

The Second Victim and Me. My personal account

As Paramedics in the pre-hospital setting, we work independently and are often required to make difficult decisions. For paramedics like myself who are lone responders on a Rapid Response Vehicle (RRV) this makes us vulnerable as we are alone on scene with no other clinical assistance. Whilst making these clinical decisions there is always a risk that clinical errors can occur and concerns or complaints can be raised against us. The consequences of these situations can have a profound impact on our clinical performance and future decision making, mental health, and general self-confidence.

Being requested to visit your manager to be presented with a complaint that effectively brings your clinical practice, decision making or attitude into question causes instant personal anguish. Added to this, the information that the actions you have taken may have caused harm to a patient who was in your care causes even greater personal pain. No one comes to work to cause intentional harm to a patient and every decision which we make is with the patient's best interest at heart. We arrive at our decisions by utilising our clinical knowledge as well as the information/history we have been given whilst at the incident scene to come up with a care plan that we believe is the correct one for the patient at that moment in time.

As with all health care organisations any complaints or concerns need to be actioned in a timely manner, in a way that is transparent following local policies and procedures to ensure standards of patient care are at the required level. Further to this, it is essential to ensure that any learning points highlighted during the investigative process are disseminated to staff so as to prevent similar occurrences happening again.

Historically the mentality of dealing with complaints/clinical errors in the ambulance service was via an old school attitude of the big stick approach with the perceived mind-set of being made to feel guilty until proven innocent. Thankfully within the health care setting this way of working is now slowly changing into a learning approach looking into all the factors that may have played a part in the concern raised. This includes human factors which have been acknowledged as playing a huge part in why errors occur as well as understanding that there may be issues within the organisational processes that may be contributory factors also.

A new addition to investigations is a thought process called the "second victim". I thought it was a very interesting concept when I first read about it but then parked it away and did not think much more of it. However, the day I was called into my manager's office and informed of the complaint made against me, my journey as a second victim began.

The second victim methodology in a nutshell understands and accepts that once a complaint has been made against an individual, that person automatically becomes a victim in their own right.

The rationale for the term second victim is very simple. If a potential error or concern has been raised against you then whilst the issue is being investigated this will have a negative impact on you. This is not only as a person but as a clinician and as such will make you a victim due to the negative impact the investigation/fact finding assessments may have. This has the result of having a potentially negative impact on your mental/ physical health, confidence and ability to offer your patients the level of care that you would normally expect from yourself.

I am telling my story as a second victim after having had my clinical judgment brought into question. I hope to bring the second victim methodology to a wider audience allowing other members of the thin green line the opportunity to know that feeling sad, frustrated, angry, confidence battered, and worried are all normal feelings. Sadly, these feelings are not necessarily helpful and as such need to be fully understood by the investigating team. This should then prompt the investigating team to offer you the support you need and make efforts to limit and certainly not add any additional negative impact to your already fragile mental state.

Throughout the whole investigative process I was aware that there had been a noticeable deterioration in my clinical performance, I felt angry and anxious that I was being investigated which then affected my home life and my two weeks leave as the investigation into the complaint commenced just before our holiday. Throughout the investigation I wasn't sleeping and became very insular due to being deep in thought regarding the incident. Due to my inability to concentrate properly I was aware that my clinical judgement was impaired. This was proven when in the same time period there was another concern raised. I have worked within the ambulance sector for 7 years and never had any form of complaint or concern raised against me. I can only put this down to the pressure and stress of the process that I was under causing a significant drop in my clinical performance as well as making my demeanour very negative. This in-turn increased my anxiety and made me very conscious that I was at a high risk of potentially making other error's which would then necessitate another investigation. Sadly, this caused a cascade of further worry and concern.

Since this incident and the reading which I have completed I am now very much aware of the detrimental impact being investigated can have on personal performance, mental health and how this impact not only affects us personally but also affects our families. It is hugely important that we have an understanding of this. It is vital that any leaders who are managing investigations do so with the understanding of how being under investigation affects us and as such offer clinical staff protection and assistance whilst the proceedings are ongoing. Done well clinical reviews or investigations should be a positive experience, where learning and development are the key focus points. Where an error has been made with no malice then any member of staff involved should feel confident that the process will offer a positive outcome for their education and learning.

If you are an investigator, please understand that the staff member under scrutiny will be having a difficult time and as such the way you conduct your investigation should be empathetic to how the stress will have an impact on your colleague's clinical abilities. As an example, the little details of how the room is set up for the meetings can and does have a huge impact on how a meeting will be experienced by those involved. In my case I was sat on one side of two tables and the investigating officer was sat on the opposite side. In between us there was a copy of JRCALC as well as NICE guidance and the rest of the case notes laid out. This instantly stepped over the line of potentially feeling like a supportive meeting to a defensive investigation and as such made the experience uncomfortable and not a safe or relaxed space.

From my experience it is also important that any investigative officer offers frequent communication to keep those who are being investigated as up-to date as possible. One of the biggest anxieties when under scrutiny is the fear of the unknown; this is because it allows your mind to go wild due to the multiple outcomes that may be faced. It is sometimes difficult to think rationally when we feel at risk, trapped and powerless, which is exactly how being under investigation makes you feel.

As part of the investigation I was requested to complete a reflective piece which I found very useful and actually enjoyed writing as I value reflective practice and the positives this can bring. I requested to have some educational training with a senior clinician as well as some supervisory shifts with a clinical supervisor in order for me to have some reassurance that my clinical judgement was on par. This was what I knew I needed for my own personal management of the situation and I was not scared to offer my thoughts on what I needed in order to progress positively after this experience. Sadly many people who are in the situation of sitting in front of an investigation panel do not have the confidence or strength of knowledge to be able to confidently state, 'for me to move forward I need X'. As part of a relaxed informal discussion it should be agreed what course of action is taken with the second victim being at the fore of this decision making. For some, reflective practice is difficult especially if it has to be referenced and formal (remember not all of our frontline staff are university educated) and as such will not necessarily offer a positive learning experience. Any relevant learning should also be linked to the member of staff's scope of practice as this ensures that the learning they will undertake is relevant to their work setting.

This was my first ever experience of being investigated and although the outcome offered me the learning which I requested I felt very much in limbo. I was left to get on with things and still worked my full time rota whilst the investigation was on going. Thankfully I actively had the strength to seek help and guidance from a senior clinical manager within my Trust who was very pragmatic and non-judgemental in his approach to my support.

Within the modern day expectations of ambulance service clinicians, we are now more than ever encouraged to leave people at home, utilising alternative care pathways. With this, the

ambulance sector and the senior clinical management teams as well as clinicians within Trusts need to accept that clinical investigations will become ever more prevalent as there is always going to be a higher risk of clinical concerns being highlighted. As the Ambulance Services haemorrhage staff there is an understanding that mental health and wellbeing issues are a key aspect of this attrition. It is time that all investigative procedures are changed to utilise modern evidence of how to and how not to manage investigations. This subject has been talked about for a long time but I now feel it needs prompt positive action in order to remove some of the anxiety related barriers that the investigative procedures create. This is a cultural problem that needs to be managed not only from the top down but also the bottom up. This is one of the reasons why I chose to write this personal account. We are all part of the improvement process and as such should feel safe and confident to be able to air our opinions on matters that are of a serious concern to all involved.

If you find yourself under investigation please remember it's ok not to be ok, but it is certainly not ok to hide yourself away from the world. If you are under scrutiny please remember many of us have been in the same situation, support is always available and that the hardest decision to make is often to seek assistance. I did, and all I can say is without my crew room peers and friends then this would have been an even harder time for me to cope with. Being a second victim is a very personal thing and it is important to know that some people will be more affected than others. We are all there to look after each other so please look out for your colleagues if they are under investigation, but also look out for yourself. I hope by discussing this topic it will open avenues of communication and reflection for you regardless of your clinical grade or role within the Ambulance Service.

Thank you for taking the time to read my account and I hope this can be of use to you, your friends or your colleagues.

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