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The Effects of the Second Victim Phenomenon on Work-Related Outcomes: Connecting Self-reported Caregiver Distress to Turnover Intentions and Absenteeism

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Abstract

Objectives—Second victim experiences can affect the well-being of healthcare providers and compromise patient safety. The purpose of this study was to assess the relationships between self-reported second victim-related distress to turnover intention and absenteeism. Organizational support was examined concurrently because it was hypothesized to explain the potential relationships between distress and work-related outcomes.

Methods—A cross-sectional, self-report survey of nurses directly involved in patient care ($N = 155$) was analyzed by using hierarchical linear regression. The Second Victim Experience and Support Tool, which assesses organizational support, distress due to patient safety event involvement, and work-related outcomes, was also used.

Results—Second victim distress was significantly associated with intentions to turnover ($\beta = .377, p < .001$) and absenteeism ($\beta = .316, p < .001$), while controlling for the effects of demographic variables. Organizational support also fully mediated the distress–intentions to turnover ($Sobel = 2.11, p < .05$) and distress–absenteeism ($Sobel = 2.40, p < .05$) relationships.

Conclusions—The personal effects of involvement in patient safety events and the important role of organizational support in limiting caregiver event-related trauma have been acknowledged. This study is one of the first to connect second victim distress to work-related outcomes. It also demonstrated that the relationships among distress and work outcomes can be explained by perceptions of organizational support. This reinforces the efforts health care organizations are

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Conflicts of Interest

There are no perceived conflicts of interest from any of the authors.

making to develop resources to support their staff after patient safety events occur. This study broadens the understanding of the negative effects of a second victim experience and the need to support caregivers as they recover from adverse event involvement.

INTRODUCTION

In roughly the past decade, the second victim phenomenon has been identified by name,¹ defined,² and made measurable.³ Research on how to minimize and prevent trauma from health care worker involvement in patient safety events and medical errors is advancing. It is now largely accepted that a second victim experience is not limited to involvement in medical errors, and that non-error patient safety events and near-miss events can also elicit a second victim response.^{4,5}

Second victims report a common set of symptoms, similar to those characterizing post-traumatic stress disorder. These symptoms include anxiety, sleeping difficulties, guilt, anger, and shame.⁶⁻¹² Second victims have reported reimagining and fixating on the details of the patient safety event that elicited the second victim response for years or even decades. A second victim's professional life can also be affected by fears of litigation and punishment (when errors are involved), reduced professional confidence, reduced job satisfaction, and thoughts of leaving the health care profession altogether.^{6,7,10,13,14} Patient safety is also a concern because the chance for committing medical errors has been reported as being elevated after a second victim experience.^{11,15-18} Therefore, the consequences of a second victim experience are multiple and potentially long lasting and life changing. One factor that has emerged in the second victim literature that can mitigate a second victim response and aid recovery is organizational support in the aftermath of a patient safety event.

Research has confirmed the importance of organizational support throughout post—patient safety event recovery.⁷ The significance of clinician support (or lack thereof) has also been demonstrated to impact not only individual clinician's perceptions of patient safety but also that of entire care teams.¹⁹ Support from organizational leadership and management in the form of a *just culture* perspective throughout a patient safety event's investigation may help minimize the shame and stigma associated with being involved in medical errors.^{8,20,21} Second victims have expressed a desire to be included in the investigation process of patient safety events, and personal involvement in correcting systems and process failures may aid recovery.⁷ Peer support is also widely mentioned in second victim literature, where having a colleague to discuss the details of a safety event in confidence consistently emerges as a desire of second victims.^{2,7-9,21-28}

This study examined the relationships among second victim—related distress, intentions to turnover, and absenteeism while considering the role of organizational support. The second victim experience has been well characterized, yet the effects of involvement in adverse safety events on one's professional life are less studied.^{29,30} Evidence that second victim distress may lead to greater desires to quit one's job or take otherwise unnecessary time off has implications for health care workers and their organizations. Also, evidence for organizational support's role in reducing negative work outcomes that stem from a second victim experience would add to the already valued body of information affirming the

importance of support in the second victim recovery process. The purpose of this study was assess the relationships between second victim–related distress and two work-related outcomes: patient safety event–related *intentions to turnover* and *absenteeism*.

Organizational support in the aftermath of patient safety event involvement was examined concurrently and was hypothesized to mediate the potential relationships between distress and the work-related outcomes.

METHODS

Setting and Participants

The study was conducted at a pediatric hospital that specializes in the treatment of cancer and other catastrophic illnesses. Nursing staff were selected as the study population because they conduct the majority of direct patient care, and because this population has demonstrated a greater likelihood to incur a second victim experience in the aftermath of patient safety event involvement.²³ Of the invited nurses, 164 (49.7%) participated in the study. After review of the data, 14 responses were removed due to incomplete responses; therefore, 155 responses were included for final analysis in the study. This number was determined to be sufficient for statistical power through post-hoc power analysis.³¹ The hospital's institutional review board approved the study.

Procedure and Measures

Participants completed an online version of a self-report survey (i.e., the Second Victim Experience and Support Tool, SVEST³) designed to measure second victim–related distress, the perceptions of organizational second victim–related support, and intentions to turnover and absenteeism directly related to one's experience with patient safety events. Items from the Agency for Healthcare Research and Quality's Hospital Survey on Patient Safety Culture were used to collect demographic information.³² Demographic data included participants' average hours worked per week and years of tenure in specialty, hospital, and work unit. The development and psychometric evaluation of the SVEST has been discussed previously.³ Informed consent was obtained prior to completing the survey, and participants were provided with debriefing information explaining the second victim phenomenon. The debriefing section also contained information on organizational and community resources for potential second victims.

Survey items reflect first-person perceptions, and responses were measured on a 5-point Likert scale, with answer choices ranging from 1 (“strongly disagree”) to 5 (“strongly agree”). Instructions for the survey asked respondents to consider their experiences with patient safety events at the study hospital whether they resulted in harm, no harm, or were due to errors.

Second victim–related distress was measured by using 12 items that assessed components of psychological distress, physical distress, and reduced professional self-efficacy (4 items for each). An example of an item assessing psychological distress is “I feel remorse for my involvements in these types of instances.” A physical distress item is “My experience with these occurrences can make it hard to sleep regularly,” and an item measuring reduced

professional self-efficacy is “My experience makes me wonder if I’m not really a good health care provider.” The responses for these 12 items were averaged to compute a composite *second victim distress* dimension.

Organizational support was measured by using 11 items that assessed the perceived level of support received from colleagues, supervisors, and the institution overall. An example of an item measuring colleague support is “Discussing what happened with my colleagues provides me a sense of relief.” A supervisor support item is “I feel my supervisor treats me appropriately after a patient safety event,” and an item for institutional support is “My organization understands that those involved in safety events may need help to process and resolve any effects they may have on care providers.” The responses for these 11 items were averaged to compute a composite *organizational support* dimension.

For the 2 work-related outcomes, patient safety event–related *intentions to turnover* were measured by using 2 items, and *absenteeism* was measured by using 2. For both outcomes, the items were worded so that they specifically related to involvement with patient safety events. An example of one turnover intention item is “Sometimes the stress from being involved in these events make me want to quit my job.” The absenteeism item was “My experience with an adverse patient event or medical error has resulted in me taking a mental health day.”

Data Analysis

Descriptive statistics and Pearson's bivariate correlations were computed for demographic and study variables. Hierarchical linear regression was used to test for the primary hypothesized relations, as well as the mediation analyses. Mediation analyses were used to assess if *organizational support* explained the potential primary hypothesized relationships. For the mediation analyses, the procedure originally described by Barron and Kenny was used.³³ This technique evaluates the role the mediated variable has on a primary relationship by assessing how the statistical significance changes due to its presence. If the primary relationships become less or non-significant due to the presence of the mediated variable, that variable is said to provide explanation of why the primary relationships occurred. For the regression models, *second victim distress* was the predictor and the outcome variables were *intentions to turnover* and *absenteeism*. The variable *organizational support* was assessed as the mediator. Sobel's tests were used to assess the significance of the indirect, mediated relations. Data were analyzed by using IBM SPSS (version 22.0, SPSS, Chicago, IL).

RESULTS

Descriptive statistics for the demographic variables can be found in Table 1. Table 2 contains the descriptive statistics for the study variables and the correlation among the demographics and study variables. The most prevalent tenure in specialty was greater than 21 years (25.2% of the sample), 1-5 years for tenure in hospital (32.3%), and 1-5 years for work unit (39.4%). For average hours worked weekly, 97.4% of the respondents choose either 20-39 hours or 40-59 hours. The demographic variables were not significantly correlated to any of the study

variables. The study predictor *second victim distress* and mediator *organizational support* significantly correlated with the study outcomes ($p < .01$).

Hierarchical Linear Regression Results

Results assessing the relations among the predictor *second victim distress* and the outcomes *intentions to turnover* ($\beta = .377, p < .001$) and *absenteeism* ($\beta = .316, p < .001$) were significant (Table 3). When controlling for demographic variables, Hospital Tenure ($\beta = .456, p < .01$) and Work Unit Tenure ($\beta = -.413, p < .000$) were significant contributors to the model assessing *intentions to turnover* as the outcome. The directionality of these relations indicated that as tenure in one's hospital increased, so did intentions to turnover, and that as tenure in one's work unit increased, intentions to turnover were reduced. A possible explanation for this result is that employees who have long tenures in their hospital yet relatively short tenures in their work unit may represent individuals who are less satisfied with their jobs. That is, these staff members may have elected to take a position in a different work unit of their hospital for reasons associated with poor job satisfaction or performance. This was assessed by evaluating the intentions to turnover scores from respondents who had greater than 11 years' tenure in their hospital while having 0 to 5 years' tenure in their work unit. These individuals ($n = 9$) had an average *intentions to turnover* score of 3.38. Compared to the score of the remaining sample, who had an average *intentions to turnover* score of 2.17, this difference was statistically significant ($t = 2.95, df = 129, p < .01$). Rather, the negative relation observed between Work Unit Tenure and *intentions to turnover* may suggest stability and satisfaction in one's job.

The tests for *organizational support* as a mediator in the observed *second victim distress*–*intentions to turnover* & *absenteeism* relations indicated full mediation (Figures 1 and 2). This result was affirmed by controlling for the effect of *organizational support* on the *distress – outcomes* relations in the regression models and by the results of Sobel's tests (intentions to turnover, *Sobel* = 2.11, $p < .05$; absenteeism, *Sobel* = 2.40, $p < .05$). The mediation effect suggests that *organizational support* explains the aforementioned observed relations such that *organizational support* may ameliorate second victim distress and reduce desires to quit or take time off from work.

DISCUSSION

The constellation of second victim distress symptoms, which include fear, shame, and a loss of professional confidence, has been established. In the aftermath of patient safety event involvement, support from one's peers, management, and health care institution has also emerged in the second victim research literature as being essential in second victim recovery. Less studied are the effects of patient safety event involvement on discrete worker outcomes. Previous research has used anecdotal data to connect the second victim experience with quitting (i.e., “dropping out” as described by Scott et al.³⁰) and absenteeism.^{29,30} The results of our study compliment these similar findings and broaden the understanding of the professional effects of second victim distress and organizational support.

The primary results of this study (i.e., connecting self-reported second victim distress to negative worker outcomes) were explained by organizational support as a mediator. That is, the observed second victim distress, intentions to turnover, and absenteeism pathways occurred through a mechanism of perceived lower organizational support. This finding affirms the important role that a clinician's work environment plays in the recovery from involvement in adverse events.

More health care organizations are investing in resources to improve the well-being of their staff members and reduce second victim–related trauma. Organizational support, often in the form of peer-to-peer networks, is the central focus of these programs. Research has highlighted the development of such programs,^{8,34} and toolkits to guide their successful implementation are publically available.³⁵ By helping establish a relationship between second victim-related distress and work-related outcomes while demonstrating that these relationships exist through a mechanism of organizational support, our study supports these efforts. Voluntary turnover and absenteeism are costly and often preventable, with recent data indicating that the costs to hire and train a skilled worker can be up to the equivalent of 24 weeks of pay.³⁶

Given the limitations of our study design, it is impossible to connect the results of our study to actual turnover. However the direct patient care nurse turnover rate for the year in which the data were collected was 25.3% (2013). Since the data were collected for this study, many resources designed to address adverse event–related negative outcomes have been developed by our institution (e.g., education and awareness, Schwartz center rounds, employee wellness program additions). Although there is no way to connect these resources to turnover causally, the most recent yearly (i.e., 2015) direct care nursing turnover rate was 10.5%. One possibility for future research would be to include exit interview questions that pertain to the former employee's experience with patient safety events. If involvement in patient safety events affected a staff member drastically enough for him or her to leave the organization, an exit interview sensitive to this possibility could reveal this occurrence. With this information, it may be possible to detect actual voluntary turnover versus the proxy measure used for the current study.

The findings from this study are subject to the standard limitations associated with self-report cross-sectional research. Common method bias should be considered while interpreting these results, and the cross-sectional design precludes drawing causal inferences between our variables of interest. Further research should explore the observed relations by using more causal methods to assess the directionality of these findings. However, the method used for our study, a survey that can be distributed broadly to clinical staff, is a fairly efficient technique when compared to similar research on this topic (i.e., using interviews and focus groups). Cross-sectional surveys have their limitations, yet can provide meaningful information across large portions of a population in a timely manner. Our data could potentially be site-specific as it was collected at a hospital that specializes in treating catastrophic childhood illnesses.

CONCLUSION

As research on the second victim phenomenon has advanced, this study contributes to this growing body of knowledge by connecting self-reported second victim distress to work-related outcomes. By demonstrating that organizational support explains these relationships as a mediator, this also provides a deeper understanding of the aforementioned relationships and helps substantiate second victim programs that are designed around a core of caregiver support. Future research, both attempting to replicate and extend our results to additional worker outcomes is needed to grasp a more complete comprehension of patient safety event involvement on caregiver's professional lives.

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Figure 1.

Standardized regression coefficients of the relationships between second victim distress and turnover intentions as mediated by organizational support. The standardized regression coefficient between second victim distress and turnover intentions while controlling for organizational support is in parentheses.

Note. *** $p < .001$

Figure 2.

Standardized regression coefficients of the relationships between second victim distress and absenteeism as mediated by organizational support. The standardized regression coefficient between second victim distress and absenteeism while controlling for organizational support is in parentheses.

Note. $^{***}p < .001$

TABLE 1Respondents' tenure by specialty, unit, hospital, and weekly work hours (*N*= 155)

<i>Demographic Variable</i>	<i>n(%)</i>
<i>Specialty</i>	
RN	146(94.2)
LVN/LPN	9(5.8)
<i>Specialty tenure (y)</i>	
<1	7(4.5)
1-5	28(18.1)
6-10	38(24.5)
11-15	20(12.9)
16-20	23(14.8)
21 years	39(25.2)
<i>Hospital tenure (y)(n = 154)</i>	
<1	16(10.3)
1-5	50(32.3)
6-10	37(23.9)
11-15	28(18.1)
16-20	9(5.8)
21	14(9.0)
<i>Work unit tenure (y)</i>	
<1	25(16.1)
1-5	61(39.4)
6-10	39(25.2)
11-15	15(9.7)
16-20	9(5.8)
21	6(3.9)
<i>Work hours per week (h)</i>	
< 20	2(1.3)
20-39	77(49.7)
40-59	74(47.7)
60-79	1(0.6)
80-99	1(0.6)

Abbreviations: RN, registered nurse LVN, licensed vocational nurse; LPN, licensed practical nurse

TABLE 2
Means, standard deviations, Pearson's correlations, and Cronbach's alpha for demographic and study variables

	Mean	SD	1	2	3	4	5	6	7	8
<i>Demographic variables</i>										
1. Specialty tenure	3.91	1.60	–							
2. Hospital tenure	3.04	1.41	.55**	–						
3. Work unit tenure	2.61	1.26	.50**	.83**	–					
4. Work hours per week	2.50	.57	.29	.12	.01	–				
<i>Study variables</i>										
5. Second victim distress	3.44	1.02	–.04	.04	.02	.00	(.93)			
6. Intentions to turnover	2.22	.1.21	.01	.08	–.06	–.05	.38**	(.78)		
7. Absenteeism	1.90	1.08	.03	.07	.03	.05	.32**	.63**	–	
8. Organizational support	3.76	.69	–.02	–.11	–.01	.17	–.40**	–.55**	–.44**	(.87)

Note.

Abbreviation: SD = standard deviation

**

p<.01

TABLE 3
Hierarchical regression model assessing demographic variable and second victim distress on worker outcomes

Variable	Intentions to Turnover				Absenteeism			
	Step 1 ($R^2 = .08$)	SE	β	Step 2 ($R^2 = .19$)	SE	β	Step 2 ($R^2 = .13$)	SE
Unit Tenure	-.42**	.16	-.41**	.15	-.02	.14	-.02	.13
Hospital Tenure	.49**	.14	.46**	.13	.19	.12	.17	.12
Specialty Tenure	-.04	.09	-.00	.08	-.08	.08	-.05	.07
Hours Per Week	-.07	.23	-.07	.21	.06	.18	.05	.17
Second Victim Distress			.38***	.19			.32***	.13

Note.

β = standardized regression coefficient; SE = standard error, R^2 = coefficient of determination

**
 $p < .01$

 $p < .001$