Artículo

Falls Suffered by Hospitalized Adult Patients: Support to the Nursing Team as the Second Victim*

* Article extracted from the master's thesis: "Modelado de proceso en caída de pacientes adultos hospitalizados y la perspectiva del trabajador de enfermería como segunda víctima", presented to the Graduate Nursing Program of the Universidade Federal do Rio Grande do Sul, in 2020.

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Subject: promotion and prevention

Contributions to the subject: In this study, aspects of the relevance of providing support to the nursing team involved as the second victim of adverse events in the hospital context are contemplated, which raise the need for the development of structured institutional programs that promote early support, actively provided to the team. In addition, the discussion in academia during nursing training programs constitutes another possible contribution of the study, as there is a close relationship between attentive and welcoming leadership and the strengthening of the bond between the members of the nursing team in the work environments.

Abstract

Objective: To describe the support received by the second victim in falls suffered by hospitalized adult patients from the nursing team's perspective. **Materials and Methods:** This is an exploratory and descriptive study with a qualitative approach, conducted in a large general hospital in the southern region of Brazil. Data collection was carried out through semi-structured interviews with 21 nursing professionals (seven nurses and fourteen nursing technicians) selected by random sampling, who worked in the inpatient units where falls occurred with a level of harm ranging from moderate to severe during March and May of 2020. The data were submitted to content analysis from July to August of the same year. **Results:** On the one hand, from the nursing team's perspective, support for the second victim was considered incipient by the hospital institution. On the other, participants highlighted the support received by their families and peers in the work environment. The study followed the guidelines of the Consolidated Criteria for Reporting Qualitative Research (COREQ) . **Conclusions:** An institutional flow of support for the second victim needs to be formalized to mitigate the repercussions on staff.

Keywords (Fonte: DeCS)
Nursing; fall accidents; occupational health; patient safety; safety management.

Caidas de pacientes adultos hospitalizados: soporte al equipo de enfermería como segunda víctima*

* Artículo derivado de la tesis de maestría "Modelado de proceso en caída de pacientes adultos hospitalizados y la perspectiva del trabajador de enfermería como segunda víctima", presentada al Programa de Posgrado en Enfermería, de la Universidade Federal do Rio Grande do Sul, en 2020.

Resumen

Objetivo: describir el soporte recibido por la segunda víctima en las caídas de pacientes adultos hospitalizados desde la perspectiva del equipo de enfermería. **Materiales y método:** estudio exploratorio y descriptivo, con enfoque cualitativo, realizado en hospital general de gran tamaño en la región sur de Brasil. Se realizó la recolección de dados por medio de entrevista semiestructurada con 21 trabajadores de enfermería (siete enfermeros y 14 técnicos de enfermería) seleccionados por muestra aleatoria y que trabajaban en las unidades de hospitalización en que ocurrieron caídas con grado de daño comprendido de moderado a grave, de marzo a mayo de 2020. Se sometieron los datos al análisis de contenido, de julio a agosto de dicho año. **Resultados:** por una parte, desde la percepción del equipo de enfermería, el soporte a la segunda víctima se consideró incipiente por la institución hospitalaria. Por otra, los participantes destacan el apoyo recibido por sus familiares y pares en el entorno laboral. El estudio siguió las directrices del Consolidated Criteria for Reporting Qualitative Research (Coreq). **Conclusiones:** hay necesidad de formalizar un flujo institucional de soporte a la segunda víctima con el fin de mitigar las implicaciones a los trabajadores.

Palabras clave (Fuente: DeCS)
Enfermería; accidentes por caída; salud del trabajador; seguridad del paciente; gestión de la seguridad.

Quedas de pacientes adultos hospitalizados: suporte à equipe de enfermagem como segunda vítima*

* Artigo extraído da dissertação de mestrado "Modelagem de processo em quedas de pacientes adultos hospitalizados e a perspectiva do trabalhador de enfermagem como segunda vítima", apresentada ao Programa de Pós-Graduação em Enfermagem, da Universidade Federal do Rio Grande do Sul, em 2020.

Resumo

Objetivo: descrever o suporte recebido pela segunda vítima nas quedas de pacientes adultos hospitalizados sob a perspectiva da equipe de enfermagem. **Materiais e método:** estudo exploratório e descritivo, de abordagem qualitativa, realizado em hospital geral de grande porte na região sul do Brasil. A coleta de dados foi realizada por meio de entrevista semiestruturada com 21 trabalhadores de enfermagem (sete enfermeiros e 14 técnicos de enfermagem) selecionados por amostragem aleatória e que trabalhavam nas unidades de internação em que aconteceram quedas com grau de dano compreendido de moderado a grave, de março a maio de 2020. Os dados foram submetidos à análise de conteúdo, de julho a agosto do mesmo ano. **Resultados:** por um lado, na percepção da equipe de enfermagem, o suporte à segunda vítima foi considerado incipiente pela instituição hospitalar. Por outro, os participantes destacam o apoio recebido pelos seus familiares e por pares no ambiente de trabalho. O estudo seguiu as diretrizes do Consolidated Criteria for Reporting Qualitative Research (Coreq). **Conclusões:** há necessidade de formalizar um fluxo institucional de suporte à segunda vítima a fim de mitigar as repercussões sobre os trabalhadores.

Palavras-chave (Fonte: DeCS)
Enfermagem; acidentes por quedas; saúde do trabalhador; segurança do paciente; gestão da segurança.

Introduction

The classification of incidents and adverse events related to patient safety by the World Health Organization (WHO) in the late 1990s revealed a pressing need for improvement in the quality and management of care processes and health services. Patient safety is an issue related to care practices with the objective of reducing adverse events and unsafe actions that put patients' health at risk (1). Among the identified events, which compromise patient safety, are falls in the hospital environment (2). The WHO defines 'fall' as the unintentional displacement of the body to a level below the initial position, without the possibility of timely correction, compromising stability, adding a variety of associated factors (3, 4).

Falls cause injuries in almost half of the patients who are affected by this event, which may, in the most severe cases, lead to death (2). In addition, a fall can generate psychological impact by the fear of the patient falling again, which influences the risk of future falls (5), in addition to negatively interfering with the patient's functional capacity and mobility (6), which can increase the length of hospital stay and care costs, generating anxiety in the nursing team and producing repercussions on the institution's credibility, in addition to legal consequences (7, 8).

Nursing teams who are directly involved in the care of a patient who has fallen experience feelings such as guilt, distress, and helplessness. These feelings stem from a self-judgment that leads to devaluation by patients, who are instructed on fall prevention care and do not adhere to the measures, and from the understanding that falls are a reflection of a work process that is solely the responsibility of the nursing team (9), when, in fact, it should be the reason for multiprofessional care, considering that it is an event that requires a multimodal approach. This happens because the implementation of collaborative practices results in better outcomes for patients and safer care, based on the promotion of trust relationships between healthcare teams (10) and, consequently, on the promotion of healthcare staff safety.

Institutions that fail to emphasize work processes related to healthcare and to promote a safety culture in the workplace lead their staff to be more susceptible to feelings of guilt due to patient falls. Moreover, this type of event can have repercussions on the institution's image (11), consisting of a challenge for nursing leaders to ensure the quality of care and patient safety (12). An organization that recognizes its susceptibility to errors is more likely to implement safety processes while supporting those that become instances of such imperfection (13).

Although an adverse event with a severe outcome and even death causes suffering to patients and their families, they are the first victims of this process, but not the only ones. The staff involved, directly or indirectly, also suffers and is considered the second potential

victim; moreover, the impact caused to the caregivers involved — regardless of sex, age, and professional category— can leave permanent marks on most individuals. Therefore, any team member who is providing care to a patient who is a victim of harm resulting from care may suffer impacts from this, with repercussions on their private or professional lives, and is therefore considered a "second victim" of the event. This expression emerged in the literature for the first time in 2000, in an editorial of the *British Medical Journal*, concerning the impact on healthcare staff involved in an error or when they feel responsible for the adverse event and the unexpected injuries caused to the patient (14).

Second victims may experience negative feelings resulting from patient outcomes, which may vary depending on the support provided to healthcare staff. This support, although essential, is not usually widespread and frequent, but it is an effective measure to mitigate the symptoms that often affect the second victim (13, 15-17).

In light of this scenario, this study's objective was to describe the support second victims received in falls suffered by hospitalized adult patients from the nursing team's perspective.

Materials and Methods

This was an exploratory and descriptive study with a qualitative approach supported by content analysis. The study was carried out in a large general hospital in the southern region of Brazil, in a reference hospital for high complexity cases, with an installed capacity of 843 beds. The study followed the Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines.

Data collection was carried out from March to May 2020 through semi-structured interviews with the nursing team members (nurses and nursing technicians), who were selected via random sampling (simple draw) based on the following inclusion criteria: to work as a nurse or nursing technician in one of the five inpatient units and to be working at the time of the study on a work schedule, in the respective shift where the falls occurred. The exclusion criteria considered were being a member of the nursing team with less than one year of experience in the institution, being on vacation or leave of any kind, in addition to those working under a temporary contract during the data collection period.

The five inpatient units listed for the nursing team interviews were among those where fall events had occurred, classified with moderate to severe harm, from July 2018 to July 2019, totaling 12 falls.

The participants were drawn in the presence of the unit manager for each shift where a fall had occurred; one nurse and two nursing technicians were drawn. One staff member declined the invitation to participate in the study, and another was un-

able to participate due to problems in the unit. After they accepted, the informed consent form was presented, describing the study objectives, the research area of interest, the opportunities for care practice, as well as the possibility of withdrawing, if desired, and the researcher's credentials. A sample of 21 nursing team members answered the interview, which was defined by information saturation, i.e., the interviews were terminated when repeated information about the study's theme was found. The sample consisted of a total population of 153 nursing team members working in the shifts of the five inpatient units where the falls occurred.

The interview script was developed by the researchers based on the literature on which the study was based. First, a pilot test was conducted with a nursing technician belonging to a unit not included in the study, which allowed adjusting the script in order to meet the study objective.

Initially, institutional data related to the frequency and classification of safety incidents related to falls in the last year were contextualized to the nursing team. Subsequently, the participant was invited to talk about a patient fall that happened under their or a colleague's responsibility, describing the repercussions of the occurrence and how the approach was carried out with the staff member involved in that incident.

The interview was conducted in person by the main researcher, who has a master's degree, during the participants' work shifts, at a previously scheduled time, in a reserved room at the workplace of the study participant, with an average duration of 35 minutes, with audio recording and subsequent transcription. Immediately after the interviews, field notes were taken to prevent information loss. The researcher worked at the study's focus institution, was acquainted with most participants, had experience in conducting group interviews in event analysis, and periodically met with the other researchers to share information. When the researcher and the participant had not previously met, the moment of the draw and the invitation to participate in the study was the first interaction between them. It was clarified to the staff invited to answer the interview that participation was voluntary and that they could quit at any time without harm to or interference with their care attributions or work relationship. This information was also included in the informed consent form handed out to the study participants.

The data were submitted to content analysis, applying the steps of pre-analysis, material exploration, treatment of results, inference, and interpretation, without using any software (18). The codes "NUR" for nurses and "NT" for nursing technicians were used, in addition to the numbers referring to the order in which the interviews were conducted, with the objective of ensuring the participants' anonymity.

The original statements of the research participants were preserved in order to respect the internal and original vision of the thoughts

and feelings of the researched group. The researcher's perspective contemplated the interpretations based on the literature and on the inferences expressed in the discussion of the data with the objective of furthering knowledge.

This study complies with Resolution 466 of 2012, issued by the National Health Council. It is a project approved by the Research Ethics Committee of the institution and complies with all ethical precepts.

Results

Seven nurses and fourteen nursing technicians participated in the study. Among the nurses, all were female, aged between 30 and 52 years. Their time working as nurses ranged from 8 to 27 years, and their time of employment at the researched institution ranged from 7 to 20 years. Regarding the nursing technicians, five were male, and nine were female, aged between 36 and 65 years, their time working as nursing technicians ranged from 7 to 34 years, and their time working at the researched institution ranged from 1 to 29 years.

The support received in the instances of involvement with a fall event was described by the nursing team based on individual aspects ("individual support" category) and institutional aspects ("institutional support" category).

Individual support

When nursing team members were asked about the support they received in a situation where a hospitalized patient suffered a fall, responses varied, ranging from receiving support from a close colleague, from the immediate manager, or from one of their family members.

[...] I receive support from colleagues first because they go through the same circumstances because of the shift nurse's point of view, but nurses already understand things in a more managerial way, while technicians are more practical. (NT1)

We tell our immediate bosses, but there is no support. (NUR1)

According to the interviewees, this support is provided by the proximity of previously established relationships, a possible dialogue space between the different members of the work teams, by colleagues who offer to listen and welcome the feelings arising from the experiences related to the patient's fall.

With my colleagues... just talking like this is already a relief. Whether it's over a cup of coffee or when you're sitting at the computer typing, it's already a relief; you can get it out, and it seems to give you some peace of mind. (NT9)

But then you get closer to your colleague, you support them because you see that they are a little shaken, as I said [...] "but how come so-and-so fell down if they were fine just now," but then they say, "it happens," you see, there's nothing you can do. (NT10)

Another aspect mentioned as desirable by the staff was to receive immediate support from their colleagues when an adverse event occurs with a patient under their care. However, they report that this is not always the case, either because the family bond is able to meet this demand in a more welcoming way or because the work environment sometimes does not allow this listening moment, given the exhausting routine and situations that may involve the denial of feelings related to the experience of the incident.

I think that mostly from my family, from the people that I have affection for out of here, [it is in this environment] that I will report that a negative situation happened with a patient. (NUR7)

[...] the unit itself does not give you this space. [...], you arrive already working, asking [...] There is no way to say you want to sit down to have a conversation with the nurse for 10 minutes. [...] she has five, six assistants, [...] to coordinate and over 15, 16 patients [...] She may even want to, but while she is talking to me, another one comes. (NT10)

The nursing team members also reported that immediate support from a colleague with whom they have an affinity bond promotes effective welcoming and reduces the feeling of judgment for being involved in an incident.

Institutional support

When questioned about the institutional support received, the nursing team members demonstrated not having found this support or that they understood that it had to be requested.

There is no support like that, I think it is very much in our heads, [...] the other day I was with the researcher [...] she even cried and felt responsible for this. But I think that there is no support. We make practical and rational referrals and I keep working because the demand is very high and we can't stop to think. (NUR5)

Totally upset [...] feeling down. That would be the case of... that kind of follow-up we would have to have with someone who was not from the unit. (NT10)

[...] there is some support, but for the feelings, there's nobody. I looked for some support to find out what happened [...], but not for my feelings. (NUR4)

Even though interviewees listed institutional support exists, they did not perceive it as efficient, requesting that it could be actively provided. They ask for structured institutional support provided by someone outside the unit who could address their feelings in the field of mental health.

[...] requesting support, reporting that I went through a certain situation, that's how I felt, I think I would receive the appropriate support. But I would have to look for that [...] there's no way to know what's happening here, [...] unless it was a constant program or a follow-up. (NUR7)

I believe that it exists, but it's not culturally used. I understand that the OMS [Occupational Medicine Service] provides an occupational psychologist, I don't know if there's an open schedule. [...] Some of us seek care outside. Anyway, these things end up coming up in our own therapies. I think that the hospital has it, we culturally don't adhere to it or maybe come across it that way, as explicit that this resource exists to

be used in this context, you know? Because, if you think about the managerial aspect of things, what reaches us is the demand, is the indicator, is the answer that there is a problem. (NUR6)

Today [...] it would be this follow-up with a psychologist, this counseling with the doctor or with someone who comes to talk to us. Without asking for it, it happened automatically because when we do something wrong with the medication we are automatically called, we are charged. [...] because we are interested [...] when, in reality, there should be interest from the institution to tell us. (NT10)

The nursing team members understand that the welcoming can be structured in a better way and proposed in a continuous way. In addition, they understand that the support should be of interest to the institution in order to invest in the nursing team.

I think that in the first place the institution should give me some support within the occupational medicine service, psychology [...] they could provide this support and offer me a follow-up and I think that it's also up to the person because sometimes employees don't feel comfortable to report something within the psychology and occupational medicine environment, I see that many people seek it. (NUR3)

[...] I didn't look for it because I thought it wouldn't be effective since it takes so long to receive care down there that I didn't even try [...] other times that we needed it for illnesses, for more serious things, you stay there for hours waiting and sometimes they don't take it seriously. [...] I think that in a case like this they won't even take it seriously. I think, honestly, that the OMS doesn't give us the welcoming that it should [...] they keep waiting, waiting, waiting. I don't have time to wait. We have no support for this. (NT12)

The statements reveal that there is an identification of the need for institutional support and the consolidation of an approach for the welcoming of the staff, which possibly requires dedicated personnel for this purpose.

[...] the staff works a lot and needs more care. We need this care as much as they [the patients] do, so that they are well taken care of, we have to be well taken care of by the institution. (NT11)

[...] I don't know if everyone would accept a follow-up, would want to talk, to open up to the psychologist. [...] I already had the notion of talking to a psychologist about other things and it didn't help me at all, it didn't solve anything. (NT6)

The previous speech also displays some disbelief regarding the effectiveness of the existing service, restating the need for investment and improvement in this aspect. In turn, staff members who are involved as the second victim of adverse events recognize that the institutional approach represents a way to value and invest in their emotional safety.

Discussion

The falls suffered by patients represent not only frequent incidents in healthcare but are also the source of feelings of guilt among the nursing team members involved, amid other negative feelings typically experienced in second victim situations. These facts are evidenced in the statements when nursing team members identify the need to share with a close colleague or family

members the feelings experienced by having a patient who has suffered a fall during the work schedule, which is a way of seeking support. From this perspective, it is necessary to provide greater support to the nursing team (13, 19).

The psychological impact of becoming a second victim is directly related to the severity of an event. A study with healthcare staff from 93 hospitals in Belgium showed that the impact of a death is the greatest among nurses, whereas, with severe harm, it is the greatest among medical professionals. According to the researchers, the justification lies in the nature of the profession and ultimate responsibility towards the patient (20).

The second victim phenomenon occurs widely and more frequently in places with patients who require more care and with the occurrence of death. However, patients who suffered severe injuries, where the care provided had a direct impact on the outcome of these patients, led to feelings of guilt, a fact that demonstrates the importance of structuring programs that support second victims (9, 20).

It is not uncommon that, in circumstances where the harm to the patient stands out, the nursing team needs to deal individually with the emotional repercussions of the event. These circumstances are validated by previous situations where the staff member needed the occupational medicine service and could not identify the organizational support.

Nursing is a profession strongly rooted in the outcome of success, disregarding the fallibility inherent in complex processes, and it holds a strong sense of responsibility, a quality that, in addition to harm reduction, influences the impact of the occurrence (20). The constant focus on outcomes intensifies the attention to adverse events and identifies opportunities for improvement, retrospectively analyzing practice scenarios, implementing improvement plans, and focusing on the continuing education of the staff who provide care.

Although all these factors are relevant, it is necessary to monitor work environments (21) and identify the repercussion of adverse events for staff in order to influence the organizational safety culture, indicating the importance of discussing when something unexpected happens, both from the perspective of the work process and of welcoming staff, aiming to create a sense of purpose.

Becoming a second victim can be equated to post-traumatic syndromes, considering the range of feelings encompassed, with about 50% of healthcare professionals having experience feelings that caused them to doubt their ability to work and feel a profound responsibility regarding the negative repercussions on the patient's future life, which is in line with the interviewees' statements (13, 16).

Among the feelings experienced by the second victim are guilt stemming from the harm done to the patient, fear for the loss of reputation, and distress over the charge of uncleared or unaddressed situations are all part of the second victim's experiences (9, 20, 22).

The reduction of psychological impact requires active and planned strategies well beyond any individual capacity for resilience and support-seeking, although the latter is important. The failure to clearly identify institutional support or the ineffectiveness of occupational care are important reports concerning support as a way to appreciate both the staff members and the patients. The support provided and organizational cultures with clear guidelines allow feelings like these to be at least mitigated (20).

Strategies such as avoidance are described in the literature and may become common among nurses, as the focus on tasks and emotions are also reported as second victim coping alternatives (23). Strategies such as these lead to an environment of dissatisfaction among staff members and deconstruct trusting relationships among peers (16). In this sense, institutional support, both to provide the staff with protagonism for this action and to support them, is the key to these measures (13, 15).

Feelings and behaviors of avoidance and denial related to incidents, despite when they are likely to be classified as defense mechanisms, hinder the investigation of more effective possibilities for coping with situations that cause psychic suffering. These situations can occur in the absence of formal institutional support, allowing the emergence of feelings of disrespect and depreciation of staff members, in addition to the preservation of second victim feelings (24).

Appropriate coping strategies have positive repercussions when they elicit proactive actions and behaviors that are beneficial to patients, but it is necessary to identify that inappropriate strategies can weaken the provider-patient therapeutic bond, reflected by more aggressive or defensive behavior from the healthcare staff (25), representing a warning for hospital institutions and an important reason for the implementation of structured support with an early, scaled, and continuous approach.

Considering that, after an incident, the staff member feels the need to talk about it to be relieved from the work schedule and to feel supported by colleagues and the institution, it is essential to train representatives of the care and management teams who can be implemented through attentive leadership and qualified listening. For this, the level of organizational support to leaders is crucial so that they can identify programs and projects that support second victims (15, 20, 26).

Institutional support is paramount to mitigate the impacts of the second victim's experience, and the immediate response consti-

tutes a form of welcoming. Awareness of an adverse event assists the development of individual coping strategies and support for peers going through similar situations. Therefore, avenues of support for second victims must be available, visible, and accessible; sharing the staff experiences allows restitution in the work team and enables the restoration of integrity (13, 15) since the emotional disruption of participating in an adverse event can alter professional relationships and the type of support received, which influences the emotional responses (27).

The creation of a support program for second victims called Resilience in stressful events (RISE) at the Johns Hopkins University Hospital (United States) proved to be beneficial for the institution, structuring the support of the healthcare team after the occurrence of a stressful event related to patients. Other programs with a similar purpose have been created, such as the "Mitigating Impact in Second Victims" (MISE) , with a virtual support format, which aims to train frontline staff and managers to assist members of the healthcare team involved in events with repercussions for second victims. In this line, the University of Missouri (United States), with the For You program, has shown that only 10% of second victims need specialized mental health support, which demonstrates the importance of immediate welcoming and of qualified listening to peers in the work environment (17, 26, 28, 29).

Moreover, it is noteworthy that the support provided to the second victim by the institution can help prevent new instances of the event, as it is an investment in the staff members, not exempting them from liability, considering the repercussions of the harm. Likewise, it is important to identify the experiences of nursing team members as second victims in healthcare institutions in order to propose measures and support programs appropriate and possible to be carried out (30), immediately, in the medium and long terms for reducing the emotional stress and promoting individual and systemic resilience (25).

Finally, this is a small-scale study, where the results are sensitive to the context applied, which may characterize a study limitation, as well as the researcher's previous knowledge of the study participants. However, this methodology can be replicated, which allows for alternatives to be identified for planning support for staff members as a way of valuing and investing in workplace relationships.

As far as nursing is concerned, the identification of people who are willing and have a welcoming and empathetic profile in the healthcare units is a relevant possibility to be implemented, as a form of immediate support, based on previously built relationships and an initial step in the approach to the second victim. In addition, the discussion in academia during training constitutes another possible contribution of the present study, as there is a close relationship between attentive leadership and the promotion of a welcoming environment.

Conclusions

The present study identified the perceptions of the nursing team regarding the relevance of individual support, whether from peers in the work environment or family members in the private context or in situations that predispose second victims among nursing team members. The incipiency of institutional support and the need to talk openly about the situations experienced by second victims, even if in fear of the repercussions, is necessary to mitigate the feelings of the staff involved in care failures, to appreciate the nursing team, and to promote humanized care for the members of the healthcare teams.

The support to the nursing team enables contributing to the promotion of an institutional culture of safety that allows learning, strengthening trust relationships, and promoting the team members' well-being as a way to provide care in the search for qualification in the work environment, represented by the managerial challenge translated by the relevance of falls in the international context.

The level of investment in healthcare staff assumes that the implementation of support programs for the second victim needs to be provided early and actively, in a structured, scaled, and continuous way, identifying reference individuals with a welcoming profile that can provide this immediate and longitudinal approach, which is the main suggestion for future studies.

Conflict of interest: none declared.

References

1. Camargo FC, Iwamoto HH, Galvão CM, Monteiro DAT, Goulart MB, Garcia LAA. Models for the implementation of Evidence-Based Practice in hospital based nursing: A narrative review. Texto Contexto Enferm. 2017;26(4):e2070017. DOI: https://doi.org/10.1590/0104-07072017002070017
2. Morris R, O'Riordan S. Prevention of falls in hospital. Clin Med (Lond). 2017;17(4):360-2. DOI: https://doi.org/10.7861/clinmedicine.17-4-360
3. World Health Organization. Charter health worker safety: A priority for patient safety. [Internet]. Geneva: WHO; 2020. Available from: https://www.who.int/docs/default-source/world-patient-safety-day/health-worker-safety-charter-wpsd-17-september-2020-3-1.pdf
4. Severo IM, Kuchenbecker RS, Vieira DFVB, Lucena AF, Almeida MA. Risk factors for fall occurrence in hospitalized adult patients: A case-control study. Rev Lat Am Enfermagem 2018;26:e3016. DOI: https://doi.org/10.1590/1518-8345.2460.3016
5. Barbosa AS, Chaves EHB, Ribeiro RG, Quadros DV, Suzuki LM, Magalhães AMM. Characterization of the adult patients' falling incidents in a university hospital. Rev Gaúcha Enferm. 2019;40(spe):e20180303. DOI: https://doi.org/10.1590/1983-1447.2019.20180303
6. Morello RT, Barker AL, Haines T, Zavarsek S, Watts JJ, Hill K *et al*. In-hospital falls and fall-related injuries: A protocol for a cost of fall study. Inj Prev. 2013;19(5):363. DOI: https://doi.org/10.1136/injuryprev-2012-040706
7. Florence CS, Bergen G, Atherly A, Burns E, Stevens J, Drake C. Medical costs of fatal falls and fall injuries among older adults. J Am Geriatr Soc. 2018;66(4):693-8. DOI: https://doi.org/10.1111/jgs.15304
8. Paulino GME, Matsuda LM, Matta ACG, Ferreira AMD, Dias AO, Silva LF. Costs and root causes of medication errors and falls in a teaching hospital: Cross-sectional study. Texto Contexto Enferm. 2021;30:e20200045. DOI: https://doi.org/10.1590/1980-265x-tce-2020-0045
9. Quadros DV, Magalhães AMM, Wachs P, Severo IM, Tavares JP, Dal Pai D. Modeling of adult patient falls and the repercussions to Nursing as a second victim. Rev Lat Am Enfermagem. 2022;30:e3618. DOI: https://doi.org/10.1590/1518-8345.5830.3618
10. Schmutz JB, Meier LL, Manser T. How effective is teamwork really? The relationship between teamwork and performance in healthcare teams: A systematic review and meta-analysis. BMJ Open. 2019;9(9):e028280. DOI: https://doi.org/10.1136/bmjopen-2018-028280

11. Falcão RMM, Costa KNFM, Fernandes MGM, Pontes MLF, Vasconcelos JMB, Oliveira JS. Risk of falls in hospitalized elderly people. Rev Gaúcha Enferm. 2019;40(spe):e20180266. DOI: https://doi.org/10.1590/1983-1447.2019.20180266

12. Ferreira VB, Amestoy SC, Silva GTR, Trindade LL, Santos IAR, Varanda PAG. Transformational leadership in nursing practice: Challenges and strategies. Rev Bras Enferm. 2020;73(6):e20190364. DOI: https://doi.org/10.1590/0034-7167-2019-0364

13. Mira JJ, Carrillo I, García-Elorrio E, Andrade-Lourenção DCDE, Pavan-Baptista PC, Franco-Herrera AL *et al*. What Ibero-American hospitals do when things go wrong? A cross-sectional international study. In J Qual Health Care. 2020;32(5):313-8. DOI: https://doi.org/10.1093/intqhc/mzaa031

14. Wu AW. Medical error: The second victim. The doctor who makes the mistake needs help too. BMJ. 2000;320(7237):726-7. DOI: https://doi.org/10.1136/bmj.320.7237.726

15. Chan ST, Khong PCB, Wang W. Psychological responses, coping and supporting needs of healthcare professionals as second victims. Int Nurs Rev. 2017;64(2):242-62. DOI: https://doi.org/10.1111/inr.12317

16. Ajri-Khameslou M, Abbaszadeh A, Borhani F. Emergency nurses as second victims of error: A qualitative study. Adv Emerg Nurs J. 2017;39(1):68-76. DOI: https://doi.org/10.1097/TME.0000000000000133

17. Merandi J, Liao N, Lewe D, Morvay S, Stewart B, Catt C *et al*. Deployment of a second victim peer support program: A replication study. Pediatr Qual Saf. 2017;2(4):e031. DOI: https://doi.org/10.1097/pq9.0000000000000031

18. Bardin, L. Análise de conteúdo: edição revista e ampliada. São Paulo: Edições 70; 2016.

19. Busch IM, Moretti F, Purgato M, Barbui C, Wu AW, Rimondini M. Psychological and psychosomatic symptoms of second victims of adverse events: A systematic review and meta-analysis. J Patient Saf. 2020;16(2):e61-74. DOI: https://doi.org/10.1097/PTS.0000000000000589

20. Mok WQ, Chin GF, Yap SF, Wang W. A cross-sectional survey on nurses' second victim experience and quality of support resources in Singapore. J Nurs Manag. 2019;28(2):286-93. DOI: https://doi.org/10.1111/jonm.12920

21. Navarro Maldonado XA, Nascimento ERP, Lazzari DD. Nursing professionals and adverse event reporting. Texto Contexto Enferm. 2020;29(spe):e20190282. DOI: https://doi.org/10.1590/1980-265x-tce-2019-0282

22. Burlison JD, Quillivan RR, Scott SD, Johnson S, Hoffman JM. The effects of the second victim phenomenon on work-related outcomes: Connecting self-reported caregiver distress to turnover intentions and absenteeism. J Patient Saf. 2021;17(3):195-9. DOI: https://doi.org/10.1097/PTS.0000000000000301

23. Busch IM, Moretti F, Purgato M, Barbui C, Wu AW, Rimondini M. Dealing with adverse events: A meta-analysis on second victims' coping strategies. J Patient Saf. 2020;(2):51-60. DOI: https://doi.org/10.1097/PTS.0000000000000661

24. Vieira FO, Mendes AM, Merlo ARC, editores. Dicionário crítico de gestão e psicodinâmica do trabalho. Curitiba: Juruá; 2013.

25. Busch IM, Moretti F, Campagna I, Benoni R, Tardivo S, Wu AW *et al*. 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. DOI: https://doi.org/10.3390/ijerph18105080

26. Stone, Misty. Second victim support programs for healthcare organizations. Nurs Manag. 2020;51(6):38-45. DOI: https://doi.org/10.1097/01.NUMA.0000662664.90688.1d

27. Cabilan CJ, Kynoch K. Experiences of and support for nurses as second victims of adverse nursing errors: A qualitative systematic review. JBI Database System Rev Implement Rep. 2017;(9):2333-64. DOI: https://doi.org/10.11124/JBISRIR-2016-003254

28. 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. DOI: https://doi.org/10.1136/bmjopen-2016-011708

29. Mira JJ, Carrillo I, Guilabert M, Lorenzo S, Pérez-Pérez P, Silvestre C *et al*. 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;19(6):e203. DOI: https://doi.org/10.2196/jmir.7840

30. Quadrado ERS, Tronchin DMR, Maia FOM. Strategies to support health professionals in the condition of second victim: Scoping review. Rev Esc Enferm USP. 2021;55:e03669. DOI: https://doi.org/10.1590/s1980-220x2019011803669