

First or second victim, who cares?



Dr. Filiep Bataillie

First or second victim? Who cares!

Filiep Bataillie
AZ Herentals



Summary

Two
stories

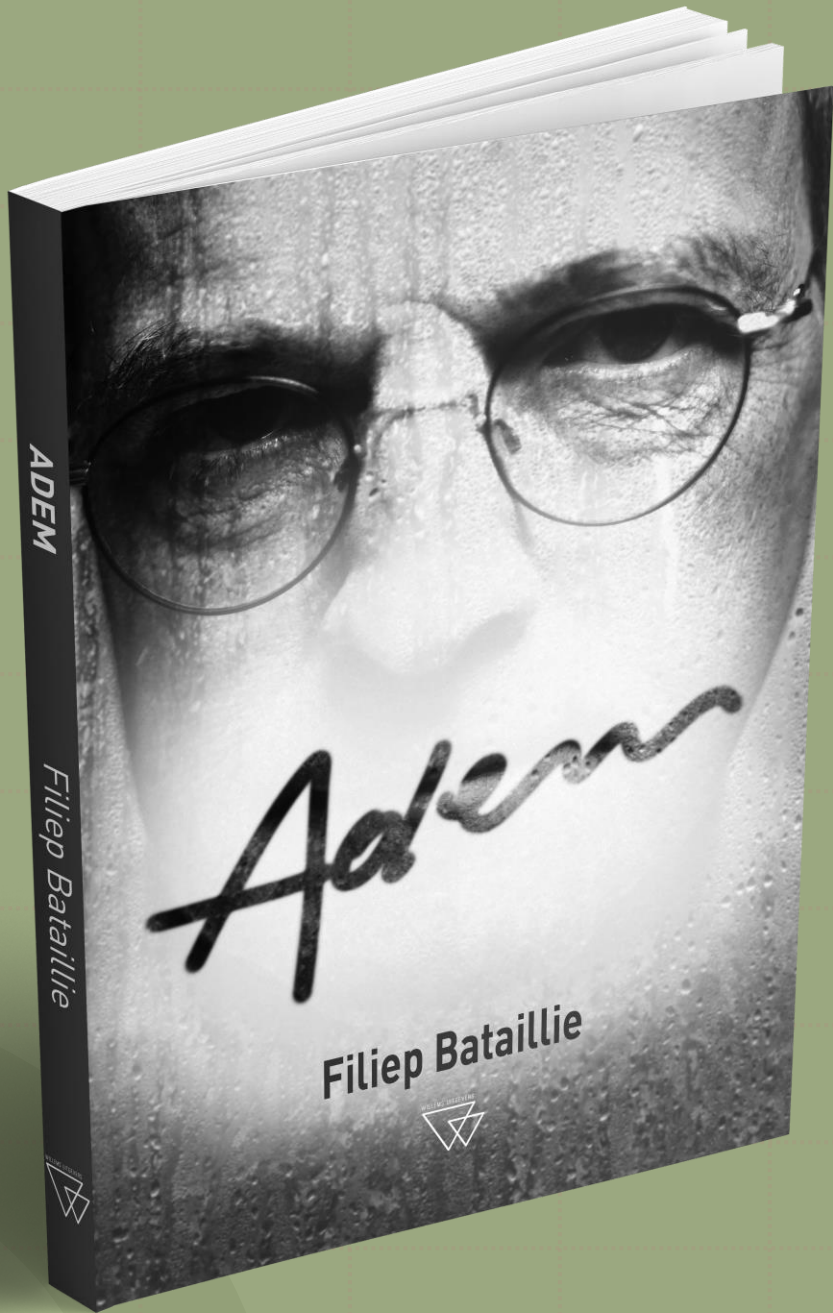
Open
disclosure

Second
victim

Why I started in healthcare

- Stephan H. 9 y
- Januari 1974 diagnosis Ewing left tibia
- No treatment
- + 30 november 1974





The Story

- February 2020
- Working hard with friends
- Isolated from the outside world
- Lots of fun
- No radio
- No television



The Story

- A rollercoaster of organising, emotions, untill
- ... I got Covid
- I want to continue to work!
- ...Intensive Care

Anoniem

Adem



My husband and I were very emotional. I myself got COVID on March 13, 2020, resulting in intubation. Was hospitalized for a month. Haven't spoken to or seen anyone outside of nursing. That leaves a wound in social beings.

I am/was working as a nurse in a residential care centre. Because of my illness, there was all hands on deck in the house! I enjoyed and cried during your performance. Of emotion, of realising what was going on behind the scenes... After the performance, I wanted to thank you, but after more than a year, I can't handle the hustle and bustle in a cafeteria with a lot of buzz. I had to get over sitting in a crowd, but I'm very glad I did it and dared.

... I wish you all the best.

Conclusion 1

We can all be victims



First - Second - Third

WHAT IS OPEN DISCLOSURE?

Patient Safety Incident

"An unintended event during the care process that has resulted or could result in harm to the patient."



What and why?



Culture - Process

Everything that didn't go the way we planned, foreseen or expected it

Expressing regret (note: ≠ admit guilt / liability)

Victim:

- Patient/family
- Healthcare providers involved (second victim)
- Organization

Disclosure = open disclosure

Open conversation with the patient/family after an incident

Starting point

Framework open disclosure: versie 1.0

30/04/2021

Prof. dr. Steven Lierman*, Dr. Wouter Marchand*^o, Dhr. Jeroen Brouwers^o, Mevr. Ilse Weeghmans^o, Prof. Dr. Kris Vanhaecht*

**Leuvens Instituut voor Gezondheidszorgbeleid, KU Leuven; ^oAZ Delta, Roeselare ^oVlaams Patiëntenplatform*

Starting point

An open disclosure **conversation** is a part of an **open disclosure process**, which cannot be reduced to a single conversation.

- A framework to provide tools for a wide range of patient safety incidents.
- How to apply open disclosure, who to involve, what are the principles of open disclosure and how does an open disclosure process work?

Open disclosure: why?

Various benefits for all parties involved (literature)

| Patient/family | Healthcare providers | Healthcare Organization |
|--|--|---|
| Sense of recognition and respect | Improves caregiver-patient relationship | Reinforces a culture of openness and security |
| Increased/maintain trust in healthcare providers | Involvement and support of the team | Demonstrate respect and trust for the organization/team |
| Reduction of negative feelings (anger, disappointment, fear) | Reduction of negative feelings (anger, disappointment, fear) | Learning organization (zv allowed to make mistakes = learning opportunity) |
| Receiving information, about further treatment, consequences, | Prevention of burnout | Reduces the risk of disputes |

Expressing regret vs liability

Recommendations from Assuralia

ASSURALIA The insurers – members of Assuralia are of the opinion that their position is already fully contained in the preliminary memorandum on the Open Disclosure framework. We would only like to emphasize the importance for insurers not to be able to deduce an acknowledgement of liability from the open disclosure, e.g. from the expression of regret or apology for the undesirable course of a medical procedure by the healthcare provider.

Moreover, such **an expression of regret** by a healthcare provider/healthcare institution is not perceived negatively by the insurers towards them.



ORDE DER ARTSEN



How we did it?

- Shared vision on open disclosure within AZH
- Education KUL



KU LEUVEN
LEUVENS INSTITUUT
VOOR GEZONDHEIDSZORGBELEID

NIEUWE OPLEIDING Open Disclosure

Deze opleiding biedt zorgverleners een leidraad wanneer zij, naar aanleiding van een patiëntveiligheidsincident, een open disclosure-proces willen opstarten.

De opleiding met een theoretisch en een praktisch gedeelte is gebaseerd op het nieuwe **Raamwerk voor Open Disclosure** dat onlangs gepubliceerd werd en opgesteld werd in samenwerking tussen LIGB-KULeuven met het Vlaams Patiëntenplatform, Zorgnet Icuuro, Assuralia, VVOVAZ, NVKVV, de orde der artsen en de Vlaamse Vereniging voor Hoofdartsen.







How we did it?

- Raising awareness
- Promote the culture through key figures (doctors, nurses, believers,...)
- Reporting form incidents and complication registration: check open disclosure conversation (reminder)
- Follow-up

het spijt me **het spijt me**

HET SPIJT ME

het spijt me **het spijt me**

Open disclosure

do 1 juni • 19.30 uur • 't Schaliken

Panelgesprek met

- Christophe Aussems (regisseur van *Hybris*)
- prof. Kris Vanhaecht (LIGB)

Praktisch

- Voor medewerkers en artsen
- Inschrijven via formulier

 azherentals



Open disclosure

maandag 20 november
19.30 uur • 't Schaliken

Panelgesprek met

- Christophe Aussems (regisseur van *Hybris*)
- prof. Kris Vanhaecht (LIGB)

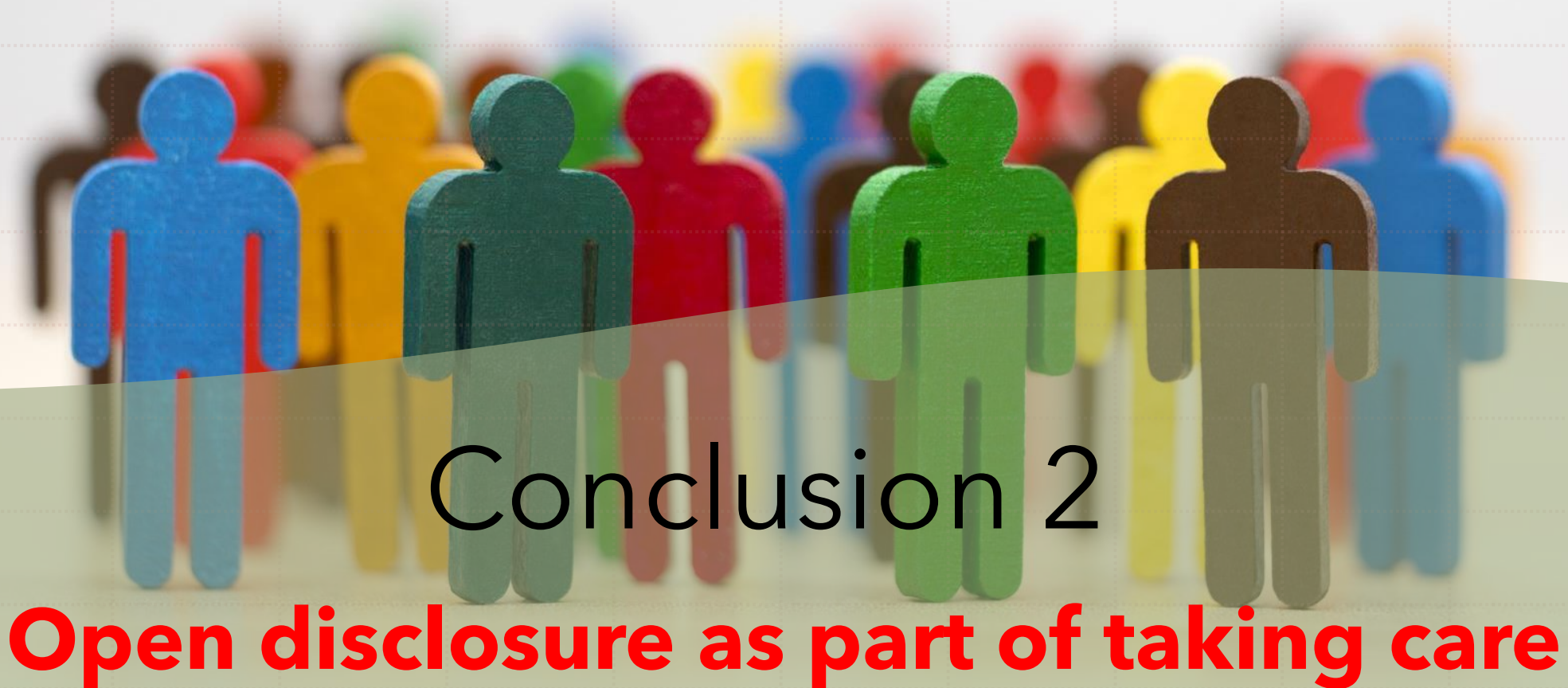
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ziekenhuisnetwerk
kempens 

Open disclosure
11 rules
to guide an
effective and fully
open disclosure
process
Prof. Van Haecht

1. Good preparation
2. Never alone
3. If involved, please participate in the conversations
4. Take your time - time for questions
5. The first interview in the first 24 hours
6. Factual information
7. Empathy and understanding
8. Expressing regret and saying "I'm sorry"
9. Next steps and contact person
10. Together with your team and discuss with each other
11. Share your improvement actions



Conclusion 2

Open disclosure as part of taking care

Second Victim

- The caregiver have to deal with the consequences of an incident.
- Common reactions can be **emotional**, **cognitive**, and **behavioral**.
- The coping strategies used by second victims have an impact on their **patients**, **colleagues**, and **themselves**.

Second Victim



Professional Issue: "Personal"

Health Care Professionals as Second Victims after Adverse Events: A Systematic Review

Deborah Seys¹, Albert W. Wu², Eva Van Gerven¹, Arthur Vleugels¹, Martin Euwema³, Massimiliano Panella⁴, Susan D. Scott⁵, James Conway⁶, Walter Sermeus¹, and Kris Vanhaecht¹

- It is estimated that **half of the healthcare workers** are 'second victims' at least once in their career.
- 9% of doctors and nurses are directly involved in a Patient Safety Incident in a span of 6 months.
- As much as 15% of care givers, who are involved in an adverse event, **think about leaving their job**

Second Victim



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- After the adverse event, **defensive** as well as **constructive** changes have been reported in practice.
- When an adverse event occurs, it is critical that **support networks** are in place to protect both the patient and involved health care providers.

Second Victim

- From a survey (Van Gerven 2016) of 913 doctors, nurses and midwives who were involved in this type of incident, we could conclude that **the psychological impact** of a Patient Safety Incident is greater
 - if the incident is more serious for the patient,
 - if the person in question feels responsible or
 - if it concerns a female caregiver.
- The psychological impact is lower for caregivers who work in an organization with **a safer and more open culture**.

Second Victim – Peer Support

- 'Peer supporters' selected in a systematic way and within the group of **colleagues** of a hospital.
- They also receive **specific training to have conversations**.
- Second victims are **invited** for this conversations according to a predetermined pattern, of which important components are:
 1. offering a peer support conversation
 2. the conversation itself (introducing, listening, reflecting, reframing, reviewing coping strategies, closing)
 3. follow-up

It is very important that such a program is **supported by the entire organization**, and certainly by the **management**.

Rules of thumb for second victims for **the caregiver**

- Talk about it with colleagues, with the patient and his/her family, with your own partner
- Write down what you know in the file
- Take your time and if necessary stop your work
- Ask a peer supporter
- Go to the debriefing
- Think about why you choose healthcare

Rules of thumb for second victims
for

the colleague

- Listen, listen, listen
- Don't be too quick to say: I've had this too, or I know that
- Organize a debriefing
- Join the open disclosure conversation
- Take over his/her work
- Suggest help or peer support

Second Victim

- Peer support
- Debriefing
- NO BLAME!
- How do we prevent this incident?

Conclusion 3

Take care of second victims



Conclusion



TAKE CARE OF EVERYONE



USE YOUR EMPATHY



NEVER FORGET WHY YOU
STARTED IN HEALTHCARE

Thank you