



ERNST - RESCUE

INNOVATION GRANT BY COST19113

A EUROPEAN STRATEGY FOR SUPPORTING SECOND VICTIMS IN HEALTHCARE AND LONG-TERM CARE



PREPARED BY
**RESCUE CORE
INITIATIVE**

FOREWORD
**EUROPEAN PATIENT
SAFETY FOUNDATION (EUPSF)**



This document is based upon work from COST Innovators Grant (IG19113) supported by COST (European Cooperation in Science and Technology). COST (European Cooperation in Science and Technology) is a funding agency for research and innovation networks. Our Actions help connect research initiatives across Europe and enable scientists to grow their ideas by sharing them with their peers. This boosts their research, career and innovation.

DIGITAL ISBN - 978-84-09-73611-9

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Prologue

There are moments in healthcare when silence speaks louder than anything else. When something goes wrong, and everyone moves on, except the person who was holding the syringe, standing in the theatre, or answering the call. The second victim phenomenon captures this silence, this isolation, and this monograph gives it form, substance, and direction.

What the ERNST network has achieved here is not just a consolidation of definitions, data and pioneering practices. It's a call to action.

Through their work, they have mapped the human impact of adverse events not only on the professionals themselves, but on the safety and resilience of the system as a whole. When second victims are left unsupported, the consequences stretch far beyond the individual: defensive medicine, emotional withdrawal, early resignation from the profession. All of which make care less safe for the next patient.

At the European Patient Safety Foundation, we are convinced that no system can be safe if it neglects those who deliver care. You cannot build safety on exhaustion. You cannot build resilience on silence. This monograph is a powerful reminder that caring for healthcare professionals is not a luxury; it is a cornerstone of patient safety.

What is more, it does not stop at diagnosis. It proposes a way forward: clear standards for certifying peer support programmes for second victims and training programs. It shows that this can be done, and that it matters.

We are proud to see this work coming together. The ERNST consortium was awarded our 2024 Butterfly Impact Award in Patient Safety not by chance, but because they laid the foundation for something essential that can, from a single, concrete starting point, set off real and lasting change. We support this ambition, and we stand by the initiative as it moves from vision to reality.

This publication marks a turning point, not a final word. The path ahead is clear and belongs to those who refuse to let silence be the answer when caregivers are in pain.

Mirka Čikkelová

General Secretary European
Patient Safety Foundation (EUPSF)

About us

THE RESCUE INITIATIVE (IG19113)

The RESCUE Programme is an extension of the COST Action 19113 –ERNST Consortium (The European Researchers' Network Working on Second Victims, TheERNSTGroup), running from 2020 to 2024, whose objective was to foster discussions, exchange scientific knowledge, perspectives, and best practices related to the second victim phenomenon in health and care institutions across 31 European countries.

The aim of the RESCUE initiative is twofold:

- To implement the existing Action technology to certify both individuals and systems, thereby facilitating effective interventions that support second victims and introducing a European Certification-based recognition system, named RESCUE (based on Action 19113 outcomes).
- To devise a business model for the implementation of RESCUE across Europe and globally.

Secondary objectives:

1. To ensure that the RESCUE certification system reaches a Technology Readiness Level 8 (TRL-8) maturity level.
2. To certify 23% of current European second victim support interventions and involve a minimum of 30% of the peer supporters engaged in these interventions.
3. To increase the number of institutions implementing certified second victim support interventions, including at least two in primary care and two in nursing homes.
4. To develop a comprehensive business model for RESCUE's global utilization, emphasizing its expansion beyond Europe.

WORKING GROUPS (WGS)

The RESCUE team is composed of professionals from 25 countries with clinical, health, social, legal, and academic backgrounds. The activities of this multi-disciplinary group of experts are organised into three working groups described below.

WG1 – RESCUE MATURITY TASKFORCE

Objective: To achieve a maturity level TRL-8 for RESCUE.

Deliverables:

- Intellectual Property Rights (IPR) agreement.
- Website.
- Meetings.
- Training materials and Guidelines.
- Training School.
- Webinars.
- Scientific article.

WG2 – RESCUE BUSINESS PLAN

Objective: To elaborate RESCUE's business plan.

Deliverables:

- Marketing analysis report.
- Return on Investment (ROI).
- Revenue streams Report.
- Podcasts and videos of RESCUE end users.
- Webinars.

WG3 – STRATEGIC ALLIANCES AND SCALING-UP

Objective: To establish alliances to ensure RESCUE's viability and sustainability while establishing international credibility.

Deliverables:

- Sustainability strategy.
- Meetings.
- Agreements based on perdurable alliances.
- Financial sustainability.

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About us - Participating Countries



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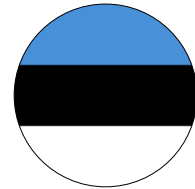
**Bosnia &
Herzegovina**



Croatia



Denmark



Estonia



Finland



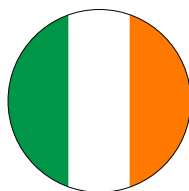
Germany



Greece



Iceland



Ireland



Israel

About us - Participating Countries



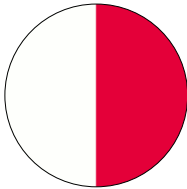
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Lithuania



Macedonia



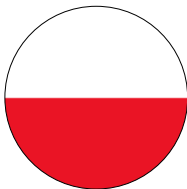
Malta



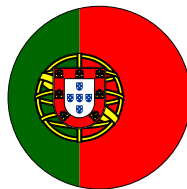
Moldova



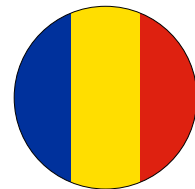
Norway



Poland



Portugal



Romania



Serbia



Slovakia



Spain

About us - Participating Countries



Turkey



Ukraine



United States

Context



IMAGE 1. Healthcare workers collaborating and supporting each other.

Healthcare professionals are the backbone of our health and care systems. Their commitment, resilience, and expertise sustain the delivery of high-quality care across Europe—often under immense pressure and in emotionally demanding circumstances. However, the human cost of this responsibility has long been underestimated. When a clinical event results in harm, the emotional impact on the involved professional can be profound. These second victims—doctors, nurses, residents, students, and support staff—are too often left to cope in silence.

The second victim phenomenon is not a marginal issue. It affects a significant portion of the healthcare workforce and, when left unaddressed, jeopardizes not only the well-being of professionals but also patient safety, team functioning, and the sustainability of health systems. As Europe faces critical shortages in healthcare personnel and a growing demand for care, we cannot afford to lose those who care for others.

Recognising and supporting second victims is more than an act of compassion: it is a concrete way to protect the quality and safety of care. When professionals are left alone to process distress, the risk of burnout, disengagement, or defensive practice increases—putting future patients at risk. Conversely, when institutions acknowledge this reality and offer structured, timely support, they not only help their staff recover, but strengthen the resilience of the entire system.

Caring for professionals, in this sense, is inseparable from caring for patients. A health system that safeguards the emotional well-being of its workforce creates the conditions for safer, more human, and more sustainable care.

The RESCUE Initiative, developed within the European Researchers Network on Second Victims (ERNST), offers a timely and robust response to this challenge. By establishing clear certification standards for support interventions and training programmes, RESCUE transforms empathy into structure, and concern into action. It provides healthcare organisations—across hospitals, primary care, and long-term care settings—with a concrete, evidence-based pathway to protect staff and improve safety culture.

This monograph brings together the scientific foundations, practical models, and policy recommendations that underpin the RESCUE strategy. It reflects the best of European cooperation: knowledge sharing, consensus building, and commitment to human dignity in care. As a political representative deeply committed to health equity and professional well-being, I am proud to support this initiative.

This work deserves the attention of all those who shape health policy and strategy across Europe. By recognising second victims—not as collateral consequences, but as individuals who also need care—we take a necessary step toward more human and just health systems.

About ERNST

The European Researchers' Network on Second Victims



IMAGE 2. ERNST – COST Action CA19113 - The European Researchers' Network Working on Second Victims website landing image.

The European Researchers' Network Working on Second Victims (ERNST) is a multidisciplinary, international initiative funded by the European Cooperation in Science and Technology (COST Association) under Cost Action 19113.

Established in 2019, ERNST aims to facilitate cross-national collaboration, knowledge exchange, and the development of shared strategies to support healthcare professionals who become second victims following adverse events.

ERNST brings together more than 170 experts from over 30 countries across Europe and beyond—including Canada, the United States, Latin America & Japan.

Participants include clinicians, researchers, legal scholars, psychologists, patient safety specialists, and educators, working together to address the emotional, professional, and systemic consequences of the second victim phenomenon.

ERNST has delivered impactful outputs such as training manuals, case studies, scientific publications, podcasts, and international forums. It is currently finalizing certification standards for support interventions (RESCUE and training programmes for peer supporters).

By building a sustainable community of practice, ERNST seeks to promote staff well-being, resilience, and patient safety across all health and social care settings in Europe.

More information is available at:
<https://cost-ernst.eu>

About ERNST

The European Researchers' Network on Second Victims

The network's objectives include:

- 1 Advancing the conceptual definition of the second victim.
- 2 Promoting the inclusion of second victim awareness in health professional curricula.
- 3 Developing evidence-based support interventions and training tools.
- 4 Fostering open dialogue on the legal, ethical, and organisational implications of adverse events.
- 5 Advancing the conceptual definition of the second victim.
- 6 Building bridges between second victim and patient safety research, policy, and practice.

Introduction

Health and care services are increasingly delivered in environments marked by uncertainty, complexity, and growing systemic demands. These challenges are compounded by continuous technological innovation, rapidly evolving clinical protocols, the pressure to integrate new scientific knowledge, and chronic constraints such as budgetary restrictions, rising workloads, and a shortage of qualified professionals.

Healthcare institutions are widely recognised as high-reliability organisations, given the systemic risks inherently associated with their operations. Despite ongoing efforts to strengthen care systems and deliver optimal outcomes, healthcare professionals are regularly exposed to emotionally demanding situations. These include unexpected patient deterioration, resuscitation attempts, patient deaths, or unintended adverse events—some of which are preventable. Most of these events stem from systemic factors, whether through organisational failures or human errors within complex environments, and they can have a profound psychological impact on the professionals involved.

In many cases, these professionals experience a range of emotional and behavioural responses that can include guilt, anxiety, anger, or detachment—reactions that, if unaddressed, may evolve into defensive practices, burnout, or disengagement. As previously discussed, these outcomes not only threaten the individual's well-being but may also contribute to increased patient risk and system inefficiency. This experience constitutes the bases of the second victim phenomenon.

While many adverse events in healthcare arise from systemic issues, a significant number are also linked to human error. It is essential to acknowledge that healthcare professionals operate in complex, high-pressure environments where mistakes—despite best intentions—are sometimes inevitable. In many situations, the procedures in place may not be optimally designed, contributing to confusion, cognitive overload, or ambiguity in clinical decision-making. In these contexts, we speak of honest errors—unintentional mistakes made by competent



IMAGE 3. Healthcare worker in silent distress.

professionals acting in good faith, typically under demanding conditions, without recklessness or wilful neglect. [These errors highlight the inherent fallibility of human performance and the limitations of working within imperfect systems¹. Addressing them effectively requires a Just Culture²](#)—one that distinguishes between blameworthy acts and human honest error—and embraces a non-punitive approach to learning and improvement. Such a culture fosters transparency, encourages reporting, and is essential for protecting both patient safety and the emotional well-being of professionals. When such events result in patient harm, the emotional impact on the involved professional can be profound. Feelings of guilt, fear of judgment, and a sense of personal failure are common, marking the onset of what is now recognised as the second victim phenomenon cited above. If left unaddressed, these reactions may evolve into defensive practices, burnout, or emotional withdrawal. These outcomes not only threaten the individual's well-being, but may also compromise care quality, increase patient risk, and reduce organisational efficiency. Recognising and addressing this phenomenon is therefore essential to safeguarding both patient safety and staff resilience.

Introduction

Key Principles of a Just Culture

Principle	Example
Distinguishing human error from reckless behaviour or misconduct	A nurse administers the wrong medication due to a label confusion — not punished, but supported.
Promoting accountability without assigning blame	A surgeon reports an intraoperative complication honestly and helps analyse contributing factors.
Encouraging incident reporting by reducing fear of punishment	A junior doctor feels safe to report a near miss after a supervisor shares their own experience.
Learning from errors to improve systems	After a medication error, the hospital updates barcode scanning protocols to avoid recurrence.
Supporting emotional well-being of professionals involved in professionals and students' incidents	A peer-support team checks in with a clinician after a traumatic resuscitation failure.
Ensuring fair and proportionate response to unsafe behaviours	A staff member who deliberately bypasses safety checks is subject to disciplinary review.
Creating psychological safety and team trust	Post-incident debriefings allow open dialogue without fear of blame or retaliation.

TABLE 1. Key principles of Just Culture. Adapted from Dekker, 2018.²

In such circumstances, the ability to adequately cope with these incidents—which are, in practice, frequent—relies heavily on the resilience of both individuals and teams.

Resilience refers to the ability of individuals, teams, and organizations to adapt, recover, and grow in the face of stress, adversity, and challenging circumstances³.

It not only allows professionals to absorb and manage adverse experiences, but also enables them to sustain performance under pressure.

In healthcare settings, this capacity is essential for maintaining well-being and ensuring the continuity of high-quality care despite repeated exposure to emotionally distressing events. Far from being merely a personal trait, resilience is a collective and institutional resource.

Strengthening resilience helps mitigate the long-term psychological impact of clinical adversity, supports professional engagement, and reinforces the overall safety and effectiveness of care systems. Promoting resilience is thus both an ethical and strategic imperative.

Second Victim Phenomenon

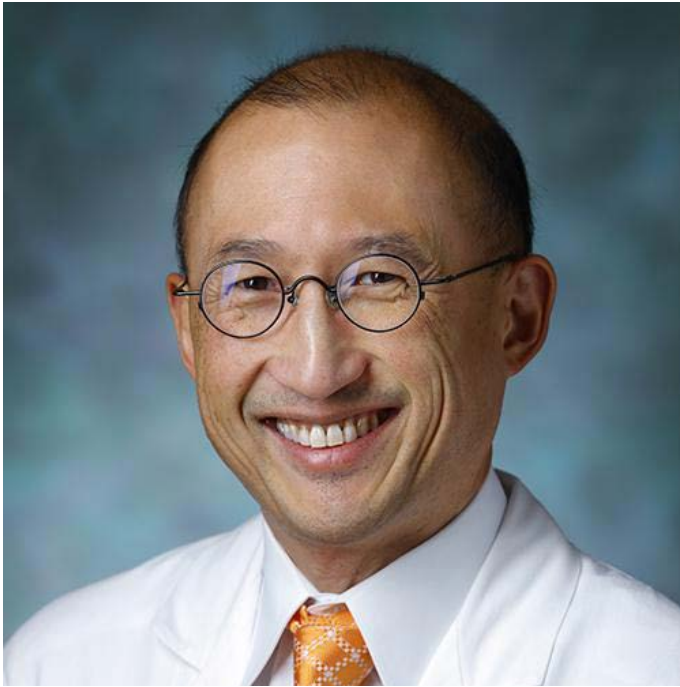


IMAGE 4. Albert W. Wu, MD, PhD, creator of the term “Second Victim.”

The term [second victim](#) was first introduced by Dr. Albert W. Wu in a 2000 editorial published in *BMJ*⁴.

Reflecting on a tragic case from his residency, Wu described how a colleague, after overlooking critical clinical signs, was swiftly and harshly judged by his peers. In a moment of empathetic insight, Wu questioned whether he himself might have made the same mistake—and, if so, whether he would have also become a second victim. His editorial brought to light a rarely acknowledged consequence of medical error: the emotional suffering of the healthcare professional involved.

Since then, the understanding of the phenomenon has significantly evolved. It is now widely accepted that any healthcare professional emotionally affected by an incident involving patient harm—or with the potential to cause harm—may become a second victim.

This includes not only adverse events in the strictest sense, but also other emotionally charged situations such as unexpected patient deaths, ethically complex cases, or serious breakdowns in communication and coordination.

Whether or not the professional is directly responsible, the psychological impact of these events can be profound.

They may seriously impair a professional’s emotional well-being and diminish their capacity to continue providing safe, effective care. This broader interpretation has informed newer definitions and models, which frame the second victim not only as an individual in distress, but also as a reflection of institutional and systemic vulnerability. More recently, the European Researchers’ Network on Second Victims (ERNST, COST Action 19113) has played a pivotal role in formalizing and expanding this concept.



IMAGE 5. Susan Donnell Scott, BSN '88, MS '94, PhD '14.

The initial definition of what a second victim was reworked by Susan Scott in 2009. Also, she described the usually natural history of recovery of the second victims⁷.

This comprehensive definition highlights the emotional, psychological, and functional consequences for professionals, and acknowledges that these consequences are shaped not only by the incident itself, but also by the organisational response.

Second Victim Phenomenon



IMAGE 6. Patient and nurse, both suffering the consequences of an adverse event.

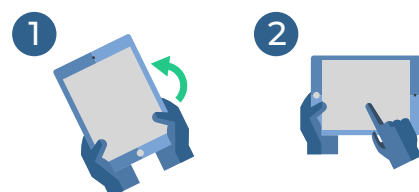
It reflects the understanding that adverse events, when not adequately managed at the institutional level, can lead to a cascade of harm affecting both patients and staff. Building on this perspective, the ERNST Consortium developed a conceptual model to illustrate how second victims often enter a vicious cycle of escalating emotional and behavioural distress. When a distressing clinical event occurs, the affected professional may initially experience shock, guilt, anxiety, or a sense of professional inadequacy. In the absence of timely institutional recognition or support, these reactions often go unacknowledged and remain internalised.

This invisibility reinforces feelings of isolation and self-blame, which may lead to maladaptive coping strategies such as hypervigilance, risk aversion, or emotional withdrawal. Over time, these behaviours can impair clinical performance, increase the likelihood of further incidents, and deepen the sense of failure or loss of confidence. Without structured intervention to disrupt this cycle, the suffering intensifies—placing both the individual and the organisation at risk. Institutions that fail to recognise and address this process may unwittingly perpetuate a culture of silence, blame, and vulnerability, ultimately eroding team resilience and patient safety.

This conceptual model developed by the ERNST Consortium visually captures the vicious cycle of loss of quality and well-being experienced by second victims. It highlights the progressive emotional toll that certain clinical events may exert on healthcare professionals and their teams, and how the lack of appropriate institutional responses can entrench this cycle—ultimately comprising both individual resilience and patient safety.

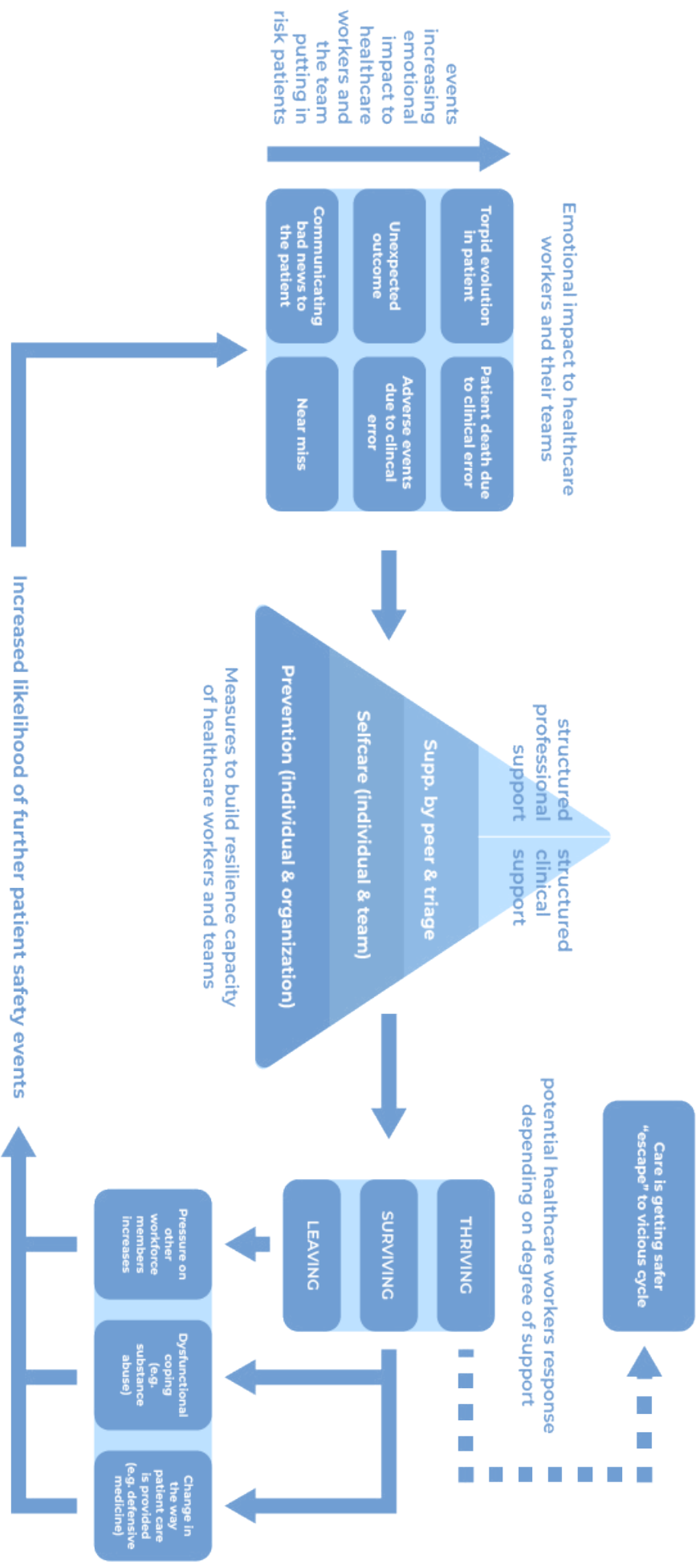
These range from near misses and the need to communicate bad news, to adverse events due to clinical error, unexpected outcomes, and ultimately patient death following a clinical error. Each of these situations not only affects the professional involved but also puts patients at further risk if the emotional impact is not addressed. On the left side of the following diagram, a vertical sequence of events is shown, ordered by their increasing emotional impact on professionals and teams.

Please rotate your device to landscape format to correctly display the following figure.



Second Victim Phenomenon

Vicious Circle of Loss Quality and Well-Being



Second Victim Phenomenon

1**PREVENTION (INDIVIDUAL & ORGANISATIONAL)**

Preventive actions implemented before any incident occurs, such as fostering a non-punitive environment, promoting a just culture, and providing training on the second victim phenomenon.

2**SELF-CARE OF THE INDIVIDUAL AND/OR TEAM**

Early emotional support encouraged through personal reflection, peer communication, and efforts to find meaning in the aftermath of the event.

3**SUPPORT BY PEERS AND TRIAGE**

Support provided by trained colleagues or rapid response teams. This includes early detection of affected individuals, guidance on next steps, and access to appropriate resources.

4**STRUCTURED PROFESSIONAL SUPPORT**

Formal interventions delivered by experts (such as psychologists, coaches, or clinical mentors), including debriefing sessions, clinical discussions, or incident reviews.

5**STRUCTURED CLINICAL SUPPORT**

Specialised clinical care when psychological distress requires it, involving medical support or psychotherapy (e.g., eye movement desensitization and reprocessing, cognitive-behavioural therapy, pharmacological treatment).

6**LEARNING ABOUT THE SUPPORT AND THE PROCESS TO IMPROVE ACTION**

Collecting feedback from the stakeholders to learn from support in practice. Integrating learning in all levels of the safety system (Plan-Do-Study-Act).

Second Victim Phenomenon

This model expands upon the foundational framework developed by Susan Scott and implemented in the ForYOU Team for second victim support⁵.

While Scott's approach has been instrumental in recognising the emotional impact of adverse events and offering immediate peer support, the ERNST model goes a step further. It acknowledges not only the importance of intervening after a second victim experience has occurred, but also the critical need to prevent such experiences through proactive institutional strategies. It further underscores the necessity of continuous evaluation to ensure lasting improvement in systems.

By embedding the phenomenon of second victims within a broader organisational and cultural context, the ERNST model promotes a more systemic and anticipatory response. It encourages health and care institutions to move beyond isolated support measures and instead adopt comprehensive resilience-building strategies, which include prevention, early detection, peer-based triage, and structured clinical and psychological support.

In doing so, it positions second victim support not as a reactive response to individual suffering, but as a strategic component of patient safety, workforce sustainability, and quality of care.

The ERNST Consortium has conceptualised the experience of second victims as a vicious cycle composed of interlinked psychological, organisational, and cultural elements. When a distressing incident occurs, the professional involved may experience shock, guilt, anxiety, or a sense of professional failure. In the absence of timely institutional recognition or support, these reactions often remain internalised and invisible. This lack of acknowledgement reinforces feelings of isolation and self-blame, leading to changes in behaviour such as hypervigilance, risk aversion, or emotional detachment.

Over time, these changes may impair clinical performance, increase the risk of future incidents, and further undermine the professional's confidence. Without an active intervention to break this cycle, the professional's suffering may escalate, and the organisation risks perpetuating a culture of silence and vulnerability, ultimately affecting the safety and resilience of the entire care team.

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Second Victim Phenomenon

These interventions represent a pathway to break the cycle and support recovery. Second Victims' route leads to three possible outcomes for the affected professional:

1

THRIVING – full recovery and growth, where care becomes safer as a result of learning.

2

SURVIVING – coping with residual effects while remaining in the system.

3

LEAVING – Professional disengagement or departure, often due to lack of support.

The bottom-right corner of the model illustrates what happens when no support is provided or interventions fail.

1

Changes in care practices, such as defensive medicine.

2

Dysfunctional coping strategies, including substance abuse or withdrawal.

3

Increased pressure on other staff members, further propagating stress and risk. These outcomes feed back into the system, raising the likelihood of new patient safety incidents, and perpetuating a cycle of harm and organisational fragility.

Second Victim Phenomenon



IMAGE 7. Healthcare workers claiming to protect the second victims.

The model not only reveals the individual trajectory of the second victim but also emphasizes the institutional responsibility to intervene. It provides a compelling rationale for structured support systems and the implementation of standards like those developed by the RESCUE Initiative. The emotional toll experienced by second victims goes far beyond personal suffering. Left unaddressed, it can impair clinical judgment, increase the risk of additional adverse events, and fuel a cycle of defensive medicine.

These reactions compromise not only the well-being of professionals but also the safety of patients and the cohesion of healthcare teams. At a systemic level, the consequences include reduced workforce stability, diminished organisational learning, and escalating costs tied to absenteeism, turnover, and litigation.

Recognising and mitigating the second victim phenomenon is therefore essential to safeguarding both individual resilience and the sustainability of care systems.

Manifestation of the Second Victim experience

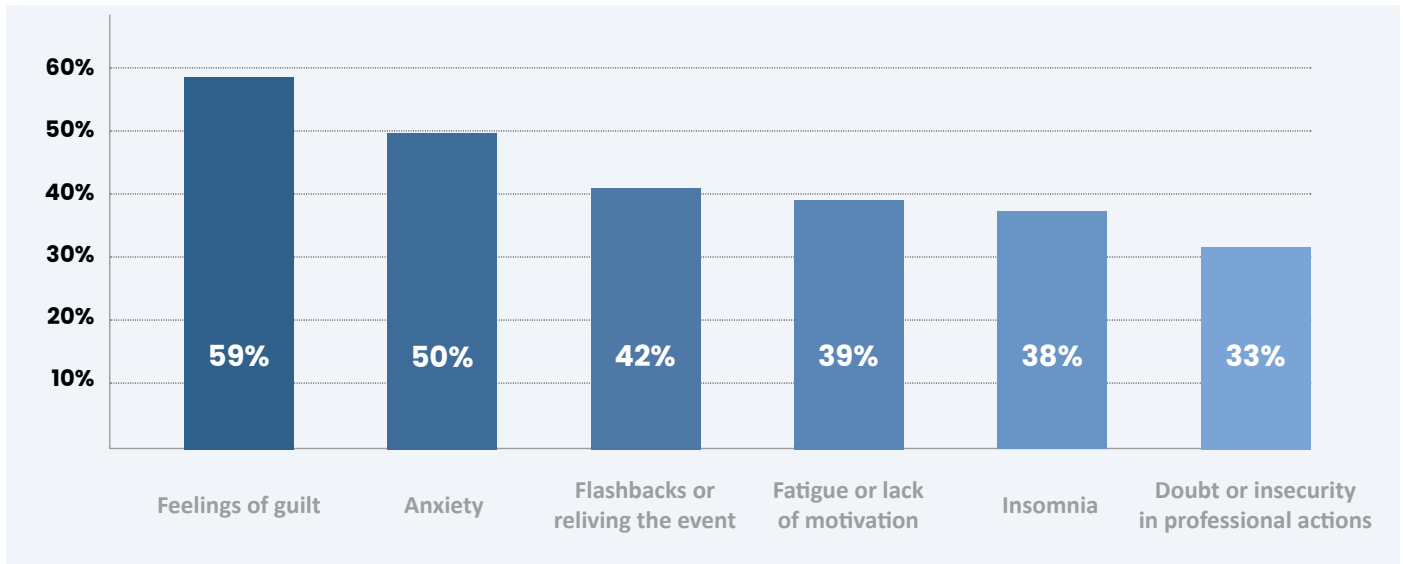


FIGURE 2. Graphical adaptation for the most common emotional responses reported by second victims. Adapted from Seys et al., 2013.⁶

The emotional and psychological impact of becoming a second victim can be profound. [Healthcare professionals exposed to distressing clinical events may experience a wide range of reactions, from acute feelings of guilt or shame to serious outcomes such as anxiety disorders, depression, or post-traumatic stress disorder \(PTSD\)](#)⁶. These responses are not limited to adverse events involving patient harm; they may also arise from emotionally charged situations like unexpected patient deaths, ethically challenging cases, or perceived failures in communication or care—regardless of whether an actual safety incident occurred.

Quantitative studies from various countries show that this is not a marginal issue. The second victim experience is increasingly recognised as a common occupational risk, with estimated prevalence ranging from 40% to 90% among healthcare professionals, and even higher among students and residents.

In Spain, 72.5% of hospital-based professionals reported experiencing symptoms consistent with the second victim phenomenon. In Germany, prevalence ranges from 59% to 60% among nurses and physicians. Belgium reported one of the highest rates, with 87.2%

of general practitioners in training identifying as second victims. In Canada, 86% of professionals involved in clinical incidents reported emotional impact, while figures in the United States vary from 43% to 84%, depending on the setting and population studied.

It is important to note that prevalence rates vary depending on the time frame used in studies. Some surveys ask professionals whether they have experienced second victim symptoms at any point in their career, while others focus on more recent periods, such as the past five or three years, or even the last 12 months. Unsurprisingly, lifetime prevalence tends to be higher, often exceeding 70%, whereas point or short-term prevalence usually falls within the 40%–60% range.

In the most severe cases, the second victim experience can trigger PTSD (estimated prevalence ranging from 5% to 17%). Despite variation, the evidence consistently shows that the second victim phenomenon is a common and recurrent experience in clinical practice, underscoring the need for long-term institutional commitment to staff support systems.

Manifestation of the Second Victim experience

Synthesising across contexts, it is estimated that over two-thirds of healthcare workers will experience second victim symptoms during their careers. This widespread prevalence highlights the urgency of institutional responses that prioritize staff well-being.

It is important to note that these stages are not always experienced sequentially. Many professionals may oscillate between phases or remain stuck in one stage—particularly in the absence of timely and compassionate support.

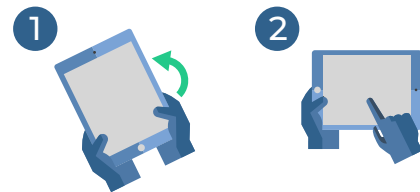
Recognising this, several pioneering institutions have developed structured programmes to address the needs of second victims. The ForYOU Team at the University of Missouri Healthcare offers a three-tiered response: immediate support from trained peer responders, access to professional counselling, and follow-up care. Similarly, the RISE (Resilience In Stressful Events)⁸ programme at Johns Hopkins Hospital provides 24/7 peer support to staff involved in emotionally taxing patient-related events, promoting early intervention and recovery.

Despite these promising initiatives, access to such support remains inconsistent across healthcare systems. Many professionals report feeling abandoned or stigmatized following distressing incidents.

Institutions must therefore move beyond reactive responses and commit to proactive, system-wide strategies that recognise second victims, validate their experiences, and integrate psychological support into routine patient safety and staff well-being policies.

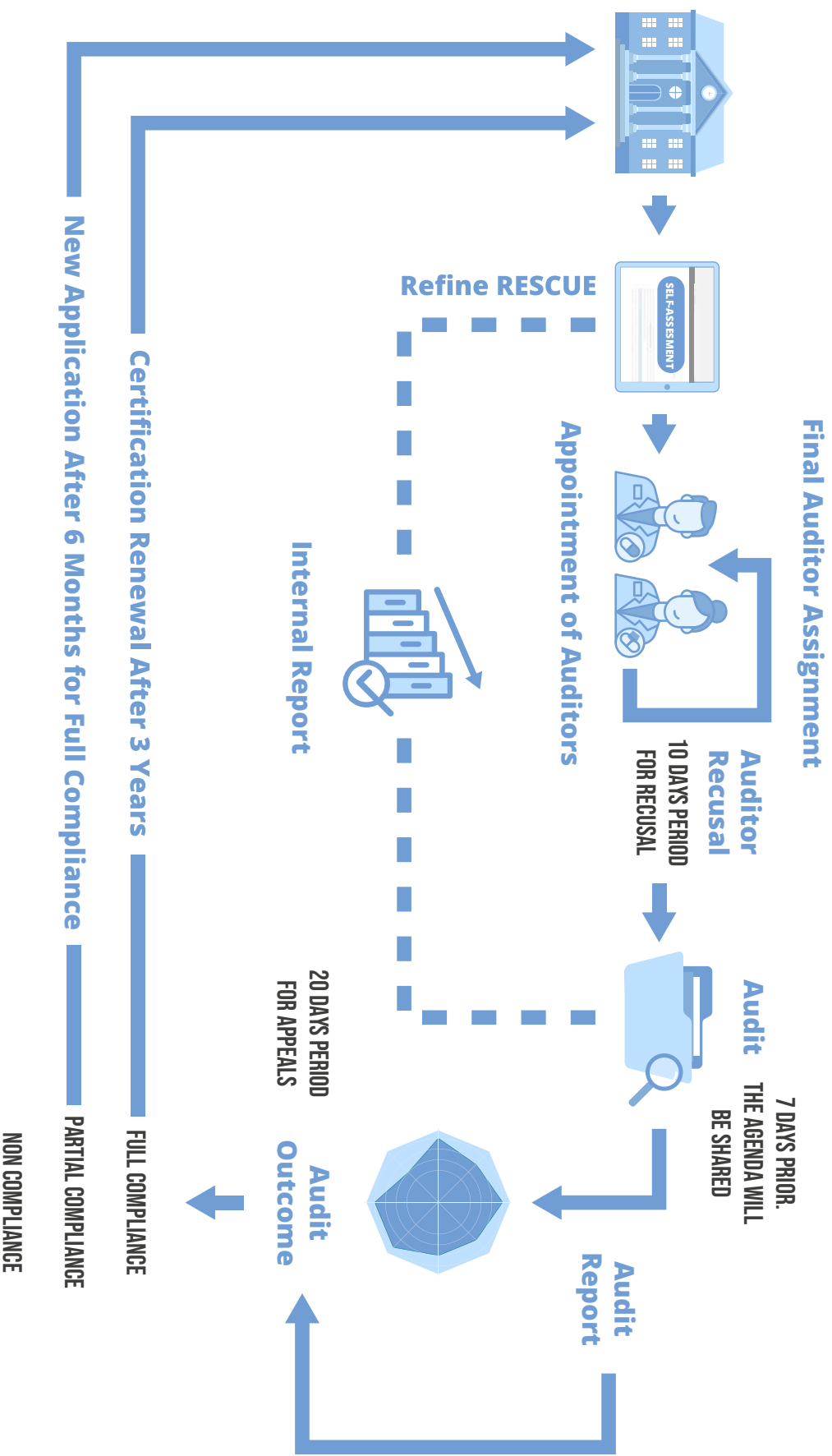
The trajectory of a second victim's experience has been conceptualized by Susan Scott in a six-stage model that captures the progression of psychological and emotional responses⁷:

Please rotate your device to landscape format to correctly display the following figure.



Manifestation of the Second Victim experience

Stages of Second Victim Phenomenon



Impact on healthcare systems



IMAGE 8. Bearing the weight of medical error.

The consequences of the second victim phenomenon extend well beyond the emotional distress of individual professionals. When healthcare workers experience unacknowledged trauma following distressing clinical events, the effects can compromise team functioning, clinical safety, workforce stability, and the financial sustainability of health systems.

ABANDONMENT AND PROFESSIONAL DISENGAGEMENT

One of the most concerning outcomes is the potential for professional disengagement or abandonment. In a large-scale survey conducted in the United States, 12% of second victims reported intentions to leave their current position, and 13% stated they had considered leaving the healthcare profession entirely as a direct result of their experience.

Available data highlight that 50% of healthcare professionals affected by an adverse event continue to experience emotional consequences more than one month after the incident, and in 20% of cases, these symptoms persist for over six months⁹.

In Europe, emerging data from several national contexts reinforce this concern. Studies indicate that between 1.4% and 2% of professionals who go through

a second victim episode ultimately leave the profession altogether. While these figures may appear modest in isolation, they represent a significant loss of expertise and continuity when extrapolated across national workforces—particularly in a time of acute healthcare staff shortages. The departure of experienced clinicians contributes to gaps in service delivery, increased recruitment costs, and a reduction in institutional knowledge and leadership capacity.

INTERNAL ROTATION AND DESTABILIZATION

In addition to outright abandonment, second victim distress frequently leads to requests for reassignment or rotation between departments. These internal transfers—often used as a coping strategy to escape environments associated with traumatic experiences—can disrupt team cohesion, undermine clinical continuity, and require additional training and adaptation time for receiving teams.

This phenomenon, though less visible than resignation, constitutes a hidden cost to organisational resilience and performance.

Impact on healthcare systems

Metric	Physicians	Nurses	Total
Average cost per affected professional	€14,078	€14,078	—
Estimated annual cost (pre-intervention)	€1.56 billion	€1.87 billion	€3.43 billion
Estimated annual cost (post-intervention)	€850 million	€1.02 billion	€1.87 billion
Potential savings per year	€710 million	€850 million	€1.56 billion

TABLE 2. Estimated economic impact of the second victim phenomenon and potential savings after intervention. Adapted from Rösner et al., 2024.¹⁰

DEFENSIVE PRACTICES AND CLINICAL EFFICIENCY

Second victim distress also contributes to the adoption of defensive clinical behaviours, widely documented in both medicine and nursing. After emotionally charged events, professionals often increase diagnostic testing, prolong documentation, or refer patients more frequently—not always based on clinical necessity, but out of fear of future scrutiny or litigation.

These defensive practices increase healthcare expenditures, overburden care systems, and may inadvertently expose patients to new forms of risk, such as overtreatment or care delays.

QUANTIFYING THE ECONOMIC BURDEN

The economic impact of the second victim phenomenon is now well established¹⁰. A recent European analysis estimated that the average direct cost per affected professional is €14,078, taking into account absenteeism, reduced productivity, and staff turnover¹¹.

When scaled to the system level, these individual costs translate into staggering annual losses: €1.56 billion per year for physicians, and €1.87 billion annually for nurses, attributable specifically to the consequences of unaddressed second victim trauma.

Encouragingly, the same analysis shows that implementing structured peer-Support Programmes could significantly mitigate these losses. Reducing physician-related costs to €850 million, and nursing-related costs to €1.02 billion, yielding potential annual savings of more than €1.5 billion across the workforce.

A preventable risk to system sustainability



IMAGE 9. Healthcare workers standing for a better system.

Beyond the numbers, what emerges is a clear message: failure to address second victim needs imposes a high and preventable cost on healthcare systems. Not only does it reduce professional effectiveness and compromise team stability, but it also places an unnecessary financial burden on services already under strain.

Conversely, investing in proactive institutional responses—such as peer support, training, and just culture practices—protects staff well-being, enhances care quality, and reinforces the long-term sustainability of health systems.

Intervention Models and ERNST Contributions

In recent years, several structured intervention models have been developed to support healthcare professionals affected by emotionally distressing clinical events. These programmes aim to provide timely, tiered responses to mitigate the impact of the second victim experience and to promote psychological recovery, professional reintegration, and patient safety.

Two of the most prominent and well-documented initiatives come from the United States: ForYOU, developed at the University of Missouri, and RISE, implemented at Johns Hopkins Hospital. Both represent comprehensive institutional responses to second victim trauma and share several common components:

1

Formal recognition of the second victim phenomenon

2

Training of peer responders and frontline staff

3

Support structures embedded in the organisation

4

Integration into risk management and quality systems

5

Continuous monitoring and evaluation

European Initiatives

The ForYOU Team (University of Missouri Healthcare) - USA

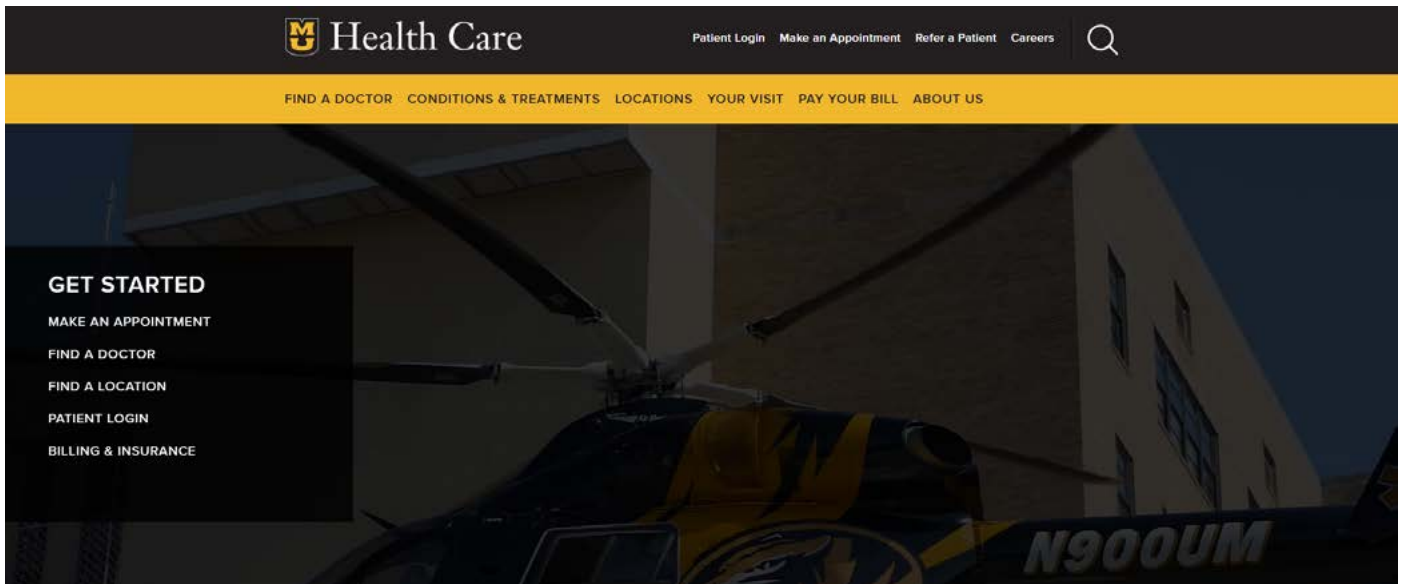


IMAGE 10. ForYOU Team webpage. (<https://www.muhealth.org>)

Among the international models, the ForYOU Team, directed by Susan Scott, stands out as one of the most comprehensive and evidence-informed approaches. Developed at the University of Missouri Healthcare, ForYOU was designed specifically to support healthcare workers who become emotionally impacted by adverse or traumatic clinical events.

The programme is grounded in the understanding that second victims often experience a progression of emotional stages, and that support must be proportional to the level of distress and timely in order to be effective. The ForYOU team provides what could be described as emotional first aid—offering psychological containment and peer support in the aftermath of distressing incidents, such as unexpected patient deterioration, failed resuscitation efforts, the death of a child, or emotionally charged interactions with families.

A distinctive strength of the programme is its three-tiered intervention model, designed to guide professionals through the six stages of emotional recovery identified in earlier research:

- **LEVEL 1:** Immediate peer support by colleagues trained in active listening, who are embedded in high-risk clinical areas. This is the most frequently accessed level of support.
- **LEVEL 2:** Intervention by specially trained peer responders from within the organisation, including safety officers, risk managers, or senior clinicians.
- **LEVEL 3:** Referral to external psychological support, including clinical psychologists or other mental health professionals, for individuals with ongoing or escalating symptoms.

European Initiatives

The ForYOU Team (University of Missouri Healthcare) - USA

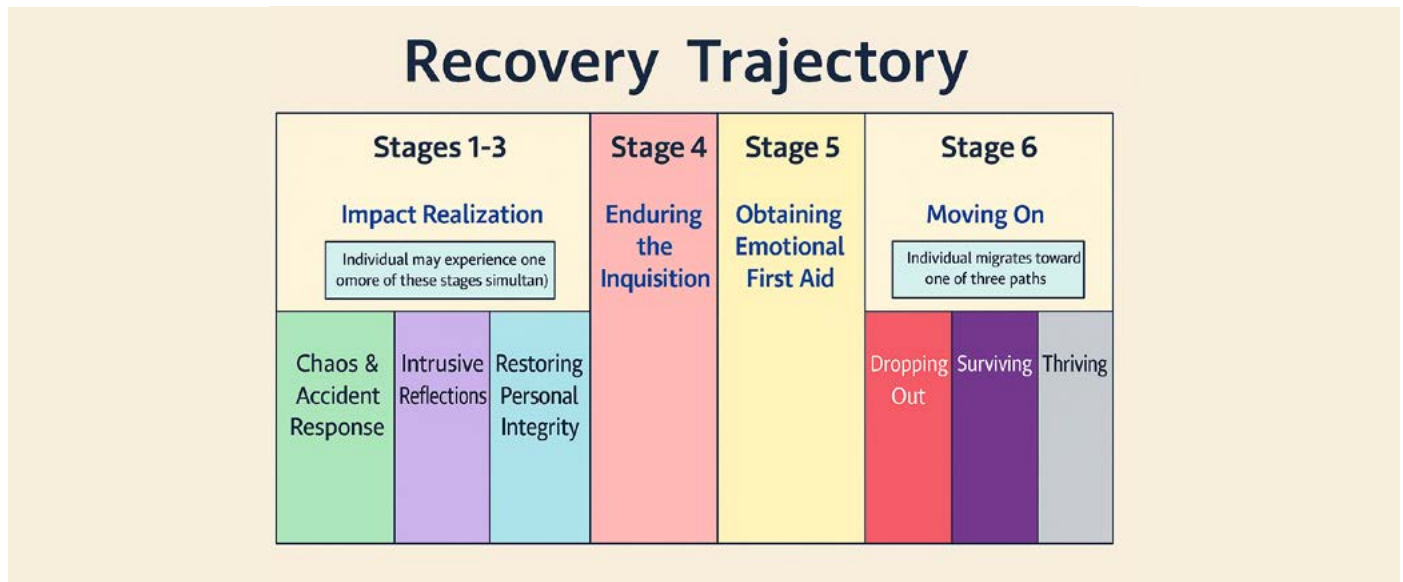


FIGURE 4. Six stages of second victim recovery. (<https://www.muhealth.org>)

The multidisciplinary composition of the ForYOU team—including physicians, nurses, therapists, and administrators—ensures broad institutional ownership and clinical credibility.

According to published results, approximately:

- 60% of affected professionals recover with local, informal peer support (Level 1),
- 30% benefit from structured institutional guidance (Level 2),
- and only 10% require external psychological referral (Level 3).

The ultimate goal of ForYOU is to help employees return to their pre-event baseline performance, preserving both individual well-being and organisational function. The programme has served as a model for many other initiatives worldwide and continues to inform good practices for second victim support.

European Initiatives

The RISE Programme (Johns Hopkins Hospital) - USA



IMAGE 11. The Johns Hopkins Hospital in Baltimore.

The RISE programme (Resilience In Stressful Events), developed at Johns Hopkins Hospital in the United States and directed by Albert W. Wu, is another internationally recognised model for second victim support. RISE was launched in 2011 as a proactive, institutional response to the emotional needs of healthcare professionals involved in patient-related incidents, particularly those that are unexpected, traumatic, or result in serious harm.

The programme was created in response to growing evidence that clinicians and staff exposed to such events frequently experience intense emotional reactions—including guilt, anxiety, and fear of judgment—and often have no formal support mechanisms available within their institutions. Programme Structure and Philosophy: RISE is structured around a peer responder model, with a strong emphasis on accessibility, immediacy, and confidentiality.

Its core aim is to offer psychological first aid to staff shortly after a distressing clinical event, helping them

process the experience, reduce emotional burden, and return to professional function.

KEY FEATURES INCLUDE:

- A 24/7 on-call system, ensuring that trained responders are available at any time.
- A team of multidisciplinary peer supporters, including physicians, nurses, social workers, and chaplains, all of whom have undergone specialised training in crisis intervention, active listening, and emotional support.
- A rapid response process, whereby any staff member can activate the RISE team via phone or electronic request following an event.
- A confidential, non-evaluative approach, ensuring that the responder's role is purely supportive and separate from clinical governance or performance management.

European Initiatives

The RISE Programme (Johns Hopkins Hospital) - USA



IMAGE 12. RISE online presentation. Peer Support in the Midst of Crisis.

The programme provides support after a wide range of incidents, including:

- Unexpected patient deterioration or death
- Adverse events, near misses, or medical errors
- Emotional encounters with families or end-of-life cases
- Workplace violence or other safety-related stressors.

IMPACT AND EVALUATION. EVALUATIONS OF RISE HAVE DEMONSTRATED:

- High levels of user satisfaction, particularly regarding the speed and empathy of the response.
- Positive effects on staff resilience, emotional well-being, and team morale.
- Increased awareness of the second victim phenomenon throughout the institution.

The programme has also helped foster a just culture at Johns Hopkins, reinforcing the message that emotional support is not a weakness but a professional need—and that psychological safety is a prerequisite for learning and improvement.

RISE continues to serve as a model for other institutions seeking to develop or strengthen their own second victim support systems. Its strong integration with clinical operations, safety culture, and human resource strategies makes it one of the most comprehensive and replicable initiatives currently in practice.

European Initiatives

MISE (Mitigating Impact in Second Victims) - Spain

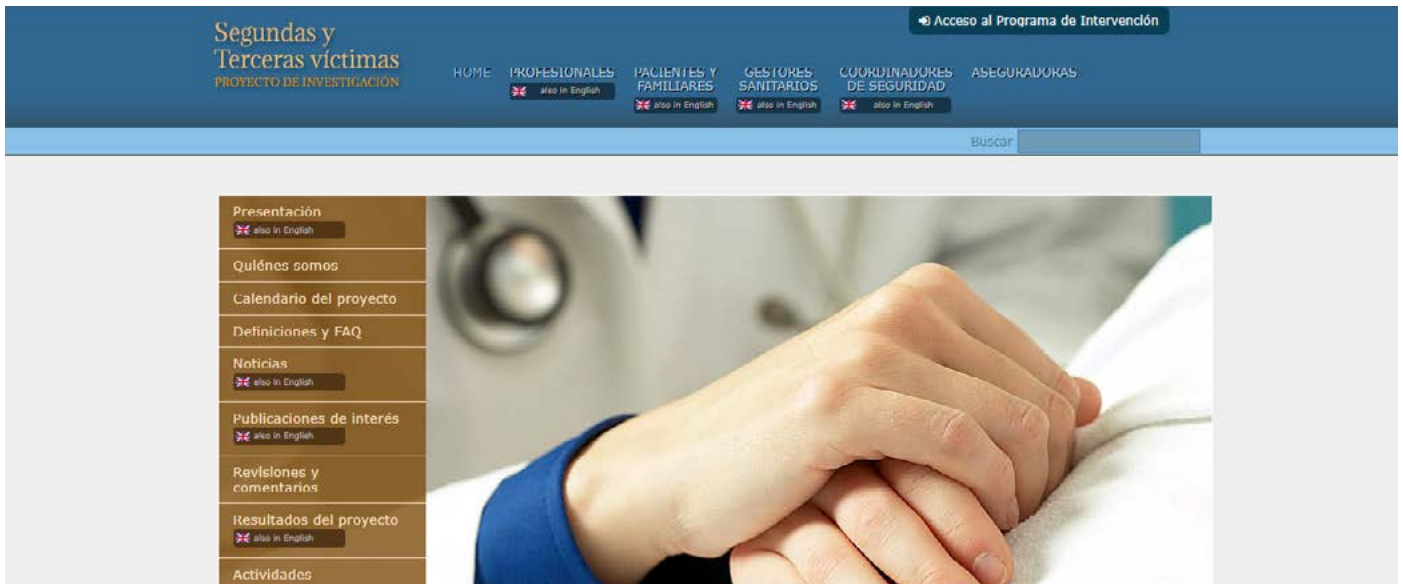


IMAGE 13. MISE website.

MISE (Mitigating Impact in Second Victims)¹² is a structured programme developed to prevent and mitigate the emotional and professional consequences experienced by healthcare providers involved in distressing clinical events. Its goal is to provide proactive, early-stage support, reducing the risk of escalation into burnout, disengagement, or professional abandonment.

KEY OBJECTIVES OF MISE:

- Raise awareness of the second victim phenomenon within healthcare teams.
- Reduce stigma associated with clinical errors or adverse events.
- Promote early identification of professionals at risk of emotional distress.
- Provide structured, peer-based support before symptoms escalate.
- Preserve clinical performance and team cohesion following critical incidents.

CORE COMPONENTS:

Awareness and Training. MISE emphasizes the importance of sensitizing all staff—including non-clinical personnel—about the second victim phenomenon. Through targeted training, it equips teams with the tools to detect early signs of distress among peers and respond constructively.

PEER-SUPPORT NETWORK:

The programme establishes a team of trained peer responders—professionals from within the institution who can offer immediate, confidential, and empathetic support. These responders are trained in active listening, emotional triage, and escalation protocols.

European Initiatives

MISE (Mitigating Impact in Second Victims) - Spain

ORGANISATIONAL INTEGRATION:

The programme is designed to be fully embedded in hospital risk management and quality systems, ensuring coordination between support services, human resources, occupational health, and patient safety teams.

MONITORING AND EVALUATION:

MISE encourages institutions to track the impact of peer-support actions, both in terms of professional recovery and clinical risk reduction, contributing to a culture of learning and continuous improvement.

PREVENTION AND EARLY CONTAINMENT:

Unlike reactive interventions that respond after symptoms have progressed, MISE is built around the principle of early containment. It recognises that the first hours and days following an adverse event are crucial. Timely support during this period can prevent the internalization of guilt, fear, or shame, which are core triggers of long-term distress.

European Initiatives

UZ Leuven Second Victim Support Programme - Belgium

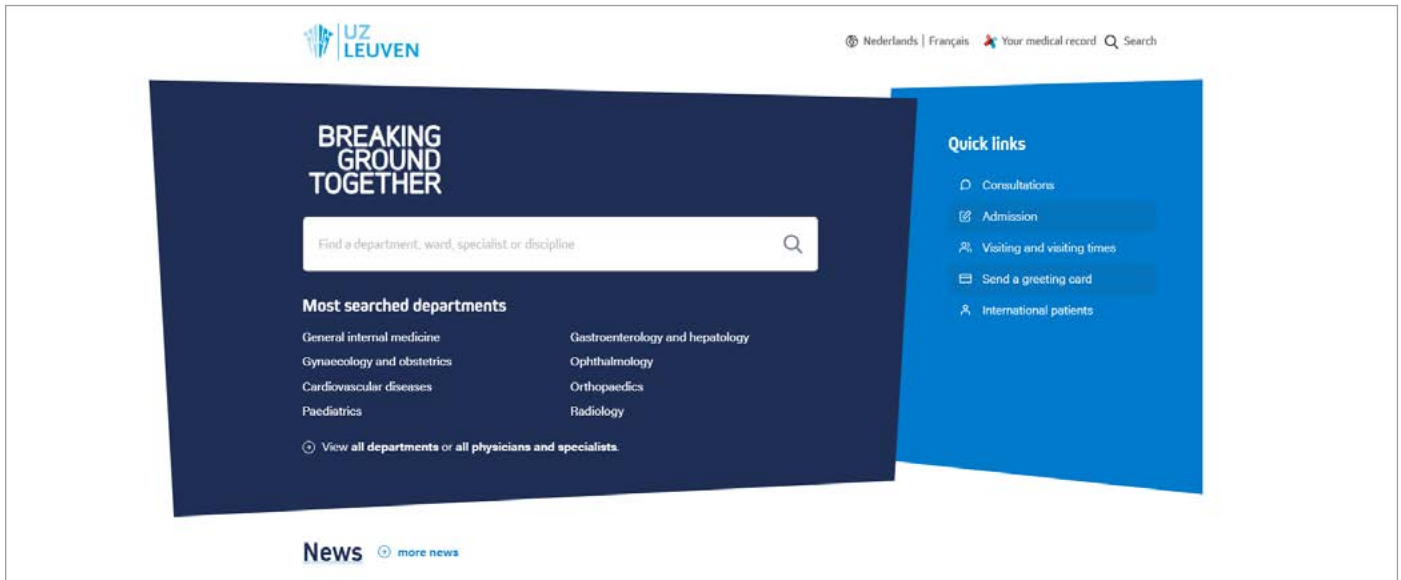


IMAGE 14. UZ Leuven website. (www.uzleuven.be/en)

The UZ Leuven Second Victim Support Programme is a structured institutional initiative developed at University Hospitals Leuven, Belgium, designed to identify, support, and accompany healthcare professionals who experience emotional distress following adverse events, unexpected clinical outcomes, or emotionally taxing patient interactions. It is a tiered and proactive institutional response.

The programme is built on a multi-level model, aligned with the principles of just culture and organisational resilience, and has been recognised as a best practice within the European ERNST network.

KEY OBJECTIVES:

- To ensure that no professional affected by a clinical incident is left unsupported.
- To embed emotional safety and recovery mechanisms into the hospital's patient safety strategy core.
- To promote peer solidarity, openness, and system learning after distressing events.

CORE ELEMENTS:

Tiered Support Model UZ Leuven adopts a three-level response framework, similar to that of ForYOU but adapted to the Belgian context:

- Tier 1: Immediate collegial support – Informal conversations and emotional first aid offered by team members or supervisors.
- Tier 2: Peer supporter intervention – Involvement of trained second victim responders, available across clinical departments, offering structured and confidential peer support.
- Tier 3: Professional help – Referral to institutional resources such as psychologists, occupational health services, or external mental health professionals when needed.

European Initiatives

UZ Leuven Second Victim Support Programme - Belgium

SECOND VICTIM RESPONDERS NETWORK:

The hospital has developed a network of trained peer supporters across departments, who serve as the first structured point of contact. These responders are trained in:

- Active listening and emotional triage.
- Recognising signs of distress.
- Supporting colleagues without judgment.
- Knowing when-how escalate to professional care.

INTEGRATION WITH RISK AND QUALITY SYSTEMS:

The programme is formally embedded within UZ Leuven's risk management and quality improvement structures, ensuring alignment between emotional support, patient safety learning, and system improvement.

AWARENESS AND PREVENTION:

In addition to post-incident support, the programme includes ongoing awareness-raising activities, debriefing tools for teams, and training sessions on resilience, second victim awareness, and just culture.

ANONYMITY AND ACCESSIBILITY:

Support is designed to be easily accessible, confidential, and stigma-free, with clear communication about how and when to request help.

The programme has contributed to an improved culture of psychological safety and incident reporting, enabling system learning and personal recovery to co-exist.

European Initiatives

The Buddy Programme - Denmark



IMAGE 15. Odense University Hospital (OUH). Denmark.

The Buddy Programme (A Peer-Support Model for Early Emotional Response in Healthcare)¹³, developed and implemented in Denmark, is an institutional peer-support initiative aimed at providing immediate emotional and psychological support to healthcare professionals involved in stressful or traumatic clinical events.

It is based on the principle of early, informal, and collegial support, embedded within daily clinical practice.

CORE OBJECTIVES:

- Ensure that no healthcare professional is left alone following a traumatic or adverse event.
- Normalise emotional responses to clinical stress, reduce stigma, and foster psychological safety within teams.

- Provide low-threshold and easily accessible support that requires no formal reporting or referral. Embedded in team culture and daily practice, rather than functioning as an external intervention.

The programme offers peer support through a formalised buddy system and includes a mandatory seminar on second victims and collegial support.

FIVE CORE PRINCIPLES OF PEER SUPPORT IN THE BUDDY PROJECT

1 • Recognition of exposure to adverse or traumatic events as an inherent condition in healthcare.

The prevention of errors and adverse events is essential, but we must also address their consequences when they occur. Healthcare professionals operate within complex systems, where the risk of serious incidents will always be present.

European Initiatives

The Buddy Programme - Denmark

2 • Organisational Responsibility Towards All Staff – Every Time.

Support following an unintended event must not be arbitrary or dependent on the judgement of individual managers. All staff should have access to assistance.

3 • Relationships are of central importance.

Many second victims experience guilt and uncertainty, which they may only wish to share within a safe and trusted relationship. For this reason, healthcare personnel should be able to choose a buddy of their own preference.

4 • Utilisation of Existing Resources.

Healthcare professionals are trained to care for individuals in crisis, and the necessary resources to provide peer support are therefore already present within the organisation.

5 • Research-based evaluation of the intervention.

The programme was designed as a research intervention in order to contribute to the evidence base on what works best in practice.

HOW THE BUDDY PROGRAMME WORKS

The programme consists of three components:

- A mandatory 2-hour seminar.
- Self-selected appointment of two buddies.
- A system for activating buddy support.

Seminar content:

- Knowledge about second victims and common reactions.
- Guidance on identifying support needs in oneself and others.
- Examples of how to support a colleague and when to refer for additional help.

The buddy system:

- After the seminar, each participant selects two colleagues to act as their buddies.
- If a staff member wishes to receive support, a buddy can be activated – by the individual, a colleague, or a manager.
- The buddy contacts the staff member within 24 hours and commits to providing two hours of conversation time over a four-week period.
- Support conversations take place outside of working hours, and the buddy is compensated for the two hours of support.

European Initiatives

The Buddy Programme - Denmark

High Acceptance and Accessibility

The Buddy Programme has been well received by healthcare staff, who value its simplicity, confidentiality, and immediacy.

It requires minimal infrastructure and is easily implemented across settings.

Strengthening Team Cohesion

By providing early peer support, the programme helps prevent escalation of distress and fosters a sense of solidarity within clinical teams.

Culture Change and Compassion

Seminars have contributed to a more open and compassionate workplace culture, encouraging reflection and emotional awareness among staff.

Part of a Broader Organisational Strategy

While effective on its own terms, the programme must be embedded in a wider organisational approach to psychological safety and continuous learning.

European Initiatives

KoHi - Austria



IMAGE 16. Klinik Hietzing. Vienna.

KoHi, short for *Kollegiale Hilfe*¹⁴ (“Collegial Help”), is a structured peer-support programme developed in Austria to provide early emotional and psychological assistance to healthcare professionals following critical incidents.

The initiative is grounded in the principles of just culture, emotional safety, and institutional responsibility, and is currently implemented across several Austrian hospitals and healthcare institutions.

PROGRAMME OBJECTIVES:

- To offer immediate and confidential emotional support after clinical events with high emotional impact.
- To break the cycle of isolation, guilt, and fear often experienced by second victims.
- To integrate emotional safety into existing patient safety and risk management systems.

MAIN COMPONENTS:

Peer Support Teams. KoHi relies on designated and trained peer supporters, typically clinicians or nurses with experience and credibility within their institution. These individuals are trained to offer structured emotional first aid, facilitate reflection, and guide colleagues toward appropriate follow-up resources if necessary.

Structured Activation Pathways. The programme includes clear protocols for activating KoHi support after an adverse or stressful event, either through self-referral, team leader referral, or automated triggering following incident reports.

Training and Certification. Peer supporters receive standardised training in communication, emotional support, stress reactions, and boundary setting. In many hospitals, certification is required and monitored by the institutional quality or risk management department.

European Initiatives

KoHi - Austria

Integration into Hospital Systems. KoHi is formally integrated into hospital governance structures, including risk management, occupational health, and quality assurance. It is viewed as an essential element of a safe care environment—not an optional or informal add-on.

Confidentiality and Low Barrier Access. Professionals accessing KoHi support can do so without fear of judgment or disclosure, and no formal documentation is required unless requested by the individual.

NOTABLE STRENGTHS:

- **Strong institutional alignment:** KoHi is designed to work in tandem with reporting systems, legal advice, and human resources support structures.
- **Focus on sustainability:** The programme is embedded in the hospital's quality and safety culture, ensuring continuity and long-term impact.
- **Scalability:** Though developed locally, KoHi has been adapted for use in both large urban hospitals and smaller regional centres.

European Initiatives

The following table summarises these examples of second victims support interventions.

Comparative Overview of Second Victim Support Programmes:

PROGRAMME	KEY FEATURES	TARGET AUDIENCE	NOTABLE STRENGTHS
<i>MISE (Mitigating Impact in Second Victims)</i>	Early detection-response, peer support network, integration with risk systems, training all staff	All healthcare professionals	Prevention-focused, strong institutional integration, early intervention model
<i>ForYOU (University of Missouri Healthcare)</i>	Three-tiered support system: informal, peer responder, professional referral	Healthcare workers exposed to traumatic or adverse events	Structured, scalable, evaluated positively by staff
<i>RISE (Resilience In Stressful Events, Johns Hopkins)</i>	24/7 peer response, confidential debriefing, resilience focus	Staff involved in emotionally challenging patient events	Immediate support, strong accessibility, resilience-driven
<i>Buddy Programme (Denmark)</i>	Pre-assigned peer contacts, informal emotional check-ins, early debriefing	All clinical staff (especially frontline teams)	Low-threshold, team-based, normalizes emotional reactions
<i>KoHi (Kollegiale Hilfe, Austria)</i>	Trained peer supporters, activation protocols, institutional integration	Clinical staff across Austrian hospitals	Strong systemic alignment, confidentiality, formal peer training
<i>UZ Leuven Programme (Belgium)</i>	Three-tiered model, trained peer responders, integrated with patient safety systems	Medical and nursing staff at UZ Leuven	High engagement, leadership commitment, formalized process

TABLE 3. Comparative overview of second victim support programmes. Created by the authors.

Recommendations for Designing Second Victim Support Interventions

Designing effective Support Programmes for second victims requires a comprehensive and systemic approach. Based on recent evidence and expert consensus provided by the ERNST, the following recommendations offer a framework that is both evidence-based and adaptable to diverse healthcare settings across Europe.

1. PROGRAMME OBJECTIVES

The primary goal of any second victim support programme must be to alleviate the emotional and physical distress experienced by healthcare professionals involved in adverse or traumatic clinical events. These programmes should not only focus on psychological containment but also aim to:

- Reduce the likelihood of repeated errors, by helping professionals regain focus and confidence.
- Minimise institutional exposure to legal claims, which may arise when distress is left unaddressed.
- Prevent burnout and long-term psychological harm.
- Ultimately, these initiatives contribute to enhancing psychological safety in the workplace and improving the quality of care delivered by emotionally supported teams.

2. ORGANISATIONAL APPROACH

Support for second victims should be embedded within the strategic priorities of healthcare institutions, particularly in occupational health, quality management, and patient safety domains. Rather than being framed as optional or secondary, emotional support must be:

- Formally institutionalized as a standard element of staff well-being policy.
- Recognised as a professional right, particularly in environments that value accountability and learning.
- Framed within a just culture that distinguishes honest mistakes from misconduct and promotes compassion over blame.

This organisational anchoring ensures sustainability, legitimacy, and alignment with broader safety and human resource strategies.

3. RECOMMENDED MODEL OF INTERVENTION

Evidence strongly supports the use of peer support as the cornerstone of second victim interventions. Programmes should be designed to:

- Offer tiered levels of support, beginning with informal emotional first aid and escalating, when needed, to professional psychological care.
- Operate on a 24/7 basis, particularly in acute care settings, ensuring timely response after critical incidents.

Peer support is widely preferred by healthcare workers due to its accessibility, trustworthiness, and low threshold for activation. It is also economically sustainable and relatively simple to scale across departments and institutions.

Recommendations for Designing Second Victim Support Interventions

4. TARGET POPULATION

Support Programmes must be inclusive and comprehensive, available to:

- All healthcare professionals, regardless of their role, clinical specialty, or level of seniority.
- Non-clinical personnel, such as administrative or technical staff, who may also be exposed to emotionally disturbing events.
- Students, trainees, and residents, who often experience second victim symptoms but face barriers to seeking help due to hierarchy or fear of stigma.

Particular attention should be given to structurally vulnerable groups, whose limited job security or training status may increase their emotional risk and reduce their access to informal support.

5. OPERATIONAL SUPPORT

For these programmes to be effective in practice, institutions must ensure that support is:

- Easy to access, with activation pathways that include self-referral, peer observation, or supervisor notification, as well as integration with incident reporting systems.
- Visible and well-communicated, through posters, internal communications, onboarding materials, and leadership endorsement.
- Supported by continuous monitoring and evaluation, assessing effectiveness, reach, and cost-efficiency, while incorporating feedback from users and staff.

These operational supports guarantee that peer response systems are not only available, but used, and continuously improved.

6. PEER SUPPORTER TRAINING AND PROFILE

Peer responders are central to the success of second victim interventions. Their role requires:

- Specific training in emotional first aid, active listening, confidentiality, and identification of cases that require escalation.
- Ideally, lived experience as second victims themselves, enhancing empathy and credibility.
- Coordination with mental health professionals for cases requiring clinical intervention or long-term support.

The selection, preparation, and ongoing supervision of peer supporters should follow standardised procedures, ensuring consistency and ethical rigour.

7. SUPPORT FOR REINTEGRATION

An often-overlooked dimension of second victim care is safe reintegration into the workplace. Institutions should:

- Establish clear, compassionate pathways for returning to clinical duties after leave related to emotional trauma.
- Support staff with follow-up conversations, flexible scheduling, or gradual return options, when appropriate.

Recommendations for Designing Second Victim Support Interventions

- Promote a culture in which emotional vulnerability is recognised as a legitimate and human response, rather than a weakness.

This approach reduces the risk of chronic distress, disengagement, or recurrence of the traumatic experience.

8. PATIENT AND FAMILY INVOLVEMENT

Second victim support should also be connected to broader communication practices, particularly those involving patients and families affected by adverse events. Where relevant, programmes should:

- Ensure alignment with institutional disclosure protocols.
- Offer emotional guidance to professionals during patient or family communication.
- Consider providing support to families themselves, particularly in cases of serious harm or death.

This integrative approach reflects the shared human impact of adverse events and reinforces trust in the healthcare system.

ERNST underscores that Support Programmes for second victims are not a luxury, but a strategic necessity for health systems committed to quality, safety, and workforce sustainability. Their implementation leads to:

- Fewer repeated errors and lower incidence of defensive medicine.
- Greater psychological resilience and team solidarity.
- Reduced staff turnover, absenteeism, and associated costs.

- A stronger, more compassionate organisational culture aligned with the principles of just culture.

While these programmes may draw inspiration from models such as RISE (Johns Hopkins) or ForYOU (University of Missouri), their success in Europe depends on thoughtful adaptation to legal, cultural, and institutional contexts.

In summary, while substantial progress has been made in developing structured support interventions for second victims, their implementation remains uneven across healthcare systems. Pioneering programmes such as ForYOU and RISE have demonstrated the value of peer support and institutional engagement through well-defined, tiered response models. However, many organisations still lack clear guidance on how to initiate, structure, and sustain these types of interventions.

In Europe, a growing number of second victim support initiatives have been launched in diverse contexts, reflecting differences in labour regulations, organisational structures, and cultural norms. Despite this variability, these programmes share a common foundation built on recognition, training, peer support, system integration, and continuous evaluation. This diversity of approaches enriches the field and enables mutual learning between institutions and countries, facilitating more widespread and context-sensitive implementation.

At the same time, there has been a notable increase in requests for practical frameworks and technical assistance to launch Support Programmes, particularly in environments under growing emotional and operational pressure. Interest in second victim support now extends beyond hospitals to include primary care, emergency services, and long-term care settings such as nursing homes—where the emotional impact of adverse events is increasingly recognised as similar to that observed in hospital environments.

Recommendations for Designing Second Victim Support Interventions

This need has become even more pressing in the post-COVID era, where the psychological toll on healthcare professionals has revealed the limits of existing institutional resilience. In this context, there is a clear imperative to move beyond isolated initiatives and towards coordinated, high-quality support systems.

Certification emerges as a critical tool to meet this challenge. By establishing a set of validated standards and benchmarks, certification allows organisations to align their interventions with best practices, monitor progress, and reinforce their institutional commitment to staff well-being. Furthermore, it ensures that second victim support becomes a reliable and measurable component of quality and safety systems—benefiting not only affected professionals, but also the overall functioning and sustainability of healthcare services.

Practical Implications

The evidence gathered from scientific literature, institutional experiences, and the recommendations of networks such as ERNST clearly demonstrate that the second victim phenomenon must be recognised as a strategic priority. Addressing it requires ethical sensitivity, political will, organisational commitment, and structured planning.

Europe cannot afford to ignore this everyday reality in health and social care settings. It cannot afford to lose those who care for others. Failing to address the suffering of second victims means neglecting a critical component of the system: the emotional well-being of healthcare professionals, while simultaneously placing patients at greater risk. Addressing the second victim phenomenon requires translating evidence and consensus into concrete institutional action. First and foremost, healthcare organisations should formally recognise second victims as an occupational risk category and incorporate this recognition into their strategies for clinical risk management, occupational health, and patient safety. Promoting a just culture—one that balances accountability with learning—is essential to creating emotionally safe environments where professionals feel supported rather than blamed. To that end, institutions should establish formal psychological and emotional support networks and ensure that targeted training on second victim dynamics is integrated into continuous professional development programmes.

In practical terms, implementation involves setting up internal response teams composed of trained staff members capable of providing immediate support. Clear post-incident protocols should be developed, guaranteeing confidential access to help resources and ensuring that affected professionals are not excluded but rather included in safety discussions and review processes. Awareness campaigns can foster institutional sensitivity, while evaluation systems—based on both process and outcome indicators—can monitor effectiveness and promote continuous improvement.

Cross-institutional and cross-national collaboration is also essential to develop and adopt common standards for training, evaluation, and intervention. A key component of a comprehensive response is the practice of open disclosure. Ethically and emotionally, informing patients and families after an adverse event is fundamental—not only to ensure transparency and trust, but also to support the recovery of the involved professionals. When practiced within a just culture and supported by appropriate training and structures, open disclosure contributes to emotional resolution, reduces litigation, and strengthens the safety culture of the organisation. ERNST recommends embedding open disclosure into institutional frameworks as part of a broader commitment to second victim support and learning-oriented systems.

WHY SHOULD EUROPE BE CONCERNED?

The second victim phenomenon must be addressed at the European level because of its broad and serious implications. First, it compromises patient safety: emotionally affected professionals may enter a cycle of stress, insecurity, and defensive practice that increases the likelihood of new errors. Second, it contributes to workforce attrition: unaddressed emotional exhaustion leads to absenteeism, internal rotations, and even professional abandonment—at a time when Europe faces critical shortages in the health and care workforce. Third, the phenomenon generates a significant economic burden.

According to the ERNST Policy Statement (2024), preventable adverse events represent between €17 and €38 billion in annual costs across Europe, with up to 15% of hospital expenditure directly linked to such events. Many of these incidents could be prevented or better managed by investing in emotional support for professionals. Finally, cost-effective solutions already exist. Peer-Support Programmes implemented in multiple countries have proven to be effective, well-accepted by staff, and financially sustainable—offering potential savings of up to €1 million per hospital per year.

Practical Implications



IMAGE 17. Healthcare workers' planning.

WHAT DOES ERNST PROPOSE?

The European Researchers' Network on Second Victims (ERNST) has developed a rigorous, consensus-based proposal to support action at both national and European levels. This includes:

- Political recognition of the second victim phenomenon as part of patient safety and workforce well-being strategies.
- Implementation of evidence-based support interventions, such as multi-level peer support models adapted to the severity of each case.
- Awareness-raising and training to reduce stigma around error and promote a just, transparent culture.
- Review of legal frameworks, ensuring protection for professionals in the context of unintentional human error—mirroring practices already used in sectors like aviation.

- Smart investment focused on prevention, staff retention, and reducing the social and economic costs associated with unaddressed emotional harm.

WHAT CAN EUROPE DO?

- Incorporate the second victim phenomenon into public health, patient safety, and occupational mental health policies.
- Provide funding to pilot emotional support models in national and regional health systems.
- Promote the adoption of shared European standards for training, certification, and evaluation of second victim interventions.
- Develop and support non-punitive regulatory frameworks that turn honest errors into opportunities for learning and systemic improvement.

In the aftermath of the COVID-19 crisis, which further intensified the emotional demands on healthcare staff, the need for action is clearer than ever. The second victim phenomenon is not just a personal matter—it is a systemic challenge.

Building on the pioneering work of ERNST, we now have a unique opportunity to move towards more human, resilient, and safer healthcare systems. This is a matter of political responsibility, organisational justice, and efficient use of public resources. In this context, the RESCUE Initiative emerges as a strategic European response to an urgent need: to establish shared standards, institutional procedures, and specialised training to identify, support, and protect second victims across health and care systems.

For this reason, the certification system for second victim support interventions that we propose has been developed with the firm belief that it will contribute to the expansion and consolidation of these programmes across Europe.

From conceptual understanding to strategic action: the need for certification

The growing awareness of the second victim phenomenon and the institutional responses developed to address it have made substantial progress in recent years. However, this progress remains uneven and fragmented across countries and care settings.

While pioneering initiatives and evidence-based recommendations—such as those promoted by ERNST—have laid the groundwork for action, the lack of shared standards and external validation continues to limit the scale, quality, and sustainability of second victim support interventions. To move from isolated good practices to a coherent, Europe-wide strategy, a structured system for evaluating, guiding, and certifying these interventions is urgently needed.

In this context, the RESCUE certification system emerges as a comprehensive response: a set of validated standards and procedures designed to ensure that second victim Support Programmes are ethically grounded, professionally robust, and consistently implemented across healthcare and long-term care settings. The following section presents the structure, scope, and methodology of this certification framework, detailing how it supports institutions in aligning with best practices while promoting emotional safety, professional resilience, and overall quality of care.

The RESCUE certification standards were developed through a multidisciplinary, international consensus process involving a wide group of experts. These experts collaborated to identify and agree on critical aspects related to the second victim phenomenon and the most effective ways to respond to it, considering available evidence, practical experience, and relevant regulations.

Since October 2024, both online and in-person meetings have been held to refine these standards,

with key milestones reached during the meetings in Lisbon and Krakow. In these sessions, the initial draft of the standards was consolidated, and following several pilot tests in different countries, the results were reviewed in Krakow, leading to the finalization of the most appropriate standards.

The outcome of this process is presented here:

RESCUE CERTIFICATION STANDARDS FOR SECOND VICTIMS SUPPORT

RESCUE Certification Standards for Second Victims Support include two complementary certification systems: the certification system for second victim support interventions (RESCUE-Intervention) and the certification system for training peer supporters (RESCUE-Training). They have been designed to be applied in hospitals, primary care, and long-term care settings, including nursing homes and social-health-care centers.

RESCUE is the result of the work conducted by the European Researchers' Network on Second Victims (ERNST), funded by the European Cooperation in Science and Technology (COST), and validated in practice through the Innovative Grant IG19113, also funded by COST. As a general rule, the audit covers actions designed or implemented over the past three years. The certification remains valid for a period of three years, after which institutions wishing to maintain their certification must apply for renewal.

The RESCUE Certification Standards incorporate both Elementary and Advanced standards.

Certification is granted if all CORE standards are met and at least 75% of the standards are fulfilled. Partial compliance applies to cases where the un-

From conceptual understanding to strategic action: the need for certification

met or incomplete elements are minor and do not compromise the overall purpose or objectives of the standard. The support application's algorithm on the RESCUE platform facilitates the correct implementation of this instruction.

PROCEDURE FOR APPLYING FOR RESCUE CERTIFICATION

How and When to Apply for Certification:

Institutions seeking RESCUE certification may submit their application at any time through the RESCUE platform (<https://cost-RESCUE.eu>).

To initiate the process, the institution must designate a local certification coordinator or promoter who will serve as the primary point of contact with the ERNST Consortium and the assigned auditors. The application must include the results of the self-assessment (accessible via the self-assessment tool on the RESCUE website).

The candidate must indicate whether the institution trains its own peer supporters, relies on external peer supporters, or is exclusively focused on training peer supporters.

By submitting the application, the institution agrees to the terms of the certification procedure. The decision issued by the RESCUE Core Group will be final and non-appealable.

Within 20 days of submission, the promoter will be informed whether the initial certification requirements are met and will receive a proposed list of auditors. The promoter will have 10 days to challenge the proposed auditors in case of incompatibility. Once the audit team is confirmed, the evaluation date will

be scheduled, including an on-site visit to the institution in all cases.

At least 7 days in advance, the audit team will provide the visit agenda and specify any additional documentation required.

Only certified institutions will be listed on the RESCUE website. Applications will not be made public or recorded on open platforms.

Audit Panel:

RESCUE maintains a panel of auditors who have completed specific training as RESCUE auditors.

Auditors operate with full independence and strict confidentiality in accordance with the RESCUE Code of Ethical Conduct (available at <https://cost-RESCUE.eu>).

Audit Process:

The audit takes a maximum of one and a half days. The agenda includes:

- Review of work schedules.
- Examination of required documentation.
- Scheduled interviews with the promoter, the support team, managers, peer supporters, and other relevant groups.

Under no circumstances will interviews be conducted with second victims.

Within 20 days of the audit, the audit team will provide the promoter with provisional report of the audit results. The promoter will have 10 days to submit any objections. The audit team will then have 20 days

From conceptual understanding to strategic action: the need for certification

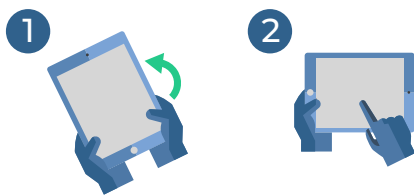
to submit its final report to the RESCUE Core Group, which will issue a final and non-appealable decision. In this case, the members of the Core Group affected by a conflict of interest should abstain from the decision. Starting in January 2026, an Audit Committee will be appointed, which will take over this function, replacing the RESCUE Core Group.

If partial certification is granted, the promoter will have up to 6 months to implement improvements and reapply. If certification is denied, the institution may not reapply for one year.

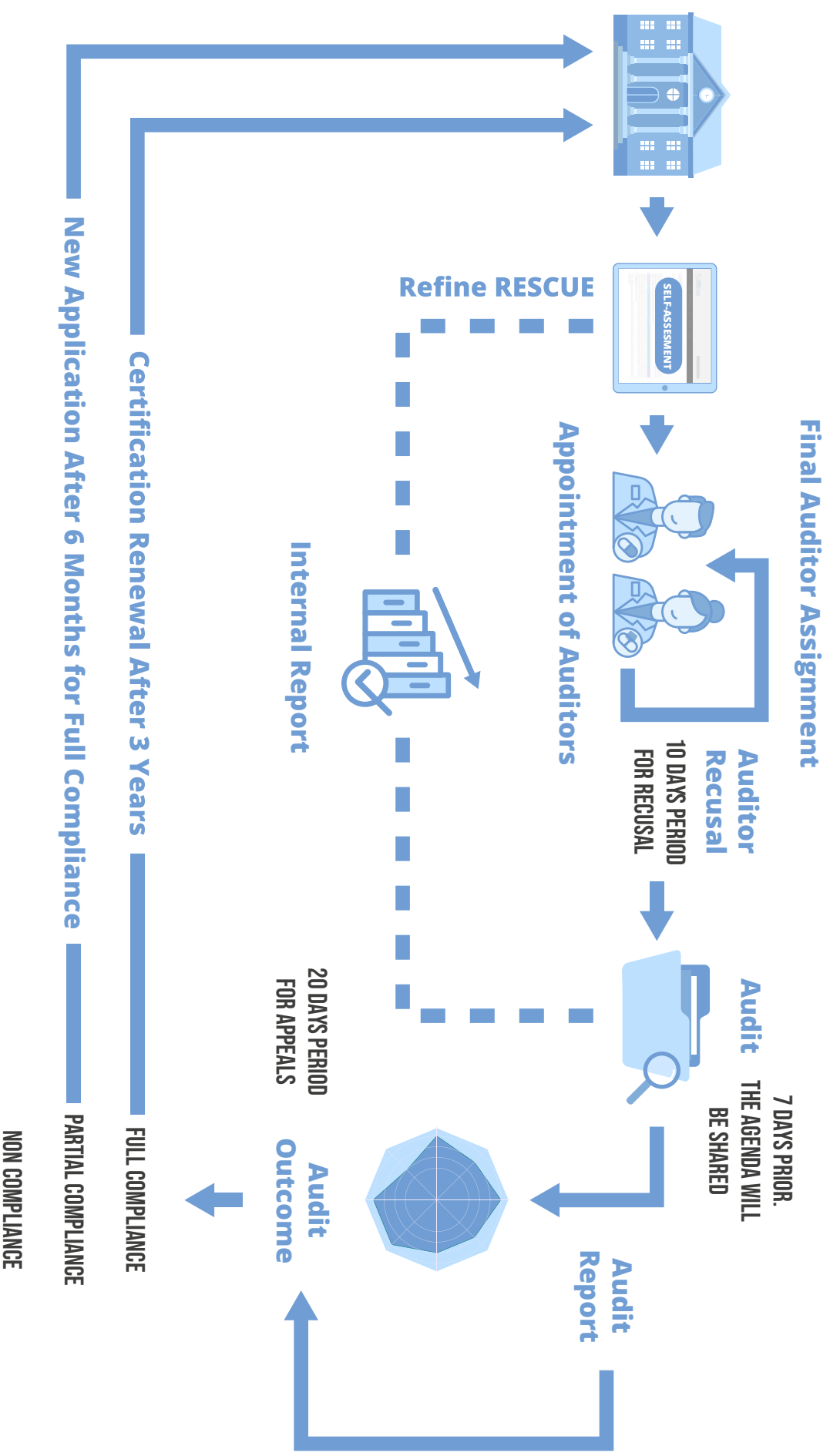
Procedure Costs:

Until October 31, 2025, all costs associated with the audits will be covered by the Innovative Grant 19113, funded by COST (European Cooperation in Science and Technology).

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From Conceptual understanding to strategic action: the need for certification



From conceptual understanding to strategic action: the need for certification

RESCUE Certification Standards for Peer Supporter Training

SCOPE

RESCUE-Training encompasses the design, structure, orientation, methodologies, training, evaluation, and continuous improvement of training programmes for Peer Supporters involved in Second Victim Support Interventions. This certification provides institutions with a structured framework to ensure the quality of their Second Victim Support Interventions through well-trained personnel and robust organisational practices. [RESCUE-Training is aligned with ERNST's definition of second victims.](#)¹⁵

This certification adopts the [ERNST Five-Level Framework for Second Victim Support](#)¹⁶, and aligns with the principles and foundational statements declared by ERNST to effectively address the [Second Victim Phenomenon](#)¹⁷.

This certification is designed for institutions that implement Second Victim Support Interventions based on trained Peer Support, an approach that has proven to be acceptable to professionals and effective in reducing recovery time for Second Victims while enhancing resilience in managing stressful situations inherent to health and care practice. It is also intended for other institutions that provide training programmes for individuals who assume the role of peer supporters, working in collaboration with health and care organisations, professional associations, or other entities to ensure an appropriate and proportional response to the needs of Second Victims.

By setting clear criteria, this certification enables institutions to ensure that Peer Supporters are thoroughly prepared to deliver effective, ethical, and high-quality assistance to Second Victims. This frame

work fosters recovery and resilience while promoting safer and more supportive environments for patient care professionals. It applies to various settings, including hospitals, primary care facilities, and long-term care settings, comprising nursing homes and social-healthcare centers.

RESCUE-Training Certification consists of 11 standards: two are CORE (mandatory) and 9 non-CORE).

PROCEDURE

The candidate designates a contact person responsible for submitting the application on behalf of the institution. This individual conducts a self-assessment to determine the institution's positioning within the certification system. Once the institution is deemed ready to apply for certification at either level, the application is submitted. To complete the application, the candidate must upload the self-assessment results and supporting evidence demonstrating compliance with each standard on the platform.

The auditor reviews the institution's self-assessment results, verifies the supporting documentation, and proceeds with the evaluation. The entire process is conducted on the RESCUE platform. The self-assessment and audit cover actions that were designed or implemented within the past three years.

From conceptual understanding to strategic action: the need for certification

RESCUE Certification Standards for Peer Supporter Training

The auditor will use the following scale to determine the degree of compliance with the standard in both cases.

1. Full Compliance (FC). The standard is fully met.

- Example: All peer supporters have completed the required training. The institution has maintained detailed records for each peer supporter on the panel, updated as of February 1, 2025.

2. Partial Compliance (PC). The standard is partially met, but some elements are incomplete or missing. This does not apply to CORE standards, which only allow for FC.

Partial compliance refers to cases where the unmet or incomplete elements are minor and do not compromise the overall purpose or objectives of the standard. The total number of partially compliant standards must not exceed 2 out of the 9 required.

The support application's algorithm facilitates the correct implementation of this instruction.

- Example: The institution has offered the required training, but only 70% of peer supporters have completed it, or there is no record confirming they finished all training modules.

3. Non-Compliance (NC). The standard is not met.

- Example: Training sessions were conducted, but there are no assessments of these activities, and no up-to-date records of which peer supporters were actually trained.

Certification is granted if all CORE standards are met and at least 8 out of 9 non-CORE standards are in compliance (with a maximum of 2 partially compliant standards permitted). Failure to comply with a CORE standard means that the Peer Supporters Training Program cannot be certified at this time.

From conceptual understanding to strategic action: the need for certification

RESCUE Certification Standards for Second Victims Support Interventions (RESCUE-Intervention)

RESCUE - Second Victims Support Intervention Standards			
No.*	NAME	CORE	Non-CORE
REST01	Comprehensive Training Framework		
REST02	Peer training sessions with adequate duration		
REST03	Methodological diversity for effective learning		
REST04	Theory-Practice Balance for Peer Supporters Training		
REST05	Instructors Qualifications and Experience		
REST06	Understanding the Second Victim Phenomenon		
REST07	Ethics and Confidentiality		
REST08	Effective Communication Skills		

From conceptual understanding to strategic action: the need for certification

RESCUE Certification Standards for Second Victims Support Interventions (RESCUE-Intervention)

RESCUE - Second Victims Support Intervention Standards			
No.*	NAME	CORE	Non-CORE
REST09	Resilience Building		
REST10	Competency Certification upon Training Completion		
REST11	Ensuring Quality of Peer Supporter Training		

Certification is granted if all CORE standards are met and at least 8 out of 9 non-CORE standards comply (with a maximum of 2 partially compliant standards permitted). * REST: RESCUE-Training + number

From conceptual understanding to strategic action: the need for certification

RESCUE Certification Standards for Peer Supporter Training

RESCUE - Peer Supporters Training Standards		
No.*	NAME	STANDARD
REST01	Comprehensive Training Framework	Learning objectives, structured training content, teaching methods and schedule are outlined. Trainees are familiar with them before the training begins.
SOURCE		
Description of the learning and teaching methods of the course, training plan, date of dissemination.		
No.*	NAME	STANDARD
REST02 (CORE)	Peer training sessions with adequate duration	The minimum dedicated training time complies with national regulations or recommendations. In absence of any national regulation or recommendation, the minimum acceptable duration of peer supporters training is four hours (240 minutes). Training must be conducted either in-person and/or through synchronous online sessions.
SOURCE		
Programs, minutes or reports describing the training received		

From conceptual understanding to strategic action: the need for certification

RESCUE Certification Standards for Peer Supporter Training

RESCUE - Peer Supporters Training Standards		
No.*	NAME	STANDARD
REST03	Methodological diversity for effective learning	Different learning and teaching methods are used to address the training objectives, for each type of module, both theoretical and practical.
SOURCE		
Description of the learning and teaching methods of the course, activity plan, session records		
No.*	NAME	STANDARD
REST04	Theory-Practice Balance for Peer Supporters Training	At least one third of the training hours is dedicated to supervised practical sessions. Online delivery is acceptable, but its effectiveness must be measured and monitored.
SOURCE		
Course curriculum, record of practical and theoretical hours.		

From conceptual understanding to strategic action: the need for certification

RESCUE Certification Standards for Peer Supporter Training

RESCUE - Peer Supporters Training Standards		
REST05 (CORE)	Instructors Qualifications and Experience	Instructors have knowledge and teaching experience in the areas related to their module (e.g., Second Victim Phenomenon, Peer Support techniques such as Psychological First Aid, etc.).
SOURCE		
Instructors' experience (e.g., CV) and certificates (relevant to the specific module they are teaching).		
No.*	NAME	STANDARD
REST06	Understanding the Second Victim Phenomenon	Successful completion of training certification requires all Peer Supporters to demonstrate knowledge and understanding of the Second Victim Phenomenon, including its nature, phases, symptoms, and recovery trajectories.
SOURCE		
Course curriculum, record of practical and theoretical hours.		

From conceptual understanding to strategic action: the need for certification

RESCUE Certification Standards for Peer Supporter Training

RESCUE - Peer Supporters Training Standards

No.*	NAME	STANDARD
REST07	Ethics and Confidentiality	Successful completion of training certification requires all Peer Supporters are informed about the importance of endorsing the Code of Conduct for each Second Victim Support Intervention in which they participate.

SOURCE

Certificates obtained by Peer Supporters, validating their competency in these skills.

No.*	NAME	STANDARD
REST08	Effective Communication Skills	Successful completion of training certification requires all Peer Supporters to complete a training in effective communication skills which includes training in active and empathetic listening.

SOURCE

Certificates obtained by peer supporters, validating their competency in these skills.

From conceptual understanding to strategic action: the need for certification

RESCUE Certification Standards for Peer Supporter Training

RESCUE - Peer Supporters Training Standards		
No.*	NAME	STANDARD
REST09	Resilience Building	Successful completion of training certification requires all peer supporters to have formal training in resilience-building strategies, coping strategies, and basic emotional management skills.
SOURCE		
Certificates obtained by peer supporters, validating their competency in these skills.		
No.*	NAME	STANDARD
REST10	Competency Certification upon Training Completion	Participants receive a participation certificate to be sure than they have completed the training.
SOURCE		
Records of certificate issuance.		

From conceptual understanding to strategic action: the need for certification

RESCUE Certification Standards for Peer Supporter Training

RESCUE - Peer Supporters Training Standards		
No.*	NAME	STANDARD
REST11	Ensuring Quality of Peer Supporter Training	The training programme is reviewed at least every three years. Changes, or the decision to maintain the current approach, content, and trainers, are justified.
SOURCE		
Outline of the learning objectives and structured training content, annual assessment report, minutes of meetings, trainees' data, report of the review of the training programme.		

From conceptual understanding to strategic action: the need for certification

RESCUE Certification Standards for Second Victims Support Interventions (RESCUE-Intervention)

SCOPE

RESCUE-Intervention encompasses the design, orientation, structure, methodologies, training, implementation, procedures, evaluation, and continuous improvement of support interventions in healthcare and social-healthcare institutions to assist Second Victims, aligning with ERNST's definition of second victims¹⁹. This certification provides institutions with a structured framework to ensure the quality of their Second Victim Support Intervention through evidence-based measures and robust organisational practices, benefiting patients, professionals, and the institution itself in achieving its goals. This certification adopts the ERNST Five-Level Framework for Second Victim Support²⁰, and aligns with the principles and foundational statements declared by ERNST to effectively address the Second Victim Phenomenon²¹.

Moreover, implementing Second Victim Support Programmes has proven to be largely self-sustaining, as the direct cost savings from minimizing the impact on second victims and shortening their recovery process compensate for the required investment²².

By reducing the long-term consequences associated with highly stressful events inherent to daily health and care practice, these programmes not only enhance the well-being of professionals involved in patient care but also contribute to safer and more resilient healthcare environments, ultimately improving the quality of care and patient safety²³. By setting clear criteria and benchmarks, RESCUE-Intervention enables institutions to guarantee the adequacy of the Second Victim Support Interventions.

This framework fosters recovery and resilience while promoting safer and more supportive environments for health and care professionals.

When using this certification guide, the specific setting (hospitals, primary care facilities, or long-term care settings, including nursing homes and social-healthcare centers) must be selected, as the criteria may vary depending on the context.

This certification encompasses institutions that have designed their intervention, have firmly implemented support interventions, and completed at least one evaluation and improvement cycle.

RESCUE-Intervention Certification Standards are divided into two levels:

1. Elementary criteria (RIEL01 to RIEL17):

Establishes fundamental standards for implementing and executing the Second Victim Support Intervention. It includes institutional policies, staff education on the Second Victim Phenomenon, Codes of Conduct, Peer Supporter training, immediate emotional support, referral protocols, resource availability, and periodic policy reviews. It also promotes a culture of openness to reduce stigma and encourage seeking help.

2. Advanced criteria (RIAD01 to RIAD12):

Defines advanced standards, including institutional policies to enhance transparency, patient safety, and long-term sustainability.

From conceptual understanding to strategic action: the need for certification

RESCUE Certification Standards for Second Victims Support Interventions (RESCUE-Intervention)

It promotes Just Culture, prevention of emotional exhaustion of high-risk groups, specific support for residents and students, and non-permanent staff, comprehensive monitoring and evaluation systems to assess intervention effectiveness and guide continuous improvement, and collaboration frameworks with universities and training institutions to integrate Second Victim awareness into education

RESCUE-Intervention Certification consists of 30 standards: 17 elementary and 13 advanced. Of the elementary standards, five are CORE (mandatory) and 12 non-CORE. Overall, these standards ensure that interventions align with advancements and developments established by sector leaders, supporting recovery and fostering resilience to face future highly stressful events.

These standards result from a collaborative effort by an international team that is part of the Innovative Grant IG19113 funded by COST (<https://cost-RESCUE.eu>). They are designed to align with the principles on the Second Victim Phenomenon established by ERNST³.

The validity of this certification is three years. Before this period expires, institutions wishing to maintain RESCUE certification must apply for renewal.

PROCEDURE

The candidate designates a contact person responsible for submitting the application on behalf of the institution. This individual conducts a self-assessment to determine the institution's positioning within the

certification system. Once the institution is deemed ready to apply for certification at either level, the application is submitted. To complete the application, the candidate must upload the self-assessment results and supporting evidence demonstrating compliance with each standard on the platform. Institutions with their own peer supporter training programme will also be eligible for RESCUE certification of this programme, to ensure the suitability of their approach and practical implementation. Institutions that rely on external peer supporters must ensure that the qualifications of this personnel are appropriate and in accordance with the specified standards.

The auditor reviews the institution's self-assessment results, verifies the supporting documentation, and proceeds with the evaluation. The entire process is conducted on the RESCUE platform. The self-assessment and audit cover actions that were designed or implemented within the past three years.

There are two levels of certification.

- Elementary Certification: Covers standards classified as elementary.
- Advanced Certification: Includes additional standards classified as advanced. To obtain Advanced Certification, institutions must meet the criteria for Elementary Certification in addition to the advanced standards.

The auditor will use the following scale to determine the degree of compliance with the standard in both cases.

From conceptual understanding to strategic action: the need for certification

RESCUE Certification Standards for Second Victims Support Interventions (RESCUE-Intervention)

1. Full Compliance (FC). The standard is fully met.

- Example: The commitment to the Second Victim Support Intervention's Code of Conduct is signed by all peer supporters and the institution's leadership, when all of them have signed the Code of Conduct and this can be verified.

2. Partial Compliance (PC). The standard is partially met, but some elements are incomplete or missing.

This does not apply to CORE standards, which only allow for FC.

Partial compliance refers to cases where the unmet or incomplete elements are minor and do not compromise the overall purpose or objectives of the standard. None of the unmet elements are considered critical for the respective category (Elementary or Advanced Certification), and the total number of partially compliant standards must not exceed 3 out of the 13 required.

Furthermore, these elements must not prevent full compliance from being achieved within six months. The support application's algorithm facilitates the correct implementation of this instruction.

- Example: The commitment to the Second Victim Support Intervention's Code of Conduct is signed by all peer supporters and the institution's leadership, when at least 75% of them have signed the Code of Conduct and this can be verified.

3. Non-Compliance (NC). The standard is not met.

- Example: The commitment to the Second Victim Support Intervention's Code of Conduct is only signed by 55% of all peer supporters and the institution's leadership and this can be verified.

Elementary Certification is granted if all CORE standards are met and at least 11 out of 13 non-CORE standards are comply (with a maximum of 3 partially compliant standards permitted). Advanced Certification is granted if at least 11 out of 13 standards are fulfilled (also allowing a maximum of 3 partially compliant standards).

In cases where RIAD09 or RIAD10 do not apply, compliance with the standards is proportionally adjusted. Failure to comply with a CORE standard means that the intervention cannot be certified at this time.

From conceptual understanding to strategic action: the need for certification

RESCUE Certification Standards for Second Victims Support Interventions (RESCUE-Intervention)

RESCUE - Second Victims Support Intervention Standards					
No.*	NAME	CORE	Non-CORE	ELEMENTARY	ADVANCED
INSTITUTIONAL POLICIES					
RIEL01	Institutional Policy to Support Second Victims				
RIEL02	Systematic Actions to Prevent Recurrence of Clinical Errors or System Failures				
RIEL03	Top Management and Leaders Informed on Roles and Responsibilities Regarding Health and Care Workers' Safety				
RIAD01	Transparency of Patient Safety Incident Management and Protection of Patient Rights				
RIAD02	Safety Culture Based on Just Culture Principles				
RIAD03	Institutional Policy to Support Second Victims				

From conceptual understanding to strategic action: the need for certification

RESCUE Certification Standards for Second Victims Support Interventions (RESCUE-Intervention)

RESCUE - Second Victims Support Intervention Standards					
No.*	NAME	CORE	Non-CORE	ELEMENTARY	ADVANCED
SECOND VICTIM SUPPORT INTERVENTION					
RIEL04	Management & Coordination Team				
RIEL05	Interdepartmental Coordination for the Provision of Comprehensive Support to Second Victims is in Place				
RIEL06	Confidentiality of the Service				
RIEL07	Awareness of the Centre's Professionals on the Second Victim Phenomenon and Resources Available				
RIEL08	Ensure Support Availability by Trained Peer Supporters				
RIEL09	Appropriate Spaces for Second Victim Support and Meetings Provided by the Institution				
RIEL10	Referral of the Second Victim from Peer Support Team (level 3) to Specialised/ Structured Support (levels 4 and 5)				

From conceptual understanding to strategic action: the need for certification

RESCUE Certification Standards for Second Victims Support Interventions (RESCUE-Intervention)

RESCUE - Second Victims Support Intervention Standards					
No.*	NAME	CORE	Non-CORE	ELEMENTARY	ADVANCED
PEER SUPPORTERS					
RIEL12	A Diverse Range of Professionals is Part of the Team				
RIEL13	Second Victim Support Intervention Code of Conduct				
RIEL14	Engagement of Peer Supporters to Complete Initial Training and Subsequent Updates				
RIEL15	Referral Process and Resource Activation				
RIEL16	Institutional Training for Peer Supporters				
RIEL17	Peer Supporters Receiving Support (institutional mechanisms for support)				

Elementary Certification is granted if all CORE standards are met and at least 11 out of 13 non-CORE standards comply (with a maximum of 3 partially compliant standards permitted). Advanced Certification is granted if at least 11 out of 13 standards are fulfilled (also allowing a maximum of 3 partially compliant standards). In cases where RIAD09 or RIAD10 do not apply, compliance with the standards is proportionally adjusted. * RIEL: RESCUE-Interventions ELEMENTARY certification + number; RIAD: RESCUE-Interventions ADVANCED certification + number

From conceptual understanding to strategic action: the need for certification

RESCUE Certification Standards for Second Victims Support Interventions (RESCUE-Intervention)

RESCUE - Second Victims Support Intervention Standards					
No.*	NAME	CORE	Non-CORE	ELEMENTARY	ADVANCED
PEER SUPPORTERS					
RIAD11	Peer Supporters Receiving Support (self-reflection instrument after support encounters)				
RIAD12	Institutional Support for Peer Supporter Self-Care				
RIAD13	Peer Supporters Recognition				

Elementary Certification is granted if all CORE standards are met and at least 11 out of 13 non-CORE standards comply (with a maximum of 3 partially compliant standards permitted). Advanced Certification is granted if at least 11 out of 13 standards are fulfilled (also allowing a maximum of 3 partially compliant standards). In cases where RIAD09 or RIAD10 do not apply, compliance with the standards is proportionally adjusted. * RIEL: RESCUE-Interventions ELEMENTARY certification + number; RIAD: RESCUE-Interventions Advanced certification + number

From conceptual understanding to strategic action: the need for certification

RESCUE Certification Standards for Second Victims Support Interventions (RESCUE-Intervention)

ELEMENTARY CRITERIA

INSTITUTIONAL POLICIES

No.*	NAME	STANDARD
RIELO1 (CORE)	Institutional Policy to Support Second Victims	An institutional policy exists to support Second Victims. Just Culture and no blame principles are emphasised. Support for Second Victims is integrated into institutional policies and clearly define responsibilities and resources. When applicable, the institutional policies also accounts for the specific needs and circumstances of Second Victims among non-permanent staff (e.g., freelancers, volunteers, and other professionals who may provide services in long-term care institutions), ensuring that they have access to appropriate support mechanisms.
No.*	NAME	STANDARD
RIELO2 (CORE)	Systematic Actions to Prevent Recurrence of Clinical Errors or System Failures	The analysis of severe safety incidents, utilising appropriate techniques such as Root Cause Analysis (RCA), the London Protocol or other in-depth analysis frameworks, is an integral component of supporting Second Victims and is executed appropriately.
No.*	NAME	STANDARD
RIELO3 (CORE)	Top Management and Leaders Informed on Roles and Responsibilities Regarding Health and Care Workers' Safety	Top management and leaders have been informed on their roles and responsibilities regarding workers' health and safety, specifically the Second Victim Phenomenon.

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RESCUE Certification Standards for Second Victims Support Interventions (RESCUE-Intervention)

ELEMENTARY CRITERIA

SECOND VICTIM SUPPORT INTERVENTION

No.*	NAME	STANDARD
RIELO4	Management & Coordination Team	The institution has established a formally designated team responsible for management, coordination, and supervision of the Second Victim Support Intervention. This team has sufficient authority and resources to implement, assess, and improve the intervention.
No.*	NAME	STANDARD
RIELO5	Interdepartmental Coordination for the Provision of Comprehensive Support to Second Victims is in Place	Coordination mechanisms between relevant structures and stakeholders involved in the Second Victim Support Intervention such as patient safety, quality of care, occupational health and safety, mental health, and legal services are clearly defined and documented in an action protocol or algorithm.
No.*	NAME	STANDARD
RIELO6	Confidentiality of the Service	The Second Victim Support Intervention has specific mechanisms to guarantee the confidentiality of the service. The institution has a Code of Conduct that governs the policy of the Second Victim Support Intervention. It applies to leaders, Peer Supporters and staff of the Second Victim Support intervention.
No.*	NAME	STANDARD
RIELO7	Awareness of the Centre's Professionals on the Second Victim Phenomenon and Resources Available	The institution executes a communication plan to ensure that workers are aware of the existence of the Second Victim Support Intervention. The organization enhances the visibility of the Second Victim Support Intervention through various measures (e.g., annual Second Victim Day, dedicated website, etc.).

From conceptual understanding to strategic action: the need for certification

RESCUE Certification Standards for Second Victims Support Interventions (RESCUE-Intervention)

ELEMENTARY CRITERIA		
SECOND VICTIM SUPPORT INTERVENTION		
No.*	NAME	STANDARD
RIEL08 (CORE)	Ensure Support Availability by Trained Peer Supporters	The intervention has the necessary resources and trained Peer Supporters to provide Peer Support to Second Victims in a timely manner after the request for support (within the first 72 hours).
No.*	NAME	STANDARD
RIEL09	Appropriate Spaces for Second Victim Support and Meetings Provided by the Institution	The organisation provides appropriate spaces for Second Victim support and meetings.
No.*	NAME	STANDARD
RIEL10	Referral of the Second Victim from Peer Support Team (level 3) to Specialised/Structured Support (levels 4 and 5)	The support intervention includes a referral protocol that guides shared decision-making between Peer Supporters and Second Victims regarding access to higher levels of support. Second Victims whose condition worsens despite level 3 support, or those requesting follow-up, are referred to specialised resources (levels 4 and 5).
No.*	NAME	STANDARD
RIEL11	Involvement of the Second Victim in the Search for Solutions	The possibility of involving the Second Victim in identifying solutions to prevent the recurrence of unsafe events is considered, as it helps address their psychological needs and contributes to improving overall healthcare outcomes. This always takes place with the consent of the Second Victim, ensuring that their participation does not negatively impact them by reliving the experience. Additionally, choosing not to participate will have no negative consequences for Second Victims.

From conceptual understanding to strategic action: the need for certification

RESCUE Certification Standards for Second Victims Support Interventions (RESCUE-Intervention)

ELEMENTARY CRITERIA

PEER SUPPORTERS

No.*	NAME	STANDARD
RIEL12	A Diverse Range of Professionals is Part of the Team	A diverse team structure is in place, comprising professionals from various backgrounds to provide tailored support to the wide range of both healthcare and non-healthcare professionals which could become Second Victim within the institution/organisation.
No.*	NAME	STANDARD
RIEL13	Second Victim Support Intervention Code of Conduct	All Peer Supporters are informed about and acknowledge the Code of Conduct of the support intervention.
No.*	NAME	STANDARD
RIEL14	Engagement of Peer Supporters to Complete Initial Training and Subsequent Updates	All Peer Supporters serving in this role within the institution have successfully completed the initial training with all curricular aspects outlined in RESCUE-Training standards.
No.*	NAME	STANDARD
RIEL15	Referral Process and Resource Activation	All Peer Supporters have knowledge of supporting resources networks available within the specific institution, specifically in the case of severe impact of Second Victim Phenomenon (levels 4 and 5), as well as other support resources (e.g., legal counselling).

From conceptual understanding to strategic action: the need for certification

RESCUE Certification Standards for Second Victims Support Interventions (RESCUE-Intervention)

ELEMENTARY CRITERIA

PEER SUPPORTERS

No.*	NAME	STANDARD
RIEL16	Institutional Training for Peer Supporters	The training programme is reviewed at least every three years. Changes, or the decision to maintain the current approach, content, and trainers, are justified.
No.*	NAME	STANDARD
RIEL17 (CORE)	Peer Supporters Receiving Support	The Second Victim Support Intervention includes mechanisms that allow peer supporters being self-affected after an encounter with the Second Victim to receive support as needed.

From conceptual understanding to strategic action: the need for certification

RESCUE Certification Standards for Second Victims Support Interventions (RESCUE-Intervention)

ADVANCED CRITERIA		
INSTITUTIONAL POLICIES		
No.*	NAME	STANDARD
RIAD01	Transparency of Patient Safety Incident Management and Protection of Patient Rights	The institution evaluates and improves its transparency practices in communicating with patients and/or their families about safety incidents at least every three years. This includes regular assessments of how effectively open disclosure is applied.
No.*	NAME	STANDARD
RIAD02	Safety Culture Based on Just Culture Principles	Existence of a policy strategy to support Just Culture approved by the institution and it's reviewed at least every three years.
No.*	NAME	STANDARD
RIAD03	Institutional Policy to Support Second Victims	The Second Victim Support Policy is reviewed at least every three years.
No.*	NAME	STANDARD

From conceptual understanding to strategic action: the need for certification

RESCUE Certification Standards for Second Victims Support Interventions (RESCUE-Intervention)

ADVANCED CRITERIA		
SECOND VICTIM SUPPORT INTERVENTION		
No.*	NAME	STANDARD
RIAD05	Institutional Investment in Prevention and Self-care (levels 1 and 2 of Second Victim Support)	Annually, the institution conducts at least two activities aimed at preventing the Second Victim Phenomenon and promoting self-care among its workers. The scope of these activities also includes non-permanent staff when applicable (e.g., freelancers, volunteers, and other professionals categorised as non-permanent staff who may provide services in long-term care institutions).
No.*	NAME	STANDARD
RIAD06	Commitment and Support of the Centre's Management	Senior and middle management participates biennially in activities/meetings related to the Second Victim Phenomenon.
No.*	NAME	STANDARD
RIAD07	Ensure Support Availability	The number of first requests that experience a delay (within 72 hours) in the provision of support to the second victim due to unavailability of resources does not exceed 10% of valid requests.
No.*	NAME	STANDARD
RIAD08	Specific Support Protocol for Non-Permanent Staff as Second Victims	The support protocol is tailored to the specific needs of non-permanent staff, with a particular focus on, but not limited to, residents and other institutional staff who are still in training. When applicable, e.g., in long-term care institutions, it can extend to personnel hired as freelancers, volunteers, or other workers providing services in these settings.

From conceptual understanding to strategic action: the need for certification

RESCUE Certification Standards for Second Victims Support Interventions (RESCUE-Intervention)

ADVANCED CRITERIA		
SECOND VICTIM SUPPORT INTERVENTION		
No.*	NAME	STANDARD
RIAD09	Specific Support Protocol for Student Trainees/Interns as Second Victims	The support protocol is adapted to the specific characteristics of the Second Victim Phenomenon in students, trainees/interns to ensure their inclusion in the intervention.
No.*	NAME	STANDARD
RIAD10	Assessing Measures of the Second Victim Support Intervention	Appropriate measures aligned with the designed intervention are defined and continuously monitored to implement improvements where necessary.

From conceptual understanding to strategic action: the need for certification

RESCUE Certification Standards for Second Victims Support Interventions (RESCUE-Intervention)

ADVANCED CRITERIA		
PEER SUPPORTERS		
No.*	NAME	STANDARD
RIAD11	Peer Supporters Receiving Support	The organisation provides a self-reflection instrument to all Peer Supporters which can be used after each support encounter with a Second Victim.
No.*	NAME	STANDARD
RIAD12	Institutional Support for Peer Supporter Self-Care	The institution has a training programme for self-care available to Peer Supporters and reviews these resources at least every three years.
No.*	NAME	STANDARD
RIAD13	Peer Supporters Recognition	Peer supporters receive appropriate recognition and support for their role, including, but not limited to, reserved time for their peer support duties, public recognition in institutional communications (e.g., newsletters, meetings), certificates or awards recognising their contribution, professional development opportunities, and monetary and non-monetary compensation.

RESCUE Glossary



IMAGE 18. Open glossary and a laptop, study setup.

Health and care worker

Refers to all individuals, including clinical and non-clinical staff (both permanent and non-permanent), who provide healthcare services or support the operation of health and care facilities such as hospitals, primary care centers, and long-term care settings, including nursing homes and social-healthcare centers.

This group includes physicians, nurses, nurse auxiliaries, allied healthcare professionals, social workers, administrative personnel, and support staff across various healthcare settings²⁴⁻²⁵.

In long-term care institutions, personnel hired as freelancers should be included in the category of non-permanent staff and should receive support if they experience the second victim phenomenon.

Just Culture

An organisational environment that fosters transparency, respect, and fairness. Staff feel safe expressing their opinions and learn from errors²⁶⁻²⁷.

Peer Supporter

A trained healthcare worker who provides emotional and psychological support to second victims, fostering resilience and well-being. They must have completed a standardised training programme within their own institution or through other institutions, scientific societies, or professional organisations²⁸.

Peer Supporters Training Programme

A structured educational initiative aimed at equipping health and care workers with the skills, knowledge, and competencies necessary to support second victims effectively³.

RESCUE Glossary

First-Line Emotional Support

An early intervention strategy designed to reduce initial distress, promote adaptive coping strategies, and facilitate access to further support for second victims²⁹. Key elements include providing support with a calm and reassuring attitude, practicing active listening without judgment, allowing expression without forcing conversation, acknowledging the second victim's feelings without minimising them, fostering resilience, and guiding them to professional support if needed.

Psychological Safety

A belief that individuals can express dissent, ask questions, and report errors without fear of negative repercussions fosters an environment where teamwork is built on mutual trust and respect³⁰. Psychological safety plays a crucial role in clinical training by encouraging professionals to report adverse events and voice concerns, ultimately contributing to enhanced patient outcomes and a stronger culture of safety³¹.

Second Victim

Any healthcare worker, directly or indirectly involved in an unanticipated adverse patient event, unintentional healthcare error, or patient injury and who becomes victimised in the sense that they are also negatively impacted.

These are types of events that can evoke a second victim response³²: preventable harm to patient, unexpected patient death, multiple patients with bad outcomes within a short period of time within one clinical area, or failure to detect patient deterioration in timely manner.

Second Victim Support Interventions

Structured programmes designed to support second victims, helping them cope with emotional distress, enhance their resilience competencies, and maintain professional performance^{33,34,35}. These interventions are based on the five-level support model, which includes prevention, self-care, peer supporter assistance, and structured professional support³⁶.

Prevention

Implementing Just Culture principles within the organisation that promotes learning from errors without blame. Regular patient safety training and clinical simulations to reduce the occurrence of adverse events.

Self-care

Providing written guides or online platforms with coping strategies to help healthcare workers manage emotional impact independently. Dedicated wellness spaces within the hospital where staff can take time to emotionally process work-related stress and emotional overload.

Peer Support

Trained healthcare professionals offer emotional support to colleagues.

RESCUE Glossary

Structured Professional Support

Access to psychiatrists and clinical psychologists or trauma counselors within the healthcare institution.

External professional support

Referral to external mental health services for cases where symptoms of post-traumatic stress, anxiety, or depression persist.

Self-Reflection Instrument

A structured tool (e.g., questionnaire, checklist, etc.) that allows peer supporters to assess their emotional well-being after providing support to a second victim.

Synchronous Online Training

An online training modality conducted in real-time with interactive engagement between trainers and participants.

Referral process

Refers to the structured procedure by which a second victim is directed to additional support services or professional assistance when their emotional, psychological, or professional needs exceed the scope of peer support. This process ensures timely access to appropriate interventions, such as counseling, psychological therapy, or occupational health services, tailored to the individual's level of distress and coping capacity³⁷⁻³⁸.

Resilience

Resilience in second victims refers to the ability of healthcare workers who have experienced higher stressful event to adapt, recover, and regain confidence in their professional role. It involves managing emotional distress, mitigating feelings of guilt or self-doubt, and gradually restoring well-being while continuing to provide safe and effective patient care. Resilience in second victims is a dynamic process influenced by individual coping strategies, institutional support, and peer assistance²⁰⁻³⁹.

References

1. Reason J. Human error: models and management. *BMJ*. 2000;320(7237):768–770.
<https://pubmed.ncbi.nlm.nih.gov/10720363/>
2. Dekker S. *Just Culture: Restoring Trust and Accountability in Your Organization*. CRC Press; 2016.
<https://www.taylorfrancis.com/books/mono/10.1201/9781315590813/just-culture-sidney-dekker>
3. Van Gerven E, Seys D, Panella M, et al. Involvement of healthcare professionals in an adverse event: The role of resilience. *Supportive Care in Cancer*. 2016;24(11):4901–4907. doi:10.1007/s00520-016-3326-5
<https://pubmed.ncbi.nlm.nih.gov/25882547/>
4. Wu AW. Medical error: the second victim. *BMJ*. 2000;320(7237):726–727.
<https://pubmed.ncbi.nlm.nih.gov/10720336/>
5. Scott SD, Hirschinger LE, Cox KR, et al. Caring for our own: deploying a second victim rapid response team. *Joint Commission Journal on Quality and Patient Safety*. 2010;36(5):233–240.
<https://pubmed.ncbi.nlm.nih.gov/20480757/>
6. Seys D, Wu AW, Van Gerven E, et al. Healthcare professionals as second victims after adverse events: a systematic review. *Evaluation & the Health Professions*. 2013;36(2):135–162.
<https://pubmed.ncbi.nlm.nih.gov/22976126/>
7. Scott SD, Hirschinger LE, Cox KR, et al. The natural history of recovery for the healthcare provider “second victim” after adverse patient events. *Qual Saf Healthcare*. 2009;18(5):325–330.
<https://pubmed.ncbi.nlm.nih.gov/19812092/>
8. Edrees H, Connors C, Paine L, Norvell M, Taylor H, Wu AW. Implementing the RISE second victim support programme at the Johns Hopkins Hospital: a case study. *BMJ Open*. 2016;6(9):e011708.
<https://bmjopen.bmj.com/content/6/9/e011708>
9. Vanhaecht K, Seys D, Schouten L, et al. Duration of the second victim effect: how long does the distress last after a patient safety incident? *BMJ Open*. 2019;9(7):e029923.
<https://bmjopen.bmj.com/content/9/7/e029923>
10. Rösner H, Neusius T, Strametz R, Mira JJ. Economic Value of Peer Support Program in German Hospitals. *International Journal of Public Health*. 2024;69:1607218.
<https://pubmed.ncbi.nlm.nih.gov/38939515/>
11. Strametz R, Neusius T, Rösner H, Mira JJ. The Economic Implications of Psychosocial Peer Support for Health Workers in German Hospitals. *Journal of Healthcare Leadership*. 2025;17:123–134.
<https://www.dovepress.com/the-economic-implications-of-psychosocial-peer-support-for-health-wo-peer-reviewed-article-JHL>

References

12. Mira JJ, Carrillo I, Guilabert M, Lorenzo S, Pérez-Pérez P, Silvestre C, Ferrús L; Spanish Second Victim Research Team. The Second Victim Phenomenon After a Clinical Error: The Design and Evaluation of a Website to Reduce Caregivers' Emotional Responses After a Clinical Error. *J Med Internet Res*. 2017 Jun 8;19(6):e203.
<https://www.jmir.org/2017/6/e203/>
13. Schrøder K, Bovil T, Jørgensen JS, Abrahamsen C. Evaluation of 'the Buddy Study', a peer support program for second victims in healthcare: a survey in two Danish hospital departments. *BMC Health Services Research*. 2022;22:566.
<https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-022-07941-3>
14. Krommer E, Ablöschner M, Klemm V, Gatterer C, Rösner H, Strametz R, Huf W, Ettl B. Second Victim Phenomenon in an Austrian Hospital before the Implementation of the Systematic Collegial Help Program KoHi: A Descriptive Study. *Int J Environ Res Public Health*. 2023 Jan 20;20(3):1913.
<https://www.mdpi.com/1660-4601/20/3/1913>
15. Vanhaecht K, Seys D, Russotto S, Strametz R, Mira J, Sigurgeirsdóttir S, Wu AW, Pölluste K, Popovici DG, Sfetcu R, Kurt S, Panella M; European Researchers' Network Working on Second Victims (ERNST). An Evidence and Consensus-Based Definition of Second Victim: A Strategic Topic in Healthcare Quality, Patient Safety, Person-Centeredness and Human Resource Management. *Int J Environ Res Public Health*. 2022;19(24):16869. doi: 10.3390/ijerph192416869.
<https://www.mdpi.com/1660-4601/19/24/16869>
16. Seys D, Panella M, Russotto S, Strametz R, Joaquín Mira J, Van Wilder A, Godderis L, Vanhaecht K. In search of an international multidimensional action plan for second victim support: a narrative review. *BMC Health Serv Res*. 2023;23(1):816.
<https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-023-09332-2>
17. Mira J, Carillo I, Tella S, Vanhaecht K, Panella M, Seys D, Ungureanu MI, Sousa P, Buttigieg SC, Vella-Bonanno P, Popovici G, Srulovici E, Guerra-Paiva S, Knezevic B, Lorenzo S, Lachman P, Ushiro S, Scott SD, Wu A, Strametz R. The European Researchers' Network Working on Second Victim (ERNST) Policy Statement on the Second Victim Phenomenon for Increasing Patient Safety. *Public Health Rev*. 2024 Sep 18;45:1607175.
<https://publichealthreviews.biomedcentral.com/articles/10.1186/s40985-024-00175-4>
18. Strametz R, Roesner H, Neusius T, Wiesenhuetter I, Bushuven S, Mira JJ, Hinzmann D, Heininger S. The Economic Implications of Psychosocial Peer Support for Health Workers in German Hospitals. *J Healthc Leadersh*. 2025 Jan 25;17:15-22.
https://www.dovepress.com/the-economic-implications-of-psychosocial-peer-support-peer-reviewed-article-JHL_L
19. Schiess C, Schwappach D, Schwendimann R, Vanhaecht K, Burgstaller M, Senn B. A Transactional "Second-Victim" Model-Experiences of Affected Healthcare Professionals in Acute-Somatic Inpatient Settings: A Qualitative Metasynthesis. *J Patient Saf*. 2021;17(8):e1001–e1018.
<https://pubmed.ncbi.nlm.nih.gov/32276556/>

References

20. WHO. Health workforce.
https://www.who.int/health-topics/health-workforce#tab=tab_1
21. Frankel AS, Leonard MW, Denham CR. Fair and just culture, team behavior, and leadership engagement: The tools to achieve high reliability. *Health Serv Res.* 2006 Aug;41(4 Pt 2):1690-709. doi: 10.1111/j.1475-6773.2006.00572.x
<https://pubmed.ncbi.nlm.nih.gov/16898986/>
22. van Baarle E, Hartman L, Rooijackers S, et al. Fostering a just culture in healthcare organizations: experiences in practice. *BMC Health Serv Res.* 2022;22:1035.
<https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-022-07966-9>
23. Guerra-Paiva S, Lobão MJ, Simões DG, et al. Key factors for effective implementation of healthcare workers support interventions after patient safety incidents in health organizations: a scoping review. *BMJ Open.* 2023;13:e078118.
<https://bmjopen.bmj.com/content/13/7/e078118>
24. Busch IM, Moretti F, Campagna I, Benoni R, Tardivo S, Wu AW, Rimondini M. Promoting the Psychological Well-Being of Healthcare Providers Facing the Burden of Adverse Events: A Systematic Review of Second Victim Support Resources. *Int J Environ Res Public Health.* 2021;18(10):5080.
<https://www.mdpi.com/1660-4601/18/10/5080>
25. Edmondson A. Psychological safety and learning behavior in work teams. *Adm Sci Q.* 1999;44(2):350-383.
<https://www.jstor.org/stable/2666999>
26. Appelbaum NP, Dow A, Mazmanian PE, Jundt DK, Appelbaum EN. The effects of power, leadership and psychological safety on resident event reporting. *Med Educ.* 2016;50(3):343-350.
<https://pubmed.ncbi.nlm.nih.gov/26763180/>
27. ForYou. Office of Clinical Effectiveness, MU Health.
<https://www.muhealth.org/about-us/quality-care-patient-safety/office-of-clinical-effectiveness/foryou>
28. Scott SD, Hirschinger LE, Cox KR, McCoig M, Hahn-Cover K, Epperly KM, Phillips EC, Hall LW. Caring for Our Own: Deploying a Systemwide Second Victim Rapid Response Team. *Jt. Comm. J. Qual. Patient Saf.* 2010;36:233–240.
<https://pubmed.ncbi.nlm.nih.gov/20480757/>
29. Edrees H, Connors C, Paine L, Norvell M, Taylor H, Wu AW. Implementing the RISE Second Victim Support Programme at the Johns Hopkins Hospital: A Case Study. *BMJ Open.* 2016;6:e011708.
<https://bmjopen.bmj.com/content/6/9/e011708>
30. Mira JJ, Carrillo I, Gil E, et al. Key elements for designing effective second victim support interventions: a focus group study in European clinical settings. *BMJ Open.* 2025;15:e089923.
<https://bmjopen.bmj.com/content/15/1/e089923>

References

31. Seys D, Panella M, Rusotto S, Strametz R, Mira JJ, et al. In search of an international multidimensional action plan for second victim support: a narrative review. *BMC Health Serv Res.* 2023;23:816.
<https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-023-09332-2>
32. Scott SD, Hirschinger LE, Cox KR, McCoig M, Brandt J, Hall LW. The natural history of recovery for the healthcare provider "second victim" after adverse patient events. *Qual Saf Healthcare.* 2009;18(5):325-330.
<https://pubmed.ncbi.nlm.nih.gov/19812092>
33. Edrees H, Connors C, Paine L, Norvell M, Taylor H, Wu AW. Implementing the RISE second victim support programme at the Johns Hopkins Hospital: a case study. *BMJ Open.* 2016;6(9):e011708.
<https://bmjopen.bmj.com/content/6/9/e011708>
34. Seys D, Wu AW, Van Gerven E, et al. Healthcare professionals as second victims after adverse events: A systematic review. *Evaluation & the Health Professions.* 2013;36(2):135-162.
<https://pubmed.ncbi.nlm.nih.gov/22976126/>