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Peer Supporters' Experience of Supporting Second Victims (KoHi-III-Study)

Elisabeth Krommer , Victoria Klemm , Milena Trifunovic-Koenig , Christian Gatterer , Hannah Roesner , Wolfgang Huf , Brigitte Ettl , Reinhard Strametz *

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Elisabeth Krommer [1], Victoria Klemm [2], Milena Trifunovic-Koenig [2,3], Christian Gatterer [1], Hannah Roesner [2], Wolfgang Huf [1], Brigitte Ettl [1] and Reinhard Strametz [2,*]

[1] Karl Landsteiner Institute for Clinical Risk Management, Wolkersbergerstraße 1, 1130 Vienna, Austria; elisabeth.krommer@gesundheitsverbund.at (E.K.); christian.gatterer@gesundheitsverbund.at (C.G.); wolfgang.huf@gesundheitsverbund.at (W.H.); brigitte.ettl@me.com (B.E.)

[2] Wiesbaden Institute for Healthcare Economics and Patient Safety (WiHelP), Wiesbaden Business School, RheinMain University of Applied Sciences, Bleichstr. 44, 65183 Wiesbaden, Germany; victoria.klemm@hs-rm.de (V.K.); milena.trifunovic-koenig@notis-ev.de (M.T.-K.); hannah.roesner@hs-rm.de (H.R.)

[3] Training Center for Emergency Medicine (NOTIS e.V.), 78234 Engen, Germany

* Correspondence: reinhard.strametz@hs-rm.de

Abstract: (1) Background: Second Victims are health care workers negatively affected by adverse events and are prone to developing dysfunctional coping strategies compromising not only their own, but also patient safety. An effective way to address this issue is the implementation of peer support programs. This paper reports on the effectiveness of a peer support program at the Austrian Hietzing Clinic (KHI). (2) Methods: Telephone interviews were carried out after peer support sessions using a questionnaire. Descriptive analysis was carried out reporting frequencies and proportions for nominal variables, means with standard deviations for ordinal and interval-scaled variables. (3) Results: So far, 45 peer supporters have completed telephone interviews after a peer support session. The main reasons for the session were bad news from the private sphere and death of a patient. The peer supporters rated the helpfulness of the sessions for their colleagues as very high while not feeling very burdened themselves afterwards. (4) Conclusions: Underutilization of the program is probable. However, the high rating of helpfulness of the carried-out sessions by the peer supporters in combination with them not feeling very burdened, shows that the program is safe for the peer supporters and an upscaling is warranted.

Keywords: second victims; peer support; emotional distress; peer intervention; stress management

1. Introduction

The Second Victim Phenomenon is common among health care workers [1–3]. Second Victims (SVs) are health care workers also negatively impacted by unanticipated adverse events while caring for their patients [4]. The Second Victim Phenomenon (SVP) may negatively affect the involved health care workers, their organizations, and future patients. Consequences for healthcare workers can range from mainly psychological reactions, such as anxiety, loss of self-confidence [5], to physical symptoms, such as backpain, headaches, etc. [6–8]. Reactions detrimental for the organizations are common as well, such as absenteeism, or turnover intentions [9]. For patients SVP compromises patient safety and the received quality of care, for example by SVs practicing defensive medicine [10,11] or a heightened error rate as a result of developing post-traumatic stress disorder (PTSD) after the incident [5]. If recognized correctly, SVP is effectively treatable [12]. Scott introduced the three-tiered integrated model of interventional support for SVs [12]. The first tier is basic emotional aid at the local level and estimated as sufficient for approximately 60% of SVs. The second tier involves an escalation of support through the inclusion of specially trained peer supporters within healthcare institutions, addressing an additional 30% of SV cases. The last level of escalation involves professional counseling, support, and guidance for those unable to attain sufficient assistance in the initial two tiers. Scott estimated the third tier to be necessary for 10% of individuals affected by SVP

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[12]. This support model has been further conceptualized by the ERNST-consortium [13], introducing two additional levels to prevent or mitigate the effects of SVP: individual and organizational prevention, as well as self-care practices for individuals and/or their teams. Furthermore, organizational support for SVs has shown to reduce turnover intentions and absenteeism [9].

Consequently, Clinic Hietzing in Austria, Vienna (KHI) developed a peer support program tailored for employees encountering adverse events possibly leading to SVP on the basis of the three-tiered integrated model of interventional support. A preliminary descriptive study was conducted and published reporting on the prevalence, symptom load and preferred support measures for SVs within the institution (KoHi-I) [14]. This study revealed a 43% prevalence of SVP at KHI, with colleagues identified as the most important support group for those affected. These findings further justified the implementation of the peer support program KoHi (Kollegiale Hilfe/Collegial Help) at KHI. The description of the interventional program KoHi is described in detail elsewhere [15]. Following KoHi-I, members of all occupational groups were invited to participate in a five-hour training course concentrating on psychological first-aid, equipping 122 of them to become peer supporters. Participation in this training course was on a voluntary basis.

The findings of numerous studies have shown that volunteers' decision to continue helping is influenced by how satisfied they are with their experiences [16]. Volunteers can make a substantial contribution to the success of the intervention, especially when they feel valued, acknowledged, and confident in their abilities. Volunteer dropout is a critical challenge for organizations and interventions, as it directly affects their sustainability. Therefore, successful volunteer retention is crucial for an intervention's survival. To retain volunteers as crucial stakeholders in volunteer-based interventions such as peer support programs for SVs, exploration of volunteers' views on the success and efficacy of their efforts is very important.

While the effectiveness of different peer support programs for SVs has been researched [17–20], there remains a research gap concerning the peer supporters' experiences and psychological safety when dealing with colleagues affected by SVP. Therefore, our aim was to explore the peer supporters' experiences and self-perceived psychological safety after supporting SVs within KHI. This study aims to provide valuable insights that can support the development and enhancement of peer support interventions for SVs tailored to the unique needs of both SVs and their supportive peers.

2. Materials and Methods

KoHi-III is a cross-sectional study conducted among the KoHis (Collegial Helpers) of KHI's peer support program. KHI is a hospital in Vienna, Austria with approximately 3,300 employees and 1,100 beds. Approximately 250,000 outpatients and 52,000 inpatients are treated annually [21].

Eligible participants were trained KoHis that completed a KoHi-peer support session for any reason. Upon completion of a KoHi-peer support session, KoHis were advised to contact the psychological team at KHI via telephone who utilized a questionnaire in a standardized and pseudo anonymized manner to collect the data used in this study. The questionnaire used was designed for this study and consisted of 15 items. The questions regarded the information about the KoHi-session as well as the rating of helpfulness of the sessions. The participants were also asked to assess their own psychological wellbeing after having completed a KoHi-session. The complete questionnaire is provided as supplementary material in the Appendix A (Table A1). The telephone interviews were conducted between May 2020 and March 2024. All participants gave informed consent in written form. The questionnaire was externally analyzed by scientific staff at the Wiesbaden Institute for Healthcare Economics and Patient Safety (WiHelP) in Germany using SPSS Statistics Version 29 (IBM, New York, NY, USA). Descriptive statistics were reported using means (M) and standard deviations (SD) for interval-scaled variables independent of normal distribution [22–24]. The ordinal-scale variables, each measured on a 10-point Likert scale, can be treated as interval-scaled, as demonstrated in the simulation study [25]. -Frequencies (n) and proportions (%) were calculated for nominal variables.

Before implementation of the KoHi-program, ethical approval was given by the ethical committee of the city of Vienna in September 2019 for the entire KoHi-project (EK-19-074).

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3. Results

Forty-five telephone interviews were conducted after KoHi-sessions utilizing the previously described questionnaire.

Regarding initiation of the session, 53.3% (n=24) of the meetings were initiated by the KoHis themselves, 27.3% (n=12) by colleagues or supervisors of the person in need of support. Seven out of 45 KoHi sessions (15.6%) were initiated by the persons in need of support themselves. Most KoHi-sessions took place within 30 minutes after establishing first contact with the KoHis (77.8%) and 56.8% of the sessions (n=25) took place within 30 minutes after the adverse event that triggered them. The sessions' mean duration was 40.02 minutes (Mdn=30; SD=29.28; min=1; max=180). Almost all (93.3%, n=42) KoHis found the duration of the sessions to be sufficient. Forty-two of 45 sessions took place during day-shift and most sessions were conducted within the KoHi's own departments (n=33, 73.3%).

Most important triggers for the KoHi-session are shown in table 1.

Table 1. Events triggering the KoHi-session.

Triggers	n (%)
Incident with patient injury	3 (6.7)
Incident without patient injury (near miss)	3 (6.7)
Death of a patient	7 (15.6)
Suicide / attempted suicide of a patient	2 (4.4)
Death / suicide / illness / accident at work of a colleague	4 (8.9)
Terrible news from the private sphere	12 (26.7)
Other	14 (31.1)

The events categorized as "other" were specified as (excerpt):

- "Acute mobbing at workplace" (this was indicated three times)
- "Sudden change in workplace"
- "Car accident on the way to work"
- "Suicide threat of a patient"

After 36 of the 45 reported meetings, the KoHis deemed the potential SVs as sufficiently stable and capable of acting and 18 of them continued working after the meeting. In 19 cases, KoHis established contact with further, professional support sources, (psychiatric department at KHI n=11, psychological service center (external) n=10). Seven potential SVs left work early after the session. Three potential SVs canceled their session prematurely. KoHis rated the perceived helpfulness of their sessions for the potential SVs highly (M=8.57 (SD=1.56) on a 10-point Likert-scale, 1=not helpful at all; 10= most helpful). Regarding the KoHi's own psychological safety, KoHis reported to not feel very burdened after their sessions (M=3.42 (SD=2.41) on a 10-point Likert scale, 1=not burdened at all; 10=most burdened)

4. Discussion

To offer initial insights into the effectiveness and utilization of KoHi's peer support program for healthcare workers involved in SV incidents, we conducted our study exploring triggers, timelines, and overall helpfulness ratings evaluated by peer supporters. KHI's KoHis reported 45 sessions in 47 months. Most sessions were initiated by the KoHis themselves and main trigger for the sessions were terrible news from the private sphere. The KoHis reported the majority of SVs to be sufficiently stable and able to continue working after the session. The meetings were rated very helpful on a scale of

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one to ten (M=8.5). Further, the peer supporters themselves didn't feel very burdened after conducting KoHi-sessions (M=3.42).

Though the 45 reported number of sessions align with numbers of comparable peer support programs at other hospitals [12,26,27], it still seems to be rather low taking the baseline study into account where 43% of the participating employees stated to consider themselves as SVs [14]. One possible reason for these low numbers is underreporting. Discussions during quarterly team meetings with the psychological department indicated that, particularly during the initial year of the COVID-19 pandemic, some KoHi-sessions went unreported via telephone due to elevated workloads. In order to mitigate barriers associated with reporting, KHI should consider streamlining the reporting protocol. One proposed measure is the implementation of an additional, less time-consuming online reporting option in the future. Furthermore, the data collection could be conducted anonymously in this way. This adjustment aims to enhance the efficiency of reporting mechanisms and ensure a more comprehensive documentation of KoHi sessions. Another explanation for the low numbers of reported sessions is underutilization of the program itself. Main trigger for KoHi-sessions was terrible news from the private sphere. This contrasts with the results of the preliminary KoHi-I study, which examined the main events leading to SVP at KHI before implementation of the peer-support-program and identified them to be aggressive behavior of patients or relatives and unexpected death/suicide of a patient [14]. The observed discrepancy raises concerns about potential underutilization of the program, especially by individuals involved in adverse patient events. A possible explanation for this is self-stigmatization, which may inhibit their willingness to seek out help [28]. Another indicator for self-stigmatization is the initiation of KoHi-sessions: in over 50% of the cases, the KoHis themselves initiated the meetings and only in roughly a quarter of the cases the SVs approached the KoHis. Therefore, barriers, such as self-stigmatization, can be suspected for other SVs to seek out help. This should be addressed by the peer-support-program. Nevertheless, this emphasizes the proactive role of KoHis in providing support. Additionally, a significant proportion of sessions were initiated by colleagues or supervisors, highlighting the importance of organizational support and recognition of the need for peer support.

The promptness of the sessions is notable, with most taking place within 30 minutes after initial contact with the KoHis and over half occurring within 30 minutes after the triggering adverse event. This timely response reflects the effectiveness of the peer support program in providing immediate assistance to individuals in need. Moreover, the average session duration of around 40 minutes implies that KoHi sessions were timely efficient. The high proportion of KoHis who found the session duration adequate further supports this notion, indicating that the sessions effectively balance thoroughness with efficiency.

Most sessions happening during the day shift and within the KoHi's departments show that peer support is easily accessible and well-integrated into the healthcare workplace. Being nearby allows for quick help and makes the individuals involved in an adverse event feel comfortable, providing them with a feeling of familiarity. This could have enhanced how KoHis perceived the effectiveness and satisfaction of their sessions.

To summarize, the proactive initiation of sessions, prompt response, adequate duration, and integration into the workplace environment may have all played a role in the perceived success of the peer support program, as evaluated by KoHis, in meeting the needs of healthcare workers dealing with adverse events. The perceived success of the program by KoHis is very important as it ensures their continued involvement and support, while also providing information on its effectiveness and impact on healthcare workers' well-being.

Another notable finding of this study is that according to free text answers, three KoHi sessions were initiated in response to acute workplace mobbing. Workplace mobbing has been associated with detrimental effects on the physical and mental well-being of employees [29]. This, in combination with SVP, may increase the potential for psychological harm and occupational stress. A systematic review has suggested that there is only low-quality evidence supporting the effectiveness of organizational interventions in preventing workplace bullying [30]. Encouraging reporting empowers employees to speak up, knowing their concerns will be taken seriously. Healthcare

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organizations must receive input from peer supporters regarding workplace mobbing while maintaining confidentiality between peer supporters and affected colleagues, refraining from disclosing the personal data of affected individuals while still reporting the issue. Transparency ensures organizational leaders are aware of the issue while upholding privacy, allowing for appropriate measures to be taken to address mobbing while respecting the sensitivity of individual situations. Therefore, to mitigate the negative effects of workplace bullying, as well as SVP, KHI should take measures into consideration to increase healthcare workers' resilience. This includes adapting leadership behavior, crisis communication and the continuous support of KHI's employees [31]. Continuous support should encompass initiatives that encourage employees to practice self-care [31], which is also beneficial for preventing or mitigating the effects of SVP [13]. By fostering a resilient and supportive work environment, KHI can contribute to the well-being of its staff and potentially reduce the adverse consequences of workplace mobbing and SVP incidents.

The KoHis perceived their sessions as very helpful for the potential SVs (M=8.57), while not feeling very burdened by carrying out these sessions (M=3.42), indicating a high satisfaction of the peer supporters with their work. Another study on volunteer retention and sustainability of a SV peer support program found that volunteers found their assignments to be meaningful and personally satisfying and reported confidence in their resilience [32]. Our study's results reflect these findings. It is advisable for the management of volunteer-based interventions to consider factors that impact volunteer's satisfaction for a better volunteer retention [16]. Furthermore, understanding the factors that contribute to volunteers' resilience can help in optimizing training programs for both current and incoming volunteers. The previous research indicated that the primary motivation to join volunteer programs is based on mobilizing personal relationships, and issues around retention are manifested at a personal level, where the relationships in the team are very important [33]. However, the present study did not focus on examining how team and organizational factors relate to the satisfaction of peer supporters. Future research should explore how team dynamics, organizational support, and leadership impact peer supporters' experiences and overall satisfaction. Therefore, volunteers' satisfaction should be continuously monitored and drops in satisfaction addressed immediately. However, to achieve a more in-depth understanding, the quantitative findings should be complemented by qualitative data in the future.

This study encounters several limitations. The use of a convenient sampling method and the setting of the study within one hospital restricts the generalizability of the findings. Further, social-desirability bias may play a role in the high ratings of helpfulness of the KoHi-sessions by the KoHis along with them not feeling very burdened by the sessions. While acknowledging these limitations, we still believe this study provides a first insight especially since integration and evaluation of peer support programs for SVs is a relatively unexplored area in European countries.

5. Conclusions

We identified a relevant need for the KoHi peer support program and a high effectiveness regarding stabilization after an adverse event. Main barrier of the program seemed to be underutilization of the program possibly due to self-stigmatization. KHI should address this by continuously informing their employees about the program and investigating the reasons behind this further. The peer supporters themselves do not feel psychologically burdened after offering peer support. Therefore, this peer support program is deemed safe for the voluntary peer supporters and an upscaling of this project is advisable.

6. Patents

This section is not mandatory but may be added if there are patents resulting from the work reported in this manuscript.

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Supplementary Materials: The following supporting information can be downloaded at: www.mdpi.com/xxx/s1, Figure S1: title; Table S1: title; Video S1: title.

Author Contributions: E.K.: conceptualization, original draft preparation; V.K.: formal analysis, original draft preparation; M.T.-K.: formal analysis, original draft preparation; C.G: original draft preparation; H.R: original draft preparation; R.S, W.H., B.E.: conceptualization, methodology, supervision, draft review and editing; All authors read and approved the final manuscript.

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Institutional Review Board Statement: The study was conducted in accordance with the Declaration of Helsinki, and approved by the Ethical Committee of the city of Vienna (EK-19-074, September 2019).

Informed Consent Statement: Informed consent was obtained from all subjects involved in the study.

Data Availability Statement: The datasets used and/or analyzed during the current study are available from the corresponding author on reasonable request.

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Conflicts of Interest: The authors declare no conflicts of interest.

Appendix A

Table A1. KoHi-III questionnaire.

Item	Possible Answers
I1: How did you become involved as a KoHi for this mission?	1 KoHi initiated the conversation 2 KoHi was personally contacted by the affected co-worker 3 KoHi was contacted by a colleague or supervisor 4 KoHi was contacted by a central office 5 other
I2: How much time passed between the involvement and KoHi-conversation?	X minutes
I3: How much time passed between the event and the KoHi conversation?	X minutes
I4: Did the KoHi meeting take place before the person concerned left work for the day	1 yes 2 no
I5: How long did the KoHi conversation last?	X minutes
I6: Was the time sufficient?	1 yes 2 no
I7: At what time of day did the KoHi meeting take place?	1 Day shift 2 Night shift 3 Weekend/holiday
I8: At which department/institute did the meeting take place?	List of possible departments at KHI
I9: Did the assignment take place within your own department?	1 yes 2 no
I10: In which area did the adverse event occur?	1 Outpatient clinic 2 Ward 3 Special areas 4 Other
I11: What was the trigger for the KoHi meeting? (Multiple choice)	1 incident with patient injury 2 Incident without patient injury (near miss) 3 Death of a patient 4 Suicide / attempted suicide of a patient 5 Event with child 6 Attack or threat by patients or relatives

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	7 Ethical conflict in patient treatment 8 Personal acquaintance with patient or strong resemblance to relatives 9 Death / suicide / illness / accident at work of a colleague 10 Terrible news from the private sphere 11 Other
I12: The person concerned…	1 ... was sufficiently stable and able to act after the meeting 2 ... was not yet sufficiently stable and capable of acting after the meeting 3 ... refused or canceled the meeting 4 ... continued working after the meeting 5 ... left work early after the meeting
I13: KoHi…	1 ... has organized a safe way home for the person (e.g. relatives, cab) 2 ... has recommended professional (psychological) support 3 ... has handed out information material about professional (psychological) support 4 ... has established contact with professional support. If yes, to whom? -> 5 psychiatric department 6 KHI Pastoral care 7 Crisis supervision (via KHI Personnel Development) 8 Psychological service center of the KAV 9 Other 10 … tried, but did not receive professional support 11 ... had to break off the conversation prematurely 12 ... has handed over the conversation to another KoHi
I14: How helpful did you think the interview was for the person involved?	1-10; 1 = not helpful at all, 10 = most helpful
I15: How much of a burden do you feel after the meeting?	1-10; 1 = not burdened at all, 10 = most burdened

References

1. Seys, D.; Wu, A.W.; van Gerven, E.; Vleugels, A.; Euwema, M.; Panella, M.; Scott, S.D.; Conway, J.; Sermeus, W.; Vanhaecht, K. Health care professionals as second victims after adverse events: a systematic review. *Eval. Health Prof.* **2013**, *36*, 135–162, doi:10.1177/0163278712458918.
2. Naya, K.; Aikawa, G.; Ouchi, A.; Ikeda, M.; Fukushima, A.; Yamada, S.; Kamogawa, M.; Yoshihara, S.; Sakuramoto, H. Second victim syndrome in intensive care unit healthcare workers: A systematic review and meta-analysis on types, prevalence, risk factors, and recovery time. *PLoS One* **2023**, *18*, e0292108, doi:10.1371/journal.pone.0292108.
3. Potura, E.; Klemm, V.; Roesner, H.; Sitter, B.; Huscsava, H.; Trifunovic-Koenig, M.; Voitl, P.; Strametz, R. Second Victims among Austrian Pediatricians (SeViD-A1 Study). *Healthcare (Basel)* **2023**, *11*, doi:10.3390/healthcare11182501.
4. Vanhaecht, K.; Seys, D.; Russotto, S.; Strametz, R.; Mira, J.; Sigurgeirsdóttir, S.; Wu, A.W.; Põlluste, K.; Popovici, D.G.; Sfetcu, R.; et al. An Evidence and Consensus-Based Definition of Second Victim: A Strategic Topic in Healthcare Quality, Patient Safety, Person-Centeredness and Human Resource Management. *International Journal of Environmental Research and Public Health* **2022**, *19*, doi:10.3390/ijerph192416869.

5. Nydoo, P.; Pillay, B.J.; Naicker, T.; Moodley, J. The second victim phenomenon in health care: A literature review. *Scand. J. Public Health* **2020**, *48*, 629–637, doi:10.1177/1403494819855506.
6. Strametz, R.; Fendel, J.C.; Koch, P.; Roesner, H.; Zilezinski, M.; Bushuven, S.; Raspe, M. Prevalence of Second Victims, Risk Factors, and Support Strategies among German Nurses (SeViD-II Survey). *International Journal of Environmental Research and Public Health* **2021**, *18*, 10594, doi:10.3390/ijerph182010594.
7. Marung, H.; Strametz, R.; Roesner, H.; Reifferscheid, F.; Petzina, R.; Klemm, V.; Trifunovic-Koenig, M.; Bushuven, S. Second Victims among German Emergency Medical Services Physicians (SeViD-III-Study). *International Journal of Environmental Research and Public Health* **2023**, *20*, doi:10.3390/ijerph20054267.
8. Strametz, R.; Koch, P.; Vogelgesang, A.; Burbridge, A.; Rösner, H.; Abloescher, M.; Huf, W.; Ettl, B.; Raspe, M. Prevalence of second victims, risk factors and support strategies among young German physicians in internal medicine (SeViD-I survey). *J. Occup. Med. Toxicol.* **2021**, *16*, 11, doi:10.1186/s12995-021-00300-8.
9. Burlison, J.D.; Quillivan, R.R.; Scott, S.D.; Johnson, S.; Hoffman, J.M. 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*, 195–199, doi:10.1097/PTS.0000000000000301.
10. Panella, M.; Rinaldi, C.; Leigheb, F.; Donnarumma, C.; Kul, S.; Vanhaecht, K.; Di Stanislao, F. The determinants of defensive medicine in Italian hospitals: The impact of being a second victim. *Rev. Calid. Asist.* **2016**, *31 Suppl 2*, 20–25, doi:10.1016/j.cali.2016.04.010.
11. Pyo, J.; Choi, E.Y.; Lee, W.; Jang, S.G.; Park, Y.K.; Ock, M.; Lee, S.I. Physicians' Difficulties Due to Patient Safety Incidents in Korea: a Cross-Sectional Study. *J. Korean Med. Sci.* **2020**, *35*, e118, doi:10.3346/jkms.2020.35.e118.
12. Scott, S.D.; Hirschinger, L.E.; Cox, K.R.; McCoig, M.; Hahn-Cover, K.; Epperly, K.M.; Phillips, E.C.; Hall, L.W. Caring for Our Own: Deploying a Systemwide Second Victim Rapid Response Team. *The Joint Commission Journal on Quality and Patient Safety* **2010**, *36*, 233–240, doi:10.1016/S1553-7250(10)36038-7.
13. 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*, 816, doi:10.1186/s12913-023-09637-8.
14. Krommer, E.; Ablöscher, 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. *International Journal of Environmental Research and Public Health* **2023**, *20*, doi:10.3390/ijerph20031913.
15. Gatterer, C.; Krommer, E.; Ablöscher, M.; Klemm, V.; Rösner, H.; Strametz, R.; Huf, W.; Ettl, B. Kollegiale Hilfe (KoHi) – Beschreibung des Interventionsprogramms zur Reduktion der Auswirkung belastender Arbeitssituationen im Sinne des Second-Victim-Phänomens bei patientennah tätigem Personal in der Klinik Hietzing, Wien, Österreich (KoHi-II-Studie). *Zbl Arbeitsmed* **2023**, doi:10.1007/s40664-023-00517-w.
16. Cho, H.; Wong, Z.; Chiu, W. The Effect of Volunteer Management on Intention to Continue Volunteering: A Mediating Role of Job Satisfaction of Volunteers. *SAGE Open* **2020**, *10*, 215824402092058, doi:10.1177/2158244020920588.
17. Pelikan, M.; Finney, R.E.; Jacob, A. Use of the Second Victim Experience and Support Tool (SVEST) to Assess the Impact of a Departmental Peer Support Program on Anesthesia Professionals' Second Victim Experiences (SVEs) and Perceptions of Support Two Years After Implementation. *AANA J.* **2023**, *91*, 371–379.
18. Finney, R.E.; Czinski, S.; Fjerstad, K.; Arteaga, G.M.; Weaver, A.L.; Riggan, K.A.; Allyse, M.A.; Long, M.E.; Torbenson, V.E.; Rivera-Chiauzzi, E.Y. Evaluation of a Second Victim Peer Support Program on Perceptions of Second Victim Experiences and Supportive Resources in Pediatric Clinical Specialties Using the Second Victim Experience and Support Tool (SVEST). *J. Pediatr. Nurs.* **2021**, *61*, 312–317, doi:10.1016/j.pedn.2021.08.023.
19. Dukhanin, V.; Edrees, H.H.; Connors, C.A.; Kang, E.; Norvell, M.; Wu, A.W. Case: A Second Victim Support Program in Pediatrics: Successes and Challenges to Implementation. *J. Pediatr. Nurs.* **2018**, *41*, 54–59, doi:10.1016/j.pedn.2018.01.011.
20. Thompson, M.; Hunnicutt, R.; Broadhead, M.; Vining, B.; Aroke, E.N. Implementation of a Certified Registered Nurse Anesthetist Second Victim Peer Support Program. *J. Perianesth. Nurs.* **2022**, *37*, 167-173.e1, doi:10.1016/j.jopan.2021.05.005.
21. Klinik Hietzing. Available online: https://klinik-hietzing.gesundheitsverbund.at/das-haus/ (accessed on 1 November 2023).

22. Lydersen, S. Hvordan oppsummere ordinale data? *Tidsskr. Nor. Laegeforen.* **2020**, *140*, doi:10.4045/tidsskr.20.0033.
23. Lydersen, S. Statistical review: frequently given comments. *Ann. Rheum. Dis.* **2015**, *74*, 323–325, doi:10.1136/annrheumdis-2014-206186.
24. Lydersen, S. Mean and standard deviation or median and quartiles? *Tidsskr. Nor. Laegeforen.* **2020**, *140*, doi:10.4045/tidsskr.20.0032.
25. Wu, H.; Leung, S.-O. Can Likert Scales be Treated as Interval Scales?—A Simulation Study. *Journal of Social Service Research* **2017**, *43*, 527–532, doi:10.1080/01488376.2017.1329775.
26. Edrees, H.; Connors, C.; Paine, L.; Norvell, M.; Taylor, H.; Wu, A.W. Implementing the RISE second victim support programme at the Johns Hopkins Hospital: a case study. *BMJ Open* **2016**, *6*, e011708, doi:10.1136/bmjopen-2016-011708.
27. Lane, M.A.; Newman, B.M.; Taylor, M.Z.; O'Neill, M.; Ghetti, C.; Woltman, R.M.; Waterman, A.D. Supporting Clinicians After Adverse Events: Development of a Clinician Peer Support Program. *J. Patient Saf.* **2018**, *14*, e56-e60, doi:10.1097/PTS.0000000000000508.
28. Riegel, M.; Klemm, V.; Bushuven, S.; Strametz, R. Self-Stigmatization of Healthcare Workers in Intensive Care, Acute, and Emergency Medicine. *International Journal of Environmental Research and Public Health* **2022**, *19*, doi:10.3390/ijerph192114038.
29. Grotto-de-Souza, J.; Pohl, H.H.; Aguiar-Ribeiro, D. Mobbing as a source of psychological harm in workers. *Rev. Bras. Med. Trab.* **2022**, *20*, 670–675, doi:10.47626/1679-4435-2022-766.
30. Gillen, P.A.; Sinclair, M.; Kernohan, W.G.; Begley, C.M.; Luyben, A.G. Interventions for prevention of bullying in the workplace. *Cochrane Database Syst. Rev.* **2017**, *1*, CD009778, doi:10.1002/14651858.CD009778.pub2.
31. Strametz, R.; Raspe, M.; Ettl, B.; Huf, W.; Pitz, A. Handlungsempfehlung: Stärkung der Resilienz von Behandelnden und Umgang mit Second Victims im Rahmen der COVID-19-Pandemie zur Sicherung der Leistungsfähigkeit des Gesundheitswesens. *Zentralbl. Arbeitsmed. Arbeitsschutz Ergon.* **2020**, *70*, 264–268, doi:10.1007/s40664-020-00405-7.
32. Connors, C.A.; Dukhanin, V.; Norvell, M.; Wu, A.W. RISE: Exploring Volunteer Retention and Sustainability of a Second Victim Support Program. *J. Healthc. Manag.* **2021**, *66*, 19–32, doi:10.1097/JHM-D-19-00264.
33. Baxter-Tomkins, T.; Wallace, M. Recruitment and retention of volunteers in emergency services. *Australian Journal on Volunteering* **2009**, *14*, 1–11.