PRIORITY PROCESSES: SUPPORT

Second victim support

The current pandemic moment has imposed on health professionals a reality that will be difficult to forget: dubious and sometimes ineffective care practices. It is not a simple decision between medication A or B, to associate or not to use other practices; but the constant doubt in offering an almost experimental patient care. Decision-making to this practice, imposed in critical moments, sometimes brings tragic results, the outcome of which cannot be measured, both for health professionals and for patients.

Since the publication "To err is human" it has been argued that adverse results can occur in healthcare practice. Errors are not uncommon, and studies show that this prevalence can reach more than 10%, being the fourth leading cause of death in some countries. In this moment of crisis, we asked ourselves, what would these numbers be, in the face of an exhausting reality, of an unknown disease, insufficient resources, long working hours, fear of contamination, insufficient teams, among other factors.

Knowing the true impact of this pandemic, wanting to understand the situation of people in need of scarce or nonexistent resources, exhausted and confused employees and the situation of family members and closest people will be very difficult, but what is already known is that the reality experienced in post-pandemic health will not be the same. This professional, the "second victim" of these facts, needs an attentive and careful look, with an effective support system to face the consequences of the lived experiences: emotionally stressful work,

living with frequent and unexpected deaths, contamination and deaths of co-workers and unsafe or empirical practices.

"Second victim" is a term referring to a health care provider involved in an unexpected patient adverse event, medical error and / or a patient-related injury; in which he becomes victimized by the trauma experienced. Second victims often feel personally responsible for patients' unexpected results and feel guilty as if they have failed their patients, their clinical skills or knowledge base. In its broadest concept, the application of this term is recognized for all health professionals involved in any unforeseen event that adversely affects the patient, even if it is not due to an error.

This phenomenon is characterized by low quality of life, the presence of Burnout, high levels of depression, emotional exhaustion and low personal achievement, with the perception of professional incompetence and insecurity. The high impact for patients and their families at this event is recognized, so promoting support for this first and second victim is necessary to favor learning in the face of error, in addition to preventing future consequences.

A common reaction after an event is to escape the situation, demonstrating a lack of interest in talking about the subject; however, what happens is the sequential experience of similar situations, which does not allow these professionals to "forget" these situations. There is a constant counterpoint between the event lived and its role in saving lives.

It thus becomes a devastating event, whose emotions can vary, in different areas: emotional, behavioral and cognitive. Professional performance is impacted, and may even lead to substance abuse (which requires control? Illicit? ...).

It is not uncommon the stigma to access mental health programs, distancing these professionals from a possible path to be followed, after the event. The support of co-workers or informal support networks are highly functional, promoting less impact and a healthy return to work.

Thus, it is important to create channels open to this communication, in order to provide active listening, comfort and advice. It is important to encourage speech, recognize the importance of the incident and not try to minimize it. Sharing similar stories among professionals who have experienced similar situations can help to recognize the impact of the problem and promote reaffirmation and professional rehabilitation.

This second victim support is essential in this post-crisis moment, for the reconstruction of the work environment, in a transparent manner, for a new institutional safety culture to be formed. These events or errors are the result of a system with multiple defects and varying levels of failure, not just the result of individual actions. Thus, it is important to remember that most health workers at some point have experienced or will experience an event or near event ("near miss"), which demonstrates the emerging need to prioritize organizational support activities.

For this organizational support, it is essential to recognize the extent to which the phenomenon of the second victim affected these professionals, psychologically, physically and professionally; generating an organizational awareness of the problem. When offering support to this second victim, it is necessary that the leaders and the organization itself evaluate the quality of this support, as well as what they learned from this experience.

The construction of support programs implies time and organizational cost, thus, monitoring their implementation as well as the results over time is

necessary to substantiate and guide new actions. For this program, it is necessary to:

- Establish clear goals;
- Have the governance support;
- Use a tool to obtain accurate information from professionals, regarding the impact experienced and necessary support;
- Have an established policy that guarantees the necessary resources and how the program will be implemented;
- Establish leaders roles and responsibilities in relation to the program, ensuring the proper referral;
- Guarantee the confidentiality of those involved;
- Attention to program supporters, in their selection and training process.

A multiplicity of forms and methods for the programs development of this nature is possible, however, the first necessary step is the recognition of the problem. Serious consequences for professionals and organizations are expected after the pandemic. Failure to recognize these impacts can have even greater consequences for the sustainability of institutions as well as society. The post-COVID-19 confrontation imposes on society attitudes never experienced, essential for the resumption of a new unknown moment that needs to be worked in a concrete and innovative way.

References

Agency for Healthcare Research and Quality. (2015). Systems Approach. Retrieved April 25, 2021 from https://psnet.ahrq.gov/primers/primer/21.

Burlison, J. D., Scott, S. D., Browne, E. K., Thompson, S. G., & Hoffman, J. M. (2017). The second victim experience and support tool (SVEST): validation of an organizational resource for assessing second victim effects and the quality of support resources. *Journal of patient safety*, *13*(2), 93.

Coughlan, B., Powell, D., & Higgins, M. F. (2017). The second victim: a review. *European Journal of Obstetrics & Gynecology and Reproductive Biology*, *213*, 11-16.

Denham, C. R. (2007). TRUST: the 5 rights of the second victim. *Journal of Patient Safety*, *3*(2), 107-119.

Edrees, H., Connors, C., Paine, L., Norvell, M., Taylor, H., & Wu, A. W. (2016). Implementing the RISE second victim support programme at the Johns Hopkins Hospital: a case study. *BMJ open*, *6*(9), e011708.

Hall, L. W., & Scott, S. D. (2012). The second victim of adverse health care events. *Nursing Clinics*, *47*(3), 383-393.

Lawton, R., Johnson, J., Janes, G., Foy, R., & Simms-Ellis, R. (2019). Supporting doctors who make mistakes. *BMJ*, *365*, l2161.

OZEKE, Ozcan et al. Second victims in health care: current perspectives. Advances in medical education and practice, v. 10, p. 593, 2019.

Petersen, I. G. (2019). The term" second victim" is appropriate for frontline workers. *BMJ*, *365*, l2157-l2157.

Pratt, S., Kenney, L., Scott, S. D., & Wu, A. W. (2012). How to develop a second victim support program: a toolkit for health care organizations. *Joint Commission journal on quality and patient safety*, *38*(5), 235-240.

Scott SD, Hirschinger LE, Cox KR, et al. Caring for our own: deploying a systemwide second victim rapid response team. Communication of Critical Test Results. 2010