WR P EM
Wellness Resilience and Performance

Medical Error and 2nd Victim - Facilitator Guide

Learning Objectives:

1. Describe the impact that medical errors have on the individual doctor, team & healthcare organisation.

2. Introduce the concept of the "second victim" in medical error.

3. Describe the role of debriefing after critical incidents.

4. Outline the difference between a blame culture and a just culture in healthcare.

5. Identify personal strategies that may assist in dealing with your response to failure.

6. Encourage the adoption of a growth mindset and learning from error.

This module discusses the impact that medical errors have on the individual doctor and the healthcare team. You may prefer to use the term “Clinical Errors” if the discussions will include members of a multidisciplinary team, as this module applies to all members of the healthcare team regardless of their role.

Module Delivery
The module can be delivered in a variety of ways with some options listed below:

1. Lecture Format
   - The powerpoint slides provided could be used to form part of a presentation at a Morbidity & Mortality style meeting or during a departmental teaching session.
   - The goal is to remind participants of the impact of medical errors and to start a discussion about building a culture in your organization that supports learning from error.

2. Small group learning
   - Reflection Exercise:
     - Reflect on a clinical error that you have been involved in.
     - How did it make you feel?
     - What was the response in your workplace?
     - Did you feel supported?
     - Has it affected your ongoing ability to practice?
     - Share your stories with the group if you feel comfortable doing this.

- A facilitated discussion on how errors are handled in your department and what type of culture exists in your organization.
    - How does your department inform the individuals involved when clinical errors occur?
    - What are the barriers to seeking support in your department following a clinical error?
    - What support structure exists for clinical errors in your department? If it doesn't exist, what might it look like in the future?
    - What type of culture exists in your department with regards to handling of medical errors?
    - Areas to consider in the discussion include:
        - Major critical errors
        - Minor errors (eg missed fracture)
        - Students
- Debriefing Case Study: (15 minutes)
    - See Case Studies Learner and Facilitator Versions
    - Small groups of 2-3 to read the case study.
    - Role play with one person acting in the role of the clinician who has made the clinical error and others to act in the role of debriefer and observer.
    - Feedback given to debriefer by rest of group.
    - Key principles of each debrief discussed by the facilitator.

3. Individual One-to-One sessions
    - The attached resources could be used to support a colleague who has been involved in a clinical error in a peer support or mentoring style conversation.
    - Use of an assessment tool such as Myers-Briggs type indicator or the Harvard Business Review "Response to Blame survey" may be useful in a discussion with individuals about how they respond to failure.
    - Cognitive restructuring exercise from the website "MindTools" could be done with an individual as part of a mentoring conversation.