Second Victims Support Interventions
Recommendations

ERNST
The European Researchers' Network Working on Second Victims

COST
EUROPEAN COOPERATION IN SCIENCE & TECHNOLOGY

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Second Victims Support Interventions: Recommendations

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Background

This document contains recommendations agreed upon by a group of experts from five different European countries in relation to the design and management of an intervention[a] to support second victims. A second victim is defined as:

> "Any health care worker, directly or indirectly involved in an unanticipated adverse patient event, unintentional healthcare error, or patient injury and who becomes victimized in the sense that they are also negatively impacted." (Vanhaecht *et al.*, 2022)[1]

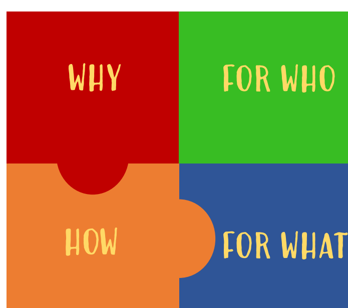
Pursuing the occupational well-being of healthcare teams is a prerequisite for patient safety and quality of care. Work stress, shame/blame culture, burnout, or disengagement in the healthcare setting may compromise patient safety and quality of care. Enhancing the resilience of health workers in the aftermath of stressful events (like adverse events) is needed to assure patient safety.

Several evidence-based interventions have been designed worldwide and are being applied in healthcare institutions. In some places of Europe, there are also good practices of interventions to support healthcare workers. European and beyond approaches could be extended to many other healthcare institutions across Europe. This is one of the main targets of the ERNST Consortium (funded by the European Cooperation in Science and Technology, CA19113).

Most interventions have focused on the healthcare institution's support response to second victims after a patient safety incident. Many of these initiatives are aligned with the Scott Three-Tier Model of Support[2], which includes peer and unit supervisor support (tier 1), trained peer support (tier 2), and specialized resources (tier 3). However, adopting a just culture approach requires complementing support interventions with efforts aimed at prevention. For this reason, Seys et al. (2023)[3] have recently proposed a five-level model of support, the main novelty of which is a first preventive level based on individual (e.g., self-care) and organizational (e.g., non-punitive culture) actions. Thus, second victim frameworks should integrate both preventive and interventive approaches.

This study is focused on the development of a framework and a set of recommendations for supporting healthcare institutions in the implementation of Second Victim Peer Support Interventions (SVSI).

The script for the development of the sessions was designed taking into account the crucial aspects to be explored[4,5]. The issues discussed during the group sessions focused on:



1. Objective, scope, and integration in the institutional policy of interventions to support second victims - *Why and for what purpose?*
2. Types of stressful situations and profile of professionals to whom they are addressed - *For who?*
3. Support intervention procedure - *How?*
4. Intervention outcomes, metrics, and quality standards - *For what results?*

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[a] In this document, an intervention is defined as a program, initiative, service or policy designed to address second victim syndrome or the factors that contribute to its occurrence.

The sociodemographic data of the participants in the groups conducted are as follows:

Total:	43

Country:	
Spain	9
Denmark	7
Finland	9
Croatia	8
Portugal	10

Sex:	
Woman	31
Man	12

The profiles of the invited experts were members of government, health care quality managers, public health specialists, occupational health specialists, and mental health specialists.

In the following, the ideas proposed by the participants in the different focus groups are summarized in an integrated way. The report is structured according to the four key aspects discussed in the group sessions (why, for who, how, and for what). The annex presents a model checklist that includes the essential elements for implementing an intervention or institutional resource to support second victims.

1. WHY (objective, scope, and integration in the center's policy

What is the objective of the intervention to support second victims?

Intervention focus

The intervention focus must be on **supporting healthcare workers' emotional well-being to recover second victims' performance levels before the patient safety incident and restore their ability to deal optimally with their care tasks**, learning about what happened so that it will not happen again. Following a traumatic incident, it is essential to provide immediate psychological first aid and promote long-term resilience. Support should be given to the second victim to overcome negative impacts and prevent emotional suffering.

It is crucial for the intervention to target on **prevention** of psychosocial and physical distress in second victim (education and supervision, acknowledging adverse events as a fundamental condition when working in healthcare), and **handling the aftermath** for first, second, and third victims (i.e., the patient/relatives, the healthcare professionals, the organization or department, respectively). Existing first victim support was seen as an important part of second victim support.

Addressing the distress of second victims will improve patient safety by reducing the potential increase of further adverse events. Risk reduction will also mitigate the costs associated with potential staff turnover, additional treatments required by the first victim, and litigation, among others. Furthermore, a comprehensive second victim support program must include first victim support and address with guarantees and respect for patients' rights the open disclosure of adverse events.

The legal framework of each country may condition the development and implantation of support programs for second victims of adverse events. These aspects must be considered throughout the design and implementation of these resources to ensure the adjustment and viability of the support.

The experience of the dean's programs, RISE and ForYou[6], shows that when defining the focus of the intervention, the appropriateness of including other stressful situations that may trigger responses akin to that of the second victim in healthcare professionals (e.g., the torpid course of the patient, violence against the professional, death of a pediatric patient, etc.) should be considered.

Integration of the resource into the patient safety policy

Support provision for second victims should be **part of the center's patient safety policy** and an **essential component of the integral management plan for serious adverse events**. Ideally, it should also be a national objective and integrated into the national patient safety plan. Healthcare facilities should consider objectives, resources, and activities to care for second victims framed within a positive, open, and proactive vision of safety culture.

Feasibility of implementing a second victim support intervention in a healthcare facility

Most initiatives to address the second victim phenomenon are based on the provision of peer support and, in the most severe cases, from the **specialized resources of the center** (mental

health, occupational health, etc.), which amortizes the investment that the institution has to make for its implementation as **it does not require the hiring of additional personnel**. The cost study of such a program (e.g., RISE at Johns Hopkins Hospital) has shown substantial cost savings (US $1.81) associated with decreased staff turnover and sick leave days[7]. Consequently, the **intervention represents a smaller investment than the long-term cost of neglecting the consequences of adverse events**. For this reason, programs should be identified as a priority by the institution's management.

Implementing an intervention to support second victims requires local adaptation of its objectives to the available structures and resources, considering the particularities of each care level and setting. External support, training, and ongoing monitoring might be of great importance for effectively putting this program into practice. In relation to care for second victims in primary care, the resources and activities allocated should be adapted to the structure and organization of outpatient care in each territorial area in each country.

Minimum structures are required to carry out the intervention, both physical (office, pavilion, etc.) and multimedia (table, computer, telephone).

Consolidated patient safety policy as an institutional prerequisite for the implementation of a second victim support intervention

The effective implementation of a second victim support intervention only seems possible within the **framework of a positive safety culture** that promotes the management of risks and patient safety incidents from a systemic approach. A clear commitment of healthcare workers policy can create a climate that will benefit the support program implementation. A European and national level guidance is needed. Therefore, the framework must take on a **dual preventive and interventionist** approach.

Recommended level of involvement of top management for the success of the second victim support intervention

The successful implementation of interventions to support second victims requires the **commitment and support of the center's management**. The management should undertake internal communication actions to inform the institution's staff of the support intervention, providing information on why, how, for what, and by whom, and on the conditions for personal data protection (anonymity).

Although the management does not participate in the first line of intervention, its involvement in the implementation, promotion, and monitoring of the results is crucial. Managers should act as role models and facilitate a psychologically safe environment to speak-up about errors, fallibility, and vulnerability from a non-blaming perspective.

A starting point is to **make top and middle level management aware of the second victim phenomenon** and how it negatively affects staff and, consequently, quality of care and patient safety. It is also essential for top management to support patients and their families by designating specific resources for this purpose and supporting the professionals managing the incident on the front line.

Bodies or commissions of the health center in which the support intervention for second victims should be linked

Second victim support **includes all the bodies and commissions in the organization**. The scope and characteristics of care for second victims should be implemented through clinical commissions, working groups, or Patient Safety or Occupational Health units, when these address, in addition to ergonomic issues, other psychosocial factors at work that affect the health and well-being of the center's professionals. Legal departments can also be considered to provide advice to second victims by addressing any legal concerns and ensuring that the rights and interests of the professionals involved are protected in the event that the safety incident involves major implications.

The second victim phenomenon is considered an **occupational risk derived from the nature of care activity**. Consequently, the support intervention should be based on an occupational health approach, without prejudice to the possibility of intervention by mental health units if the signs of the second victim suggest the need for specialized support.

It would be desirable that the assistance intervention be included in the center's portfolio of services, specifying the responsibilities, activities, and resources assigned.

FOR WHO

2. FOR WHO (type of stressful situations and profile of professionals targeted)

In what situations is the support is activated? To which professional profiles is the support addressed?

Type of stressful situations

The organization should define whether it has an intervention aimed at promoting the well-being of healthcare professionals in general or specifically in the case of second victims.

If the support intervention is specifically designed for second victims, it will be activated in the case of a **serious adverse event** and, particularly, in the case of a sentinel event. However, this does not preclude that it can also be used, in the case of incidents without harm or torpid evolution of the patient (poor health outcomes) when the professional in question meets the inclusion criteria (second victim syndrome).

Some support interventions designed for second victims can **take a broader approach** and be activated in any stressful event, for example, in cases of violence against healthcare professionals.

Profile of professionals targeted by the support intervention

Second victim support should be provided to **any individual or team working in the facility who meets the locally defined inclusion criteria**. This includes subcontractors' staff whose work activity may affect the patient's experience and health outcomes during their stay in the facility, even if they do not have a healthcare profile (e.g., administrative personnel, cooking staff who prepare meals for inpatients, or orderlies responsible for transfers of patients who may be involved in falls or identification errors).

Pay **special attention to the young healthcare professionals** (including students and residents) who may be more vulnerable and afraid to speak up because of the hierarchical structures of the organization. Furthermore, they may have a poor social network in the organization due to educational rotation between departments. To ensure adequate support for young staff and trainees in second-victim experiences, it is highly advisable to establish agreements between universities and healthcare centers. Some other aspects to take into account are the coverage of internship insurance, strict compliance with supervision activities by the direct supervisor, and the way in which the error is conceptualized and managed, since these are personnel who have not yet completed their training and, therefore, are not fully qualified for professional practice.

The support program should be sensitive to individual variability in emotional response and address all situations associated with safety incidents that may lead to a decrease in the quality of care or an increase in risk for patients.

In all cases, **receipt of support will be voluntary**. Therefore, the institution will respect the decision of those who meet the inclusion criteria and refuse to receive support. However, in these cases, information on the resource's availability and operation will be provided in case they change their mind in the future.

HOW

3. HOW (support intervention procedure)

What issues should be considered regarding the procedure to support second victims?

After an adverse event, the provision of support to second victims is structured in levels according to the nature, intensity and specificity of the support that responds to the needs of the second victim throughout the recovery process. The definition of these levels of support according to their specificity also requires the involvement of different professional profiles and agents of the organization with variable degrees of awareness and training.

Support for the second victims should begin in their own unit or service where he/she must be provided with psychological first aid by their own colleagues, immediate hierarchical superiors, or natural sources of support. However, it is important to tailor this to the local context.

Peer support should aim at providing **psychological first aid**, so active listening and emotional accompaniment of the second victim form the basis of the support intervention. Depending on the resources available, the intervention could contemplate the second victim's **free choice of peer supporter**. In practice, some second victims seek to talk to colleagues in their own service, others prefer to talk to professionals with whom they have no direct professional relationship, and still others choose to talk to people completely outside the health sector. This places emphasis on an already established safe relation. It would also be desirable to have the possibility of requesting a change of support provider. Evaluating the functionality of the support after each session could be useful.

There is **no recommended limit to the number of support sessions**, as it should be based on individual needs. However, if it is extended to more than 3 or 4 sessions (four weeks approximately), it is advisable to change supporter to avoid burnout. It should be noted that it must be an agreed time frame for the support case to care also for the peer support person. Compulsory debriefing or sessions are not recommended.

It is of utmost importance that the organization supports second victims to regain their self-confidence. This can include specific or general supervision or support during procedures or clinical decision-making, as well as handling complaint cases or conducting an open dialogue with the patient and relatives. The contextual factors of each event must be uncovered to match the level of support to the needs. To this end, it is desirable to create trained and differentiated teams to support professionals and that are integrated or articulated with risk management structures.

It must be noted that peer support model does not preclude the support network from including **specialized mental health** staff for cases where more intensive support is needed. In cases where it may be helpful, support from a chaplain or other spiritual figure may also be considered. The **protocol for referral** to a professional should be agreed upon in advance. The **provision of support will be progressively adapted to each case** as the needs of the professional concerned evolve. In addition, peer supporters must be aware of red flags (suicidal, severely decompensated person).

The subsequent set of specific recommendations is divided into three main categories: support providers, resource operation, and additional considerations.

Support providers

The core of support intervention should be based on a **peer support model** as this is the most desired source of support for most professionals and is a more economically viable and sustainable option than alternatives such as hiring external support providers. Nevertheless, as mentioned above, this does not detract from the fact that psychological or psychiatric support can be used if necessary.

The profile of the support professional should be that of a person with **experience in patient safety and specifically qualified to offer psychological first aid** and make a differential diagnosis of the psychological state of the professional and have the criteria to make the appropriate referrals at the appropriate time. These people must be empathetic and calm and be available to attend the interventions. The voluntary nature of the action must be considered, and this should not be deemed an obligation or default.

In the **provision of support to residents or students**, it is worth considering the role of **mentors as a natural source of support**, given their proximity to the residents. In the case of students, it would be advisable to coordinate the support function with the academic institution to which the trainee still belongs. If the support system includes self-selection of peer supporters, the hierarchical structure is not a barrier. It is important to signal to them that adverse events can impact everybody - even those at the top of the hierarchy.

The **support team should be multidisciplinary** and adjusted to the needs of each case. It is recommended to have at least the following profiles in the design and implementation of the intervention: responsible for patient safety or quality of care, medicine (including psychiatry and occupational medicine among different specialties), pharmacy, nursing, and psychology. Optionally, it may be considered to include people who have already experienced being a second victim.

In contrast to the aviation sector or experiences in the Americas, in Europe, there is no standardized certification of the skills of supporters or the contents of training programs. For this reason, it seems **necessary to develop certification and accreditation systems** to standardize the qualifications and **competencies** required of those who act as **peer supporters** in the organization. This training should include information on the nature of the second victim phenomenon, needs, and evolution, as well as training in communication and active listening skills that allow the implementation of empathy and the provision of psychological first aid. It is essential to train peer supporters in identifying warning signs to refer the second victim to the specialized support network if necessary.

Regarding middle managers' role, they should be seen as role models and should be educated to understand that their role is to take care of the healthcare professionals, so the healthcare professionals can take care of the patients, so they must be educated in the second victim phenomenon. They should support the program implementation and foster its promotion. However, **the exclusion of managers and middle management in the interview process with the second victim should be contemplated**.

Resource operation

The **access** to the support intervention must be flexible and adjusted to the needs and resources available at any given time. Pathways and agents must be well described in the strategy and protocol, and it should exist regular evaluation of the operating model.

It can be activated at the **request of the affected professional** (second victim), his or her immediate **superior or colleagues, management, or upon notification of the incident** in the reporting systems established for this purpose. It should be considered that the request for support from the second victim may take days or even months from the occurrence of the incident.

One possible way of identifying second victims is through the sessions or interviews held by the body responsible for patient safety and quality management at the center with the aim of gathering the facts and conducting the root cause analysis of the adverse event. This meeting, during which questions related to the emotional impact of the incident sometimes emerge spontaneously, can be a good opportunity to inform professionals of the possibility of addressing these issues specifically and by a team designated for this purpose within the framework of the center's response to each incident.

The resource must be agile in response. The more peers who are available to provide support, the greater the availability and timeliness of the support. The first response should be provided within 24 hours of the event, so that **24/7 availability is recommended**. Sometimes, the second victim's request for support might be delayed for weeks. In such situations, the support resource should ensure that they make the first contact within 24 hours of the request. In case of severe events, it is the responsibility of the line manager to provide immediate defusing before the staff leaves the workplace. Although it is recommended to have face-to-face support meetings, when possible, other channels such as video-call systems should also be available to ensure support in cases where physical presence is difficult.

The support intervention should contemplate **both individual and group intervention modalities**. Although the most common preference is for individual support, group sessions incorporate elements of mutual support groups that, especially in the case of several professionals simultaneously affected by the same adverse event, can contribute satisfactorily to the recovery of the second victim. Unit or organization support can also be considered.

Although the commitment to confidentiality of those providing this support is implicit in the exercise of their professional work, it is advisable to verbally inform the second victim that **all information gathered during the support process will be confidential** and will never be used without his/her prior authorization. To guarantee the confidentiality of the information gathered during the meetings with the second victim, no minutes will be taken or any other type of record of the sessions will be stored.

If necessary, the support structure must **channel the processes of sick leave, follow-up, and programmed reincorporation of the professional** to the center in coordination with the appropriate services (e.g., Occupational Health or Occupational Risk Prevention). It should be supported and implemented based on individual needs, and always assuring the confidentiality of the cause of the sick leave. For the reinstatement after an absence, it is advisable to have a detailed action flowchart. A dedicated temporary disability platform can monitor and drive reinstatement.

Additional considerations

There are several key elements that have to be considered when implementing a second victim support intervention from the ground up. Firstly, **ensuring preparedness, awareness, and education on the matter** is essential (stressing concepts such as confidentiality, non-blaming, etc.). Safe and empathetic action and support must be provided immediately after a traumatizing event, followed by ongoing care and support for as long as necessary. Indeed, a generic 'package' of second victim support interventions should be made available – and locally tailored to the needs of the organization, which includes the necessary materials for peers (brochures and booklets, presentations, etc.). Before implementation, it may be a good idea to start with pilot studies to assess acceptance and development in the institution. In departments with a low degree of psychological safety, the first step may be to uncover this level (e.g., through Edmondson's survey) to consider whether the implementation of second victim support interventions should be imbedded in a broader occupational environment effort targeting psychological safety.

Secondly, **dissemination among employees** is essential to make them aware of the existence and availability of the resource. It may include informative documentation (posters, brochures, etc.), awareness-raising, training, and coaching and information sessions aimed at unit/service managers and their professional teams, internal circulars, messages on institutional social networks, screensavers, etc.

The processes of providing support to the second victim and analyzing the incidents are usually carried out simultaneously and coordinately, as they are articulated under the safety structures and commissions. Usually, the collection of facts for root cause analysis by **interviewing the professionals involved in the event after reporting is used as an opportunity to offer support services**. So, root cause analysis on the ward with the staff involved immediately after the adverse event should be considered. The second victim is an essential source of information for understanding what happened. Learning about adverse event requires gaining insights into second victim experience, reflection, and acquiring knowledge. The internal investigation may trigger the initial second victim symptomatology with greater intensity, so the support resource should be aware of this circumstance and increase the support if necessary.

Another process that must take place after an adverse event is the communication of the incident to the patient or their family. There is no one-size-fits-all approach to **open disclosure** of the adverse event to the patient. The position of institutions may differ slightly as to who should inform the patient of the adverse event and how. However, there is no doubt that the **processes of informing the patient and supporting the second victim should be coordinated and run in parallel**. Concerning who should communicate what happened to the patient, the severity of the event, the emotional state and willingness of the professional, and the patient's preferences should be considered, although there is no doubt that open disclosure should be encouraged.

Finally, **psychological and emotional support to the patient and their family should be part of the protocol**. It can also be considered to have a social worker to help family members manage different aspects after the adverse event.

FOR WHAT

4. FOR WHAT (results of the support intervention)

What outcomes should be measured?

Below is a list of indicators extracted from various experiences in different countries during this study. These indicators should be considered for evaluating this type of intervention and represent valuable information for developing a new metric led by ERNST in Europe. This metric involves diverse profiles of healthcare professionals. Initially, experiences and viewpoints are collected using qualitative techniques, followed by promoting consensus among experts through the Delphi technique. It will soon be published as part of ERNST's proposals to advance knowledge about the phenomenon of second victims and effectively address it.

Structure indicators

- Existence of a program with objectives, structure-human, and physical and systems resources.
- Date of implementation of the intervention strategy in the center and date of the last update.
- Number of professionals capable of providing support/Number of available hours of these professionals.
- Budget allocated to the intervention.
- Policy, strategy, and regulation document covering the support intervention.
- Action protocols:
  - Management of serious adverse events.
  - Cases of referral of the professional to other types of resources.
  - Identification tools.
  - Protocol for empathic and ethical communication including complete and meaningful apology after adverse events.
  - Action after adverse event support services.
- Existence of a monitoring committee.
- Protocol for education/training and admission as support personnel.
- Characteristics of the physical space available to conduct interviews with second victims and group meetings.
- Hierarchical structure/functional dependence of the intervention strategy to support second victims.
- Regulations governing the support intervention.
- Necessary infrastructure and equipment (mail, 24/7 telephone, etc.).
- Indicators for: psychological safety, patient safety culture and work environment.

Process indicators

- Average time elapsed from the incident to the first interview with the affected professional.
- Cases with origin in the report of safety incidents.
- Number of interventions by period. Number of cases attended segmented by sex, professional profile, type of incident.
- Activity according to modality (individual/group) and specificity of support (levels).
- Average time since the beginning of the intervention.
- Rejected cases.
- Referrals segmented by destination.
- Reception procedure after sick leave.
- Cases in mediation.
- Number of reported events and number of peer support calls/responses.
- How does the support and the support system work, feedback from first victims and second victims and other stakeholders.
- Constant evaluation of strategy, plan, process and training and learning.
- Procedure and flowchart of action - human resources (appropriate number and function).

Outcome indicators

- Number of professionals involved in adverse events with support/number of professionals involved in adverse events.
- Number of professionals interviewed who do not show signs of second victim.
- Number of dropouts.
- Number of suicides.
- Number of layoffs.
- Number of referrals to specialized care.
- Assessment of the support intervention by the professionals attended.
- Assessment of the intervention by the support professionals.
- Annual activity report.
- Type of support provided.
- Direct costs of the intervention.
- Days of delay in receiving the first assistance.
- Days of sick leave.
- Results in acute stress assessment instrument or similar (before and after the intervention).

- Ongoing litigation or property claims.
- Positive closure of root cause analysis.
- Psychosocial work environment.
- Turnover of staff.
- Impact of support services for recovering and health and wellbeing of the involved.
- Impact of the changes made after learning from the events and experiences.
- Positive experience about safety culture.
- Resilience of professionals.
- Correlation between the number of adverse events before and after the implementation of the second victim support program.

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Annex. Checklist for healthcare institutions: Implementation of Second Victim Support Program in Healthcare

BEFORE PROGRAM IMPLEMENTATION			
QUALITY & SAFETY MANAGEMENT IN HEALTHCARE INSTITUTION	YES	NO	N/A
Healthcare institution has implemented a quality & safety management system			
Healthcare institution has a person in charge for quality & safety management			
The healthcare institution has a defined policy on how to act after an adverse event, address the needs of the affected patient and provide open disclosure, including a crisis communication plan in case news of the event spreads outside the institution			
Healthcare institution has patient safety incident reporting and learning systems in place			
Healthcare management or a collegiate body, as Safety Board, supports the implementation of the psychological support for staff			
The Just Culture principles have been assumed by the healthcare institution			
STEPS FOR ORGANISING THE TEAM FOR PSYCHOLOGICAL SUPPORT	YES	NO	N/A
Healthcare top manager or Safety Board Chief has organised the team for the second victim peer support (list of the members)			
A team leader has been appointed from within the institution with experience in patient safety and emotional first aid			
Members of the team include staff from emergency, medicine surgery and central services areas. They include:			
o Medical doctor			
o Nurse			
o Psychologist			
o Psychiatrist			
o Other healthcare workers:			
The team has written procedure for work (e.g., see ERNST Manual)			
Members have completed training for second victim support (psychological first aid)			
24/7 approach to the support provision			
First meeting of team members to approve work plan			
Connection for the psychologist or psychiatrist are available if needed			
Available time for consultation is indicated			
Ensuring anonymity			

WORK ENVIRONMENT	YES	NO	N/A
The health institution has a quiet room located inside or outside the centre's facilities in a discreet place to have supportive conversations without the risk of knowing who enters to avoid rumours or being identified			
The option of face-to-face conversations is available, but also via video call systems (e.g., ZOOM) to facilitate access to support in specific cases			
IMPLEMENTATION			
STEPS FOR PROGRAM IMPLEMENTATION	YES	NO	N/A
Raise awareness on the subject of second victims in healthcare through training activities and resources (e.g., using the ERNST self-paced course)			
Prepared telephone lines and e-mails in institution for contact			
Prepared contacts for referral to professional help as needed			
An algorithm designed to support the second victim			
Prepared and adapted guide to interview second victims (see the example below this checklist)			
Additional: Online peer support request form after an adverse event			
Additional: Creation of a brochure or poster that will be in visible places in the health institution, with available contacts for psychological first aid after adverse events			
EVALUATION			
REPORT AND EVALUATION OF PSYCHOLOGICAL SUPPORT	YES	NO	N/A
Recorded the adverse events within the institution			
Evaluated the severity of the reported adverse events (mild, moderate, severe, life-threatening, death)			
Recorded numbers of individuals who needed peer support after stressful situations related to care (near miss, adverse event, torpid patient evolution, etc.)			
Recorded numbers of individuals who needed professional support (psychologist and psychiatrist)			
Documented reasons for applying for psychological assistance			
Tracked number of encounters with the second victim			
Created post-meeting feedback survey for second victims and supporters			
IMPROVEMENT	YES	NO	N/A
The team and supported second victims have been given de opportunity to suggest measures for improvement			

Guide to interview a second victim

	Create a pleasant emotional atmosphere
	Encourage the second victim to guide the conversation
	Focus on discussing feelings and the experience, aiming to understand what has happened
	Avoid using terms such as "error", "responsible" or "negligence".
	Emphasis on interpersonal relationship
	Don't tell the second victim how they should do or feel
	Active listening
	Ask open-ended questions
	Provide presence and only presence if interpretation is not applicable at the moment
	Follow the affect, not just the words
	Do not focus exclusively on the truth of claims
	Allow silence
	Normalize second victim's feelings
	Offer legal advice
	Address the information to the patient and suggest choosing an appropriate moment for it, considering if you are the right person to inform the patient
	Make a plan, ensure that next steps are clear for the second victim
	Follow up with second victim in 1-2 weeks

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Working on Second Victims

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