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ISMP Institute for Safe Medication Practices
An ECRI Company

Acute Care ISMP Medication Safety Alert!®

Educating the Healthcare Community About Safe Medication Practices

Support practitioners through second victim programs

Problem: Although patients and families are at the center of serious medication errors and unanticipated adverse events, the healthcare practitioners involved often face the difficult reality of becoming "second victims." This term, coined by Dr. Albert Wu in 2000, describes practitioners who experience emotional distress or trauma as a result of being involved in an adverse patient event such as a medication error.[1] They may experience fear of returning to work, remorse, depression, intrusive memories, nervousness, guilt, loss of confidence, self-doubt, embarrassment, anguish, and even criminal charges. Common phrases that you may hear from second victims include the following[2]:

- I don't deserve to be a doctor/pharmacist/nurse, etc.
- I came to work today to help someone, not to hurt them.
- This event shook me to my core. I'll never be the same again.
- I'm scared that the legal system might act against me.

We have written about this concern over the past two decades. In our July 14, 2011 article, Too Many Abandon the "Second Victims" of Medical Errors, we shared the tragic story of Kimberly Hiatt, a nurse who died by suicide after making a mathematical error that led to an overdose of calcium chloride and the subsequent death of an infant, which highlights the need for comprehensive support systems. According to media reports, after investigation of the event, hospital leaders made a difficult decision to terminate Kimberly Hiatt's employment after 27 years of service for undisclosed reasons, including factors not directly associated with the event. To satisfy state licensing disciplinary actions, Kimberly agreed to pay a fine and accepted a four-year probation that included medication administration supervision at any future nursing job. Just before her death, she had aced an advanced cardiac life support (ACLS) certification exam to qualify for a flight nurse position. But according to media reports, this and countless other efforts produced no job offers, increasing her isolation, despair, and depression.

Safety Culture

An organization's culture significantly influences safety. A punitive culture that cultivates fear results in cover-ups, leading to inaccurate information and ineffective problem-solving, which causes repeated errors and perpetuates the cycle. Focusing on education and vigilance without addressing the root causes of errors can lead to underreporting and a lack of improvement. Telling staff to "be more careful" and "slow down" and then imposing severe discipline based on the outcome's severity (outcome bias) creates an unfair environment and fails to address systemic issues or mitigate risk.

Besides situations where there was preventable harm to a patient, there are several types of clinical events that can evoke a second victim response, including an unexpected patient death or outcome, an unanticipated clinical event involving a pediatric patient, and a practitioner experiencing their first patient death. Being involved in minor errors, even those that do not reach

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Priorix packaging—possibility of diluent being given without the vaccine. A medical assistant (MA) working in an outpatient clinic reported concerns with how **PRIORIX** (measles, mumps, and rubella vaccine, live) is supplied by the manufacturer (GSK). Priorix comes in a carton of 10 single-dose vials of lyophilized antigen component and 10 single-dose prefilled syringes of sterile water diluent. Upon opening the carton, practitioners will find that flaps cover the vials, initially obscuring them from view (**Figure 1**). To access the vials, practitioners must lift the flap. However, the syringes are visible immediately upon opening the package. Since several other vaccines come in ready-to-administer prefilled syringes, the MA who reported this is concerned that staff may select only the diluent syringe to administer because that is all they see when they open the carton. This poses a safety risk if a practitioner unknowingly administers the diluent syringe without the lyophilized antigen component.

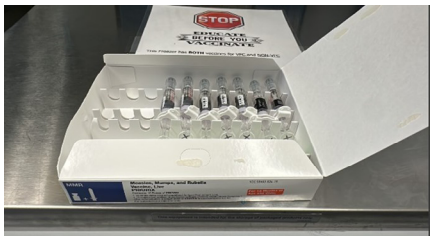

Figure 1. The design of the flap (see side flap at the near side of the carton) on the Priorix carton prevents practitioners from seeing the vials containing the lyophilized antigen component, which may result in the inadvertent administration of only the diluent syringe.

We have reached out to the manufacturer to notify them of this concern and to recommend modifying the Priorix packaging so that users can see the vials after opening the carton. When the organization receives a new product, conduct a review to identify potential risks with the product's design and storage. If your organization purchases this product, notify staff of this issue. Post a note

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the patient (e.g., good catches), can also shake healthcare staff and lead them to question their abilities. Even if they did not make an error, practitioners may feel as though they have failed the patient and second-guess their clinical skills and knowledge base, thinking they could/should have done something to prevent it.[2]

Event Reported to ISMP

A pharmacist, who was a new practitioner, was asked to respond to a pediatric code in the emergency department (ED). The child had no known medical conditions and had collapsed on the school playground. He arrived at the ED without a pulse and was not breathing. The pharmacist remembered shaking when preparing several emergent medications that the prescriber ordered during the code. Unfortunately, the child could not be resuscitated. The pharmacist was in the room when the prescriber called the time of death in front of the child's mom. Even though an error did not occur, the pharmacist reported that they suffered from nightmares reliving the traumatic event. The hospital did not have a second victim program, and the pharmacist became fearful of having to attend future pediatric codes.

While it is clear that supporting practitioners is necessary for their psychological safety as well as the safety of the patients they care for, organizations often face difficulties in creating and establishing second victim programs. Challenges include a culture of blame and judgment, practitioners feeling uncomfortable expressing the need for support, and a lack of volunteers to create a multidisciplinary response team.

Safe Practice Recommendations: Organizations should implement programs to support practitioners when unexpected outcomes occur. Consider the following recommendations:

Create a psychologically safe environment. Establish a strong leadership commitment to the implementation of the principles of a Just Culture where all staff feel safe to report and learn from mistakes, and continually look for risks that may pose a threat to patients and staff. Recognize the emotional distress that practitioners experience when they have been involved in a close call, an error that reaches a patient, or a traumatic patient event. Acknowledge and show concern for these practitioners as second victims.

Evaluate safety culture. Use results from surveys of the hospital's safety culture to gauge the level of psychological safety perceived after a medication error occurs. Take the time to understand staff's perceptions and identify an appropriate organizational response to improve the culture.

Implement a second victim program. The Joint Commission recommends including several components in second victim programs, starting with buy-in from leadership and engaging executive champions. The organization should develop policies and procedures for first responders and include evidence-based procedures. The program must also have confidentiality protections, and staff must be aware that this support is available. In our December 14, 2023 article, ISMP 26th Annual Cheers Awards: Hitting the Safety High Notes, we shared the story of the 2023 ISMP LIFETIME ACHIEVEMENT AWARD recipient, Susan Donnell Scott, PhD, RN, CPPS, FAAN, who has dedicated her career to developing strong peer support for second victims and practitioners in the aftermath of unexpected clinical events. She designed and deployed a first-of-its-kind peer support network, the forYOU team, at the University of Missouri Health Care System in Columbia, MO. This evidence-based and holistic approach to the provision of institutional support, promotes the psychological safety of staff during the period of extreme stress following emotionally challenging clinical events, and has become an international model for healthcare organizations seeking to create their own support structure. Consider utilizing the following resources and tools when planning to implement or to enhance your program:

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or signage where these products are stored alerting staff that one syringe and one vial will be needed. Establish a process to keep the Priorix vial and prefilled syringe together (e.g., band or bag them together). Dispense the products together in a bag with an auxiliary label to remind staff to reconstitute prior to administration. Barcode scanning prior to preparing and administering a vaccine could help identify an error if the system is set up to require scanning of both the vaccine vial and corresponding diluent syringe barcodes.

HIGH-ALERT

Methohexital syringes mistaken for similar-looking ketamine. After receiving a controlled substance delivery, a pharmacist mistakenly thought that methohexital 100 mg/10 mL syringes were ketamine 50 mg/mL syringes and stocked them in the incorrect bin in the controlled substance safe. Both syringes are made by a 503B outsourcer (QuVa) and have the same blue caps, similar white and yellow labels, and come in a clear plastic overwrap (**Figure 1**). The pharmacy was not expecting methohexital to arrive because it had been on back order, and they had not received the product for some time. The pharmacy reported that their process is to scan each product before stocking it in the controlled substance safe. However, when the pharmacist attempted to scan the barcode label on the overwrap of the methohexital syringe, they received an error message "unable to scan" and bypassed this safeguard without noticing that it was the wrong drug.

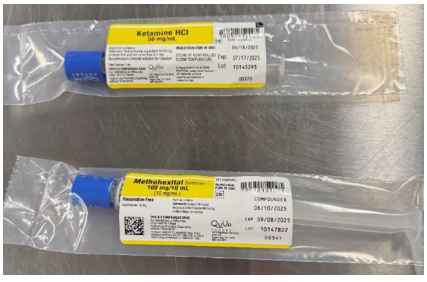

Figure 1. Similar-looking ketamine (top) and methohexital (bottom) products by QuVa.

We reached out to QuVa to notify them of this concern and recommend differentiating the product packaging and labeling, and to ensure the barcode on the overwrap is scannable. Organizations should have a process when receiving controlled substances to compare

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- The Second Victim Experience and Support Tool (SVEST). The SVEST survey helps organizations implement and track second victim support resources.
- Agency for Healthcare Research and Quality (AHRQ) Care for the Caregiver Program Implementation Guide. This guide can be used as a checklist for developing and implementing a Care for the Caregiver program.
- Resilience in Stressful Events (RISE). The RISE program at Johns Hopkins provides peer multidisciplinary group support to employees in emotional distress.
- ECRI's Strategies to Improve Aging Services Worker Well-Being. This provides information about how wellness is a key performance and quality indicator and how to implement workplace wellness programs.

Provide support systems. Recruit an interdisciplinary team and educate volunteer responders to provide 24/7 emotional support to staff. Some organizations do this in the format of deploying a second victim rapid response team to help practitioners during the acute stages of emotional trauma. Refer the practitioner to a professional (e.g., clinical psychologist, social worker, chaplain) and an employee assistance program if needs are beyond the scope of the volunteer.

Educate practitioners. Educate staff about resources available to them and provide initial and annual competency assessments related to second victim response. Introduce and provide for ongoing engagement with the second victim concept to reduce stigma, increase awareness, and guide staff on what to expect and how to access support, which are crucial for the success of second victim programs.

Include second victim training in academia. ISMP encourages academic institutions to educate students (e.g., medical, nursing, pharmacy) about Just Culture, medication error prevention, and how to seek second victim support as crucial steps for preparing them for future practice.

Conclusion

Supporting second victims in healthcare organizations requires a comprehensive approach that includes a Just Culture, effective event investigation, and robust support programs. By recognizing the impact of errors and adverse patient events on healthcare practitioners and implementing evidence-based strategies, organizations can help second victims heal and improve overall safety, including patient safety.

References

1) Wu AW. Medical error: the second victim. The doctor who makes the mistake needs help too. *BMJ*. 2000;320(7237):726-7.
2) forYOU Team. MU Health Care. Accessed May 15, 2025.

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the purchase order with the delivery to identify any discrepancies. If a medication barcode will not scan, the practitioner must visually verify the medication label and confirm if it is the intended product. Develop an escalation process when a medication barcode will not scan. The process should include when and how to report barcode-related issues, why it is dangerous to bypass scanning, and who is responsible for monitoring barcode issues.

Special Announcements

Survey on IV push medications

If you prepare, dispense, administer, or analyze errors related to IV push medications, we want to hear from you! Med Safety Board, an ISMP company, is conducting a short survey to reassess current practices and safety risks. Please take 5-10 minutes to complete the survey; the deadline has been extended to **October 15, 2025**. Thank you for your participation!

FREE ISMP webinar with CE

Join us on **October 9, 2025** for our webinar, ***Applying Best Practices to Prevent Wrong Drug Errors Associated with Generic Names***. Pharmacy and nursing continuing education (CE) will be offered. This activity is supported by an educational grant from Azurity Pharmaceuticals. For more information and to register, click here.

Virtual MSI workshop

You still have time to join us for one of our ***ISMP Medication Safety Intensive (MSI)*** workshops before the end of the year. This two-day virtual workshop is designed to help you successfully address current medication safety challenges that impact patient safety. Program faculty will provide you with the knowledge, as well as specific tools and resources needed to establish and sustain an aggressive, yet focused medication safety program. Upcoming sessions will be held on: **October 16 and 17**; and **December 4 and 5, 2025**. For more information and to register, click here.

SHARING A SAFETY MISSION

ISMP 28TH ANNUAL CHEERS AWARDS

Tuesday, December 9, 2025

House of Blues – Las Vegas, NV

The 28th Annual ISMP Cheers Awards will celebrate individuals and organizations on a mission to make strides in medication safety.

Show Your Support:

www.ismp.org/cheers-awards

Demonstrate your commitment to medication error prevention with sponsorship of our **ONLY** annual fundraising event!

When You Are a Part of Our Team, You Receive

- Branding as a prominent champion of patient safety
- Positioning as a strategic partner with ISMP
- Networking with patient safety leaders from varied practice settings

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