notification to the reporting system, the quality and risk managers will be informed, allowing detailed investigation of the incident. If appropriate, a root cause analysis can be performed, and it could inform the adoption of new procedures and safety actions.
- The notification of the event allows to address appropriately the first victims and to take care of the second victim, also minimizing consequences to the institution (third victim). In this case, that didn't happen so the quality managers didn't have the opportunity to talk with the second victim and to ensure that she was ready to do her duties right after the event.

Institutional support

- In this case, nurse Maria - the second victim - didn't speak with anyone trained to deal with her situation. Her team colleagues weren't particularly sensitive to the second victim problem, and, again, she never met with a quality manager, who might inform her about some resources that she could use for such psychological assistance.
- The institutional support to the second victims should be easily accessible and all the workers should know in advance what the organization could do for them or what strategy is implemented to respond to this kind of situation.

Open disclosure

- Open disclosure is not just the moment of incident disclosure but implies working with the first victims, discussing not only what had happened but also to co-create and implementing improvements in order to enhance the safety of care.
- In this case, the son was informed about the incident in an insufficient and inadequate way, without apologizing or explaining in detail what happened. Appropriate, open, honest, and timely disclosure is crucial, and it would prevent a conflictual relationship with the patient and or their families.
- For the second victim, it would be probably a relief to know that the first victims were receiving the best treatment possible, not just physical but psychological too.



Outcomes

- This story stresses that patients - the first victims - didn't receive the best treatment possible after the adverse event. Furthermore, they initiated a lawsuit against the institution. These outcomes could also worsen the suffering of the second victim – the anticipation of a court audience and facing the first victims would be a source of fear, anxiety, and sadness.

Next steps

Try to make an inner exercise. Which aspects do you think that need to be improved in your setting to mitigate the likelihood of a second victim experience when something wrong happens?

Discuss the patient safety topics considered in this case study with your colleagues and try to make space for an open discussion when the problems came. Try to engage all healthcare professionals and get the commitment of the leadership around this subject.

If you want to know more about the second victim phenomenon, please consult the materials developed by ERNST - The European Researchers' Network Working on Second Victims.

Find more content on the website**: https://cost-ernst.eu/**

Contributors

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- *Maria João Lobão,* who combined different stories to reach the narrative of Mr. Manuel's adverse event.

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