Evaluation

Data Collection Procedure

A PowerPoint presentation covering second victimhood in anesthesia and the effects on patient outcomes was presented to the sample study. Within the presentation, an explanation of second victimhood and commonly experienced causes of second victimhood encountered while providing anesthesia were given to participants. The presentation also included results from current research, and the search strategy utilized to obtain the studies analyzed. A survey was administered to obtain demographic information, willingness to implement change, and preferred type of support. A post-presentation Second Victim Experience and Support Tool (SVEST) was utilized to assess the degree of support currently present in the facility and the level of second victimhood experiences participants have perceived in the past by having participants rank various scenarios on a Likert scale.

Knowledge Instrument

The survey collected demographic information, willingness to implement change, and preferred type of support consisted of eight multiple-choice questions. Two of these questions had an open-ended option if participants did not feel any of the options best suited them individually. The Likert scale consisted of ten subcategories: Psychological distress, physical distress, colleague support, supervisor support, institutional support, non-work-related support, professional self-efficacy, turn-over intentions, absenteeism, and desired forms of support. Each of these subgroups contained 2-7 scenarios to be ranked on a scale of 1-5.

Data Analysis

Graphical representation was used to illustrate participants in the sample size. Responses from participants were kept anonymous. Therefore, no correlation could be made between

demographic details and SVEST responses. Instead, an average score from each SVEST scenarios was calculated (Figure 1) and utilized to create recommendations for the facility.

Demographics.

Thirty participants viewed the presentation, completed the survey, and ranked the scenarios on the Likert scale. The participants were evenly divided in terms of gender, with 47% female and 53% male. No other genders were reported. The age of participants formed a bell curve distribution among each age group. The sample size was primarily composed of master's degree nurse anesthetists, with only 27% having a doctorate in nursing anesthesia. A large portion of the participants (40%) had greater than 10 years of experience and only 6% of participants had less than 2 years of experience as anesthesia providers.

Table 1

Respondent's characteristics

Demographic data	Total sample (n=30)
Gender	
Female	14 (46.7%)
Male	16 (53.3%)
Age (years)	
25-35	7 (23.3%)
35-45	8 (26.7%
45-55	8 (26.7%)
> 55	7 (23.3%)
Level of Education	
Master's	22 (73.3%)
Doctorate	8 (26.7%)
Years of Experience (years)	
< 2	2 (6.7%)
2-5	7 (23.3%)
5-10	9 (30%)
> 10	12 (40%)

Results

All participants (100%, n=30) surveyed, found the presentation helpful in increasing knowledge regarding second victimhood and the majority (60%, n=18) admitted to having experienced second victimhood (Figure 1). Despite this, only 1 respondent (3.3%) felt "extremely motivated" to implement change in their workplace. Moreover, 36.7% (11 participants) claimed they were "definitely not motivated" to implement change. However, 60% (18 participants) reported feeling "somewhat motivated" to implement change in the workplace (Figure 2). Regarding support methods that offer the most benefit, 96.7% of respondents chose talking to a trusted peer (Figure 3). A religious leader was chosen by 3.3% of respondents, and one participant stated none of the options were helpful. The two other options presented in the survey were "relay concerns to management" and the "American Association of Nurse Anesthetists".

Second Victim Experience and Support Tool (SVEST) results detailed the degree to which anesthesia providers feel they have experienced second victimhood. An average score was calculated from each participant's ranking of each scenario offered (Figure 4). Psychological distress was admitted more so than physical distress; however, physical distress was still reported by participants, including disruption of sleep. Regarding support, talking with a colleague left providers with a sense of relief. Supervisor support was reported as fair, but institutional support was not highly rated by participants. Outside of the work-place, all participants reported utilizing the love of close friends and family members to offer emotional support after situations of second victimhood experiences. Other key takeaways include participants reporting that the stress of situations involving second victimhood made them want to quit their job and having the

ability to immediately take time away from the unit was unanimously reported as a desired form of support.

Limitations

The study's results were composed of responses from anesthesia providers who were available to listen to the presentation and complete the survey questions and scenarios. Unfortunately, participation was limited by provider availability due to being off work or being involved in a case at the time of the presentation. A larger sample size could have been obtained if all staff was required to attend the meeting in person. Another way to increase the number of responses would have been to provide the presentation on multiple days to reach providers who could not attend the presentation.

Recommendations

A mentor program should be considered so that staff knows they have a trusted colleague to discuss instances of second victimhood. Those participating in the survey stated that talking to a coworker provides relief and reassures the person that they are still a good healthcare provider even when adverse events occur. In addition, love from close friends and family members helps anesthesia providers move past second victimhood experiences.

Organizing outings that encourage team building and growing relationships amongst staff could create bonds between coworkers, thereby increasing resources when anesthesia providers need to speak to a trusted colleague. These events could be planned by management or a committee of anesthesia providers.

Furthermore, participants reported that having the ability to immediately take time away from the unit following an adverse or traumatic event is a highly desired form of support. Unfortunately, this often does not occur because minimizing turn-over time between cases is

primarily promoted. To combat this, consider having management start the next case while the provider experiencing second victimhood has a moment to debrief in their chosen location.

Impact on Practice

The immediate impact is increased awareness and knowledge about second victimhood in anesthesia providers. Every participant surveyed stated the presentation helps increase knowledge regarding second victimhood. In addition, 60% reported having to experience second victimhood. Bringing awareness to this statistic can encourage staff to seek help. By seeking help, the associated negative effects of second victimhood can be lessened. These include quitting to obtain a job at another facility or leaving anesthesia altogether.

Having fewer providers available would make it more difficult for patients to receive care when needed. For patients, this may mean further distance to travel, increased costs, delays in treatment, and increased frequency or severity of medical errors. To the hospital, loss of anesthesia providers can mean limitations in revenue and expansion of services. Anesthesia providers that feel they have their mental and physical needs met are more likely to remain with their employer. Because of this, it is imperative that we continue to educate anesthesia providers on the signs and symptoms of second victimhood, the prevalence of second victimhood, and how to seek help when needed.

Future Studies

Because the results were kept anonymous, it is impossible to evaluate whether the number of years providing anesthesia correlates with higher or lower rates of second victimhood experiences. For future studies, both the multiple-choice questions and the SVEST should be collected in one single document to extrapolate this information. Education about the subject matter should continue each year to have an impact in the long-term. This education would be

expected to further increase new staff awareness and knowledge of second victimhood while reinforcing knowledge to repeat staff.

Figure 1

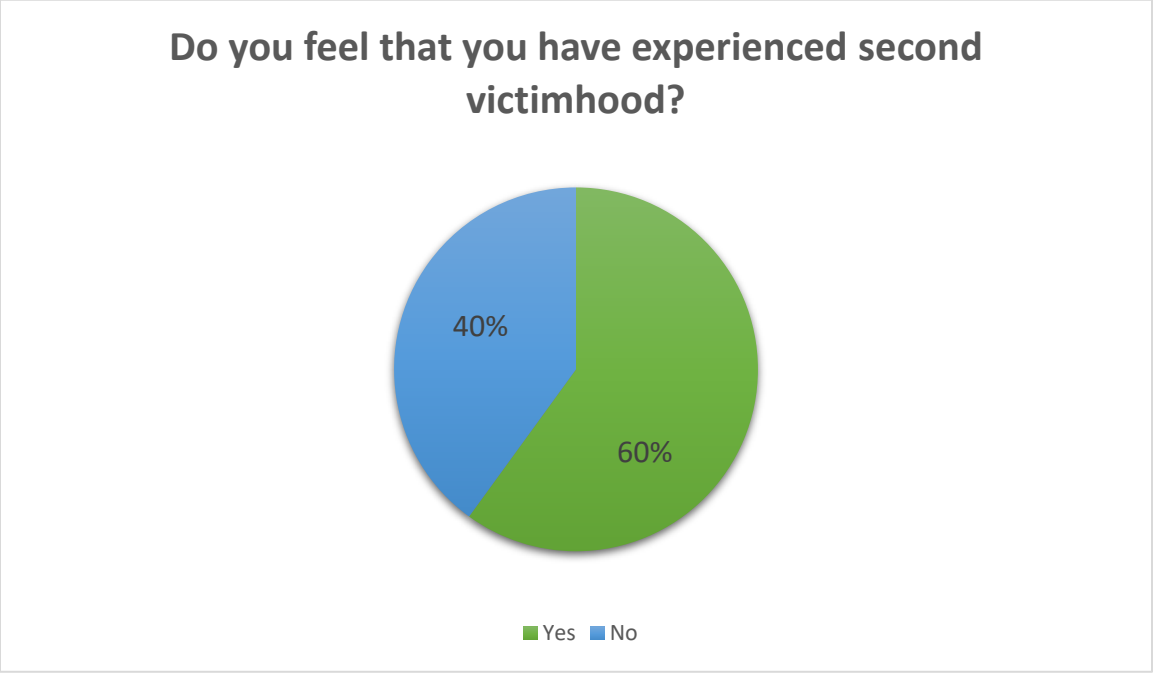

Figure 2

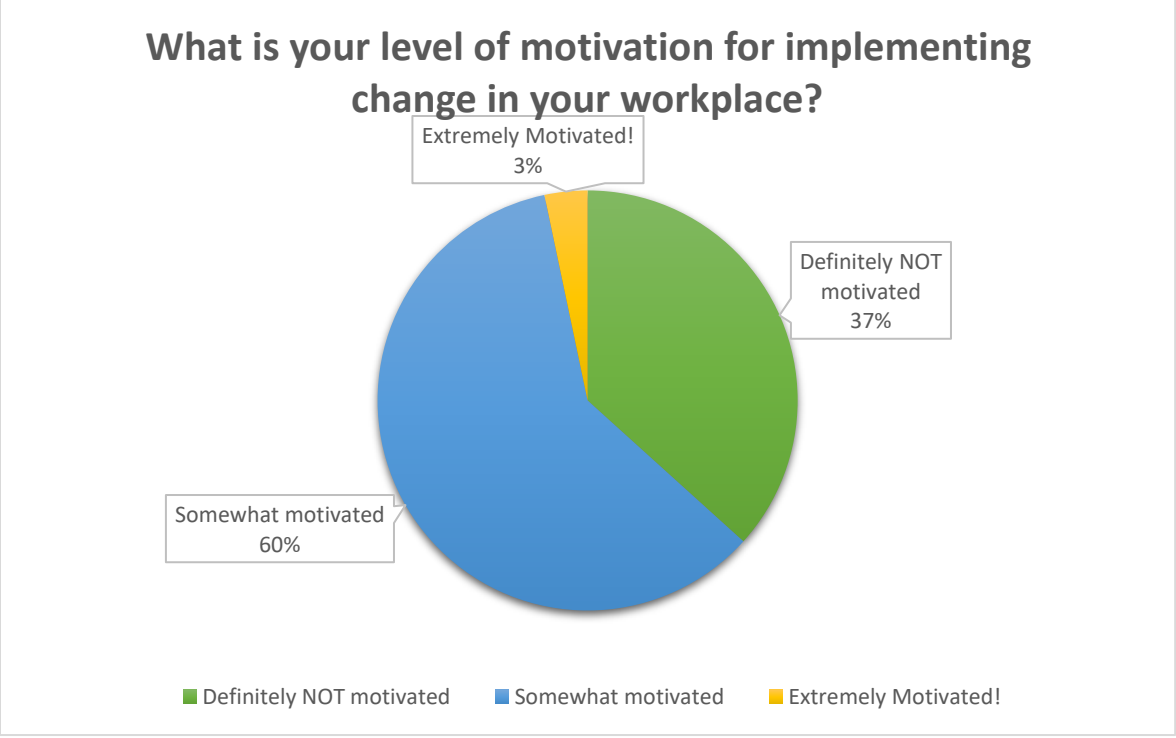

Figure 3

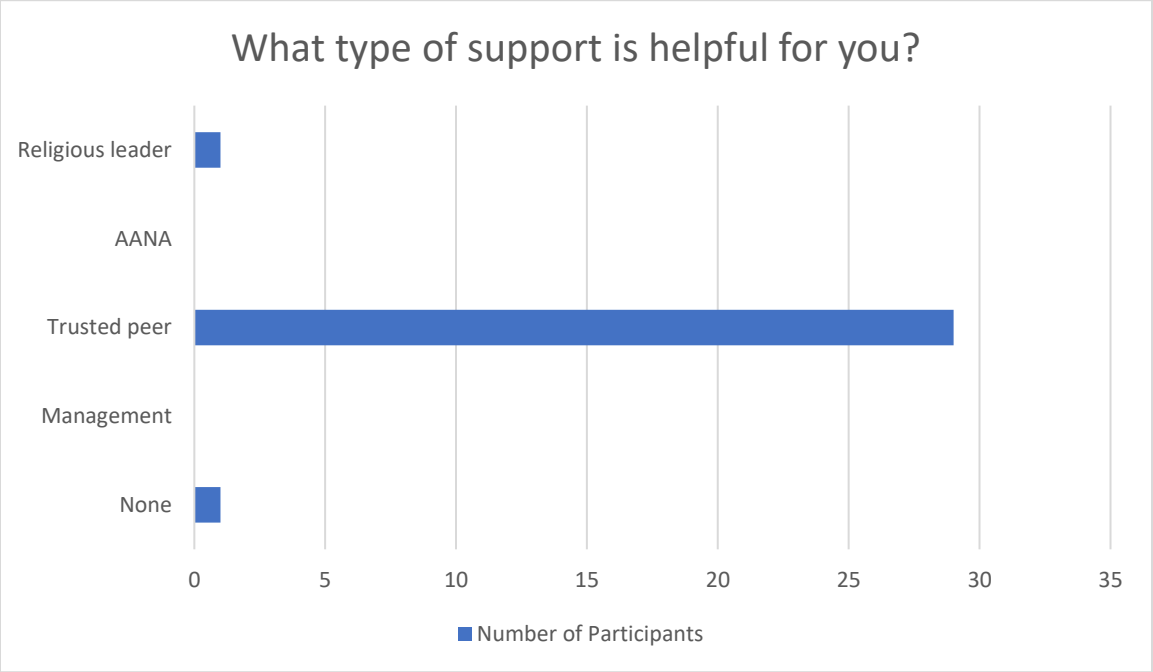

Figure 4

Average scores reported for each Second Victim Experience and Support Tool (SVEST) scenario

Psychological Distress

4 - I have experienced embarrassment from these instances.

4 - My involvement in these types of instances has made me fearful of future occurrences.

2 - My experiences have made me feel miserable.

1 - I feel deep remorse for my past involvements in these types of events.

Physical Distress

2 - The mental weight of my experience is exhausting.

2 - My experience with these occurrences can make it hard to sleep regularly.

1 - The stress from these situations has made me feel queasy or nauseous.

1 - Thinking about these situations can make it difficult to have an appetite.

Colleague Support

1 - I appreciate coworkers' attempts to console me, but their efforts can come at the wrong time.

5 - Discussing what happened with my colleagues provides me with a sense of relief.

3 - My colleagues can be indifferent to the impact these situations have had on me.

5 - My colleagues help me feel that I am still a good healthcare provider despite my mistakes

Supervisor Support

3 - I feel that my supervisor treats me appropriately after these occasions.

5 - My supervisor's responses are fair.

2 - My supervisor blames individuals.

3 - I feel that my supervisor considers the complexity of patient care practices

Institutional Support

2 - My organization understands that those involved may need help to process and resolve any effects they may have on care providers.

1 - My organization offers a variety of resources to help me get over the effects of involvement with these instances.

2 - Concern for the well-being of those involved in these situations is strong at my organization.

Non-Work-Related Support

5 - I look to close friends and family for emotional support after one of these situations happens.

5 - The love from my closest friends and family helps me get over these occurrences.

Professional Self-Efficacy

3 - After my involvement, I experienced feelings of inadequacy regarding my patient care abilities.

3 - My experience makes me wonder if I am not really a good healthcare provider.

3 - After my experience, I became afraid to attempt difficult or high-risk procedures.

2 - These situations do not make me question my professional abilities.

Turnover Intentions

2 - My experience with these events has led to a desire to take a position outside of patient care.

4 - Sometimes the stress from being involved with these situations makes me want to quit my job.

Absenteeism

3 - My experience with an adverse patient event or medical error has resulted in me taking a mental health day.

2 - I have taken time off after one of these instances occurs.

Desired Forms of Support

5 - The ability to immediately take time away from my unit for a little while.

4 - A designated peaceful location available to recover and recompose after an event.

4 - A respected peer to discuss the details of what happened.

2 - An employee assistance program that provides free counseling to employees outside of work.

1 - A discussion with my manager or supervisor about the incident.

1 - The opportunity to schedule a time with a counselor at my hospital to discuss the event.

1 - A confidential 24-hour hotline to discuss how my experience may be affecting me.