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REVIEW

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Strategies to support health professionals in the condition of second victim: scoping review*

Estratégias para apoiar profissionais de saúde na condição de segunda vítima: uma revisão de escopo

Estrategias para apoyar al profesional de la salud en la condición de segunda víctima: una revisión de alcance

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ABSTRACT

Objective: To map and analyze the knowledge produced about strategies aimed at promoting support to health professionals in the condition of second victim. **Method:** Scoping review, developed in portals, databases and academic websites, whose inclusion criteria were articles and materials indexed in the respective search sites, between January 2000 and December 2019, in Portuguese, English and Spanish. The findings were summarized and analyzed based on descriptive statistics and narrative synthesis. **Results:** A total of 64 studies were included, 100% international; 92.2% in English and 50% from secondary research. The support strategies were grouped into four categories and most of the studies referred to the use of the forYOU, Medically Induced Trauma Support Services and Resilience in Stressful Events programs and the interventions represented, through dialogue with peers, family, friends and managers. **Conclusion:** Support strategies for the second victim are pointed out in international studies and mostly developed through programs/services and interventions. It is recommended to develop studies to learn about the phenomenon and to structure feasible support strategies in Brazilian health organizations.

DESCRIPTORS

Health Personnel; Patient Safety; Safety Management; Nursing; Review.

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INTRODUCTION

Patient safety can be contextualized and discussed from different perspectives, with safe and quality care as its central axis. Despite successive national and international initiatives to mitigate errors and adverse events (AE), they are present in care, and health professionals are susceptible to failures, which can cause damage to the patient/family, the worker and the health organization.

A recent scoping review with a sample of 25 studies, carried out in different countries, indicated a median of 51.2% preventable AE, reporting among the most frequent causes of surgical procedures, administration of medications or fluids and infection associated with care[1].

In Brazil, a report by the National Health Surveillance Agency (ANVISA – *Agência Nacional de Vigilância Sanitária*) provides an overview of the registered notifications between March 2014 and January 2019 about AE, of which 30.4% represented incidents related to loss or obstruction of the feeding tube, venous catheter and phlebitis, followed by those reported as failure in care (25.2%), comprising incidents in procedures, interventions and physical restraint, among others. Of the total number of notified AEs, 93.6% occurred in a hospital environment and 0.5% led patients to death[2].

Thus, it is unquestionable that AEs affect the quality of care and patient safety, as well as a wrong decision-making can result in damage and suffering to the physical, emotional and moral integrity of the professionals involved[3]. In this respect, health workers are victims of their own mistakes.

In a historical retrospective, it was found that the first mention of the term second victim occurred in 2000, highlighting that in the presence of an AE, it is essential to recognize at least two characters, in which the first one is represented by the patient affected by the incident resulting from care, named "First Victim", and the second one is the health professional involved in the event, named "Second Victim"[4]. There is also a reference to the term "Third Victim", considering health organizations, the place where the AE occurred[5].

Over the years, in the same way that the term second victim are used to name the health professional who was directly or indirectly involved in an AE/error and has some personal or professional suffering/trauma resulting from this situation[6], the term first victim, previously assigned to the patient, is now incorporated into the family[7]. Thus, researchers have been making efforts to measure the prevalence of the second victim phenomenon in the context of health organizations, as well as to clarify the circumstances that lead the worker to error[7-8].

A systematic review study conducted in the United States of America (USA) showed that between 10.4% and 43.3% of health professionals become second victims in the hospital context[7]. A research conducted in Spain revealed that six out of 10 professionals were second victims when analyzed during the past 5 years, with 62.5% of workers working in primary care and 72.5% in hospital care[9].

Other investigations mentioned the perception of experienced health professionals directly involved in AE, exposing negative and devastating repercussions generated by the lack of support, culminating in anxiety, depression and concerns about the ability to perform their activities[4-5,10-11]. In addition, a study showed sector transfer requests, as well as the record of abandoning the profession as a result of the event[9]. Recognizing and guiding the different facets that involve the second victim is complex, given the multiple components involved, especially those that encompass the safety culture, the maturity of professionals and organizations in facing the problem.

In this context, a number of support strategies for second victims were identified in the international literature, in various modalities such as: forYOU programs, developed by the University of Missouri[12], Resilience in Stressful Events (RISE) from Johns Hopkins Hospital[13], the Center for Professional and Peer Support (CPPS) from Brigham and Women's Hospital[14] and Medically Induced Trauma Support Services – MITSS[15], besides individual and collective actions and interventions[16-17], which aim to meet the needs of professionals in a systematic way. On the other hand, there is a gap in the national literature regarding terminology, the prevalence of the second victim phenomenon in health facilities, as well as the identification of damages and their impact on the lives of professionals.

Thus, the objective of this study was to map and analyze the knowledge produced about the strategies aimed at promoting support to health professionals in the condition of second victim.

METHOD

Study design

This is a scoping review that used Joanna Briggs Institute (JBI) framework[18-19], with the objective of exploring the topic of interest, mapping evidence from primary studies, investigating specificities, extension or amplitude of the object, summarizing and disseminating the findings, as well as identifying the existing gaps[18].

This study was conducted using the first five steps provided in this methodology, namely: identification of the guiding question; identification of relevant studies; material selection; data extraction; grouping, summary, report and discussion of results[18-20]. The guiding question was developed based on the strategy named Population, Concept and Context (PCC) - respectively, in which the Population was considered the health professionals; the Concept referred to the Second Victim and the Context, understood as the health services. Thus, the following research question was formulated: "What strategies are designed to support health professionals in the condition of second victim, in the context of health services?".

Data collection

Initially, the Cumulative Index to Nursing and Allied Health Literature (CINAHL) and Medical Literature Analysis and Retrieval System (MEDLINE) databases were used, and later, there was an expansion to other portals and databases, namely: Virtual Health Library (VHL), Latin American and Caribbean Literature in Health Sciences (LILACS), Excerpta Medica dataBASE (Embase), PubMed, Scopus, Web of Science and Epistemonikos; academic websites

and search engines, including Google Scholar, Brazilian Digital Library of Theses and Dissertations (BDTD), Wiley Interscience, OpenGrey, Agency for Healthcare Research and Quality (AHRQ), National Patient Safety Foundation (NPSF), World Health Organization (WHO), Institute for Safe Medication Practices Canada (ISMPC), Pan American Health Organization (PAHO), Collaborating Center for Quality and Patient Safety (ProQualis) and Second and Third Victim Research Group, totaling 20 search sites.

The descriptors and keywords (health personnel, healthcare professional, victim, second, *segurança do paciente*, *erros*, *segunda*, second victim, health care professional, health care personnel, *segunda vítima*, *segundas vitimas*, adverse event, support, support second victim and support program), were combined by the use of Boolean operators, AND and/or OR for the construction of search strategies, according to the specificity of each base, portal, directory and academic search engine.

The period established for searches occurred from January 2000 to December 2019, in Portuguese, English and Spanish. It is noteworthy that the period mentioned above was determined considering that the terminology second victim became to be portrayed in the literature after a mention in an editorial article by Albert Wu, starting in 2000.

Data collection was carried out from November 30, 2017 to January 11, 2018, and updated between January 2 and February 12, 2020, using an adapted form[18-20], considering the variables: Identification of bibliographic material; location (portal, base, website or academic search engine); material data (origin, typology, title, authors, descriptors, year, country and language); objectives; method (type, approach/design); characteristics of the subjects (population, sample, professional category(s) involved); methodological details (data collection, period, setting, analysis and treatment of data); result (categorization and description of the strategy, scope of the approach, team composition, repercussions, feelings and emotions); conclusions/final considerations and recommendations.

Sample definition

The composition of the sample was mediated in two stages, the first one was reading the titles and abstracts of the articles/texts/materials, respecting the eligibility criteria, and the second one was established by reading the publications in full to ensure their congruence with the guiding question and validated by two independent reviewers. Then, the retrieved documents were listed and numbered, according to the chronological order of data collection in the databases and ordered in an electronic spreadsheet.

The studies were synthesized and arranged in a figure format, using the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA)[21], table and chart, contemplating the variables of interest and analyzed based on descriptive statistics, absolute and relative frequencies, and in narrative synthesis.

Ethical aspects

As this is an investigation, whose method consists of a scoping review, this study was not submitted to the Research Ethics Committee of USP School of Nursing; however, it respected Resolution No. 466/12, of the National Health Council, regarding the analysis and sharing of results.

RESULTS

The search strategies identified a total of 1488 records in which after reading the abstracts, suppressing duplicates and excluding those that did not answer the research question, totaled 64 documents, as shown in Figure 1 PRISMA[21] resulting from this step.

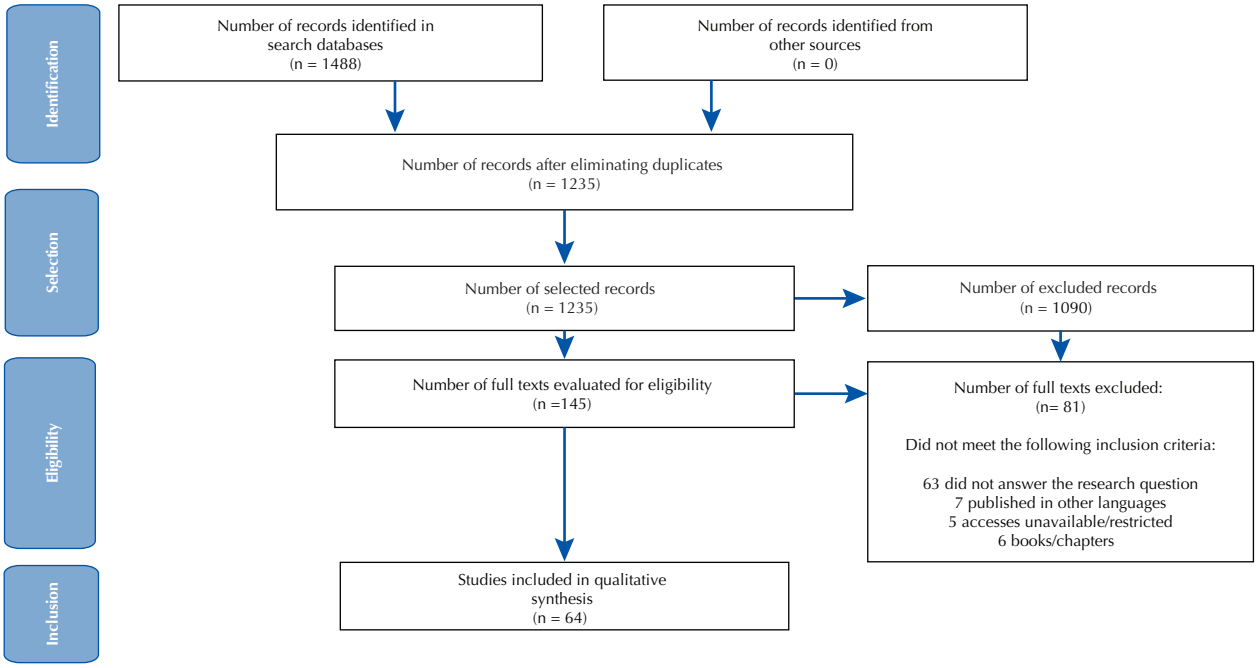

Figure 1 – Flow diagram of search in the literature and inclusion of articles.

The data in Table 1 explain the results of the articles/materials in the portals/bases/websites and academic search engines that comprised the review sample.

Table 1 presents the characterization of the findings, discriminating the search in 20 electronic databases, of which 43 come from white literature, represented by the EMBASE (11) CINAHL (nine), and SCOPUS (eight) databases and 21 from grey literature, with nine documents found at the AHRQ, followed by Google Scholar (five).

Regarding the language and type of publication, it was found that most of the studies were in English 92.2% from journals 82.8%. As for studies published in journals, it was observed that 45.3% were original articles, 18.9% theoretical/reflection articles, 18.9% review articles, 7.5% editorial/letter to the director, 3.8% event abstract, 3.8% experience report and 1.8% case study.

In this review, it was found that the authors with the largest number of publications on the second victim theme were Susan Scott and Albert Wu (nine), respectively. Related to the type of the studies, the findings showed that 50% were secondary research, 46.8% primary research and 3.2% experience reports.

The general overview of the data showed that most studies were carried out in the USA (46.9%), followed by Spain (12.9%). Regarding the institution of the study, considering primary researches, 56.7% were carried out in hospitals, 23.3% in partnerships between hospital and university, primary care center or reference organization, 16.7% developed in professional societies and 3.3% in foundation. In addition, most of these studies (40%) used the quantitative approach.

Most documents were published in 2016 (18.8%), 11 from journals and one in the form of a guide. Among the review studies, 50% were based on literature review, 30% on systematic review and 10% on narrative and integrative review.

In secondary studies, there was a predominance of theoretical/reflection articles (42.7%), followed by review (31.2%), which portrayed content focused on the recovery trajectory of the second victims and the factors that contribute to this condition, theoretical-philosophical basis of the theme, ethical-legal responsibilities of the worker and employer, support needs to minimize the negative effects experienced by professionals after an AE, impairment of the individual's health, considering the physical and emotional damage. In addition, the review studies addressed program structures and organizational models of support for second victims, established relationships between the phenomenon of second victim and the culture of institutional safety, patient safety and described the repercussions in the personal and professional level.

Table 1 – Distribution of articles/materials retrieved and selected, according to portals, databases, websites and academic search engines – São Paulo, SP, Brazil, 2000/2019.

Portals/Databases/Directories and Academic search engines	Retrieved	Number of records after eliminating duplicates	Number of completed records assessed for eligibility	Number of full texts excluded	Sample
CINAHL*	62	62	14	5	9
MEDLINE*	150	150	1	0	1
LILACS*	7	7	0	0	0
Google Scholar**	182	175	28	23	5
BDTB**	49	49	0	0	0
Web of Science*	70	54	17	12	5
SCOPUS*	58	26	13	5	8
EMBASE*	152	93	22	11	11
PubMed*	223	184	14	7	7
VHL*	36	6	0	0	0
Epistemonikos*	11	32	2	0	2
Wiley Interscience**	36	6	2	1	1
OpenGrey**	46	46	1	0	1
AHRQ**	327	307	19	10	9
NPSF**	24	24	1	0	1
WHO**	9	9	0	0	0
ISMP Canada**	18	18	5	3	2
PAHO**	0	0	0	0	0
ProQualis**	10	5	2	1	1
Segundas y Terceras Víctimas Proyecto de Investigación**	18	17	4	3	1
Total	**1488**	**1235**	**145**	**81**	**64**

*White literature **Grey literature

The reviews also exposed several segments on the second victim theme, such as: care and support available to health professionals after an AE/error, repercussions for professionals in the condition of second victim, psychological responses and coping strategies adopted to deal with the occurrence of an unexpected event and the main categories of professionals considered second victims.

Thus, the analysis of the findings made it possible to group support strategies into four categories, explained in Chart 1: programs/services, guides, tools and interventions.

Chart 1 – Distribution of the sample, according to the category, study number and the name of the support strategy for the second victim – São Paulo, SP, Brazil, 2000/2019.

Category	Name of the support strategies
Programs and Services (37)/ S6,S7,S13,S14,S15,S22,S23, S24,S25,S26,S27,S28,S29,S30, S31,S32,S33,S34,S35,S36,S37, S38,S39,S40,S41,S42,S43,S44, S45,S46,S47,S48,S49,S50,S51, S52,S53	• forYOU[6,7,22-39] • Critical Crisis Management Plan[7] • University of Illinois Program[25-26] • Critical Incident Stress Debrifing (CISD)[24,29] • For Our Team[34] • ASSIST-ME[35] • Health Work Enviroments (HWE)[36] • Resilience in Stressful Events (RISE)[13,25-26,30,35-37,39-45] • Critical Incident Stress Management (CISM)[7,33,36,41] • Immediate Debriefing Team[41] • Critical Incidence Stress/ Support Team[41] • COPE[41] • Outpatient Psychiatry Support Team[41] • "Second Victim" SharePoint[42] • Norwegian Medical Association Physician Support Program[43] • Center for Professionalism and Peer Support (CPPS)[14,24,28,30,35,42,44] • "Support our Staff"[44] • Medically Induced Trauma Support Services (MITSS)[7,15,22,24-27,29,33,35-36,43-44,46-48] • Code Lavander[30,43] • YOU Matter[37,39,49]
Programs and Services (37)/ S6,S7,S13,S14,S15,S22,S23, S24,S25,S26,S27,S28,S29,S30, S31,S32,S33,S34,S35,S36,S37, S38,S39,S40,S41,S42,S43,S44, S45,S46,S47,S48,S49,S50,S51, S52,S53	• Online intervention program[50-51] • The Washington University School of Medicine Clinician Peer Support Program[52] • Novel Surgery-Specific Second VictimPeer Support Program[53]
Guidelines (4)/ S48,S50,S54,S55	• AHRQ[48] • *Guía de recomendaciones - Grupo de Investigación em Segundas y Terceras Víctimas*[50,54] • *Guía de actuación ante eventos centinela*[55]
Tools (5)/ S24,S26,S30,S50,S56	• Toolkit[24,26,30,56] • *Basada en el Análisis Causa-RAíz* (BACRA)[50]
Interventions (48)/ S6,S7,S9,S13,S14,S15,S16,S23 S24,S25,S27,S29,S30,S32,S33, S34,S35,S39,S42,S43,S44,S46, S47,S49,S50,S51,S55,S57,S58, S59,S60,S61,S62,S63,S64,S65, S66,S67,S68,S69,S70,S71,S72, S73,S74,S75,S76,S77	• Dialogue with co-workers, family, friends, managers, mental health speciali st[6-7,9,13-14,16,23-24,29-30,33-35,44,46-47,49,51,55,57-75] • Decalogue[57] • Dialogue to reveal the AE and apology to the patient/family[29,33,42,44,58-59,61,69,71,73] • Discussing the EA with another person[44,69,71,73] • Informal and formal support strategies[6-7,9,13-16,29-30,32-34,42,44,47,49,55,58-61,65-66]
Interventions (48)/ S6,S7,S9,S13,S14,S15,S16,S23 S24,S25,S27,S29,S30,S32,S33, S34,S35,S39,S42,S43,S44,S46, S47,S49,S50,S51,S55,S57,S58, S59,S60,S61,S62,S63,S64,S65, S66,S67,S68,S69,S70,S71,S72, S73,S74,S75,S76,S77	• Support from managers at all levels, counselors or therapist, department/unit or institution and psychological support[6,9,15,29,33,43-44,55,59,61,65-66,68,70,75-76] • Website Mitigating Impact in Second Victims (MISE)[39,42-43,50-51] • Second Victim Support Unit (USVIC)[62] • Coping strategies[13,16,23-25,30,35,44,46,61,63-64] • Support from co-workers, spouse, family members, friends and multidisciplinary team[6,13,16,30,42,44,58,61,66,77] • Training and learning from error[24,42,67-68,71,75-76], positive feedback[24,42] and proactive education[74] • Solve the situation alone[6,49,66-68,77] • Institutional policies and guidelines for professional and patient protection[59-60,68] • Reflective writing[7,25] • Temporary leave[33,55,71] • Self-punishment, self-defense, denial of fact and depersonalization[27,35,55,63,66,71] • Exercise well-being: physical activity, self-forgiveness, reviewing excessive perfection[44] and self-compassion[68] • Support in prayer and spirituality[67-68,70] • Worker Assistance Program[73]

Programs and Services

The category related to Programs and Services was mentioned in 37 studies, a total of 20 reported the forYOU Program and the MITSS Service was mentioned in 16 studies. It should be noted that, although described as a program in most of the retrieved studies, MITSS consists of a nonprofit organization, which arose from a joint work between an anesthesiologist and a patient affected by AE[78]. Another program reported in the studies was RISE, initially developed at the pediatric unit of the Johns Hopkins hospital under the coordination of a multidisciplinary team, extending to the other units of the hospital[13].

Among the similarities found in the programs, those related to origin, structure, access, organization, team composition and objective were highlighted, which recommends the beginning of support for the second victim as soon as possible. They have similar structures with regard to requesting institutional support, initiating support activities through contact with the second victim, with someone involved in the event, either with colleagues or peers (professionals in the same area). Therefore, they mention the use of resources such as telephone, beep, intranet or "call button"[14,33,41].

Another common characteristic is the support offered by a multidisciplinary team, preferably by professional peers, with similar experiences, to favor interaction and establish effective communication, developing empathy and compassion, along with the second victim. Thus, the organization is responsible for the instrumentalization and development of skills necessary for the support promoter to execute the activities and be able to act in different scenarios or situations caused by the AE/error. The programs are accessible to all health professionals, on a full-time and continuous basis[6,13,78].

In the RISE program, support is provided by two professionals available during work shifts, working together to implement actions[13]. In the forYOU program, second victims receive support at three levels, also named "Scott Three-Tiered Integrated Model of Interventional Support" or Scott's Triad. In this model, the initial emotional support is provided by a supporter, regardless of the function performed, in the place or department where the AE occurred[6].

Thus, at the first level of the forYOU program, 60% of second victims have their emotional needs met, as the attention is focused on the psychological well-being of professionals and the prevention of the negative impact of the occurrence. At the second level, the supporting professionals are active in critical areas and are prepared to identify possible second victims based on signs and symptoms of suffering, with the aim of meeting the needs of second victims in a percentage higher than 30%. The third level provides specialized professional care for the second victim, when the resources of the team of supporters are exhausted. It is estimated that 10% of second victims will need actions in this sphere. Among the specialized professionals, there are psychologists, counselors and professionals from the legal department[6].

The CISM and Critical Crisis Management Plan programs were initially implemented to assist police and firefighters, and subsequently, they incorporated health professionals in order to enable them to act in any stressful situation[7,33,36,41].

Another program of the University of Illinois has been developed under seven pillars to encourage notification of AE/error along with healthcare professionals and patients, making efforts to integrate quality improvement, patient safety and risk management services, as well as identifying and assisting the second victim, while the AE/error is investigated[25-26]. In addition, the Code Lavender program was found to offer holistic psychological support to the second victim[30,43].

Finally, the programs/services mentioned above operate in partnership with the organizations' risk management service/sector, however, they are administratively independent. They were designed to keep information confidential and are based on legal and political bases, aiming to protect the second victim[33,49,51,55,60,62,64].

Guides

In this category, studies 48, 50, 54 and 55 involved the Guides as strategies to support the second victims, made up especially of recommendations aimed at fostering the safety culture, building and implementing institutional policy, aiming to assist the patient (first victim), health professionals (second victim) and institutions (third victim) after the occurrence of AE/error in several regions of Spain. For the operationalization of the strategies, instruments were used, such as: script, checklist, algorithm of actions and interventions to be performed by professionals. It is also noteworthy the Guide developed by AHRQ, to guide managers and professionals from health organizations to implement, monitor and improve the Care for the Caregiver Program[48,50,54-55].

Tools

The studies gathered in this category cited the use of tools as a mean to assist in the development of a support program for second victims, directing actions and attention, especially to areas considered at risk. The toolkit of the Institute for Healthcare Improvement (IHI) or Toolkit for Building A Clinician and Staff Support Program was developed through expert consensus and made available on the MITSS website, containing a total of ten topics, namely: 1. Internal culture of safety; 2. Organizational awareness; 3. Formation of a multidisciplinary advisory committee; 4. Purchase/Acquisition of the idea by the leadership; 5. Risk management considerations; 6. Policies, procedures and practices; 7. Operationalization; 8. Training of the support team; 9. Dissemination/Communication plan and 10. Learning and improving opportunities[24,26,30,50,56].

Another study presented the electronic tool known by the acronym BACRA, created to support Spanish institutions in conducting and analyzing AEs, improving prevention actions, guiding the professionals victimized by AEs on how and when to reveal the incident to the patient/family and indicating the approach of this professional, whose availability is by electronic means and free access[50].

Interventions

In this fourth category, emotional support strategies considered informal and formal were grouped, mentioned in a total of 48 studies. Informal ones are characterized by reports of the situation of AE/errors to colleagues, family members, spouse or person of similar importance, professional pairs, friends, manager, or to a person of trust. In formal strategies, the second victim exposed the circumstances of AE/error to the therapist, counselor, managers, supervisors and risk managers, to a professional specialized in mental health or peers. This scenario could, in most cases, be understood as something formal and discussed with professionals with more experience[6,9,14,32-34,44,47,49,59-60,66,77].

Another aspect of this category was the conception that some studies addressed interventions and actions based on strategies with an emphasis on the problem and on emotion/cognition[35,42-43,61,63] and coping strategies, among them reflective writing[7,25], temporary leave from work[33,55], self-punishment, self-defense or fact denial[27,35, 55,63,66,71] and depersonalization[55]. Learning with error[42,67-68,71,75-76], positive feedback[24,42], proactive education[74] and the participation of the second victim in the AE root cause analysis process, in the construction of action plans and in the validation of the decision-making process to avoid future incidents[71,76] were also mentioned as a source of support for training.

The fact of revealing the error with an apology to the patient/family[29,33,42,58-59,61] and talking to another person about the event[44,69,71,73] was also shown as support source.

Other sources of support were found, such as Decalogue[57], which consists of 10 recommendations of good practices to support second victims, and also those in which the professionals revealed that they had managed to resolve the situation alone[6,49,66,77]. In addition, institutions were identified as a source of support, operationalized by the workers' assistance program and by institutional policies and guidelines designed to protect the patient/professional relationship[59-60]. USVIC[62] is also noteworthy, an external unit that has, among its activities, the role of providing support to professionals affected by AE and complex events, mediating communication between the institution and the patient/family, providing legal guidance when necessary and reveal the error to the patient and family.

The development of a website – MISE[39,42-43,50-51] – came up with the proposal to present the patient safety panorama, clarify about the second victim phenomenon and provide support for communication with the patient/family, after an AE.

Studies have also mentioned physical, religious and spiritual activities[67-68,70], self-forgiveness, the review of perfectionist behavior[44] and self-compassion[68] as a source of support for the second victim.

DISCUSSION

The characterization of search sites (white and grey literature), information and communication technologies, combined with the improvement of search and recovery technologies for materials, has promoted an increase in research, considering that the first literature mentioned above provides publications in a conventional and commercial way, with medium and large circulation. In addition, it is widely disseminated, it has bibliographic control and receives an international number, while the second one brings publications in unconventional and commercial media, difficult to be located, which do not have an international number and are not included in bibliographies or catalogs[79].

The second victim phenomenon proved to be a well settled concept in international literature, as identified in Studies 6, 7, 9, 16, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 33, 34, 35, 36, 49, 50, 51, 58, 61, 63 and 65 and reported by several scholars[5,51,69,80-83]. In this theme, other findings added the concepts of first and third victims (Studies 4, 7, 16, 27, 28, 29, 40, 51 and 59)[5,51,83-84].

Furthermore, reviews as part of the findings on the second victim theme portray the interest of scholars in seeking consistent evidence to elucidate the relationship between the variables or the studied phenomenon, through rigorous and systematic investigations of the research object[85]. However, in Brazil, studies involving support strategies for second victims were not found, revealing an important gap between the knowledge produced internationally and in Brazil, which is probably reflected in practice.

The findings showed that support strategies were based on formal and informal practices. Thus, the first one showed the proposals of health institutions and reference organizations on patient safety, while the second practice presented those arising from personal relationships with several health professionals.

Thus, a systematic review study[69] which used the same methodology as this investigation, gathered the best evidence on the experience of nurses as second victims and explored support strategies. As a result, it was found that the error results in intense emotional disorder, capable of altering relationships at work, and that the type of support received influences the emotional response after an AE. With regard to support, the study authors categorized the findings as follows: 1. Source of support: the nurses sought to speak with someone they trusted (partner, friend or close family member) or with an experienced colleague, who was able to understand their experience; 2. Perception of support: professionals revealed that the expectation related to the approach of colleagues and managers was not always beneficial, however, when colleagues showed empathy and solidarity in the face of error, they brought a certain encouragement; 3. Recommendations of the second victims: the participants suggested a non-punitive approach to error, with the aim of favoring the reporting of errors and generating the implementation of improvements.

Programs and Services designed to support the second victim are similar in terms of the structure and dynamics of activities, with the first objective of establishing contact with the professional or emotionally affected team, in order to stabilize the negative effects of the impact of AE/error[6,13,15]. In addition, they proposed a peer support approach for the second victim, highlighting the reciprocal benefits, both for professionals and organizations, since this support model

refers to a friendly environment, reduces absenteeism rates, encourages the commitment of professionals and, consequently, allows improvements in care quality[86], which include the benefits found by those who have already used this type of care[45].

Another topic that deserves to be highlighted is the concern of the programs related to the confidentiality of the information and the individualized care provided to the second victims, leaving as exception regarding the breach of secrecy of the information if the affected health professionals put their or other people's health at risk[84].

Still regarding the findings in this category, there was no consensus between what the programs practice and the professional's preference as to the best time to start supporting the professional affected by the error/AE, making it possible to approach immediately after the incident[14-15,58,64] or after a period of time[13,55], considering the occasion when the professional feels better prepared to talk about the occurrence.

When analyzing the costs related to the implementation of programs and services to support health professionals, one of the implemented programs identified savings for the institution, generated by the reduction of absenteeism and the rate of job abandonment[86].

Regarding the findings related to the guides, it was observed that most of them were developed in Spain, with institutional[50,54] and regional[55] coverage, and one of them was produced in the USA, institutionally[48]. These guides provide recommendations to guide and manage the situation arising from AE/error with the first, second and third victims, providing support and care based on check lists and algorithms.

In view of the results involving informal support strategies[6-7,13-14,16,30,32,34,42,44,47,49,59-61,66-77], interpersonal relationships were reported in the studies more often, involving colleagues, spouses and friends, either by understanding the dynamics of work or the ease of expressing their feelings. Additionally, support from the multidisciplinary team of the department or unit, leaders/supervisors, risk managers and the governing body of the hospital was mentio ned[6,9,15,29,33,43-44,55,59,61,65-66,68,70,75-76], In addition, it was mentioned that the disclosure of the AE to the patient/family served as a source of support[29,33,42,58-59,61]. These findings are in line with the research that identified that colleagues were the first and most valuable support received by second victims, 95.3% and 68.7%, respectively, followed by spouses (67,2%) and friends (58,2%)[80].

The studies revealed that the second victims also sought support through dialogue with co-workers, privileging the most experienced ones, followed by family and friends, managers, professionals specialized in mental health or group discussion[6-7,9,13-14,16,23-24,29-30,33-35,44,46-47,49,51,55,57-75]. The dialogue with patients/family members to expose the event was reported as a source of support as the professional felt relieved, assuming an ethical and responsible posture[29,33,42,44,58-59,61,69,71,73], and also those who chose to face the problem alone[6,49,66-68,77].

These findings are in line with the systematic review which found that the fact of exposing about AE to someone they trust, whether spouse, friend, family member or work partner, brought a certain security and support to nurses directly involved in AE, and the disclosure of the error was presented as a reflection of the moral and ethical responsibility of these professionals[69].

Other interventions were listed to support victims of AE: reflective or expressive writing[7,25], which promotes understanding and helps in solving problems through therapeutic writing; the MISE website, which, in addition to guiding how professionals should act after an AE, provides clarifications about the second victim phenomenon[50-51]; the creation of a specific support unit for the second victims operating in the southern region of Catalonia[62] and the fact of learning from error is also considered a support strategy[24].

In addition, other ways of coping with the repercussions arising from the AE/error are described by the phases or stages of recovery, identified in a study carried out with health professionals: Stage 1 - Institution of chaos and search for an answer: the second victim has a disorder of thoughts and reflections to understand what happened; Stage 2 - Intrusive reflections: thoughts of fear appear and, sometimes, victimized professionals isolate themselves and relive the event to try to get answers that led them to commit the AE; Stage 3 - Restoring integrity: professionals seek support from people they trust, such as a colleague, supervisor, family member or friend (in this group, second victims seek people who recognize their emotional and physical state, including self-criticism in the face of professional reputation in relation to peers and the organization); Stage 4 - Supporting the inquisition: characterized by the beginning of the second victim's concern about the organization, with regard to employability, professional license and disciplinary or legal measures; Stage 5 - Obtaining first aid: inquiries about where and who to count on to be understood and concern about legal issues and the privacy of information; Stage 6 - Moving forward: characterized by the motivation to "move forward", the professionals described three possibilities: giving up (abandoning the profession or changing the work unit), surviving (despite the memories of the AE, professionals manage to carry out their activities as expected) and prosper, in which the occurrence of the event allows them to transform and improve their professional activity[12].

In this review, it was possible to outline the framework of support strategies for the second victim. However, the authors corroborate the idea of advancing patient safety education to health professionals, since educational institutions still prioritize technical knowledge, not giving necessary attention to the teaching of key concepts, attitudes, behaviors and skills aimed at safe practice[87]. Thus, they recommend future investigations in order to ascertain the effectiveness of the proposed initiatives for monitoring health professionals as a second victim.

The limitation of this review comprises the access to electronic sites, mostly intended for the health area, not considering other areas of knowledge, such as law, ethics and bioethics, which possibly discuss other facets of the second victim phenomenon. In addition, the retrieval of documents in English, Portuguese and Spanish restricts the sample.

CONCLUSION

Due to the knowledge produced in this study, a series of support strategies were identified for the second victims in care environments, with predominance of programs and services and interventions linked to the organization, which points to the interest and concern of the organization with the health of the worker and the increase in the purposes of the safety culture.

It is worth mentioning that the implementation of emotional support measures for the health professional who made the mistake does not imply an exemption from liability, since it does not reduce the damage caused to the first victim. However, it is about investing in qualified professionals to avoid the recurrence of the error and allow them to remain in the job market.

Consequently, in view of the lack of studies in Brazil, it is imperative to develop research aimed at identifying the prevalence and experience of health professionals in the condition of second victim, in order to know the reality of the phenomenon in Brazilian health organizations and structure feasible support strategies for our context.

RESUMO

Objetivo: Mapear e analisar o conhecimento produzido acerca das estratégias destinadas a promover apoio aos profissionais de saúde na condição de segunda vítima. **Método:** Revisão de escopo, desenvolvida em portais, bases de dados e diretórios acadêmicos, cujos critérios de inclusão foram artigos e materiais indexados nos respectivos sítios de busca, entre janeiro de 2000 e dezembro de 2019, nos idiomas português, inglês e espanhol. Os achados foram sumarizados e analisados com base na estatística descritiva e na síntese narrativa. **Resultados:** Foram incluídos 64 estudos, 100% de âmbito internacional, com 92,2% no idioma inglês e 50% oriundos de pesquisa secundária. As estratégias de apoio foram agrupadas em quatro categorias e a maioria dos estudos referiu o emprego dos programas *forYOU, Medically Induced Trauma Support Services* e *Resilience in Stressful Events* e das intervenções representadas, pelo diálogo com os pares, familiares, amigos e gestores. **Conclusão:** As estratégias de apoio à segunda vítima são apontadas em estudos de âmbito internacional e desenvolvidas, majoritariamente, por meio de programas/serviços e intervenções. Recomenda-se o desenvolvimento de estudos para conhecer o fenômeno e estruturar estratégias de apoio exequíveis nas organizações de saúde brasileiras.

DESCRITORES

Pessoal de Saúde; Segurança do Paciente; Gestão da Segurança; Enfermagem; Revisão.

RESUMEN

Objetivo: Mapear y analizar el conocimiento producido acerca de las estrategias para promover el apoyo al profesional de la salud en la condición de segunda víctima. **Método:** Se trata de una revisión de alcance, desarrollada en portales, bases de datos y directorios académicos, cuyos criterios de inclusión fueron artículos y materiales indexados en los respectivos sitios de búsqueda, entre enero de 2000 y diciembre de 2019, en portugués, inglés y español. Los hallazgos se resumieron y analizaron bajo la base de la estadística descriptiva y la síntesis narrativa. **Resultados:** Se incluyeron 64 estudios, 100% de alcance internacional, un 92,2% en inglés y un 50% de investigaciones secundarias. Las estrategias de apoyo se agruparon en cuatro categorías y la mayoría de los estudios utilizó los programas *forYOU, Medically Induced Trauma Support Services* y *Resilience in Stressful Events* y las intervenciones representadas por el diálogo con los pares, familiares, amigos y gestores. **Conclusión:** Las estrategias de apoyo a la segunda víctima están señaladas en estudios internacionales y se desarrollan, principalmente, a través de programas/servicios e intervenciones. Se recomienda el desarrollo de estudios para conocer el fenómeno y estructurar las estrategias de apoyo factibles en las organizaciones de salud brasileñas.

DESCRIPTORES

Personal de Salud; Seguridad del Paciente; Administración de la Seguridad; Enfermería; Revisión.

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