ISMP Draws Attention to Often-Abandoned “Second Victims” of Medication Errors

Horsham, Pa—According to the Institute for Safe Medication Practices (ISMP), healthcare practitioners involved in fatal medication errors are often left to find their own way through the devastating spiritual, personal and professional crisis that occurs. ISMP is helping to spread the word that healthcare organizations have a responsibility to support not only the first victims of the error (patient and family), but also the “second victims” (involved healthcare practitioners), who also suffer devastating consequences.

Fatal errors or those that cause permanent harm are known to haunt healthcare practitioners throughout their lives. One recent case illustrates what can happen. A veteran pediatric nurse, Kimberly Hiatt, committed suicide on April 3, 2011, seven months after making a mathematical error that led to an overdose of calcium chloride and the subsequent death of an infant. Despite 27 years of experience, she was unable to find work after the error and was plagued by guilt.

Immediately after an error is recognized, the healthcare practitioner involved typically experiences stress-related psychological and physical reactions related to sadness, fear, anger, and shame. They are plagued by loss of confidence, self-doubt, depression, remorse, distress, and humiliation. The months that follow often are characteristic of post-traumatic stress disorder (PTSD), leading to insomnia, sleep disturbances, flashbacks, and thoughts of suicide.

The second victims of harmful errors have often suffered in relative silence, unsupported by colleagues, peers, and healthcare leaders during a life-altering event. This paradigm of abandonment, isolation, and punishment of second victims needs to be changed to a supportive culture that provides accessible and effective support for practitioners.
Second victims have the right to be treated with respect, to participate in the process of learning from the error, to be held accountable in a fair and just culture, and to not be abandoned by the healthcare organization. They are often good people who mean to do well and find themselves in a situation where a patient has been harmed by their unintended actions.

ISMP urges organizations to develop a crisis management plan that includes a formal infrastructure for second victim support before it is needed. The key to learning from errors, effective safety improvements, and fair and just treatment of involved staff is planning for crisis management before the emotions of a harmful event lead to a solely punitive reaction.

The cover article in this week’s ISMP Medication Safety Alert! newsletter outlines resources available to assist, including a webinar, toolkit, and ISMP referrals. For a copy of the article, which also describes the five rights of second victims, go to:

www.ismp.org/Newsletters/acute/20110714.asp

About ISMP: The Institute for Safe Medication Practices (ISMP) is an independent, nonprofit charitable organization that works closely with healthcare practitioners and institutions, regulatory agencies, consumers, and professional organizations to provide education about medication errors and their prevention. ISMP represents more than 35 years of experience in helping healthcare practitioners keep patients safe, and continues to lead efforts to improve the medication use process. ISMP is a federally certified patient safety organization (PSO), providing healthcare practitioners and organizations with the highest level of legal protection and confidentiality for patient safety data and error reports they submit to the Institute. For more information on ISMP, or its medication safety alert newsletters and other tools for healthcare professionals and consumers, visit www.ismp.org.

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