Original Article
doi: https://doi.org/10.1590/1983-1447.2022.20210010.en

The second victim experience: cross-cultural adaptation of an instrument for the Brazilian context

A experiência da segunda vítima: adaptação transcultural de um instrumento para o contexto brasileiro

La experiencia de la segunda víctima: adaptación transcultural de un instrumento para el contexto brasileño

Luisa Petelincar De Sordi[a]
Daniela Campos de Andrade Lourenção[b]
Cristiane Helena Gallasch[c]
Patrícia Campos Pavan Baptista[b]

How to cite this article:
De Sordi LP, Lourenção DCA, Gallasch CH, Baptista PC. The second victim experience: cross-cultural adaptation of an instrument for the Brazilian context. Rev Gaúcha Enferm. 2022;43:e20210010. doi: https://doi.org/10.1590/1983-1447.2022.20210010.en

ABSTRACT

Objective: To cross-culturally adapt and analyze the evidence of content validity of the Second Victim Experience and Support Tool for the Portuguese language spoken in Brazil.

Method: Psychometric study of cross-cultural adaptation following the steps of the Patient-Reported Outcome Measurement Information System. Semantic, idiomatic, experimental, and conceptual equivalences were evaluated. The content validity was verified using the Content Validity Ratio. 31 health professionals from the city of São Paulo participated in the pre-test.

Results: The equivalence analysis showed an agreement rate was 88.7%. The content validity presented 86% of the items with Content Validity Ratio values above the stipulated. In the pre-test, the participants reported that they understood the items of the instrument and only 10% of the participants reported difficulty in understanding any item.

Conclusion: The Brazilian version of the Second Victim Experience and Support Tool presented a good translation quality and good evidence of content validity.

Keywords: Occupational health. Patient safety. Validation study. Psychometrics. Health Personnel. Nursing.

RESUMO

Objetivo: Adaptar transculturalmente e analisar as evidências de validade de conteúdo do *Second Victim Experience and Support Tool* para a língua portuguesa falada no Brasil.

Método: Estudo psicométrico de adaptação transcultural, seguindo as etapas do *Patient-Reported Outcome Measurement Information System*. Foram avaliadas as equivalências semântica, idiomática, experimental e conceitual. A validade de conteúdo foi verificada, com base no *Content Validity Ratio*. Participaram do pré-teste 31 profissionais de saúde da cidade de São Paulo.

Resultados: A análise das equivalências apresentou uma taxa de concordância de 88,7%. A validade de conteúdo apresentou 86% dos itens com valores de *Content Validity Ratio* acima do estipulado. No pré-teste, os participantes reportaram terem entendido os itens do instrumento e apenas 10% dos participantes relataram dificuldade para entender algum item.

Conclusão: A versão brasileira do Questionário de Experiência e Apoio à Segunda Vítima apresentou boa qualidade de tradução e boas evidências de validade de conteúdo.

Palavras-chave: Saúde do trabalhador. Segurança do paciente. Estudo de validação. Psicometria. Pessoal de saúde. Enfermagem.

RESUMEN

Objetivo: Adaptar y analizar transculturalmente la evidencia de validez de contenido de la *Second Victim Experience and Support Tool* para el idioma portugués hablado en Brasil.

Método: Estudio psicométrico de adaptación transcultural siguiendo los pasos del *Patient-Reported Outcome Measurement Information System*. Se evaluaron equivalencias semánticas, idiomáticas, experimentales y conceptuales. La validez de contenido se verificó mediante el índice de validez de contenido. 31 profesionales de la salud de la ciudad de São Paulo participaron en la prueba preliminar.

Resultados: El análisis de equivalencias mostró una tasa de acuerdo del 88,7%. La validez de contenido presentó 86% de los ítems con valores de Tasa de Validez de Contenido por encima de lo estipulado. En la prueba previa, los participantes informaron que entendieron los ítems del instrumento y solo el 10% de los participantes dijeron que tenían dificultades para entender algún ítem.

Conclusión: La versión brasileña del Cuestionario de Experiencia y Apoyo a Segundas Víctimas mostró una buena calidad de traducción y buena evidencia de validez de contenido.

Palabras clave: Salud laboral. Seguridad del paciente. Estudio de validación. Psicometría. Personal de salud. Enfermería.

[a] Universidade de São Paulo (USP), Escola de Enfermagem, Programa de Pós-Graduação em Gerenciamento em Enfermagem. São Paulo, São Paulo, Brasil.

[b] Universidade de São Paulo (USP), Escola de Enfermagem, Departamento de Orientação Profissional. São Paulo, São Paulo, Brasil.

[c] Universidade do Estado do Rio de Janeiro (UERJ), Faculdade de Enfermagem. Rio de Janeiro, Rio de Janeiro, Brasil.

INTRODUCTION

The interface between worker health and patient safety has been the focus of researchers recently. It evidences a number of relevant aspects, especially in the area of nursing, since the working conditions of health professionals directly impact patient quality and safety[1].

Based on the research already conducted, there is now enough data that allow us to argue in favor adequate human resources in health to maintain quality in services. This implies training, upgrading, adequate distribution and maintenance of the health of these professionals. On the other hand, when it comes to nursing, there are also quantitative and qualitative data that express illness in professionals in the category and the lack of institutional policies in health services that ensure this binomial: safe worker and safe patient[2].

Researcher Albert Wu first used the term "second victim" in 2000, pointing out that medical professionals who make a mistake end up becoming the second victim of the incident[3]. The first victim is the patient who suffered from the damage caused and the second victim is the health professional who, after being blamed for the failure, ends up traumatized, and may even develop mental disorders as a result of what happened[4]. Trauma can be caused by the professional who feels fear, shame, insecurity; or, also, by co-workers, patients, family members and leaders who judge and blame the professional for the error, and eventually interpret the professional as someone incompetent, negligent and unethical[4–5].

In 2009, the concept of second victim was expanded to describe not only physicians, but all caregivers who were involved in an adverse event, a medical error, or an unforeseen injury caused to the patient and, as a result, were traumatized by the event. These professionals feel solely responsible for the results of the incident[5].

A study developed with health professionals described six characteristic stages during the recovery trajectory of the second victim. The first stage occurs immediately after the incident, requiring greater attention to the patient who suffered the damage. At that stage, the professional is inattentive, initiating a self-reflection. The second stage is characterized by periods of isolation, reflections on possible "what if…" hypotheses, reflecting on what could have been done to have avoided the incident. In the third stage, the professional seeks support from someone of trust, a co-worker, supervisor, or even personal colleagues. At this stage, there is also insecurity and fear of how the professional will be seen by the work team. After this phase, in the fourth stage, the second victim begins to reflect on how the incident will impact the institution, considers the possibility of being fired, the punishments he/she may suffer and the impact on his/her career. The fifth stage is characterized by the search for emotional support that he/she can trust. The sixth and final stage is about the outcome of the professional. This outcome can occur by withdrawal, with a change of profession, for example; or for survival, when the individual remains in the area, but still afraid of the effects of what happened; another possible outcome is when the professional thrives and assesses the situation and uses it as a possibility for learning and development[5].

At the international level, an instrument was developed that assesses the experience of second victims and the adequacy of support resources for these professionals: the Second Victim Experience and Support Tool (SVEST), developed in 2013 in a pediatric hospital in the United States and which involved 303 professionals[6]. The SVEST is an instrument that proposes to measure the suffering related to the second victim, the perceptions of organizational support, support from colleagues and from supervision, intention to change jobs, absenteeism related to the second victim experience and the desired forms of support[7].

Through the use of a scale that measures the second victim experience in health professionals, it is possible to direct actions with the objective of reducing and preventing the negative effects on the second victim[6]. In addition, the instrument points out some opportunities for improvement in the institution, contributing to a better patient safety culture, since if an institution has a high rate of second victim experiences, the chances of health professionals getting involved in new incidents are higher[6].

In the national scenario, it stands out the lack of a validated instrument that assesses the phenomenon of the second victim experience among health professionals. In this aspect, considering the context presented, the current study proposed to cross-culturally adapt and analyze the evidence of content validity of the Second Victim Experience and Support Tool for the Portuguese language spoken in Brazil.

METHOD

This is a psychometric study of cross-cultural adaptation of an instrument that assesses the experience of professionals considered second victims. The steps of the guidelines proposed by the Patient-Reported Outcome Measurement Information System (PROMIS®) were followed, with some adaptations proposed by Beaton et al. (2002)[8–9]. First, contact was made with the main author of the original instrument, who gave the proper authorization for its adaptation to the

Brazilian culture. From then on, the 11 steps were completed, namely: 1) Translation, 2) Reconciliation, 3) Back-translation, 4) Back-translation review, 5) Expert committee review, 6) Pre-finalization, 7) Finalization, 8) Harmonization, 9) Formatting, 10) Pre-test and 11) Analysis of comments and finalization of translation.

The SVEST consists by 36 items that compose 10 dimensions. The first seven dimensions measure the responses of the second victims and the support characteristics, which are, in their original language: "psychological distress", "physical distress", "colleague support", "supervisor support", "institutional support", "non-work-related support", "professional self-efficacy". Subsequently, two dimensions are presented that address the outcome, which are: "turnover intentions" and "absenteeism". Responses to items in these dimensions are measured using a Likert-type scale, ranging from 1 (strongly disagree) to 5 (strongly agree). The instrument also measures the second victims' desire for support, thus completing the last dimension, which is also assessed by a Likert-type scale, ranging from 1 (do not strongly desire) to 5 (strongly desire), considering that there are indicated items that have the inverted score[6].

The translation and reconciliation steps were conducted by three independent, bilingual translators whose mother language was Portuguese. As qualification, two translators were doctor in Languages (literature and linguistics) and the third was a doctor in nursing, with knowledge in the health area. From the translations, the synthesis of the translations was elaborated by the third translator, later validated by the researchers.

The translators were selected for their expertise in cross-cultural translations and adaptations of instruments. They received, via e-mail, an invitation letter with the guidelines for the work and the original instrument (except the back-translator).

The back-translation step was performed by another independent translator, fluent in Brazilian Portuguese and whose first language was the same of origin of the instrument (American English). This translator received a synthesis of the translations and then elaborated the back-translation into the instrument's source language. The back-translation review was conducted by the researchers themselves and all steps (Translation 1, Translation 2, Translation 3, Synthesis of Translations and Back-translation) were sent to the original author.

The products of each step were consolidated in Excel® spreadsheets for better structuring.

The review step by the expert committee was divided into two moments. The first moment included the analysis of the quality of the translations, through the evaluation of equivalences, and the second, the evaluation of evidence of content validation.

The equivalences were evaluated: semantic, idiomatic, experimental and conceptual, taking into account the following definitions: semantic equivalence – refers to the equivalence of meaning, is related to the grammatical and vocabulary sense; idiomatic equivalence – refers to colloquial expressions (informal or popular expressions); experimental equivalence – consistency is attributed between the terms used and life experiences that may be different between cultures and; conceptual equivalence – refers to the equivalence of concept, that is, a word can have the same meaning, but with a different concept because they are different cultures[8–9].

For the analysis of equivalences, seven experts participated, being four nurses, a physician, a psychologist, and a Bachelor of Languages. The team of experts was multidisciplinary, according to the recommendation of Beaton et al (2002), as follows: specialist with expertise in psychometrics; health professional with expertise in the subject studied; linguist with expertise in the Portuguese language spoken in Brazil, and the translators involved in the translation phase[9]. The experts had the title of Doctor, and three of them were post-docs.

The experts received, via email, an invitation letter with the guidelines and concepts to be used, and an Excel® spreadsheet with all the previous steps and the synthesis of the translations for the judgment of equivalences in "totally equivalent" or "not equivalent". The Agreement Rate was calculated and it was considered the minimum rate of 80%[10].

Content validity was evaluated by seven experts who had expertise in the area of patient safety and worker health, five of whom also participated in the equivalence analysis. The following were assessed: clarity – if the items were written in an understandable way and if they clearly expressed what they were intended to measure; pertinence - if the items reflected the proposed concepts and if they were relevant and adequate to achieve the expected objectives of the instrument and; relevance – whether or not the content of the item is relevant to the culture in which it will be inserted[10].

The analysis was performed by calculating the Content Validity Ratio (CVR), ranging between perfect agreement (+1) and perfect disagreement (-1). To ensure that agreement between experts was not due to chance, the critical value of CVR was used. In the case of this study, a significance level of 0.05 was adopted, resulting in a minimum critical CVR value of 0.741[11–13]. The CVR calculation was performed using the following formula[13]:

$$CVR_{critical} = \frac{n_{critical} - (N / 2)}{(N / 2)}$$

The experts received an invitation letter with guidelines and the assessment instrument that was made available by Google Forms®. In the electronic form, each item could be assessed as "yes" and "no", considering the concepts of clarity, pertinence, and relevance. Subsequently, the responses were analyzed in Excel® spreadsheets.

In the pre-finalization stage, the researchers reviewed and evaluated the suggestions made by the experts. The finalization, harmonization and formatting were done with the verification of all the previous steps, in search of discrepancies or flaws.

The pre-test step took place in November 2020, in the city of São Paulo, with the participation of 31 health professionals from different health institutions in the city. The participants were nurses, nursing technicians, physicians, physical therapists, speech therapists, psychologists, pharmacists, and nutritionists, who, as an inclusion criterion, had or previously had an employment relationship and whose first language was Portuguese spoken in Brazil. The invitation to professionals was made digitally, containing a text with the electronic address of the data collection form, disclosed in contact groups. From the analysis of the responses, considering the inclusion criteria, a convenience sample was formed, following the recommendation proposed by Beaton et. al., of at least 30 participants[9].

In the first part, the participants responded, through an online questionnaire, the sociodemographic questions and work characteristics, then the pre-final version of the Second Victim Experience and Support Tool (BR-SVEST) and open and closed questions evaluating the clarity of understanding, difficulty understanding and suggestions.

Participants were invited to participate in this phase by means of a convenience sample, by signing the Free and Informed Consent Form (FICF).

At the end, in the comment analysis and translation finalization step, the researchers analyzed the pre-test participants' comments and the instrument's translation was completed.

This study was approved by the Ethics Committee of the *Universidade de São Paulo* School of Nursing, receiving the number CAAE 19827019.9.0000.5392 and was initiated after authorization by the authors of the original instrument.

RESULTS

The results of the initial steps of translation, the synthesis of the translations and the back-translation were structured in spreadsheets and forwarded to the original author of the instrument, who suggested only an adjustment in the title of the instrument, which in the back-translation was "Second Victim Experience and Supporting Tool" different from of the original instrument which is "Second Victim Experience and Support Tool". The Second Victim Experience and Support Tool can be checked in full in the original study[6].

As a result of the analysis of equivalences, the instrument obtained an overall agreement rate of 88.7%, above the minimum stipulated value. From the 57 items that were assessed (title, filling instructions, scoring instructions, domain titles and evaluation items), ten had the universal equivalence below the stipulated, ranging between 60.7% and 78.6%. Due to this, in relation to the items that had the lowest universal equivalence, the experts' suggestions were accepted, with the objective of improving the clarity of these items.

The filling instructions also received changes, one of them in relation to the term "near miss". This aspect had already been identified in the translation and back-translation steps. At the suggestion of two experts, the term in English was added: "...or that almost reached the patient (circumstances in which the error occurred, but did not reach the patient, the so-called near miss)". Most of the experts' suggestions were accepted, even in items that had an equivalence rate higher than 80%.

After the analysis of equivalences, the content validity was verified. In this step, the same experts as in the previous step were invited (except for the language experts), and one of them was also replaced due to unavailability. There was a total of seven experts, six nurses and one physician, all with a doctoral degree, three of them post-docs and one with a full professorship.

The analysis was performed by calculating the critical CVR, and from the 36 items evaluated, 31 items (86%) presented CVR above the stipulated value of 0.741; five items (14%) presented mean CVR below the stipulated value, and it was necessary to review according to the suggestions made by the experts. For the other items, even with mean CVR above 0.741, suggestions were also considered. The results are described in Table 1:

Table 1 - Content Validity Ratio - of items from the pre-final Brazilian version of the Second Victim Experience and Support Tool (SVEST), São Paulo, 2020.

Item	Mean CVR
Psychological Distress	
ITEM 1: I have experienced embarrassment from these instances.	0.714
ITEM 2: My involvement in these types of instances has made me fearful of future occurrences.	0.619
ITEM 3: My experiences have made me feel miserable.	0.810
ITEM 4: I feel deep remorse for my past involvements in these types of events.	0.905
Physical Distress	
ITEM 5: The mental weight of my experience is exhausting.	0.619
ITEM 6: My experience with these occurrences can make it hard to sleep regularly.	0.905
ITEM 7: The stress from these situations has made me feel queasy or nauseous.	0.905
ITEM 8: I hardly have an appetite when I think about these situations.	0.905
Colleague Support	
ITEM 9: I appreciate my co-workers' attempts to console me, but their efforts can come at the wrong time.	0.810
ITEM 10: Discussing what happened with my colleagues provides me with a sense of relief.	0.905
ITEM 11: My colleagues can be indifferent to the impact these situations have had on me.	0.905
ITEM 12: My colleagues help me feel that I am still a good healthcare provider despite any mistakes I have made.	1.000
Supervisor Support	
ITEM 13: I feel that my supervisor treats me appropriately after these occasions.	0.905
ITEM 14: My supervisor's responses are fair.	0.524
ITEM 15: My supervisor blames individuals.	0.810
ITEM 16: feel that my supervisor evaluates these situations in a manner that considers the complexity of patient care practices.	0.905

Table 1 - Cont.

Item	Mean CVR
Institutional Support	
ITEM 17: The institution where I work understands that those involved may need help to understand any effects these events may have on care providers.	0.905
ITEM 18: The institution where I work offers a variety of resources to help me get over the effects of involvement with these instances.	0.905
ITEM 19: The concept of concern for the well-being of those involved in these situations is not strong at where I work.	0.905
Non-Work-Related Support	
ITEM 20: I look to close friends and family for emotional support after one of these situations happens.	0.905
ITEM 21: The love from my closest friends and family helps me get over these occurrences.	0.905
Professional Self-Efficacy	
ITEM 22: Following my involvement I experienced feelings of inadequacy regarding my patient care abilities.	0.810
ITEM 23: My experience makes me wonder if I am not really a good healthcare provider.	0.810
ITEM 24: After my experience, I became afraid to attempt difficult or high-risk procedures.	0.905
ITEM 25: These situations do not make me question my professional abilities.	0.905
Intentions to Leave Work	
ITEM 26: My experience with these events has led to a desire to take a position outside of patient care.	0.810
ITEM 27: Sometimes the stress from being involved with these situations makes me want to quit my job.	0.905
Absenteeism	
ITEM 28: My experience with an adverse patient event or medical error has resulted in me taking a mental health day.	0.810
ITEM 29: I have taken time off after one of these instances occurs.	0.905

Table 1 - Cont.

Item	Mean CVR
Desired Forms of Support	
ITEM 30: The ability to immediately take time away from my unit for a little while.	0.429
ITEM 31: specified peaceful location that is available to recover and recompose after one of these types of events.	0.905
ITEM 32: A respected peer to discuss the details of what happened.	0.905
ITEM 33: An employee assistance program that can provide free counseling to employees outside of work.	0.905
ITEM 34: A discussion with my manager or supervisor about the incident.	0.905
ITEM 35: The opportunity to schedule a time with a counselor at my hospital to discuss the event.	0.905
ITEM 36: A confidential way to get in touch with someone 24 hours a day to discuss how my experience may be affecting me.	0.905

Source: The authors, 2020

It was decided to keep the five items that obtained CVR below the stipulated value due to their importance in the context of the questionnaire and, for that, the experts' suggestions were accepted, to improve the clarity of the items.

Most of the experts' suggestions were related to the inclusion of information about which situations or events the phrase applied to, as for example in item 15. In this item, the statement "My supervisor blames individuals" was replaced by "My supervisor blames the individuals who were involved in the adverse event".

The acronym BR-SVEST was added to the instrument title. The final version, with the experts' suggestions, can be viewed in the final instrument.

In the pre-test stage, 31 health professionals participated, all from the Southeast region of Brazil, whose sociodemographic and work characteristics are presented in the table below (Table 2).

Regarding the results of the assessment of clarity of understanding of the final version of the translated instrument, all participants mentioned understanding the items; when asked if there was any difficulty in understanding, 28 professionals (90%) reported having no difficulty understanding the items and three professionals (10%) reported having difficulties understanding them. Among the professionals who reported difficulty, no similarity of profession was observed, being a physician, a physical therapist, and a nurse. The reported difficulties referred to the Colleague Support domain – "I appreciate my co-workers' attempts to comfort me, but your help may come at the wrong time". In the comments, professionals questioned what would be the wrong time for help. The other professionals did not present suggestions for modifying the instrument.

After analyzing the pre-test comments, the final instrument of the cross-cultural adaptation process was obtained. The formatting was adapted to allow easier completion of the Second Victim Experience and Support Tool (BR-SVEST).

DISCUSSION

The term "second victim" has been controversial about the meaning of "victim" and its connotation of passivity on the health professional, according to the analysis of some authors[4]. The involvement of health professionals in adverse events impacts the health of the professional who, from the suffering of having lived this experience, becomes a "second victim"[5].

Table 2 - Sociodemographic and work characteristics of pre-test participants. São Paulo, 2020.

Sociodemographic and work variables	n	%
Gender		
Female	25	81%
Male	6	19%
Age		
20 to 29 years	8	26%
30 to 39 years	17	55%
40 to 49 years	3	10%
> 50 years	3	10%
Training		
Medicine	5	16%
Nursing	5	16%
Nutrition	5	16%
Nursing Technician	5	16%
Physical therapy	3	10%
Pharmacy	3	10%
Psychology	3	10%
Speech Therapy	2	6%
Graduation time		
< 9 years	19	61%
From 10 to 19 years	9	29%
From 20 to 29 years	1	3%
> 30 years	2	6%
Employment relationship		
CLT	16	52%
Self Employed	8	26%

Table 2 - Cont.

Sociodemographic and work variables	n	%
Public Service	5	16%
Third	1	3%
Other	1	3%
Occupation area		
Hospital	26	84%
Primary Health Care	5	16%
Weekly workload		
< 30 hours	1	3%
30 hours	6	19%
36 hours	1	3%
40 hours	11	35%
44 hours	7	22%
> 50 hours	5	16%
Employment relationships		
1 relationship	27	87%
2 relationships	3	10%
More than 3 relationships	1	3%

Source: The authors, 2020.

The suffering of the health professional comes not only from his/her involvement in the adverse event, it can also have later repercussions. Such effects can occur in the work institution and in the way they and the leadership will deal with the adverse event, or also in the forms of support to which the professional had access and how they will manifest themselves when dealing with the second victim experience[6].

Measurement instruments allow to evaluate and present quantitative results on the same construct in different populations, enabling comparisons and analysis on the subject[14]. The focus instrument of this study aims to measure the impact of the second victim phenomenon on health professionals[6].

The cross-cultural adaptation process took place in a mixed way, following the methodology of the PROMIS® guideline[8]. In the first steps of translation and back-translation, the emphasis was on the English language terms that are already present in the linguistic practices of health professionals in Brazil, such as "near miss" and "turnover". These terms were also discussed again in the expert committee review steps and in content validity. Even though they were already incorporated into Brazilian culture, including a validated instrument using the term "turnover", we chose to translate it as "intentions to leave work", making it easy to understand for the target audience[15]. Regarding the term

"near miss", we chose to keep the two terms, "near miss and almost error" at the experts' suggestion and also because it is already known among professionals who work with patient safety, as "near miss". However, as it is an instrument that will be applied to health professionals from the technical level, the word translated to "almost error" has also been maintained.

In the equivalence analysis, the instrument obtained an universal agreement rate of 88.7%, which indicates a good agreement value in the equivalence of the items, with acceptable values above 80% as reference[10]. The items that had universal equivalence below the stipulated were reformulated and, even so, they may present some difficulty in understanding as a limitation, but this was not observed in the following steps, as in the pre-test.

Regarding content validity, 86% of the items had a mean CVR above 0.741, a reference value according to the number of experts. In view of this result, it is considered that the instrument presented good CVR results, demonstrating good content validity[11,13].

In the original instrument, the construct validity was verified through confirmatory factor analysis and the instrument's reliability was tested using Cronbach's alpha coefficient (α), which obtained values above 0.70 in seven domains and only two domains presented values of 0.61 and 0.64[6]. These psychometric properties were not verified in the present study, therefore, it is emphasized the importance of these analyses in future studies.

The Korean version of the Second Victim Experience and Support Tool (K-SVEST) had its content validity assessed using the Content Validity Index (CVI), which resulted in 0.95, which is considered a good result for validity[16]. In this sense, the Chinese version Second Victim Experience and Support Tool (C-SVEST) also used the CVI calculation and obtained a result of 0.99 for the instrument and 0.89 for the validity of the item level[17]. Furthermore, the Argentine version calculated the reliability of the instrument, which obtained global Cronbach's alpha value of 0.805[18].

It was opted to include the acronym BR-SVEST in the instruments title, according to the standards used in the translations and adaptations of the instrument into other languages[16–17].

After verifying the content validity, the instrument was submitted to a pre-test, whose objective was to verify the understanding of the items by the target audience, that is, health professionals.

The studies mentioned above validated this same instrument only in the area of nursing for the Chinese, Argentine and Korean population[16,17,18]. In this study, it was decided to apply the pre-test to the entire multidisciplinary team, as well as in the study of the origin of the instrument[6].

Thirty-one health professionals participated in the pre-test, distributed among the following professions: medicine, nursing (bachelor and technical level), nutrition, physical therapy, pharmacy, psychology, and speech therapy. Following the definition by Scott et al (2009), the term second victim refers to health professionals who were involved in an adverse event, considering all of the multidisciplinary team, hence the importance of its validation in professionals from different specialties[5].

The pre-test result was satisfactory, as the 31 participants stated that they understood the instrument items, 28 reported having no difficulties and only three had difficulty understanding. Two participants reported difficulty with the item "I appreciate my co-workers' attempts to console me, but their efforts can come at the wrong time", and the comments on this item asked what would be the "wrong time" to get help.

A study conducted in Spain, which evaluated the second victim experience in health professionals (physician and nurses), observed that six out of 10 professionals had a second victim experience and that they rarely receive any type of training or education on coping strategies related to involvement in adverse events[19]. Professionals reported feelings of guilt, anxiety, fear of consequences, all of which were also evidenced in other works on the subject[19].

Health professionals in suffering, with emotional and physical distress related to work can also affect patient safety. These professionals do not have their full capacity for work, putting patient safety at risk or also increasing absenteeism and turnover, generating work overload, a situation that applies to second victim professionals[20].

The use of the Second Victim Experience and Support Tool (BR-SVEST) allows the assessment of health professionals' experience as a second victim and directs forms of support. The study of the creation of this instrument suggests its use by health leaders, before or after the implementation of support programs for the second victim, allowing the evaluation of the quality and performance of the resources offered[6].

The application of the instrument, in health services, may present, in percentage, the negative effects of the experiences of second victims of health professionals, as well as the opportunities to improve the support resources available in the institutions, showing what are the desired forms of support by professionals.

It is highlighted the importance of the use of this instrument by health organizations as part of the evaluation of institutional safety culture, since the occurrence of adverse events does not affect exclusively the patient, but also the professionals involved in the event and, later, the health institution. The analysis on the occurrence of second victims

by the health institution allows to direct actions to improve processes focused the on patient safety culture.

CONCLUSION

The Second Victim Experience and Support Tool (BR-SVEST) was translated into the Portuguese language spoken in Brazil, and it was performed the cross-cultural adaptation to Brazilian culture. Regarding semantic, idiomatic, experimental, and conceptual equivalence, the instrument showed a universal agreement rate of 88.7%, considered satisfactory. The items that had universal equivalence below the stipulated were reformulated according to the experts' suggestions and no difficulty in understanding was observed by the participants in the pre-test, however, some difficulty in understanding in a larger sample may be a limitation.

The BR-SVEST presented good evidence of content validity, verifying clarity, pertinence, and relevance of the items. Altogether, the instrument presented mean CVR results ranging from 0.429 to 1.00. Only five items had a mean CVR below the stipulated value, requiring the readjustment of the items according to the experts' suggestions.

The study presented as a limitation the non-assessment of evidence of internal structure, thus, the application of the instrument in new studies for the analysis of this aspect is justified, and it is also suggested the application of the instrument in professionals from different regions of Brazil.

Thus, the study provided a tool, the BR-SVEST, which can be used in health services to assess the second victim experience in their health professionals and, thus, develop support actions and programs for these professionals.

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Authorship contribution:

Conceptualization – Luisa Petelincar De Sordi, Daniela Campos de Andrade Lourenção, Cristiane Helena Gallasch, Patrícia Campo Pavan Baptista.
Data curation – Luisa Petelincar De Sordi.
Formal analysis – Luisa Petelincar De Sordi.
Funding acquisition – Luisa Petelincar De Sordi.
Investigation – Luisa Petelincar De Sordi.
Methodology – Luisa Petelincar De Sordi, Daniela Campos de Andrade Lourenção, Cristiane Helena Gallasch, Patrícia Campo Pavan Baptista.
Resources – Luisa Petelincar De Sordi.
Software – Luisa Petelincar De Sordi.
Validation – Luisa Petelincar De Sordi, Daniela Campos de Andrade Lourenção, Cristiane Helena Gallasch, Patrícia Campo Pavan Baptista.
Visualization – Luisa Petelincar De Sordi, Daniela Campos de Andrade Lourenção, Cristiane Helena Gallasch, Patrícia Campo Pavan Baptista.
Writing-original draft – Luisa Petelincar De Sordi.
Writing-review & editing – Luisa Petelincar De Sordi, Daniela Campos de Andrade Lourenção, Cristiane Helena Gallasch, Patrícia Campo Pavan Baptista.
Project administration – Daniela Campos de Andrade Lourenção, Patrícia Campo Pavan Baptista.
Supervision – Daniela Campos de Andrade Lourenção, Patrícia Campo Pavan Baptista.
The authors declare that there is no conflict of interest.

Corresponding author:

Luisa Petelincar De Sordi
Email: luisa.desordi@gmail.com

Associate editor:
Luccas Melo de Souza

Received: 02.12.2021
Approved: 10.08.2021

Editor-in-chief:
Maria da Graça Oliveira Crossetti