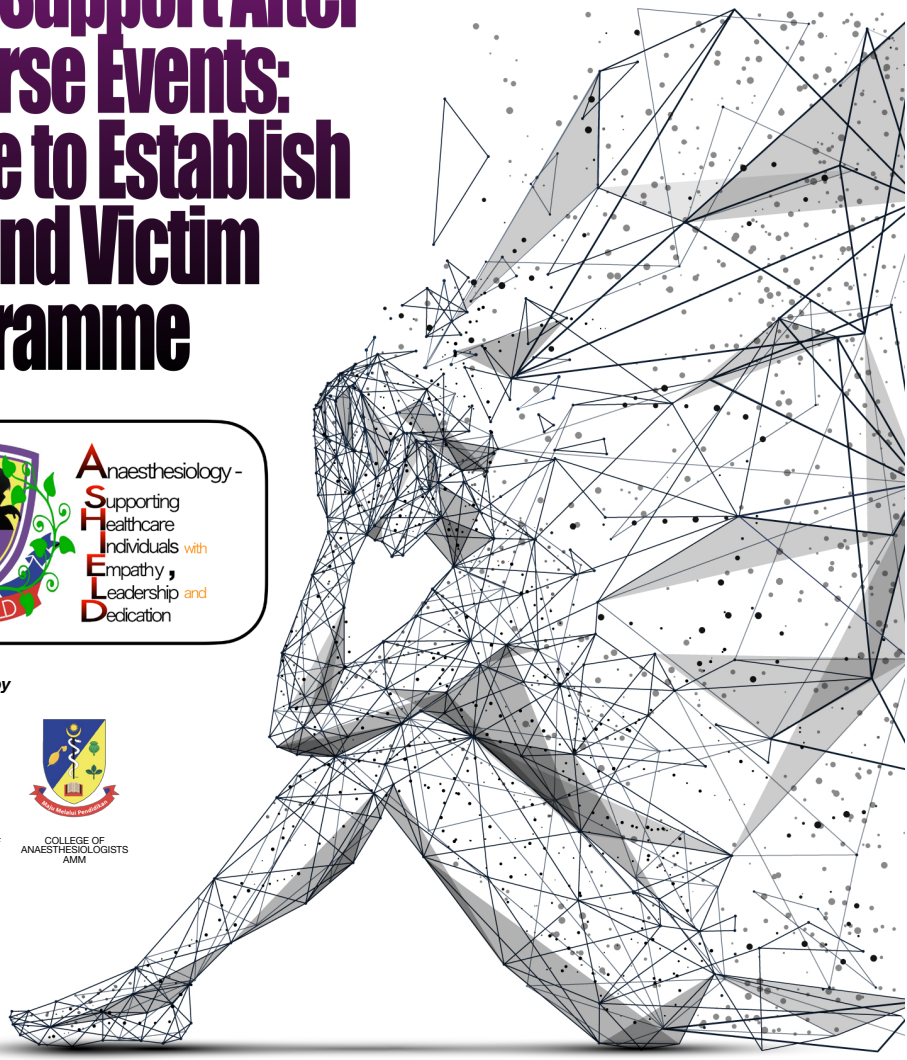
A-SHIELD

Peer Support After Adverse Events: Guide to Establish Second Victim Programme



Anaesthesiology - Supporting Healthcare Individuals with Empathy, Leadership and Dedication

Published by

MALAYSIAN SOCIETY OF ANAESTHESIOLOGISTS

COLLEGE OF ANAESTHESIOLOGISTS AMM

In collaboration with

MALAYSIAN SOCIETY OF CLINICAL PSYCHOLOGY

KEMENTERIAN KESIHATAN MALAYSIA

Endorsed by

MALAYSIAN SOCIETY OF INTENSIVE CARE

MALAYSIAN PSYCHIATRIC ASSOCIATION

A-SHIELD Peer Support After Adverse Events:

Guide to Establish Second Victim Programme

A-SHIELD Peer Support After Adverse Events:
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By
A-SHIELD Task Force
Malaysian Society of Anaesthesiologists and
College of Anaesthesiologists, Academy of Medicine Malaysia

In collaboration with
Malaysian Society of Clinical Psychology

Endorsed by
Ministry of Health Malaysia
Malaysian Society of Intensive Care
Malaysian Psychiatric Association

Published by:
Malaysian Society of Anaesthesiologists (MSA),
Unit 3.3, Level 3, Medical Academies Malaysia Building,
No. 5, Jalan Kepimpinan P8H, Presint 8, 62250 Putrajaya, Malaysia.
Email: secretariat@msa.net.my
October 2024

e ISBN: 978-629-95021-0-4

Dedicated to those of us who have walked alone…

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Foreword by the Director General Ministry of Health Malaysia

Datuk Dr Muhammad Radzi bin Abu Hassan

Anaesthesiology and critical care inherently demand the highest levels of precision, skill, and dedication. The stakes are incredibly high, and the responsibilities carried by these professionals are immense. However, despite best efforts, adverse events can and do occur, taking a profound emotional, psychological, and professional toll on those involved.

This document stands as a testament to the dedication of the Malaysian Society of Anaesthesiologists (MSA) and the College of Anaesthesiologists, Academy of Medicine of Malaysia (CoA-AMM) in safeguarding the well-being of anaesthesia healthcare professionals. It recognizes that the impact of adverse events extends beyond the patients and their families, deeply affecting the healthcare professionals involved. The concept of the 'Second Victim' highlights the often-overlooked emotional and psychological struggles that follow after an adverse event, underscoring the need and importance of providing robust support to these individuals.

The information, strategies, and resources presented in this document, aim to foster a culture of compassion, understanding, and resilience within the anaesthesiology and critical care community. By offering comprehensive support, we not only help our colleagues in their recovery but also enhance the overall safety and quality of patient care.

I wish to congratulate the MSA and CoA-AMM for addressing the Second Victim phenomenon and highlighting the importance of implementing support programmes. This document serves as a reference for institutions to systematically implement practical and effective structured support systems

for Second Victims as it provides a framework for Anaesthesiology and Critical Care Departments to follow. A supportive and compassionate workplace culture can enhance overall job satisfaction and contribute to a more positive work environment, benefiting all healthcare professionals.

Together, we can ensure that no healthcare professional faces such a challenging experience alone. I strongly recommend that Anaesthesiology and Critical Care Departments adopt this programme to facilitate healing, growth, and continued excellence in patient care.

Thank you.

Foreword by the President of the Malaysian Society of Anaesthesiologists

Dato' Dr Yong Chow Yen

Anaesthesiology healthcare professionals are a critical resource in delivering high-quality care and improving health outcomes for our population. The well-being of this workforce is vital not only to patient care but also to the sustainability of the profession. However, the demanding nature of anaesthesia and critical practice means that anaesthesiologists and related professionals are often deeply affected by adverse clinical events, which can lead to what is now recognised as the Second Victim (SV) phenomenon.

As a society that prioritises the welfare of our members, the Malaysian Society of Anaesthesiologists (MSA) is taking a proactive approach to addressing the emotional and psychological toll that these events can impose on anaesthesia healthcare professionals, especially when unintended outcomes occur despite our best efforts. Ensuring the mental and emotional health of every team member is a core professional responsibility of our discipline. Despite its impact, the SV phenomenon remains under-recognized. Increasing awareness is a critical step toward creating a safe environment where healthcare professionals can discuss the emotional aftermath of medical errors and adverse outcomes. In recognition of this, MSA, in collaboration with the College of Anaesthesiologists, Academy of Medicine of Malaysia (CoA-AMM) issued a joint statement on Peer Support After Adverse Events: A Focus on Second Victims during the Annual Scientific Congress of MSA and CoA-AMM on 3rd August 2024.

One of the most significant barriers to addressing the SV phenomenon is the stigma surrounding medical errors. Healthcare professionals often feel a deep sense of guilt and responsibility, which may prevent them from seeking help. It is essential to dismantle this culture of blame and promote a more

compassionate and understanding approach. The implementation of a Second Victim Program (SVP) is crucial for the development of a supportive culture and building resilience within our teams. With leadership support, SVPs can become an integral part of institutional culture, empowering healthcare professionals to seek help without fearing negative career implications.

Each of us has the responsibility and opportunity to champion SVPs in our workplaces. We can do this by raising awareness, advocating for multidisciplinary collaboration, and encouraging leadership to support the mental and emotional well-being of anaesthesia healthcare professionals. Leaders in Anaesthesiology and Critical Care must prioritise the mental health of team members and advocate for the resources and policy changes needed to implement and sustain SVPs. By providing a clear framework for the implementation of SVPs, MSA urges Anaesthesiology and Critical/Intensive Care Departments across the country to transform awareness into concrete action, fostering a more compassionate healthcare environment for all.

I wish to commend the MSA and CoA-AMM A-SHIELD Task Force for their initiative and dedicated commitment in developing this guide. Their work will be instrumental in advancing healthcare practices by providing vital support to anaesthesia healthcare professionals. MSA wishes to extend its heartfelt gratitude to the Malaysian Society of Clinical Psychology for their invaluable guidance in developing this framework. Their expertise has been instrumental in shaping a comprehensive approach to SVPs.

We are also deeply indebted to Dato' Seri Dr Muhammad Radzi bin Abu Hassan, Director General of the Ministry of Health Malaysia, for his unwavering support in this important endeavour. His backing is crucial in advancing the implementation of SVPs across the country. Together, we can ensure that the emotional and psychological well-being of our healthcare professionals is safeguarded, fostering a more resilient and supportive medical community. This, in turn, will enhance patient safety and the overall quality of care we provide.

Foreword by the President of the College of Anaesthesiologists, Academy of Medicine of Malaysia

Prof Dr Ina Ismiarti Shariffuddin

It is with pride that I write a foreword for this book, "A-SHIELD Peer Support After Adverse Events: Guide to Establish Second Victim Programme". This book embodies the collective wisdom, empathy, and determination of our profession to support one another during the most challenging moments we face. In anaesthesiology and critical care, we are constantly reminded of our immense responsibility for the safety and well-being of our patients. Yet, despite our expertise and dedication, adverse events can happen. It is in these moments that we, too, become vulnerable—not just as clinicians but as individuals carrying the emotional weight of our professional roles. The second victim phenomenon is real, and for too long, it has been overlooked.

This guide offers practical support for every anaesthesiologist and healthcare professional who has felt the sting of guilt, fear, or doubt after an adverse event. It provides a structured approach to creating a culture of support, resilience, and healing within our fraternity. By implementing the frameworks and peer support programs outlined in these pages, we take meaningful steps towards safeguarding the mental and emotional health of our colleagues, ultimately improving the quality of care we provide.

To all who have contributed to this work, especially the dedicated members of the A-SHIELD Task Force, I extend my heartfelt thanks. You have gifted us a tool that will transform how we approach the well-being of our own. I encourage every institution to embrace the guidance offered here, for no healthcare professional should walk this journey alone.

Together, we will foster a compassionate, supportive environment that honours the humanity of both patient and provider.

GLOSSARY OF ABBREVIATIONS

ACT	-	*Acceptance and Commitment Therapy*
A-SHIELD	-	*Anaesthesiology-Supporting Healthcare Individuals with Empathy, Leadership and Dedication*
CoA-AMM	-	*College of Anaesthesiologists, Academy of Medicine of Malaysia*
CBT	-	*Cognitive Behavioural Therapy*
DPSP	-	*Departmental peer support programme*
MSA	-	*Malaysian Society of Anaesthesiologists*
M-SVEST-R	-	*Malay Revised Second Victim Experience and Support Tool*
PFA	-	*Psychological first aid*
RCA	-	*Root cause analysis*
SV	-	*Second victim*
SVEST-R	-	*Revised Second Victim Experience and Support Tool*
SVP	-	*Second victim programme*

Chapter 1: Introduction

In the high-stakes field of healthcare, particularly in specialities like anaesthesiology and critical care, medical errors and adverse events can have profound consequences, not only for patients (the first victims) but also for healthcare providers involved in these incidents. These healthcare professionals, referred to as 'second victims' (SVs), often experience significant emotional and psychological distress following an adverse patient event.

To address this issue, many institutions have implemented Second Victim Programmes (SVPs), which are designed to provide support to healthcare professionals in the aftermath of such events.[1,2,3] As part of this endeavour, the Malaysian Society of Anaesthesiologists (MSA) and the College of Anaesthesiologists, Academy of Medicine of Malaysia (CoA-AMM) released a statement on Peer Support After Adverse Events: A Focus on Second Victims, on 3rd August 2024. This statement was intended to raise awareness on the SV phenomenon and included a call to action for all parties nationwide (Appendix 1).

This SVP document of MSA and CoA-AMM aims to highlight the issue of SV phenomenon amongst anaesthesia healthcare professionals and the importance of implementing SVPs, and provide a framework for anaesthesiology and critical care departments to implement structured support systems for SVs. Anaesthesia healthcare professionals in this document are inclusive of doctors, nurses, assistant medical officers and other healthcare providers of anaesthesiology and critical care departments.

The MSA and CoA-AMM have named this programme the Peer Support After Adverse Events: A-SHIELD Second Victim Programme, with A-SHIELD standing for "Anaesthesiology - Supporting Healthcare Individuals with Empathy, Leadership, and Dedication".

1.1 What is the Second Victim Phenomenon?

The term SV was coined by Dr. Albert Wu in 2000 to highlight the impact of unanticipated adverse events, medical errors, or patient-related

injury on healthcare providers who suffer alongside the primary victims, who are the patients and their families.[4] SVs are healthcare providers involved in an unexpected adverse event, medical error or injury affecting a patient, who become victims in the sense they are traumatised by it.[5] SVs experience significant emotional and psychological distress following these events. Surveys have shown that following perioperative adverse events, more than 70% of anaesthesiologists experienced guilt, anxiety and reliving of the events, with 88% requiring time to fully recover emotionally. Up to 19% admitted to never fully recovering, with 12% considering changing careers.[6]

These emotional burdens may also disrupt sleep patterns, leading to physical health problems such as chronic fatigue. These symptoms are similar to those experienced by patients with post-traumatic stress disorder. In addition, being a SV may impair cognitive function, decision making and clinical performance.[6] This can result in decreased job satisfaction, increased risk of burnout, and further errors in patient care.

The SV phenomenon is a widespread issue in the medical community. Although there is no data on the prevalence of SVs in Malaysia, international studies suggest that almost half of all healthcare providers involved in an adverse event will become SVs.[7] This high prevalence underscores the need for awareness, education, and support systems within the healthcare sector. Anaesthesia healthcare professionals are especially susceptible to the emotional and physical repercussions of adverse events. These professionals are uniquely vulnerable to the second victim phenomenon for several reasons as follow:

- **High-stakes environment:** Anaesthesia healthcare professionals work in environments where patients' lives often hang in the balance, such as operating rooms and intensive care units. The high-pressure nature of these settings can amplify the emotional impact of adverse events.
- **Isolation in practice:** Anaesthesia healthcare professionals frequently work in relative isolation, making critical decisions independently. This can lead to a heightened sense of personal responsibility and self-blame when outcomes are unfavourable.

- **Direct patient impact:** The role of an anaesthesia healthcare professional directly impacts patient safety and outcomes. Adverse events, such as anaesthetic complications or intraoperative crises, can have immediate and severe consequences, further intensifying the healthcare professional's emotional burden.

Recognising and addressing the needs of SVs is crucial to maintaining a healthy and resilient healthcare workforce. The process of recovery of the SV after a patient adverse event goes through several phases, as described below:[8]

1. **Chaos and accident response:** The immediate response to the adverse event is often characterised by shock, confusion and emotional turmoil.
2. **Intrusive reflections:** These consist of persistent thoughts about the event, often accompanied by self-blame and questioning one's professional abilities.
3. **Restoring personal integrity:** These involve efforts to make sense of the event and its impact, seeking support and beginning to cope.
4. **Enduring the inquisition:** Facing investigations, medicolegal actions, and institutional reviews can exacerbate feelings of guilt and anxiety.
5. **Obtaining emotional first aid:** Seeking support from peers, counsellors, or professional services to begin the healing process.
6. **Moving on:** Achieving emotional recovery through resilience, finding a new sense of purpose or, in some cases, leaving the profession.

The appropriate level of support must be available at any point after an event to prevent the worsening of psychological distress during the recovery process.

1.2 Why Implement Second Victim Programmes?

The psychological impact on SVs can be profound and long-lasting, affecting not only their mental health but also their professional performance.

The implementation of SVPs is driven by several key factors:

- **Mental health and well-being:** Healthcare professionals, including anaesthesia healthcare professionals, are at a high risk of psychological distress following adverse events. SVPs aim to provide timely and appropriate support to mitigate the negative emotional impact, thereby promoting mental well-being.
- **Patient safety:** A distressed anaesthesia healthcare professional is more likely to make errors, which could compromise patient safety. By addressing the needs of SVs, SVPs help to prevent the ripple effect of one adverse event leading to another.
- **Retention of skilled professionals**: The emotional toll of being a SV can lead to burnout and attrition, particularly in high-pressure specialties like anaesthesiology and critical care. SVPs can help retain experienced professionals by providing them with the support they need to recover and continue their practice.
- **Organisational culture:** Implementing SVPs demonstrates a commitment to a supportive and compassionate workplace culture. This can enhance overall job satisfaction and contribute to a more positive work environment, which benefits all staff members.
- **Financial impact:** A successful SVP reduces staff turnover and improves clinical care efficiency. This will lead to positive financial savings for the organisation.

1.3 How Do Second Victim Programmes Work?

This document outlines a framework for SVP based on the Scott Three-Tiered Interventional Model of Second Victim Support which consists of three tiers, with the nature of support escalating from Tier 1 through Tier 3, as shown in Figure 1.1.[1]

SVPs typically involve several tiered interventions.[1] These interventions include:

- **Immediate support:** SVPs provide immediate, on-the-spot support to healthcare professionals involved in adverse events. This includes psychological first aid (PFA) and duty relief if required.

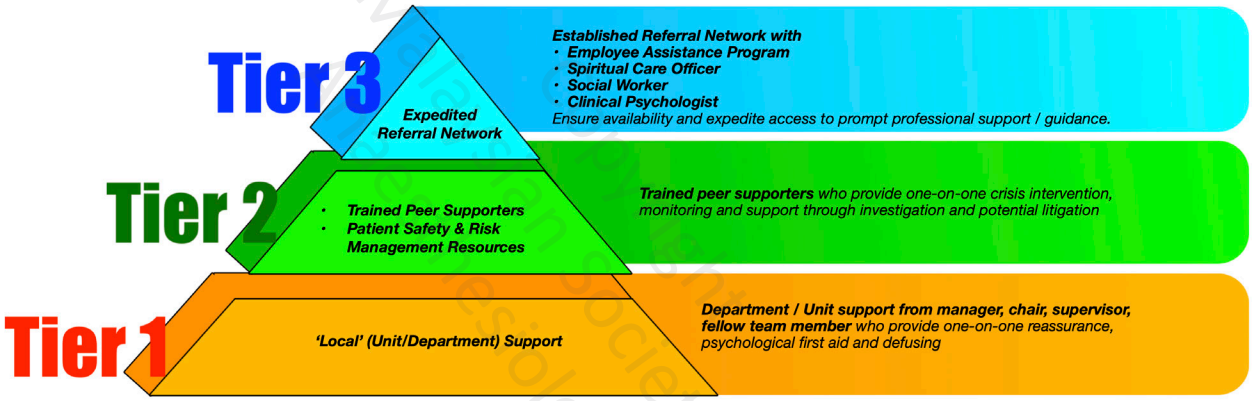

Figure 1.1 Scott Three-Tiered Interventional Model of Second Victim Support. Graphics adapted from Scott et al.[1]

- **Peer support:** SVPs include specially trained peer supporters, where trained colleagues offer empathy, understanding, and guidance. Peer supporters, who have often experienced similar situations, can provide invaluable emotional support and help normalise the SV's experience.
- **Professional mental health support:** This is a critical component of SVPs, offering more in-depth psychological support beyond what can be offered by peer supporters. This support can include individual therapy, group therapy or spiritual support. In certain circumstances, referrals to psychiatric services may be necessary.
- **Education and training:** Awareness of the SV experience is the first intervention. SVPs often include educational components to help healthcare professionals recognise the signs of SV phenomenon in themselves and others. Awareness of SV phenomenon need to focus on resilience-building, stress management and coping mechanisms, thus equipping healthcare professionals with the tools they need to handle the emotional challenges of their work.
- **Organisational support:** Successful SVPs require the backing of healthcare and professional organisations. This includes ensuring that staff are aware of the programme, encouraging participation and fostering an environment where seeking help is seen as a sign of strength, not weakness. Embedding a just culture within organisations, adopting an open disclosure framework and making professional legal support available in the event of medicolegal litigations are essential for the success of SVPs.
- **Leadership:** Leadership involvement is crucial in promoting the programme and integrating it into the overall culture of the institution. The MSA and CoA-AMM are committed to supporting our members and the broader anaesthesia and critical care community in Malaysia, by providing leadership in SVP implementation guidance, training of peer supporters and providing a helpline for anaesthesia healthcare professionals in need.

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Chapter 2 Risk Management in Second Victim Phenomenon

2.1 Introduction

Risk management in healthcare is the process of identifying events that could harm the health organisation, its patients, health care workers or anyone else within the facility.[1,2] Risk management in second victim (SV) phenomenon is the process of identifying adverse patient events that may precipitate at-risk health care worker to be a SV.[1,3] An adverse patient event is defined as a patient safety event that results in harm to a patient.[3] Adverse patient event may be stated and managed in different ways by health organisations. Just culture is of utmost importance when managing these adverse events.[2] Just culture holds both the organisation and healthcare professionals responsible while learning and focusing on improving risk reduction, systems design, human behaviour, and patient safety. It enables a voluntary reporting environment among healthcare professionals. This culture of fairness motivates healthcare professionals to assess and contribute to safety efforts in the department.[4]

Each anaesthesiology and critical/intensive care department needs to establish its own risk mitigation programme for surveillance, early detection and damage control for adverse patient events, therefore, "SHIELD"ing the anaesthesia healthcare professionals from being SVs. There should be an organisation-wide risk management plan where the department's risk management practices and processes are embedded.[5] A multidisciplinary team approach is essential in risk management with involvement across multiple levels of the healthcare organisations that aims directly to improve patient safety, quality and care outcomes, and indirectly to prevent SV phenomenon.[5]

2.2 Risk Management for Second Victims

The risk management framework consists of five important components that include risk identification, risk measurement and assessment, risk mitigation, risk reporting and monitoring, and risk governance as shown in Figure 2.1. Risk management in healthcare is a complex system of clinical and

administrative components consisting of processes, procedures, and reporting structures designed to detect, monitor, assess, mitigate and prevent risks to patients.[3,5]

Figure 2.1. Risk management for second victims.

When applying the above concepts of risk management to the SV phenomenon, it is imperative that the department's risk managers identify and evaluate adverse events that may lead to or perpetuate the SV phenomenon. Identifying risks is the first step in providing immediate support for healthcare professionals and mitigating the occurrence of the SV phenomenon. These risks may be intuitive and predictive as certain adverse events are red flags that may trigger the SV phenomenon.[2] Red flags would vary between individuals and institutions. Red flags may be in the form of patient adverse events, for example, unanticipated deaths, medical errors and adverse events involving paediatric patients, or circumstantial events, for example, first patient death experience, a personal bond developed between the healthcare professionals and patients, and workplace violence. In addition, department managers need to match clinical duties to the level of competence of the anaesthesia healthcare professionals. Clinical supervision must be made available when required. Considerations should be made to prevent anaesthesia healthcare professionals from having to work when they are fatigued or sick. A well-managed department ensures adequate intervals for rest and meals.[6]

When faced with an adverse patient event, the anaesthesia healthcare professionals need emotional support. They may experience different recovery stages after suffering from patient adverse events.[7] There are unique challenges and personal goals for SVs in each stage, as well as opportunities for institutional support provision. Appropriate risk management interventions can be taken at each stage, thereby positively influencing the final outcome. A summary of key considerations for each recovery stage can be found in Table 2.1. The immediate support entails trusted team members who provide one-on-one reassurance.[2] Often, this can also be provided by the team members involved in the events, or by those who are aware of the incident when it happens.[2,8,9] Defusing and debriefing sessions should be carried out (refer Further Resources No 1 to 4). The department must support this group of professionals with the risk mitigation programme in place.[3,5] When required, various professional support networks should be readily available.[2,8,9]

Anaesthesia healthcare professionals have the duty of candour to be open and transparent with patients when an adverse event occurs.[8-10] They should openly disclose the event truthfully and thoroughly, followed

by documentation in writing regarding the meetings and communications that occurred.[1,3,5] These meetings and communications should be done empathetically and in a caring manner. Effective open disclosure is a communication competency that requires relevant knowledge, skill and behaviour. More resources on duty of candour can be found at the end of this section *(refer Further Resources No 4 to 7).*

Root cause analysis (RCA) should be performed after an adverse event. The RCA shifts the emphasis away from the anaesthesia healthcare professionals' errors to the organisation's system properties that may have contributed to the event. During the RCA activity, the focus should be on the sequence of preceding events, why it happened and what were the precipitating and underlying factors behind the active and latent errors which contributed to the adverse outcome. Once the root causes are identified, remedial action plans must be implemented.[2,3,5]

Risk management of the SV phenomenon must include support throughout possible medicolegal processes. The adversarial judiciary system may negatively affect the well-being of anaesthesia healthcare professionals when medicolegal litigation ensues.[9-12] As a result, SVs should have access to medicolegal advice and continued peer and professional support.[12]

2.3 Conclusion

Risk management with a multidisciplinary approach and application of just culture is an important component when implementing SVP. Identifying red flags in anaesthesiology and critical care practices as part of risk mitigation process ensures that the SV receives timely support. Open disclosures, RCAs and considerations of medicolegal possibilities following adverse patient events are vital while ensuring support to the SVs.

FURTHER RESOURCES

1. New Zealand Search and Rescue. Critical incident stress debriefing (powerful event group support). Available from: *https://www.nzsar.govt.nz/assets/Downloadable-Files/Critical-Incident-Stress-Debriefing.pdf.* Accessed on 5/9/2024.

Table 2.1. Second victim recovery stages (Reproduced with permission from Scott and McCoig 2016)[6]								
Impact Realization *(Individual may experience one or more of these stages simultaneously)*						**Moving On** *(Individual migrates toward one of three paths)*		
Stage	**Chaos and Accident Response**	**Intrusive Reflections**	**Restoring Personal Integrity**	**Enduring the Inquisition**	**Obtaining Emotional First Aid**	**Dropping Out**	**Surviving**	**Thriving**
Stage Descriptors	• Point of impact = Event recognised/ error realised • Stabilise, offering immediate supportive care for patient • May or may not be able to continue providing care for this patient • Clinician commonly distracted	• Evaluate clinical events that have transpired • Self-isolation to reflect on the case and care delivered • Haunted re-enactments of event • Feelings of self-doubt and professional inadequacies • Shock and denial	• Fears rejection among work/social structure • Fear of the unknown (next steps) is prevalent • Struggling to get back to "baseline" level of professional skill and confidence	• Realisation of event severity • Reiterate scenario • Respond to numerous clinical questions surrounding the event • Interact with event responders (many strangers)	• Identify who is safe to confide in • Attempting personal/ professional support • May "hint and hope" for support from various sources	• Feelings of inadequacy and failure • Leave current role by transferring to different facility or unit • Consider quitting profession altogether	• Coping with what has transpired • Persistent sadness prevails • Trying to learn from event • Assist in defense of legal action	• Does not base practice/ work on one event • Minimal adverse effect from event • Advocates for patient safety initiatives • Tries to make a difference for the next patient or clinician
Second Victim's Personal Goals	Recognise event occurred	Conceptualise and understand what has transpired	Restore personal/ professional credibility among peers and supervisors	Provide effective accounts of the event	Identify a safe zone to communicate feelings regarding the event	Determine future professional role	Identify ways to cope from the impact of the event	Identify ways to process the event and make a positive impact on future events

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Table 2.1. Second victim recovery stages (Reproduced with permission from Scott and McCoig 2016)[6]

	Impact Realization *(Individual may experience one or more of these stages simultaneously)*					**Moving On** *(Individual migrates toward one of three paths)*		
Stage	**Chaos and Accident Response**	**Intrusive Reflections**	**Restoring Personal Integrity**	**Enduring the Inquisition**	**Obtaining Emotional First Aid**	**Dropping Out**	**Surviving**	**Thriving**
Institutional Supportive Objectives	• Identify potential second victims • Assess staff(s) ability to continue shift • Determine if second victim support needed	• Identify key individuals involved in the event • Formalise a second victim response plan • Observe staff for lingering physical or psychological symptoms	• Provide oversight of event and manage overall response including gossip control • Evaluate if a team debrief would be beneficial	• Start to collect all details of what happened from key event participants • Develop understanding of what happened and begin formulating the "why" did it happen and could it be prevented • Document event and investigation according to institutional policies	• Ensure that optimal emotional support is offered • Assure risk management and patient safety resources are available as needed	• Provide ongoing support of the second victim and maintain dialogue • If needed, assist the second victim in search for alternative employment options	• Provide ongoing support of the second victim and maintain dialogue	• Provide ongoing support of the second victim • Support second victim in how to make a difference for future events including mentoring others in similar situations
Risk Management Interventions	Gather information and start pre-claim file	Talk to staff involved and allow venting of concerns	• Contact with the staff discussing event and status of investigation • Encouraging staff not to allow event to change good practice techniques • Provide information to legal counsel and insurance	• Discuss case details with staff to preserve information for risk management/ legal use • Assistance with disclosure, apology, offer of compensation to patient/family, work with billing issues as needed • Assurance to staff of support during all phases of investigation and activity	• Answer questions about investigations or litigation process, what to expect, and assistance available • Discuss personal and family counselling options inside or outside the organisation	• Provide medical malpractice information as needed by staff for licensure, credentialing, and other applications	• Supporting and working with staff on the defence of the legal action • Working with internal and/or external lawyers	• Identify staff who have survived an event to mentor a peer who might be going through a similar experience

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Chapter 3: Revised Second Victim Experience and Support Tool (SVEST-R) to Assess Second Victim Phenomenon and Quality of Support Resources

3.1 Introduction

The Revised Second Victim Experience and Support Tool (SVEST-R) is a self-administered questionnaire designed to measure the level of emotional distress resulting from patient adverse events and assess the perceived level of support available to these healthcare workers during their difficult experiences.

The SVEST-R was developed to fulfil the pressing need for quantitative data that substantiate the establishment of effective support systems for healthcare workers who experience adverse events. By providing measurable insights, the SVEST-R empowers local departments to justify necessary interventions and allocate resources appropriately.

3.2 What is the SVEST-R?

The original SVEST questionnaire has seven dimensions with two negative outcome variables. The seven dimensions include psychological distress (4 items), physical distress (4 items), colleague support (4 items), supervisor support (4 items), institutional support (3 items), non-work-related support (2 items), and professional self-efficacy (4 items). The two negative outcome variables are turnover intentions (2 items) and absenteeism (2 items). All items are close-ended questions ranked based on a five-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree). High SVEST scores indicate a high prevalence of SV responses, a perception of insufficient support resources, and a high magnitude of negative work outcomes.

The SVEST-R is a 35-item revised version of SVEST that incorporates resilience as a positive outcome domain and omits the work-related support dimension.[2] Good construct validity was reported for the SVEST-R (chi-

square test x^2 = 1555, degree of freedom = 524, root mean square error of approximation = 0.079, comparative fit index = 0.821 and standardized root mean squared residual = 0.091). Factor loadings of all items ranged from 0.42 to 0.92, while Cronbach's alpha ranged from 0.66 for colleague support to 0.86 for physical distress.[2]

The SVEST-R has been translated and validated in Malay. The Malay version of the SVEST-R (M-SVEST-R) instrument has been adjusted into 32 items and included two new domains: distress (a combination of psychological and physical distress) and negative outcomes (a combination of turnover intention and absenteeism). The M-SVEST-R presented a good model fit with satisfactory factor loadings of all items ranging from 0.65 to 0.87. The internal consistency was determined using Raykov's rho and showed good results, with a total rho of 0.83.[3]

3.3 Why Use the SVEST-R to Assess the Second Victim Effect and the Quality of Support in Anaesthesiology and Critical Care?

The SVEST-R was initially introduced in a specific population (staff of a paediatric hospital treating children with catastrophic illnesses) and subsequent validation studies have confirmed its applicability across various populations and languages. This broad validation underscores its utility in diverse healthcare settings.

The SVEST-R can be administered at multiple timepoints: prior to an adverse event to establish baseline emotional states, immediately following an event for initial assessments and post-intervention to evaluate the effectiveness of support systems in place. This flexible timing allows local departments to tailor the tool to their specific needs and the unique circumstances of their staff.

Several stakeholders benefit from the SVEST-R implementation:

- Healthcare organisation management: The data allows for a clear justification of support system efficacy and guides decision-making processes.

- Healthcare workers: The SVEST-R enables staff to recognise the emotional impact of adverse events and seek appropriate support and resources.
- Advocacy groups: These entities can leverage the findings to assess the current impact of adverse events on healthcare workers and create benchmarks for supporting staff across international organisations.

3.4 How to Use the SVEST-R?

The use of the SVEST-R is contingent upon the specific needs of the local department and the department's stage in addressing the SV phenomenon. Initially, departmental management can utilize the SVEST-R to gauge the emotional impact of adverse events on their personnel and to assess the existing perception of supportive resources. This fundamental assessment provides baseline information critical for developing tailored support mechanisms.

Once support mechanisms have been established, the SVEST-R can serve as a continuous screening tool to identify staff requiring further assistance following adverse events. It can also act as a pre-assessment prior to intervention, followed by a post-intervention SVEST-R assessment to evaluate the outcomes of the support provided. Depending on organisational needs, the SVEST-R can be employed at various intervals to monitor staff progress and evolving support requirements.

For staff exhibiting significant emotional distress, additional psychological assessment tools should be utilised. A multidisciplinary team should be engaged for comprehensive management, including psychologists, psychiatrists, rehabilitation specialists, and spiritual support providers.

Data obtained from the SVEST-R assessments and related support initiatives can be integrated into the local department's staff wellness continuous improvement programme. This data-driven approach facilitates effective monitoring and reporting and contributes to enhancing the department's overall staff wellness index.

3.5 Where to Obtain the SVEST-R?

The English and Bahasa Malaysia SVEST-R questionnaire can be obtained from Appendices 2 and 3 respectively, in this document.

3.6 Conclusion

The SVEST-R is an essential tool for managing the SV phenomenon within local departments. By implementing this tool, departments can objectively assess SV impacts and the quality of support resources. Through its multifaceted applications and benefits, the SVEST-R will ultimately improve anaesthesia healthcare professionals' emotional well-being and enhance departmental outcomes.

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Chapter 4: A Framework for Establishing Tier 1 Support of the A-SHIELD Second Victim Programme

4.1 Introduction

According to the Scott Model, Tier 1 is local support, where local leaders and colleagues are empowered to provide psychological first aid (PFA).[1] This intervention aims to reduce acute distress by providing immediate, compassionate support to anaesthesia healthcare professionals involved in patient adverse events. All anaesthesia healthcare professionals should be equipped with basic PFA training.

To provide PFA, anaesthesia healthcare professionals should be able to (1) identify a colleague in distress, (2) provide essential support and (3) refer the colleague if necessary.[2]

In addition to the above, following a patient adverse event, a defusing session allows the anaesthesia healthcare professionals to process what has happened and get back to their routine without lingering stress. A defusing session is a shorter and informal debriefing session where emotional aspects of the event are addressed. This typically lasts 30 to 60 minutes and is most effective if done within a few hours of the event. A formal debriefing session that happens later will provide support for the anaesthesia healthcare professional as well. These processes may prevent the SVs from developing further emotional distress.[3]

4.2 Identification of a Colleague in Distress

Patient adverse events may cause SVs to feel personally responsible for the outcomes, feeling as though they failed their patients. This self-blaming tendency may affect their physical and emotional well-being, as well as professional judgment. They may also be identifying who is safe for them to confide in and may hint and hope for support.[4]

It is crucial to be aware of red flag events that may trigger distress and to pay attention to changes in the SVs' behaviours or emotional states. Textbox 4.1 outlines potential red flag events.[1] The department may establish a code or protocol trigger once these events occur.

Textbox 4.1 Potential red flag circumstances and scenarios

- Unanticipated clinical event involving a paediatric patient
- Unexpected patient death
- Preventable harm to patient
- Multiple patients with bad outcomes within a short period of time within one clinical area
- Patient who "connects" to health care professional's own family
- Long term care relationship with patient death
- Clinician experiencing his or her first patient death
- Death of a staff member or spouse of a staff member

Signs of distress may be physiological (increased heart rate, blood pressure, respiratory rate and muscle tension), emotional (crying, shivering, anger), cognitive (attention deficits, feelings of incompetencies and self-blame) and behavioural (social withdrawal and substance abuse). The SV may also complain of headaches, stomach aches, fatigue and insomnia.[5] The use of SVEST-R is valuable in assessing the degree of emotional distress experienced by the SV. An overview of the SVEST-R is provided in Chapter 3.

4.3 Provision of Essential Support

Offering support during these times should come from a professional, kindness-oriented approach.[5] It is about creating an environment where the SV feels safe, calm, in control, connected, and hopeful. The RAPID framework is a useful guide: listen **reflectively**, **assess** the situation thoughtfully, **prioritise** what the SV needs, **intervene** (take action) and **disposition** (follow through) to determine whether further psychological and professional supports are required.[6] Another useful framework is the 3 'Ls': '**Look, Listen** and **Link**'.[7]

Colleagues who are providing PFA need to differentiate between helpful and harmful actions.[5,8] Examples of helpful actions are sharing error

stories, reassuring the colleague of their competence, avoiding condemnation, and providing safe touch. Examples of harmful actions include isolating, neglecting needs for help, humiliating, and trivialising their accountability in the patient adverse event. Anaesthesia healthcare professionals operating as a single specialist or officer should be allowed to seek help across borders and to persons whom they feel comfortable with. This may include support from other departments and institutions, as well as telehealth or other digital platforms, to avoid delays in receiving PFA.

4.4 Referral of Second Victim if Necessary

If the SVs exhibit prolonged distress, or if the PFA providers feel that it is beyond their capacity to handle, it is important to refer the affected SVs to specially trained peer supporters and mental health professionals (Tier 2 and Tier 3).[1] These tiered supports may be beyond the department and may involve hospital networks in similar zones and clusters, especially when the anaesthesia healthcare professionals involved operate as a single specialist or are in an unsupportive environment.

4.5 Psychological First Aid Training

The table below outlines the framework for PFA training. Resources for further reading are also provided at the end of this chapter.

Table 4.1. Suggested training framework for psychological first aid providers. Adapted from Wolf 2023.[5]

Task	Components	Learning outcomes	Suggested learning activities
Identify a colleague in distress	1. Identify red flag circumstances and scenarios 2. Identify signs of emotional distress	1. Discuss examples of red flag circumstances and scenarios 2. Describe common physical signs & symptoms of distress 3. Use SVEST-R	1. Interactive lectures 2. Practice sessions for SVEST-R

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Table 4.1. Suggested training framework for psychological first aid providers. Adapted from Wolf 2023.[5]

Task	Components	Learning outcomes	Suggested learning activities
Provide essential support	1. Professional kindness-oriented responses 2. Establish 5 key components: sense of safety, calm, control, connection and hope 3. Use the RAPID framework: a. Reflective listening b. Assessment c. Prioritisation d. Intervention e. Disposition	1. Compare professional and unprofessional responses 2. Demonstrate: a. Establish safe environment b. Reflective listening c. Safe touch d. Identify signs & symptoms of distress	1. Lectures with videos to demonstrate and facilitate discussion 2. Role play
Refer	1. Identify referral level: a. Departmental peer supporter b. Structured professional support c. Structured clinical support d. Medico-legal support 2. Referral pathways	1. Discuss referral levels 2. Describe referral pathways	1. Lectures with videos to demonstrate and facilitate discussion 2. Role play for referral

4.6 Conclusion

Tier 1 support of the SVP is designed to recognise acute distress, provide PFA, and facilitate access to continued care if indicated. A training programme for all department members is necessary, and a framework is provided to facilitate this training.

FURTHER RESOURCES

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Chapter 5: A Framework for Establishing Tier 2 Support of the A-SHIELD Second Victim Programme

5.1 Introduction

Anaesthesia healthcare professionals who have been identified as SVs will receive basic PFA as part of Tier 1 interventions in the A-SHIELD Second Victim Programme. However, when unmet needs exist, the interventions will be escalated to a higher tier. Tier 2 of the A-SHIELD programme aims to provide psychological support by specially trained peers. This chapter will outline the key components for establishing an effective Tier 2 departmental peer support programme (DPSP). Setting up a DPSP can be divided into three phases: Phase 1: Planning and Preparation; Phase 2: Implementation; and Phase 3: Maintenance and Sustaining.

5.2 Phase 1: Planning and Preparation

5.2.1 Departmental Peer Support Programme Objectives

The DPSP for anaesthesia healthcare professionals is designed with the following objectives:

a. Provide immediate and ongoing emotional support
   The primary goal of the DPSP is to offer immediate emotional support following an adverse event. This includes providing a safe space for individuals to process their emotions and begin their journey toward healing.

b. Promote resilience and well-being
   The DPSP emphasises building resilience among anaesthesia healthcare professionals, enabling them to manage stress and bounce back from difficult situations.

c. Encourage open communication in a no-blame environment
   An essential component of the DPSP is promoting open communication

within the department. By encouraging honest discussions about adverse events, the DPSP helps create a safety culture where learning and improvement are prioritised over blame.

d. Facilitate the reintegration of SVs
The DPSP supports anaesthesia healthcare professionals' reintegration into their professional roles following an adverse event. This includes helping individuals regain their confidence and resume their duties with a renewed sense of purpose.

5.2.2 Departmental Peer Support Programme Coordinating Committee

A successful DPSP begins with the foundation of leadership and organisational buy-in. A coordinating committee involving a diverse group of anaesthesia healthcare professionals, including senior consultants, consultants, specialist, medical officers, nurses, assistant medical officers and healthcare assistants with different expertise and experience, will allow the DPSP to cater to the diverse needs of SVs. This committee oversees important decisions and aims to guide the planning and rollout of the DPSP by following a targeted timeline. The committee should meet frequently during the planning and preparation phase of the DPSP. This is estimated to take place in the first three months. Following the planning and preparation phase, the coordinating committee should continue to meet at regular intervals until the DPSP is launched and runs smoothly, after which the frequency of meetings can be reduced. This phase should be completed within six months. Support and guidance can be sought from the MSA and CoA-AMM A-SHIELD Second Victim Programme Task Force during this phase to ensure that this phase is completed within the allocated time frame.

5.2.3 Departmental Peer Support Programme Director

For the DPSP to succeed, it is crucial to identify a director responsible for coordinating all its aspects. This director should typically be an experienced anaesthesia healthcare professional with skills and experience in project management, leadership, communication, and handling work groups. Although it is not a full-time duty, the DPSP director should be allocated protected work time to manage these responsibilities.

5.2.4 Peer Supporters

The DPSP relies on specially trained peer supporters, who should comprise anaesthesiology and critical care doctors, nurses, assistant medical officers, and healthcare assistants. It is essential to decide how peer supporters will be identified and trained in the planning phase.

5.2.4.1 Recruitment of Peer Supporters

Selecting the right individuals to serve as peer supporters is critical to the DPSP's success. Although it may seem like a difficult task, it is likely that the department already has individuals that people look towards for help or who will provide a listening ear. These trusted individuals will likely have the necessary skills to be a good peer supporter.

The following criteria can be used to identify and recruit peer supporters who should sign up voluntarily:

a. Experience

- Peer supporters should have at least two years of clinical experience in anaesthesiology or critical care. This ensures that they have a deeper understanding of the work environment and challenges faced by the SVs .
- Peer supporters with experience in adverse events are an advantage, as this allows them to empathise with those they support and offer relevant insights.

b. Personal qualities

- Peer supporters must be able to demonstrate empathy and possess strong communication skills. Their abilities to listen actively, provide comfort, and maintain a neutral stance regarding the adverse event is crucial to their role.
- Confidentiality and the ability to maintain professionalism are essential. Peer supporters must be trusted to handle sensitive information with care.

c. Commitment

- Peer supporters must be willing to undergo training and participate in regular support activities. This commitment ensures that they are well-prepared to provide effective support.
- Availability is also an essential requirement, as peer supporters need to respond promptly when their colleagues require support.

A suggested way to identify these individuals is through a simple anonymous one-question survey, with the question phrased in this manner: "Following a stressful event at work, who would you seek for support or comfort? Please provide the person's name". Once the survey is completed, each identified person is formally approached and invited to join the DPSP as a peer supporter, via an official letter. In this letter, the person can be congratulated and welcomed to the DPSP, along with a clear description of the commitment and responsibilities of being a peer supporter. Upon agreeing to join the DPSP, peer supporters should sign a peer support agreement, which is a document that outlines the peer supporters' responsibilities and requirements for confidentiality.

5.2.4.2 Training of Peer Supporters

After identifying prospective peer supporters, the next step is to plan their training. It is beneficial in the long run if peer supporters who have the potential to train others are identified early. For the first training, seeking help from external trainers is recommended. The MSA and CoA-AMM have identified a group of trainers who can support the training of peer supporters in individual institutions. In the first training, at least one physician, nurse or assistant medical officer should be present to encourage participation and have future trainers from a diverse group of anaesthesiology and critical care professions. Training aims to provide the skills and knowledge needed to be effective peer supporters. A non-exhaustive summary of training modules is listed below.

a. Core training modules

- Psychological first aid: Peer supporters are trained in the basic principles and techniques of PFA, which focuses on providing immediate emotional support in the aftermath of a crisis.

- Communication skills: The DPSP's core component includes training in active listening, empathy, and providing neutral support.
- Crisis intervention: Peer supporters are taught how to manage acute stress reactions and provide immediate support during crises. This training helps them respond effectively to colleagues who are in distress.
- Fatigue management: These techniques are important to equip supporters with skills to help colleagues recognise and manage exhaustion. This training enables peer supporters to guide second victims in adopting self-care practices, setting boundaries, and utilising stress-reduction strategies for long-term recovery.
- Confidentiality and ethics: The training emphasises maintaining privacy and ethical considerations in peer support. Peer supporters are trained to handle sensitive information with discretion and professionalism.
- Self-care for peer supporters: Peer supporters are educated on recognising burnout and seeking support for themselves when needed. This ensures that they can continue to provide support without compromising their well-being.

b. Advanced training

- Trauma-informed care: Peer supporters receive training on the impact of psychological trauma and how to provide appropriate support to colleagues who have experienced traumatic events.
- Medicolegal and institutional knowledge: Understanding institutional policies and medicolegal aspects of adverse patient events is crucial for peer supporters. This training helps them navigate complex situations and provide informed guidance.

c. Ongoing education

- Regular workshops and seminars: Peer supporters participate in ongoing education through workshops and seminars that cover emerging topics in peer support and psychological care.
- Frequent and regular meetings: These meetings allow peer supporters to discuss case studies, share experiences, and learn from one another.

5.2.5 Framework for Connecting Second Victims to Peer Supporters

Many healthcare professionals may be reluctant to seek help when faced with psychological trauma due to fear of stigmatisation. Hence, it may be more effective to seek out distressed healthcare professionals actively rather than to wait for them to contact peer supporters. The coordinating committee should discuss the following questions:

1. Which cases or circumstances require the triggering of peer support?
2. How will anaesthesia healthcare professionals access or request for support?
3. How can peer supporters identify and seek out colleague(s) who need support after a stressful incident?

By addressing these questions, a framework for trained peer supporters to initiate outreach to their colleagues can be devised. This will significantly facilitate the activation of the DPSP. There can also be mechanisms for leaders or staff to notify peer supporters when an event has occurred, triggering peer support referrals.

5.3 Phase 2: Implementation

5.3.1 Communications and Marketing

To ensure the success of the DPSP, there needs to be an effective way to disseminate information and increase awareness about the local programme to the whole department. If staff remain unaware of the DPSP's benefits, there will be no engagement despite having the most excellent programme. As a suggestion, the MSA and CoA-AMM has developed the A-SHIELD catchphrase to denote the second victim support programme. Together with the A-SHIELD logo, the catchphrase can be used to promote the DPSP in the department. Brochures, fliers, handouts, email blasts and posters can all be used to promote the DPSP. Another method to increase the visibility of peer supporters can be custom-made operating theatre/intensive care unit caps, a special badge, and bulletin boards with pictures and names of peer supporters. This will be an ongoing process, and considerable effort should be invested in regularly informing staff about the availability of peer support services.

5.3.2 Identifying and Responding to Second Victims and Stressful Events

There is no one fixed method to match a SV to a peer supporter. However, some considerations can be used, as stated below.

a. Matching based on clinical seniority level – e.g. medical officer with medical officer.
b. Matching based on personality style – e.g. a vulnerable nurse with someone whose approach is highly empathetic.
c. Avoiding matching a SV with a potential peer supporter who is responsible for evaluating his/her performance review.
d. A peer involved in the post-event review should refrain from taking on the peer supporter role.

A peer support conversation must then be initiated so a peer supporter can reach out to a SV. A few crucial components of this conversation include outreach call, invitation/opening, listening, reflecting, reframing, sense-making, coping, closing, and resources/referrals (More information can be obtained from Further Resources No 1).

5.3.3 Regular Meetings

Regular meetings should be conducted, especially during the early implementation phase of the DPSP. A suggested frequency is monthly meetings, with reducing frequency as peer supporters gain more experience and the DPSP runs more smoothly. These regular meetings allow peer supporters to discuss and learn from complex cases, continually improving peer-supporting skills.

5.4 Phase 3: Maintenance and Sustaining

5.4.1 Evaluation and Feedback

Continuous evaluation is essential to ensure the effectiveness and reliability of the DPSP. Examples of evaluation mechanisms are peer supporters' reports, anonymous surveys and regular review meetings (Refer Further Resources No 2).

5.4.2 Supporting the Supporters

It is essential to provide ongoing support for peer supporters. Scheduling regular check-in meetings is recommended to offer a safe and confidential environment where peer supporters can debrief their experiences, discuss challenging interactions, and seek assistance (Refer Further Resources No 2). Peer supporters may encounter similar traumas and challenges as their colleagues, making this support crucial to their well-being. Maintaining their engagement and ensuring they feel supported are key factors in sustaining a successful DPSP.

5.5 Conclusion

A well-structured DPSP can provide crucial emotional and professional assistance to SVs. This chapter has outlined guiding principles for starting such a local programme. As healthcare continues to evolve, DPSPs will remain a vital resource for anaesthesia healthcare professionals facing the challenges of patient adverse events.

FURTHER RESOURCES

The list of resources below is highly recommended as reference materials when starting a DPSP. The various tool kits and guidance documents can be adapted to each department's local context.

1. Shapiro J, Galowitz P. Peer support for clinicians: a pragmatic approach. Academic Medicine. 2016;91(9):1200-4.
2. How to establish a peer support programme: implementation guide. From Betsy Lehman Centre for Patient Safety, available from: *https://betsylehmancenterma.gov/assets/uploads/PeerSupport_Implementation.pdf.* Accessed on 28/8/24.
3. Peer Support Toolkit, from Betsy Lehman Centre for Patient Safety, available from: *https://betsylehmancenterma.gov/initiatives/clinician-support/peer-support-toolkit#entry:71032@1:url.* Accessed on 28/8/24.

4. Edrees H, Connors C, Paine L, Norvell M, Taylor H, Wu AW. Implementing the RISE second victim support programme at the Johns Hopkins Hospital: a case study. BMJ Open. 2016;6(9):e011708.
5. Creating a Safe Space: Strategies to Address the Psychological Safety of Healthcare Workers from the Canadian Patient Safety Institute. Available from: *https://www.healthcareexcellence.ca/en/resources/creating-a-safe-space-psychological-safety-of-healthcare-workers-peer-to-peer-support/.*
6. Peer Support Programme Development, by Centre for Patient Safety *https://www.centerforpatientsafety.org/peersupport.**Payment required***

Chapter 6: A Framework for Establishing Tier 3 Support for the A-SHIELD Second Victim Programme

6.1 Introduction

When SVs' psychological distress exceeds the capabilities of Tier 2 peer supporters, they need to be referred to mental health professionals. Approximately 10% of SVs are anticipated to need escalation to Tier 3 support.[1]

An established referral network in Tier 3 of Scott's model provides fast-track professional support for anaesthesia healthcare professionals who have progressed into severe SV phenomena, such as post-traumatic stress disorder, burnout, suicidal ideation or committing self-harm.[2]

6.2 Professionals Involved in Tier 3 Support

Referral to mental health professionals may be voluntary self-referral or by a peer supporter. The professional referred to may be based on the SV's preference. Professionals involved in Tier 3 support are:[3]

a. Counsellor/psychology officer/spiritual care officer
b. Employee assistance programme
c. Clinical psychologist
d. Psychiatrist (consultation-liaison psychiatrist is preferable)
e. Social worker
f. Other professional support, including medicolegal support

6.3 Mental Health Screening Tools

Mental health professionals use screening tools to guide the intervention process, ensuring objectivity and monitoring of symptoms. The tools can also empower trained peer supporters to facilitate referrals. Links for the resources are provided at the end of this chapter. Examples of screening tools include:

a. Mood screenings such as Depression, Anxiety & Stress Scale (DASS), General Anxiety Disorder-7 (GAD-7), and Patient Health Questionnaire-9 (PHQ-9)
b. Psychological distress or trauma related screenings such as PTSD Checklist for DSM-5 (PCL-5), and Kessler Psychological Distress Scale (K-10)
c. Fatigue assessment such as Fatigue Assessment Scale (FAS)

6.4 Suggestions for Nonpharmacological and Pharmacological Approaches

6.4.1 Nonpharmacological Approach

This refers to psychological interventions that support SVs after adverse patient events, including traumatic situations, that easily lead to feelings of guilt and emotional disturbances. Psychological intervention helps to build confidence, resilience, enhance well-being and professional performance.

Below are the suggested psychological therapies for SVs:

a. Cognitive Behavioural Therapy (CBT)
SVs are often filled with distorted or unhelpful thinking patterns that contribute to emotional distress. CBT helps to identify and challenge thought patterns, followed by cognitive restructuring to build more balanced thoughts. It also teaches coping strategies to manage anxiety, depression, and other emotional responses effectively.[4]

CBT techniques are as follow:

- Psychoeducation aims to understand the SVs' experiences and psychological impact, normalise the experiences, reduce misconceptions and empower them with adaptive coping skills.
- Relaxation techniques to regulate physiological reactions and intense emotion. Examples include diaphragmatic breathing technique and progressive muscle relaxation.
- Thought identification and thought challenge are essential to help SVs manage and alter distorted thought patterns and behaviours,

which can improve emotional states.

- Cognitive restructuring to replace unhelpful thoughts with more balanced and realistic ones, leading to improved mood and function.
- Gradual exposure techniques to reduce avoidance behaviours and normalise feared situations in a controlled and safe manner.

b. Acceptance & Commitment Therapy (ACT)

ACT helps SVs to process the acceptance of their emotional experiences, defuse unhelpful thoughts and commit to actions aligned with their values even in the face of distressing emotions.[5]

ACT techniques include:

- Acceptance: Practise openness to allow thoughts and feelings to be present without trying to avoid or suppress emotional experiences. This helps to reduce psychological distress and enhance psychological flexibility.
- Cognitive defusion: SVs learn to distance themselves from their thoughts to reduce their impact. They learn to label thoughts or apply metaphors to minimise the impact of traumatic memories.
- Mindfulness: Teaching SVs to stay present in the moment without judgment can help them become more aware of their current experiences and reduce their focus on past trauma or future worries. It incorporates techniques such as mindfulness meditation, breathing exercises, and body scans.
- Self-as-context: Encourage SVs to see themselves as more than their trauma, thoughts and feelings. This helps them adopt a more flexible perspective and reduces the influence of trauma on their sense of identity.
- Values clarification: Help SVs to identify what values genuinely matter in their life and how they want to act to achieve them.
- Committed action: Encourage SVs to take proactive steps toward their values, even in the presence of trauma-related symptoms or fears. This helps them build a meaningful and fulfilling life despite their trauma history.

c. Trauma-informed care and therapy
This refers to therapies or approaches explicitly designed to address the impact of trauma and focus on the process of healing and recovery after an adverse event.[6] Depending on the nature of the event and setting, it may be offered as an individual session or a group session.

Techniques include:

- Trauma narrative processing encourages SVs to share their traumatic experiences safely and gradually, which helps to process and reduce the emotional impact.
- Empathy and validation are used to provide empathetic listening and validate their experiences in an open and nonjudgmental manner.
- Strength-based approach to focus on the individuals' strengths, resources and ability to take control of themselves. This helps to build resilience and empowerment.
- Conjoint second victim-administrator sessions to facilitate their communication of the traumatic experience, foster understanding and strengthen the supportive relationship.
- Prevention of retraumatisation involves carefully applying approaches that minimise the risk of retraumatisation and being sensitive to the SVs' responses.

d. Telehealth mental health services
Telehealth integration enhances the program's accessibility and serves as a timely intervention. This may refer to services such as PFA, debriefing sessions, or remote access to mental health professionals.

6.4.2 Pharmacological Approach

Diagnostic-based medication intervention should be in line with established clinical practice guidelines or recommended medication for specific diagnosis. Symptomatic relief can be given for insomnia or anxiety symptoms not amounting to diagnosable mental disorder.

6.5 Management Flowchart for Tier 3 Support

At Tier 3 support, the SV will be assessed for appropriate diagnosis and other possible predisposing factors perpetuating the condition. Once mental health professionals formulate a clinical care plan, the SV will be treated as a patient. A confidential client-doctor engagement will ensure compliance with goals and management plans. The management plan in Figure 6.1 below is outlined in the Guideline for Managing Doctors with Psychological Problems and Disorders in the Ministry of Health.[7]

6.6 Conclusion

Tier 3 applies a multidisciplinary approach to identifying, referring and managing SVs who require higher level of support. Screening for psychological distress by trained peer supporters and mental health professionals seamlessly facilitates the escalation of care for SVs. Local departments must identify available professionals and support to implement the comprehensive strategy.

FURTHER RESOURCES

1. Depression, Anxiety & Stress Scale (DASS)
   - *DASS 42 items: https://www.healthfocuspsychology.com.au/tools/dass-42/*
   - *DASS 21 items: https://www.healthfocuspsychology.com.au/tools/dass-21/*
   - *https://mentari.moh.gov.my/self-test/*
2. General Anxiety Disorder-7 (GAD-7)
   - *https://psychiatry-malaysia.com/public/public-education/screening-tools/phq-9-for-major-depressive-disorder/*
   - *https://qxmd.com/calculate/calculator_317/gad-7-anxiety-scale*
3. Patient Health Questionnaire-9 (PHQ-9)
   - *https://psychiatry-malaysia.com/public/public-education/screening-tools/phq-9-for-major-depressive-disorder/*
   - *https://mentari.moh.gov.my/self-test/*

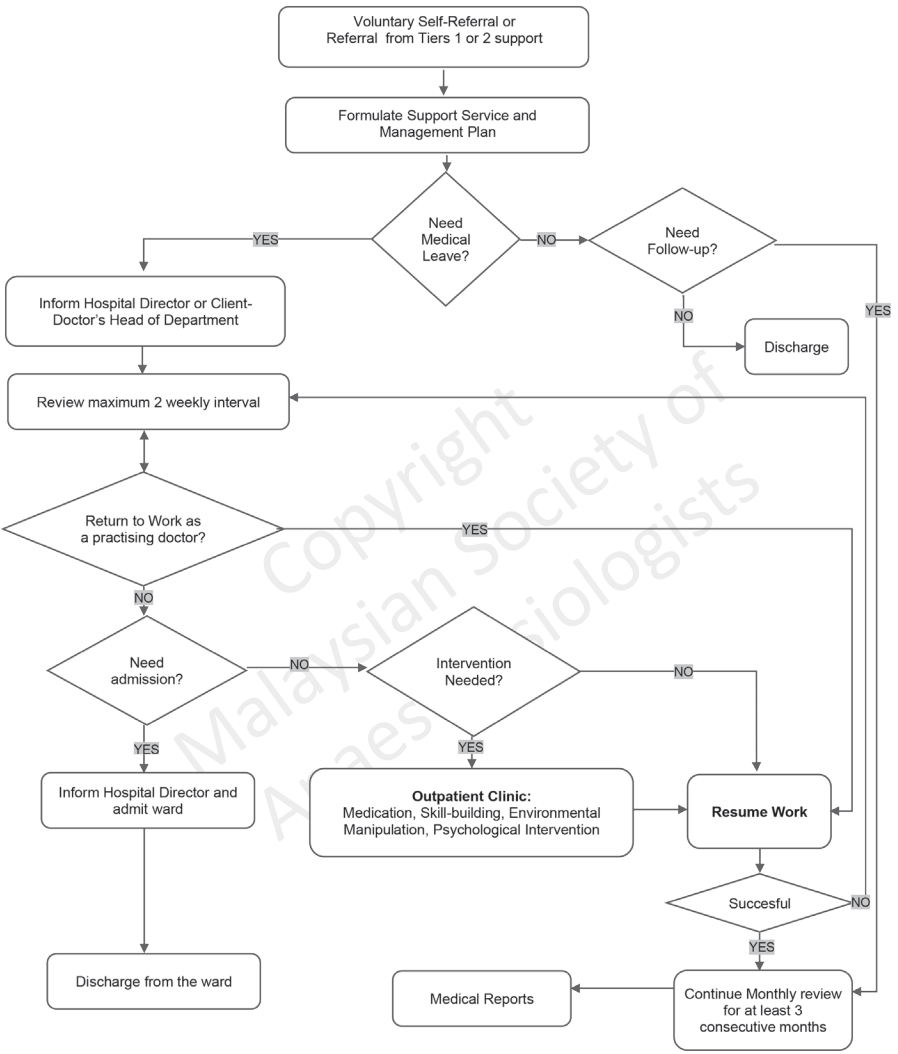

Figure 6.1 *Management Flowchart for Tier 3 Support. The figure was reproduced from the Guideline for Managing Doctors with Psychological Problems and Disorders in the Ministry of Health by the Psychiatry and Mental Health Services, Ministry of Health Malaysia, 2017.*[7]

4. PTSD Checklist for DSM-5 (PCL-5)
    - *https://www.aseanjournalofpsychiatry.org/articles/translation-and-validation-of-the-malay-post-traumatic-stress-disorder-checklist-for-civilians.pdf*
    - *https://qxmd.com/calculate/calculator_684/post-traumatic-stress-disorder-pcl-5*
5. Kessler Psychological Distress Scale (K-10)
    - *https://www.worksafe.qld.gov.au/__data/assets/pdf_file/0010/22240/kessler-psychological-distress-scale-k101.pdf*
    - *https://novopsych.com.au/assessments/outcome-monitoring/the-kessler-psychological-distress-scale-k10/*
6. Fatigue Assessment Scale (FAS)
    - *https://www.wasog.org/education-research/questionnaires.html*
    - *https://novopsych.com.au/assessments/health/fatigue-assessment-scale-fas/*

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2. *Mohd Kamaruzaman AZ, Ibrahim MI, Mokhtar AM, Mohd Zain M, Satiman SN, Yaacob NM. Translation and validation of the Malay Revised Second Victim Experience and Support Tool (M-SVEST-R) among healthcare workers in Kelantan, Malaysia. International Journal of Environmental Research and Public Health. 2022;19(4):2045.*
3. *Pratt SD, Jachna BR. Care of the clinician after an adverse event. International Journal of Obstetric Anesthesia. 2015;24(1):54-63.*
4. *Nakao M, Shirotsuki K, Sugaya N. Cognitive–behavioral therapy for management of mental health and stress-related disorders: recent advances in techniques and technologies. BioPsychoSocial Medicine. 2021;15(1):16.*
5. *Park SY. Application of Acceptance and Commitment Therapy (ACT) in hospice and palliative care settings. Journal of Hospice and Palliative Care. 2023;26(3):140.*

6. *de Arellano MA, Lyman DR, Jobe-Shields L, George P, Dougherty RH, Daniels AS, et al. Trauma-focused cognitive-behavioral therapy for children and adolescents: assessing the evidence. Psychiatric Services. 2014;65(5):591-602.*

7. *Psychiatry and Mental Health Services, Ministry of Health Malaysia. Guideline for managing doctors with psychological problems and disorders in the Ministry of Health. 2017. Available from: https://moh.gov.my/moh/resources/Penerbitan/Garis%20Panduan/Garis%20Panduan%20Umum(KKM)/Final_Version_2017.pdf. Accessed on 16/8/24.*

Chapter 7: Conclusion

This SVP document has elucidated the importance of the SV problem, described methods of assessing SVs and the quality of support given, and described risk management techniques to manage SVs involved in patient adverse events. In addition, a structured, tiered approach addresses the emotional impact on healthcare professionals following stressful events.

By systematically identifying affected individuals, offering immediate support, and assessing the severity of their distress, the programme ensures that healthcare professionals receive timely and appropriate care. The framework's flexibility allows for personalised interventions, ranging from peer support to professional counselling, and follow-up meetings ensure ongoing monitoring and adjustment of the support plan as needed. Ultimately, this comprehensive approach fosters a supportive environment, enabling anaesthesia healthcare professionals to recover emotionally while maintaining access to essential resources throughout their healing process.

Ensuring anaesthesia healthcare professionals are supported throughout the healing process after being exposed to patient adverse events is essential. A natural progression of support measures tailored to the SV's needs is summarised in Textbox 7.1 below:

Textbox 7.1 Natural progression of second victim support

1. **Event occurs:** An adverse patient event is identified, such as a medical error, patient injury, or unexpected patient death.
2. **Initial identification**
   - i. Supervisors or peers identify all the involved anaesthesia healthcare professional(s).
   - ii. Look for signs of distress, such as changes in behaviour, emotional responses, or self-reported feelings.
3. **Initial support**
   - a. Provide immediate psychological first aid by peers or supervisors in the department or cluster zone (for hospitals with single specialist).

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Textbox 7.1 Natural progression of second victim support

b. Defusing sessions: Ensure a safe and confidential space for the anaesthesia healthcare professionals to express their feelings and concerns.

4. Screening and assessment

a. Conduct a brief assessment using SVEST-R
b. Determine the level of emotional impact and the need for further intervention.

5. Referral decision: If further support is required, decide on the appropriate type of support:

a. Departmental peer support programme: Pair the provider with a trained peer supporter.
b. Counselling services: Refer to in-house or external counselling services.
c. Debriefing sessions: Facilitate group or individual debriefing sessions.
d. Referral to mental health services: Mental health services within or outside the institution for professional psychotherapy or pharmacotherapy.
e. Referral to other support services, e.g., spiritual care, social workers, expert medicolegal advice.

6. Implementation of treatment or support

a. Initiate the chosen support mechanisms.
b. Ensure that the anaesthesia healthcare professionals can access the necessary resources and support.

7. Follow-up

a. Schedule follow-up meetings to check on the well-being of anaesthesia healthcare professionals.
b. Adjust the support plan based on the anaesthesia healthcare professionals' feedback and ongoing needs.

8. Adjust support (if necessary)

a. Modify the support plan if the anaesthesia healthcare professionals' needs change or require additional resources.
b. Continue monitoring until the anaesthesia healthcare professionals show significant improvement or stabilisation.

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Textbox 7.1 Natural progression of second victim support

9. Continuation or completion of care

a. Ensure the anaesthesia healthcare professionals have reached a satisfactory level of recovery.

b. Gradually reduce support as appropriate while ensuring resources remain available if needed in the future.

The MSA and CoA-AMM are committed to supporting the implementation of this SVP for the well-being of the anaesthesiology and critical care communities in Malaysia. With close cooperation among all professionals, no healthcare professional will walk alone after an adverse patient event.

Appendix 1

MSA-CoA statement on "Peer Support After Adverse Events: A Focus on Second Victims"

The Malaysian Society of Anaesthesiologists (MSA) and College of Anaesthesiologists (CoA), Academy of Medicine of Malaysia, are committed to supporting our members and the broader anaesthesia healthcare community in Malaysia. As part of this commitment, we aim to raise awareness and address the critical issue of the 'second victim' phenomenon among anaesthesia healthcare professionals.

Definition of second victim

The term second victim was coined by Dr Albert Wu in 2000 to highlight the impact of unanticipated adverse events, medical errors, or patient-related injury on healthcare providers who suffer alongside the primary victims, who are the patients and their families.[1] Second victims experience significant emotional and psychological distress following these events. Surveys have shown that following perioperative adverse events, more than 70% of anaesthesiologists experienced guilt, anxiety and reliving of the event, with 88% requiring time to fully recover emotionally from the event. Up to 19% admitted to never fully recovering, with 12% considering changing careers.[2] These emotional burdens may also disrupt sleep patterns, leading to physical health problems such as chronic fatigue. These symptoms are similar to those

experienced by patients with post-traumatic stress disorder. In addition, being a second victim may impair cognitive function, decision making and clinical performance.[2] This can result in decreased job satisfaction, increased risk of burnout, and potential errors in patient care.

Prevalence of second victim phenomenon

The second victim phenomenon is a widespread issue in the medical community. Although there is no data on the prevalence of second victims in Malaysia, international studies suggest that almost half of all healthcare providers involved in an adverse event will become second victims.[3] This high prevalence underscores the need for awareness, education, and support systems within the healthcare sector. Anaesthesia healthcare professionals are especially susceptible to the emotional and physical repercussions of adverse events. We are uniquely vulnerable to the second victim phenomenon for several reasons:

- **High-stakes environment:** Anaesthesia healthcare professionals work in environments where patient lives often hang in the balance, such as operating rooms and intensive care units. The high-pressure nature of these settings can amplify the emotional impact of adverse events.
- **Isolation in practice:** Anaesthesia healthcare professionals frequently work in relative isolation, making critical decisions independently. This can lead to a heightened sense of personal responsibility and self-blame when outcomes are unfavourable.
- **Direct patient impact:** The role of an anaesthesia healthcare professional directly impacts patient safety and outcomes.Adverse events, such as anaesthetic complications or intraoperative crises, can have immediate and severe consequences, further intensifying the healthcare professional's emotional burden.

Mental resilience when facing an adverse event

Building mental resilience is essential for anaesthesia healthcare professionals to cope with the aftermath of adverse events. Positive coping strategies include:

- **Emotional support:** Seeking emotional support from peers, spouses, significant others, family, and friends may help to alleviate the emotional distress suffered.
- **Peer support:** Engaging in open discussions with colleagues who have experienced similar events can provide emotional validation and reduce feelings of isolation. Peer support programs can create a safe space for sharing and healing.
- **Self-care practices:** Encouraging self-care techniques, such as mindfulness, regular physical exercise, and sufficient rest, can promote overall well-being and resilience. Mindfulness practices, in particular, can help healthcare professionals stay grounded and manage stress.
- **Professional counselling:** Access to mental health professionals can help to process trauma, develop coping mechanisms, and regain emotional stability. Counselling can be particularly effective in addressing severe or prolonged distress.

Call to action

MSA and CoA urge leaders within the anaesthesia community, department heads, and hospital administrators to proactively support staff affected by adverse events. Specific actions include:

1. **Establish structured support systems:** Develop and implement formal support programs, such as peer support groups and access to mental health resources. Ensure these programs are readily available and well-publicised within the institution.

2. **Promote a culture of openness:** The success of a second victim program hinges on fostering an environment where adverse events can be discussed openly without fear of retribution. Encouraging transparency and non-punitive responses to errors can help reduce stigma and promote learning.

3. **Embracing just culture:** Just culture considers broader systemic issues when adverse events occur. It takes a balanced approach, taking into consideration organisational accountability for the

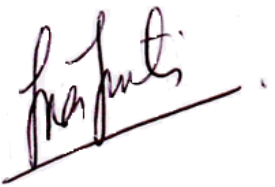
systems that have been designed which led to the adverse event, while at the same time responding to the staff's actions in a fair manner.

4. **Provide education and training:** Incorporate education on the second victim phenomenon and resilience-building strategies into regular training for all anaesthesia healthcare professionals. This can help raise awareness, normalise discussions about emotional well-being, and equip staff with essential coping skills.

5. **Timely and empathetic communication:** Ensure leaders and mentors communicate promptly and empathetically following an adverse event with affected staff. Acknowledging the emotional impact and providing reassurance can significantly aid in the recovery process.

6. **Duty relief:** Offer duty relief to anaesthesiologists and anaesthesia care team members involved in such incidents. Although it may be challenging to ensure immediate duty relief in every situation due to patient needs, every effort should be made to allow affected healthcare professionals to step away from the clinical environment for the remainder of the day or longer if necessary. This may require calling in additional personnel or extending the duties of other staff members. Duty relief following critical adverse events should be regarded with the same urgency as family emergencies and other critical situations, where relief is provided without repercussions. It is crucial that this relief is granted as soon as possible after the event to ensure prompt psychological support. Second victims should not face any indirect or direct penalties or consequences, including impacts on their clinical schedules or salary.

MSA and CoA are dedicated to fostering a supportive and resilient anaesthesia healthcare community. By acknowledging the reality of the second victim phenomenon and taking concrete steps to address its impact, we can enhance the well-being of our professionals and improve the overall quality of anaesthetic care provided to patients in Malaysia.



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Appendix 2

Second Victim Experience and Support Tool-Revised (SVEST-R)

Instructions for respondents: The following survey will evaluate your experiences with adverse patient safety events. These incidents may or may not have been due to error. They also may or may not include circumstances that resulted in patient harm or even reached the patient (i.e. near-miss patient safety events).

Using a 5-point Likert scale (1 = Strongly Disagree, 5 = Strongly Agree), please indicate how much you agree with the following statements as they pertain to yourself and your own experiences at this hospital.

Psychological Distress

1. I have experienced embarrassment from these instances.
2. My involvement in these types of instances has made me fearful of future occurrences.
3. My experiences have made me feel miserable.
4. I feel deep remorse/guilt for my past involvements in these types of events.

Physical Distress

5. The mental weight of my experience is exhausting.
6. My experience with these occurrences can make it hard to sleep regularly.
7. The stress from these situations has made me feel queasy or nauseous.
8. Thinking about these situations can make it difficult to have an appetite.
9. I have had bad dreams as a result of these situations.

Colleague Support

10. My colleagues can be indifferent to the impact these situations have had on me.
11. My colleagues help me feel that I am still a good healthcare provider despite any mistakes I have made.*

12. My colleagues no longer trust me.
13. My professional reputation has been damaged because of these situations.

Supervisor Support

14. I feel that my supervisor treats me appropriately after these occasions.*
15. My supervisor's responses are fair.*
16. My supervisor blames individuals.
17. I feel that my supervisor evaluates these situations in a manner that considers the complexity of patient care practices.*

Institutional Support

18. My organization understands that those involved may need help to process and resolve any effects they may have on care providers.*
19. My organization offers a variety of resources to help get me over the effects of involvement with these instances.*
20. Concern for the well-being of those involved in these situations is not strong at my organization.

Professional Self-Efficacy

21. Following my involvement, I experienced feelings of inadequacy regarding my patient care abilities.
22. My experience makes me wonder if I am not really a good healthcare provider.
23. After my experience, I became afraid to attempt difficult or high-risk procedures.
24. These situations have negatively affected my performance at work.

Turnover Intentions

25. My experience with these events has led to a desire to take a position outside of patient care.
26. Sometimes the stress from being involved with these situations makes me want to quit my job.
27. I have started to ask around about other job opportunities.
28. I plan to leave my job in the next 6 months because of my experience with these events.

Absenteeism

29. My experience with an adverse patient event or error has resulted in me taking a mental health day.
30. I have taken time off after one of these instances occurs.
31. When I am at work, I am distracted and not 100% present because of my involvement in these situations.

Resilience

32. Because of these situations, I have become more attentive to my work.*
33. These situations have caused me to improve the quality of my care.*
34. My experience with an adverse patient event or error has resulted in positive changes in procedures or care on our unit.*
35. I have grown as a professional as a result of an adverse patient event or error.*

**Indicates reverse-scored item*
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Appendix 3

Pengalaman Mangsa Kedua Dan Alat Sokongan – Semakan Semula (M-SVEST-R)

Faktor-Faktor Psikososial dan Berkaitan Pekerjaan

Arahan kepada responden: Kaji selidik berikut akan menilai pengalaman anda dalam menghadapi kejadian buruk berkaitan keselamatan pesakit. Kejadian-kejadian ini mungkin disebabkan (atau bukan disebabkan) oleh sesuatu kesalahan. Kejadian-kejadian ini juga mungkin melibatkan (atau tidak melibatkan) keadaan yang mengakibatkan kemudaratan kepada pesakit atau terjadi secara langsung kepada pesakit (iaitu kejadian nyaris memudaratkan keselamatan pesakit). Dengan menggunakan skala Likert 5 mata (1 = Sangat Tidak Setuju, 5 = Sangat Setuju), sila nyatakan sejauh mana anda bersetuju dengan pernyataan berikut berdasarkan kepada pengalaman peribadi ketika bekerja di hospital.

Tekanan mangsa kedua

a) Tekanan psikologi

1. Saya pernah berasa diaibkan disebabkan oleh kejadian seperti ini
2. Keterlibatan saya dalam kejadian ini membuat saya amat takut kejadian seperti ini akan berulang lagi.
3. Pengalaman ini telah menyebabkan saya berasa sengsara.
4. Saya merasakan penyesalan yang mendalam/ bersalah akibat keterlibatan lampau saya dalam kejadian seperti ini.

b) Tekanan fizikal

5. Tekanan mental disebabkan pengalaman seperti ini sangat memenatkan.
6. Pengalaman menghadapi kejadian seperti ini menyebabkan saya seringkali susah untuk tidur.
7. Tekanan dalam menghadapi kejadian seperti ini menyebabkan saya berasa mual atau ingin muntah.
8. Saya tidak mempunyai selera makan akibat memikirkan kejadian seperti ini.

9. Saya pernah mengalami mimpi buruk akibat daripada kejadian seperti ini.

Sokongan rakan sekerja

10. Rakan sekerja saya tidak mempedulikan kesan kejadian ini kepada saya.
11. Rakan sekerja saya tidak mempercayai saya lagi.
12. Reputasi profesional saya telah terjejas disebabkan oleh kejadian seperti ini.

Sokongan penyelia/atasan

13. Saya berasa penyelia/atasan melayan saya dengan sewajarnya selepas kejadian seperti ini.*
14. Respon penyelia/atasan saya adalah adil.*
15. Saya merasakan bahawa penyelia/atasan menilai kejadian seperti ini dengan mempertimbangkan kerumitan amalan penjagaan pesakit.*

Sokongan institusi

16. Organisasi saya memahami bahawa petugas kesihatan yang terlibat dengan kejadian seperti ini mungkin memerlukan bantuan untuk memproses dan menyelesaikan sebarang masalah yang timbul.*
17. Organisasi saya menyediakan pelbagai sumber untuk membantu saya menangani kesan kejadian tersebut.

Kecekapan diri profesional

18. Rentetan penglibatan saya dalam kejadian seperti ini, saya meragui kebolehan saya untuk menjaga atau merawat pesakit.
19. Pengalaman sebegini menimbulkan persoalan sama ada saya merupakan seorang petugas kesihatan yang baik atau sebaliknya.
20. Selepas mengalami kejadian seperti ini, saya tidak berani untuk melakukan prosedur yang sukar atau berisiko tinggi.
21. Kejadian seperti ini telah menyebabkan prestasi kerja saya merudum.

Kesan negatif pekerjaan

a) Keinginan Bertukar Tugas

22. Pengalaman saya dalam kejadian seperti ini telah menimbulkan keinginan untuk bertukar pekerjaan di luar skop perawatan pesakit.

23. Kadangkala saya berasa ingin berhenti kerja akibat tekanan dengan keterlibatan dalam kejadian seperti ini.
24. Saya telah mula mencari peluang pekerjaan lain.
25. Saya merancang untuk meninggalkan pekerjaan sekarang dalam tempoh 6 bulan akan datang disebabkan keterlibatan saya dengan kejadian seperti ini.

b) Ketidakhadiran

26. Saya mengambil cuti untuk merehatkan minda selepas pengalaman keterlibatan dalam kejadian yang memudaratkan pesakit / membuat kesilapan.
27. Saya telah mengambil cuti rehat selepas berlakunya kejadian seperti ini
28. Semasa saya bekerja, tumpuan saya terganggu dan gagal untuk fokus disebabkan oleh keterlibatan saya dalam kejadian seperti ini.

Ketahanan

29. Disebabkan oleh kejadian seperti ini, saya menjadi lebih teliti dengan kerja saya.*
30. Kejadian seperti ini telah menyebabkan saya meningkatkan kualiti penjagaan pesakit saya.*
31. Pengalaman saya terlibat dalam kejadian yang memudaratkan pesakit / melakukan kesilapan telah mendorong perubahan positif dalam prosedur atau penjagaan pesakit di unit/organisasi kami.*
32. Saya telah berkembang sebagai seorang profesional akibat daripada kejadian yang memudaratkan pesakit / melakukan kesilapan . *

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e ISBN 978-629-95021-0-4

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