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Caring for the Caregiver: Second Victim Recovery Following a Serious Medical Error

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This is to certify that the doctoral study by

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Walden University
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Abstract

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MN, Louisiana State University, 1995

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Project Submitted in Partial Fulfillment

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Abstract

In 1999, it was estimated that 98,000 deaths were attributed to medical errors and were the fourth most common cause of death in the United States. In 2016, medical errors were estimated as the third leading cause of death, with a mean death rate of 251,454 each year. Nurse involved in errors are known as second victims. Almost one in seven staff members reported that they had experienced a patient safety event within the last year that caused personal problems such as anxiety, depression, or concerns about their ability to perform their job. This project explored whether nurses are able to recognize physical and psychological effects of medical errors on nurses if provided education on second victims and their symptomatology. A pretest showed 18.75% of participants had heard the term second victim, 12.5% could name two symptoms of second victims, and 31.25% admitted to having participated in a medical error. After providing 30 minutes of group education, posttest results demonstrated 100% of participants had heard of second victims and could name two symptoms, while 68.5% admitted to participating in a medical error. Survey results demonstrated increased knowledge regarding second victims and associated symptomatology. This project may support social change through awareness of healthcare organizations and leaders regarding the need to support second victims following serious medical errors.

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Dedication

I dedicate this project to “The Vance Girls” - my daughter, Taylor Vance and my mother, Kathryn Vance, for their unwavering support and encouragement through hurricanes, pandemics, missed dinners and this doctoral journey. They have been an endless inspiration to me, firing my determination and confidence that has made the completion of this project a reality.

Acknowledgments

I would like to first give thanks to God, who provided me with all that I needed to complete this journey. I'd like to thank Dr. Melanie Braswell and Dr. Robert McWhirt for their guidance through this doctoral process, as well as their words of encouragement. Their support, as well as the support from my colleagues, family and friends, has made my vision a reality.

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Section 1: Nature of the Project

Introduction

A second Victim is defined as a healthcare provider who is involved in an unanticipated adverse patient event and becomes traumatized as a result of the event (Jones & Treiber, 2012). Frequently, these individuals feel personally responsible for patient outcomes, and many feel as though they have failed patients, which leads to second guessing their clinical skills and knowledge base. This doctoral project addressed caregivers' powerful feelings of guilt, incompetence, and inadequacy. Many times, these caregivers have no support or guidance, often resulting in suffering in silence. Some may consider leaving their profession or feel such guilt that they leave. The aim of this project was to examine factors that contribute to nurses becoming second victims after making errors and examining the impact that becoming a second victim has on nurses and nursing. This will change the practice of nursing for the better through understanding of the psychological impact of such events on nurses and recovery required for wellbeing.

Problem Statement

When there is a serious medical error or adverse event in healthcare, the primary focus of attention is often on the patient. According to Grober and Bohnen (2005), a serious medical error is defined as "unintended injury to patients caused by medical management, rather than the underlying condition of the patient, that results in measurable disability, prolonged hospitalization or both" (p. 40). These errors may also lead to death. In nursing practice, contributing factors to medical errors include distractions during medication

administration, inadequate staffing shortages, nursing exhaustion, being pulled to unfamiliar areas, and poorly defined clinical processes (Jones & Treiber, 2012).

Nurses on the selected unit, who had participated in a medical error, demonstrated symptomatology of second victims as circumstances of events were discussed. The nursing unit leadership of that selected unit and Patient Safety Director disclosed there have been eight serious medical errors on that unit at this organization since April 2020.

Psychological distress that healthcare workers experience following a serious medical error can be severe and prompt some to leave the profession, and some have chosen to end their own lives due to these traumatic experiences. There is a gap in the knowledge of nursing leadership, regarding how to identify and care for the nurse involved in serious medical event. and There is also a lack of structured programs to care for these injured practitioners.

Every day, nurses practice within a complex environment and sometimes experience serious medical errors. Even the most conscientious nurses make mistakes. Despite knowledge that has been gained, many nurses suffer alone after these events. Psychological and physical effects of such events are well-documented in the literature but lack solutions and support structures to care for second victims. The second victim phenomenon and phenomenon of victimization affects all nurses; therefore, there are tremendous implications for nursing practice and the nursing profession. Whether second victims recover or drop out of the profession depends largely on the culture of the institution and recovery responses following serious medical errors.

Purpose Statement

Organizations must understand how to help nurses who experience trauma following serious medical events. Literature lacks information regarding identification and assistance during recovery of affected nurses. There are symptoms that exist and are predictable following serious medical events.

The practice-focused question for this staff education DNP project was: Would an educational program with a focus on second victim symptomatology following serious medical errors lead to increases in knowledge for nursing staff? This project was used to support and recognize second victims while dealing with stressors and understanding normal responses which require coping and adaptation.

By providing education to healthcare leaders, this may prompt recognition and support needed to promote the improvement of the wellbeing of nurses following serious medical errors. This knowledge will assist in changing the practice of nursing for the better by increasing the nursing leader's and the nurse's understanding of the psychological impact of such events on nurses as well as recovery required for wellbeing.

Nature of the Doctoral Project

The literature review included Thoreau databases (CINAHL, EBSCOHost, MEDLINE, APA PsycINFO, Complementary Index, Academic Search Complete, ScienceDirect) and all referenced journals were published between 2002 and 2020. Search terms were: *second victim*, *second victim phenomenon*, *medical error*, *adverse medical error*, *medical error psychology*, *adverse event*, *adverse event response*, *sentinel events*,

medical mistakes, *victimology*, *victim symptomatology*, *trauma*, *psychological trauma*, and *consequences of second victim*.

This project involved using the *Walden University Staff Education Manual*. Prior to conducting the study, a three-question survey was used to evaluate knowledge of nurses regarding second victim symptomatology. This pretest was distributed to RN staff on the unit selected for the project. This process involved using identification numbers in order to protect the integrity of data and anonymity for participating nurses. Data was then used to determine gaps in terms of knowledge of staff, and an education program was developed addressing those gaps. This project was presented in unit staff meetings to the same nurses on the unit who participated in the pretest. Once the presentation was completed, the same nurse participants repeated the original test as a posttest, using the same identification process, in order to determine if gap in terms of knowledge of second victim symptomatology had improved. Overall scores from pre and posttests were evaluated using simple percentages to determine if education was effective, as evidenced by scores.

Significance

While discussing serious medical errors with unit nursing leadership, it was noted that nurses on the selected unit who had participated in errors demonstrated symptomatology of second victims as circumstances of the event were discussed. They recalled one specific meeting with a nurse involved in a serious medical error, where the nurse verbalized how devastated they were to have contributed to the error and stated they were not sure they could be a good nurse. They described the nurse as visibly shaken by the event. The unit nursing leadership and Patient Safety Director disclosed there have been

eight serious medical errors on the selected unit at this organization since April 2020. The focus of this staff education project was on this unit with the highest number of events.

The general adaptation syndrome (GAS) theory involves how people cope with stressful situations. Nurses as well as nursing leadership and administrators would benefit from gaining insight into how nurses involved in a medical error respond to stress and/or perceived stress. McEwin and Wills (2014) said the first of three stages of the GAS theory is the alarm reaction. This response may be seen when a nurse contributes to a serious medical error. This stage involves increased alertness and awareness and efforts to decrease anxiety. The second stage is resistance and the body's physiologic response to return to normal functioning. The individual feels threatened, panic, dread, and overloaded. There are issues with problem-solving difficulties and selective inattention. The individual is irritable, depressed, and displays psychosomatic symptoms. Finally, there is a stage of exhaustion. During the third stage, there are feelings of helplessness, loss of control and rational thoughts, dissociation, personality disorganization and disease process – physical and emotional. The body has done all that it can to return to well-being but cannot and illness can occur.

Nurses as well as nursing leadership and administrators would benefit from gaining insight regarding how individuals respond to stress and/or perceived stress. By understanding and identifying coping mechanisms and support systems to assist nurses when dealing with stressors, nurses may understand these are normal responses, and this may help to assist in terms of coping and adaptation.

There is a gap in nursing practice regarding how nursing leadership respond to nurses involved in serious medical events and lack of structured program to care for the injured practitioner. Clinical leaders lack knowledge to recognize and subsequently treat their staff, who are experiencing physical and psychological symptoms resulting from events and their contributions.

There must be a dynamic focus on the aftereffects or trauma associated with nurses who have experienced or participated in serious medical errors. With emerging complexities of healthcare, technology, and patients, nurses may find themselves involved in events which cause harm or even death to patients. Organizations must look into how they can better understand signs and symptoms of second victims, as well as support nurses through psychological and physical trauma associated with serious medical errors. Nursing unit leaders must be taught how to recognize and proactively support nurses with signs and symptoms of second victim phenomena. Through this focused approach, there is the opportunity to reduce, eliminate, and prevent recurrences following serious medical errors.

The gap in the literature is lack of information regarding the relationship between second victim symptomatology and treatments necessary to reduce, eliminate, and prevent effects on nurses following serious medical errors. While this concept might apply to other healthcare professions, the significance to nursing is documented most. There was no evidence of the terminology being used outside of the healthcare arena.

Summary

The second victim phenomenon occurs when there is a medical error. As more nurses and other clinicians are forthcoming when disclosing their medical errors, healthcare organizations are examining the effects of medical errors on their staff. Some organizations have instituted programs to create blame-free environments and help for individuals involved in errors. Section 2 includes information regarding the background of second victim symptomatology and its prevalence, theoretical framework, and implications for nursing practice.

Section 2: Background and Context

Introduction

Nurses practice their art within complex environments and sometimes experience serious medical errors. Even the most conscientious nurses make mistakes. Despite knowledge that has been gained, many nurses suffer alone after these events. Too often, the organization's emphasis on how the event occurred following a serious adverse event is on blaming someone for the event and ensuring accountability of nurses involved in the medical error. The individual who has made the error is immediately judged as incompetent or negligent and most likely subject to punitive actions, either directly by their leadership, or indirectly from their peers. This study addressed solutions and support structures to care for second victims.

The practice-focused question for this staff education DNP project was: Would an educational program with a focus on second victim symptomatology following serious medical errors lead to increases in knowledge for nursing staff? This project was focused on supporting and recognizing second victims when dealing with stressors and understanding normal responses which requires coping and adaptation.

In this section, the theoretical framework, relevance to nursing practice, local background and evidence, and my role as the DNP Student are discussed.

Concepts, Models, and Theories

The second victim theory involves the phenomenon which occurs when there is a serious medical error and a nurse is involved in the event. This involves symptoms of event trauma which are experienced by nurses. This is followed by recovery or lack thereof,

based on the organization's response to the second victim. The organization must understand how to help nurses who experience event trauma following a serious medical event. Supporting victims of medical errors is the responsibility of everyone in healthcare. This is as an ethical duty which is necessary in order to have a supportive culture of disclosure.

The general adaptation syndrome (GAS) theory involves how people cope with stressful situations. Nurses as well as nursing leadership and administrators would benefit from gaining insight into how nurses involved in a medical error respond to stress and/or perceived stress. McEwin and Wills (2014) said the first of three stages of the GAS theory is the alarm reaction. This is an obvious response when a nurse contributes to a serious medical error. This stage involves increased alertness and awareness and efforts to decrease anxiety. The second stage is resistance and the body's physiologic response to return to normal functioning. The individual feels threatened, panic, dread, and overloaded. There are issues with problem-solving difficulties and selective inattention. The individual is irritable, depressed, and displays psychosomatic symptoms. Finally, during the third stage, there are feelings of helplessness, loss of control and rational thoughts, dissociation, personality disorganization and disease process – physical and emotional. The body has done all that it can to return to well-being but cannot and illness can occur. By understanding and identifying coping mechanisms and support systems to assist the nurse in dealing with the stressor, the nurse may understand that this is a normal response and this may help to assist in coping and adaptation.

According to Grober and Bohnen (2005), a serious medical error is defined as the "unintended injury to patients caused by medical management, rather than the underlying condition of the patient, that results in measurable disability, prolonged hospitalization or both." These errors may also lead to death. Research has shown that there is a "second victim" of a serious medical error.

A second victim is a healthcare provider who has been involved in an unanticipated and serious medical error and has become traumatized as a result of the event (Jones & Treiber, 2012).

Relevance to Nursing Practice

In 1999, it was estimated that 98,000 deaths were attributed to medical errors, and were the fourth most common cause of death in the U.S. (Coughlan et al., 2017). In 2016, medical errors were estimated as the third biggest cause of death, with a mean death rate of 251,454 each year.

In nursing practice, contributing factors to medical errors include distractions during medication administration, inadequate staffing shortages, nursing exhaustion, operating in unfamiliar areas, and poorly defined clinical processes (Jones & Treiber, 2012). While there have been many advances to decrease the number of serious medical errors in healthcare, they continue to happen.

Clancy (2012) said the most experienced nurses have been associated with healthcare-associated harm in some way during their careers. Whether the second victim recovers or drops out of the profession depends largely on the culture of the institution and responses to recover them following serious medical errors.

The overarching effects of serious medical errors can have tremendous emotional, professional, and personal impacts that can involve personal or local reviews, litigation, coroner's inquests, and trial by media or peers. There have also been cases of criminal prosecution of nurses.

In a 2018 case, a Tennessee nurse was arrested and charged with reckless homicide and abuse of an impaired adult after making a medical mistake that resulted in the death of an elderly patient (Gordon, 2019). This case set a precedent that has the potential to increase risks at hospitals by making nurses hesitant to report medical errors. This nurse described experiencing feelings of guilt, shame, and embarrassment, and received severe punishment due to a medical error related, in part, to a system failure.

The gap in literature involves the relationship between second victim symptomatology and treatments necessary to reduce, eliminate, or prevent effects on nurses following serious medical errors. There was no evidence of the terminology being used outside of the healthcare arena.

Local Background and Context

In nursing practice, contributing factors to medical errors include distractions during medication administration, inadequate staffing due to shortages, nursing exhaustion, operating in unfamiliar areas, and poorly defined clinical processes (Jones & Treiber, 2012).

The setting for the doctoral project was a 35-bed medical surgical unit in a 237-bed acute care hospital. While discussing serious medical errors with unit nursing leadership, it was noted that nurses who had participated in errors demonstrated symptomatology of

second victims as circumstances of events were discussed. They recalled one specific meeting with a nurse involved in a serious medical error where the nurse verbalized how devastated they were to have contributed to the error and stated they were not sure they could be a good nurse. They described the nurse as visually shaken by the event. The unit nursing leadership and Patient Safety Director disclosed there have been eight serious medical errors at this organization since March, 2020. This unit had the highest number of events.

Involvement in serious medical errors can have tremendous physical and psychological effects on nurses (Finney et al., 2020). To cope with the devastation of being involved in an event, nurses tries to cope with situations in a number of ways. They may choose to isolate themselves and become hypervigilant, but some may be so traumatized by the event they change environments, leave the profession altogether, or turn to suicide. How leaders recognize second victim symptomatology following serious medical errors and care for caregivers is critical to the recovery of second victims.

An exhaustive literature search revealed that there were no local, state, or national defining guidelines related to second victims.

Role of the DNP Student

My role as the DNP student involved addressing interventions to influence healthcare outcomes of a population of nurses who have experienced serious medical errors and second victim symptomatology and assist nursing leadership in the management of these nurses, and development and implementation of health policies to support second victim recovery.

By providing education to healthcare leaders, this may prompt recognition and support needed to promote the improvement of the wellbeing of nurses following serious medical errors. This knowledge will assist in changing the practice of nursing for the better by understanding the psychological impact of such events on nurses and recovery required for wellbeing.

In my personal experience, nurses are devastated when they realize they are participants in serious medical errors. The emotional and psychological effects of this lived experience resemble Post Traumatic Stress Disorder (PTSD). Lack of support from leadership and colleagues has a significant impact on decisions to disclose errors and recovery processes. It is important to have a good support system to help in alleviating burdens, promote the disclosure of medical errors, and assist nurses.

The aim of this project was to provide a critical look into how nurses can be educated on second victim symptomatology, support provided to the nurse to assist them through the psychological and physical trauma (second victim phenomenon) associated with a serious medical error, and to teach leadership how to recognize and proactively support the nurse with signs and symptoms of a second victim. There were no potential biases noted.

Summary

Nurses and other healthcare professionals who may experience the second victim phenomenon due to serious medical errors suffer from a number of difficulties. Healthcare leaders and organizations must understand the circumstances of serious medical errors and accompanying symptoms of second victims in order to support them. This research is

significant to nursing practice and leadership in that it provides a comprehensive understanding of the dynamics of second victims that can be used to design and implement a support program to care for injured caregivers. In Section 3, the process for collection of data, sources for evidence, protection of participants, and data analysis are discussed.

Section 3: Collection and Analysis of Evidence

Introduction

Most organizations lack an understanding of the downstream effects that serious medical errors have on individuals apart from patients. Nurses make up the largest proportion of any hospital and provide the majority of direct patient care ((Finney et al., 2020). Serious medical errors and unanticipated outcomes associated with emotional responses are to be expected for nurses.

Psychological distress that healthcare workers experience following serious medical errors can be severe and have prompted some to leave the profession, while some have chosen to end their lives due to traumatic experiences. There is knowledge deficit in nursing leadership in how to responses of nurses involved in serious medical events and lack of structured programs to care for injured practitioners. Clinical leaders lack knowledge to recognize and subsequently treat staff who are experiencing physical and psychological symptoms resulting from events and their contributions.

The second victim phenomenon and phenomenon of victimization affects all nurses; therefore, there are tremendous implications for nursing practice and the nursing profession. Whether second victims recover or drop out of the profession depends largely on the culture of the institution and recovery following serious medical errors.

In this section, the key terminology used throughout the project was reviewed, as well as sources of evidence, participants who were included within the project, processes for data collection, protection of participants, and how data were analyzed to determine the effectiveness of the project.

Practice-Focused Question

The practice-focused question for this staff education DNP project was: Would an educational program with a focus on second victim symptomatology following serious medical errors lead to increases in knowledge for nursing staff? This project sought to support and recognize second victims when dealing with stressors and understanding coping and adaptation.

Frequently, second victims feel personally responsible for patient outcomes, and many feel as though they have failed patients, second guessing their own clinical skills and knowledge base. These second victims often suffer in silence due to shame, embarrassment, fear of disciplinary actions, and lack of support from their healthcare leaders and colleagues. The psychological distress that healthcare workers experience following serious medical errors can be severe and have prompted some to leave the profession, while some have chosen to end their lives.

According to Grober and Bohnen (2005), a serious medical error is defined as the "unintended injury to patients caused by medical management, rather than the underlying condition of the patient, that results in measurable disability, prolonged hospitalization or both" (p 40). These errors may also lead to death.

Sources of Evidence

The key terms searched through the Thoreau databases (CINAHL, EBSCOHost, MEDLINE, APA PsycINFO, Complementary Index, Academic Search Complete, ScienceDirect), were *second victim*, *second victim phenomenon*, *medical error*, *adverse medical error*, *medical error psychology*, *adverse event*, *adverse event response*, *sentinel*

events, *medical mistakes*, *victimology*, *victim symptomatology*, *trauma*, *psychological trauma*, and *consequences of second victim*. All sources were published between 2005 and 2020.

Participants

In discussion the unit nursing leadership, it was disclosed that a medical surgical unit had staff involved in serious medical errors. There are 25 RNs on this unit. This was the unit identified for the project.

Procedures

This project involved using *the Walden University Staff Education Manual*. Participation in the project was not mandatory and did not affect their jobs. Participants provided their consent by coming to the education class and completing the survey (see Appendix A).

Prior to providing education, a 3-question survey was used to evaluate knowledge of nurses involving second victim symptomatology. This pretest was distributed to the RN staff on the unit selected for the project. This process involved using an identification system with numbers in order to protect the integrity of data and anonymity of participating nurses. Data were then used to determine gaps in the knowledge of the staff, and an education program was developed addressing those needs. This program was presented in unit staff meetings to the same nurses on the unit who participated in the pretest. Once the program was completed, the same nurse participants repeated the original test as a posttest using process to determine if gaps in knowledge regarding second victim symptomatology had improved.

Protections

I provided for the protection for human subjects. There were no ethical issues that presented problems for the completion of this project. This project was reviewed and approved by the Walden University Institutional Review Board (IRB) prior to any conducting of staff education programs. All project subjects were deidentified, and no job titles were used. I was the only individual to see the results. There was no punitive action for nurses who did not wish to participate.

Analysis and Synthesis

Overall scores from pre and posttests were evaluated using simple percentages to determine if the education program was effective, as evidenced by higher posttest scores. The results of this assessment were shared with the nursing staff, nursing leaders, nursing educators, and the senior executive team to make them aware of this phenomenon and aid in the development of a second victim support program.

Summary

Nurses and other healthcare professionals who may experience the second victim phenomenon due to serious medical errors suffer from a number of difficulties. The culture of safety has a tremendous effect on whether and to what extent nurses and healthcare professionals become second victims (Schiess et al., 2020). The first step in overcoming effects and negative consequences is acknowledging the need to help second victims through the culture of an organization. Healthcare leaders and organizations must understand circumstances of serious medical errors and accompanying symptoms of second victims in order to support them. This research is significant to nursing practice and

leadership in that it provides a comprehensive understanding of the dynamics of second victims that can be used to design and implement a support program. In Section 4, the findings of the survey, implications for nursing practice, and recommendations are discussed.

Section 4: Findings and Recommendations

Introduction

Most organizations lack an understanding of the downstream effects that serious medical errors have on those individuals outside of the patient. This doctoral project involved examining knowledge of nurses regarding second victim symptomatology following serious medical errors and the impact this has on nursing and nursing practice.

The practice-focused question was: Would an educational program with a focus on second victim symptomatology following serious medical errors lead to increases in knowledge for nursing staff?

Findings and Implications

Prior to taking surveys, participants were provided with anonymous questionnaires. The nurses on the designated nursing unit were provided with a 3-question pretest to assess their general knowledge of second victims followed by an education program on second victims and then a posttest to assess knowledge. Pretest and posttest data were tabulated using simple percentages to determine if the education program was effective. There were 16 nurses who participated in the survey from the designated unit. The pre-test showed that 18.75% of participants had heard the term second victim. 12.5% of participants could name two symptoms of second victims and 31.25% had participated in medical errors. Following the pretest, education was provided to participants. Using the same survey tool, the posttest demonstrated 100% of participants had heard of second victims and could name two symptoms. 68.75% had participated in medical errors, while 31.25% said they had never participated in a medical error. Based on the results of this survey, participants

demonstrated increased knowledge of second victims and associated symptomatology. Post-tests revealed participants seemed to have a better understanding of medical errors or felt comfortable confidentially disclosing this information during the posttest. This project resulted in successful increased knowledge regarding second victim symptomatology following an educational program.

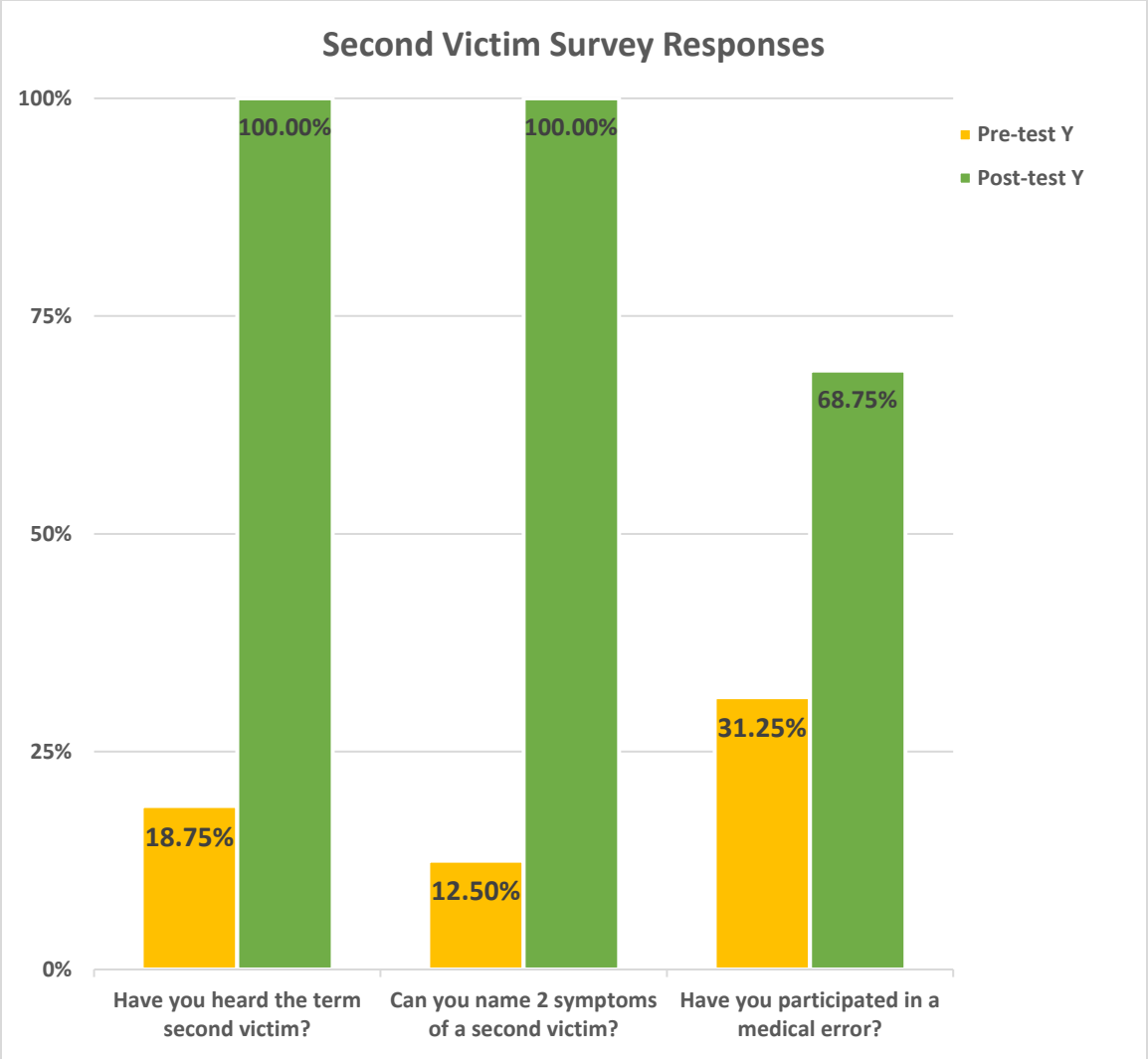
Table 1

Second Victim Survey Questionnaire Results (Pre/Posttest)

Second Victim Survey Questions	Pre-Test Y	Pre-Test N	Post-Test Y	Post-Test N
Have you heard the term second victim?	18.75%	81.25%	100.00%	0.00%
Can you name 2 symptoms of a second victim?	12.50%	87.50%	100.00%	0.00%
Have you participated in a medical error?	31.25%	68.75%	68.75%	31.25%

Figure 1

Second Victim Questionnaire Results - Graph



Recommendations

Recommendations for this project include the expansion of the survey to more units to increase the sample size and ensure generalizability of findings. Literature regarding the impact of culture or leaders on how severe the second victim phenomenon impacts affected nurses could lead to more evidence to support the severity of the phenomenon.

An additional recommendation would include the inclusion of this phenomenon in the orientation of clinical staff so they can recognize the second victim symptomatology and support available to assist them should they be a participant in a serious medical error.

Strengths and Limitations of the Project

The project had several strengths. The research was significant to nursing practice in that it identified and closed a knowledge deficit of nurses and nursing leadership of the dynamics of second victim symptomatology that can be used to design and implement a second victim support program. The questionnaire and education was brief and direct so it did not take them away from their patient care duties or long and staff showed an interest in the subject and were willing to participate in the testing and education.

A limitation of the study was the information and data were only collected from one unit; therefore, this did not necessarily represent all units within the organization. Due to the small sample size, it may be hard to generalize the results of the project. A limitation of the program also involved assessing the culture of safety of the organization, which may be tied to and compound the stressors that nurses experience when participating in or even reporting a serious medical error.

Section 5: Dissemination Plan

The results of this assessment have been shared with nursing staff, nursing leaders, nursing educators, and the senior executive team to make them aware of this phenomenon to aid in the development of a second victim support program. Information was shared in unit huddles and staff meetings, director's meetings, and weekly senior executive team meetings. This information was presented in small groups and conference-style format with a PowerPoint presentation that included the practice problem, objectives of the project, theory, designs and methods, data collection and analysis, results and findings, and a conclusion.

Analysis of Self

Since the inception of this DNP Project, I have been able to develop my research and writing skills at the doctoral level. Literature regarding this topic has enlightened me regarding the severity of this problem in the nursing arena and given me an opportunity to better the nursing practice, retention of nurses, and demonstrate caring for injured caregivers. The methodology used in this project will assist me in future research and allow me to improve the practice of nursing and possibly other healthcare professions.

Summary

The overarching effects of serious medical errors can have tremendous emotional, professional, and personal impacts. Despite the knowledge that has been gained, many nurses continue to suffer alone after a medical error. The psychological and physical effects of such events are well-documented in literature. The second victim phenomenon and phenomenon of victimization affects all nurses; therefore, there are tremendous

implications for nursing practice and the nursing profession. Nurses, nursing leaders, and organizations can become equipped to recognize and provide emotional and psychological support and recovery to care for caregivers following serious medical errors.

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Appendix A: Second Victim Survey

Second Victim Survey

Please answer each question according to your knowledge at this time.

Please understand that your individual answers are confidential

and will not be shared with anyone at your facility

1. Have you heard of the term "second victim?" ___Yes ___No

2. Can you name 2 symptoms of a second victim? ___Yes ___No
(If yes, please list)

a. _____

b. _____

3. Have you ever participated in a medical error? ___Yes ___No

Thank you for your participation in this survey!

B. Patrice Vance, DNP Student

Walden University