



## ORIGINAL ARTICLE

## Cross-cultural adaptation to the Spanish context and evaluation of the content validity of the Second Victim Experience and Support Tool (SVEST-E) questionnaire<sup>☆</sup>



Irene Santana-Domínguez<sup>a,b</sup>, Héctor González-de la Torre<sup>a,c,\*</sup>, Alicia Martín-Martínez<sup>a,b</sup>

<sup>a</sup> Servicio de Obstetricia y Ginecología, Complejo Hospitalario Universitario Insular Materno-Infantil de Gran Canaria, Servicio Canario de Salud, Las Palmas, Spain

<sup>b</sup> Universidad de Las Palmas de Gran Canaria, Las Palmas, Spain

<sup>c</sup> Universidad de La Laguna, Sede La Palma, Santa Cruz de Tenerife, Spain

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### KEYWORDS

Patient safety;  
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### Abstract

**Objectives:** To carry out a cross-cultural adaptation of the Second Victim Experience and Support Tool (SVEST) questionnaire to the Spanish context, and to evaluate its content validity (CVI).

**Methods:** The translation and cultural adaptation of a measuring instrument by means of translation and back translation conducted through the participation of 20 health professionals. The content validation was carried out through the participation of 10 experts. The content validity of each item (CVI-I), the content validity index per expert (CVI-E) and the content validity total (CVI-T) were calculated for the questionnaire. Corrections were carried out for probable random agreement and the statistical calculation Kappa (K\*) modified for each item of the instrument.

**Results:** The final instrument obtained (SVEST-E) has a CVI-Total of 0.87 and consists of 36 total items, subdivided into 7 dimensions, 2 outcome variables and a support option section maintaining the same structure as the original questionnaire. Thirty items had a CVI-I with values over  $\geq 0.79$ .

**Conclusions:** The SVEST-E questionnaire is an equivalent of the original and is an instrument that could help to evaluate the second victim experiences of healthcare professionals in our country. It is an instrument with adequate content validity to measure the experience of second victims in health professionals in our country.

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\* Corresponding author.

E-mail address: [hegontor@gmail.com](mailto:hegontor@gmail.com) (H. González-de la Torre).

**PALABRAS CLAVE**

Seguridad del paciente;  
Errores médicos;  
Estudios de validación

## Adaptación transcultural al contexto español y evaluación de la validez de contenido del cuestionario *Second Victim Experience and Support Tool* (SVEST-E)

**Resumen**

**Objetivo:** Realizar la adaptación transcultural del cuestionario *Second Victim Experience and Support Tool* (SVEST) al contexto español, así como evaluar la validez de contenido.

**Método:** Traducción y adaptación transcultural de un instrumento de medida mediante la traducción y retrotraducción y pilotaje con la participación de 20 profesionales sanitarios. La validación de contenido se realizó con la participación de diez expertos. Se calculó la validez de contenido de cada ítem (CVI-I), índice de validez de contenido por experto (CVI-E) y la validez de contenido total (CVI-T) para el cuestionario. Se realizó corrección del probable acuerdo al azar y el cálculo estadístico del Kappa modificado para cada ítem del instrumento.

**Resultados:** El instrumento final obtenido (SVEST-E) posee un CVI-Total de 0,87 y consta de 36 ítems totales, subdivididos en siete dimensiones, dos variables resultado y una sección de formas de apoyo, manteniendo la misma estructura de que el cuestionario original. Treinta ítems mostraron una CVI-I con valores por encima de  $\geq 0,79$ .

**Conclusiones:** El cuestionario SVEST-E preserva la equivalencia con el original y es un instrumento con una adecuada validez de contenido para medir la experiencia de segundas víctimas en los profesionales sanitarios en España.

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**What is known?**

Within the study of adverse events and patient safety there is growing interest on second victim impact. The only existing validated tool for assessment of the phenomenon of second victims is the *Second Victim Experience and Support Tool* (SVEST), which has been used in different environments and countries.

**What does this paper contribute?**

This study carried out the cross-cultural adaptation of the SVEST questionnaire into the Spanish context, the SVEST-E, together with validation of its content. In the expectation of its use in field studies with healthcare professionals to confirm other psychometric properties of this questionnaire, this research confirms the validity of the SVEST questionnaire -E to measure the second victim experience of healthcare professionals in Spain.

**Introduction**

Patient safety has been defined as the prevention of errors and adverse effects produced by healthcare, i.e., not causing damage to patients.<sup>1,2</sup> However, all healthcare has an error margin.<sup>2</sup> According to the study “To Err is Human” published by the Institute of Medicine in 1999, patients on occasions suffer from lesions or damage as a result of healthcare, i.e., from adverse events.<sup>3</sup> The results and conclusions

of this study led to a huge change in the way in which the quality of healthcare organisations were conceived.<sup>2,4</sup> The study of adverse events, their frequency, causes and consequences has had a booming market during the last two decades and methods and systems are currently evaluated worldwide to reduce inherent risks in patient care.<sup>4,5</sup>

In Spain, a study on patient safety in primary care estimated the prevalence of adverse events in this area at 11%, with 7% of patients suffering from more than one adverse event.<sup>6</sup> Similarly, a national study on adverse events linked to hospitalization calculated that 10% of patients cared for in a hospital suffer from one adverse event each year.<sup>7</sup> Of these, over half may have been avoided.<sup>7</sup> Although most damage derived from these adverse events have mild consequences, a variable percentage, depending on the study, may become permanent or severe, even leading to the patient’s death.<sup>8,9</sup>

When an adverse event occurs, the patient and their family members are the first people to be affected, the first victims. However, the outcome and/or development of these events generally involve one or several healthcare professionals, who also suffer from negative consequences from the event, albeit on a different level. They are called second victims.<sup>10,11</sup>

The term “Second victim” was coined by Wu in the year 2000, the definition of which is: “all professionals, providers of healthcare services, who are involved in an adverse patient event, medical error and/or a patient-related injury which was unanticipated and converts them into a victim”.<sup>12</sup>

Despite being a relatively recent issue, this has aroused great interest in recent years.<sup>10,11,13</sup> For those health professionals who suffer from it, this phenomenon may include pain, suffering, uncertainty, loss of reputation and negative repercussions on their health.<sup>10,11,13,14</sup> It also has a major

financial and reputational impact on healthcare systems and their institutions.<sup>10</sup>

The approach to healthcare errors is currently changing.<sup>15</sup> From a former, punitive model where the person or group responsible for the adverse event was sought out and where the cause of the event was explained as a lack of initiative, interest, or disposition, an updated model has come about which accepts that people make mistakes and that they are inherent to healthcare.<sup>10,11,15</sup> The occurrence of adverse events must be understood as an opportunity to improve both for the professionals and the institutions where they offer services, with regard to the care provided to their patients.<sup>15</sup> The healthcare professional is not so much a direct causing agent, but another component in the process. Only by analysing all the factors involved in the aetiology of the adverse events can valid information to prevent repetition of them occur.

A part of this analysis should include evaluation, care and support of the professional involved in this type of event, the second victim.<sup>10,11,13,14</sup> However, there is a lack of tools or instruments for this. At the moment the only validated tool for evaluation of the phenomenon of second victims is the SVEST.<sup>15</sup> This tool comprises a questionnaire which specifically measures the phenomenon of the second victims and has been validated and used in several environments and countries.<sup>16-19</sup> Although it has been translated into Spanish, the validated version was for Argentina, not Spain.<sup>16</sup>

As a result, the purpose of this study is the cross-cultural adaptation of the SVEST questionnaire into the Spanish context, in addition to evaluation of its content validity.

## Method

### Study design

Translation and cross-cultural adaptation of the measuring tool. The translation –back-translation method was used, with pilot testing and evaluation by a panel of experts,<sup>20</sup> in keeping with the methods used in cross-cultural adaptations of the SVEST questionnaire in other countries (Argentina,<sup>16</sup> Korea<sup>17</sup> and China<sup>18</sup>). The process took place from October 2019 to May 2020.

### Original tool

The SVEST questionnaire was developed by Burlison JD et al. in U.S.A. in 2014 with the purpose of measuring the second victim experience in healthcare personnel.<sup>15</sup> The questionnaire considers seven dimensions. Psychological distress (four items), physical distress (four items), colleague support (four items), supervisor support (four items), institutional support (three items), support not related to work (two items), and personal self-efficacy (four items). The tool also evaluated two outcome variables: intention to change jobs (two items) and absenteeism at work (two items). Furthermore, it provided a section with seven items with response options for the second victim to reflect their preferences on desired forms of institutional support.

Scoring of the seven dimensions and the outcome variables used a Likert 5-point scale, with scores ranging from 1 (“totally disagree”) to 5 (“totally agree”). The highest

scores were associated with greater experience and sense of being a second victim by the professional.

The responses for the section on desired forms of support used a Likert scale from 1 to 5, where 1 represented “strongly not desired” and 5 “strongly desired”.

### Cross-cultural adaptation

In order to obtain the semantic and conceptual equivalence of the tool the following phases specified below were undertaken.<sup>20</sup>

Initial confirmation of intellectual property registration was made, contacting the author of the original questionnaire to request their approval, and obtaining their authorisation.

In phase one, two translators made two translations of the original questionnaire from its source language (English) into Spanish. The first translator was a healthcare professional (midwife), a native Spanish person but bilingual since infancy in English and had completed their professional studies in England. The second was a professional translator, native English speaker with a good command of Spanish and experience in the translation of medical reports. The first translator was familiar with the subject of second victims, whilst the second translator was not.

Both translators were asked to evaluate the difficulty they had in carrying out the translations, offering them three possible options (difficult/medium and easy).

During phase two both translations were analysed and discussed by the research team, a gynaecologist and two midwives, reaching a consensus on the correct modifications, and obtaining a unified version of the same (preliminary versión 1 of the SVEST-E). An additional method used for this version was comparison with the Argentinean adaptation of the SVEST (same language, but different country and context) granted by the autor.<sup>16</sup>

In phase three back-translations were made of the preliminary versión 1 of the SVEST-E, using two professional bilingual independent translators (the first native English and the second native Spanish). These translators were different to those used in phase one. Neither of these translators were familiar with the study theme.

Both translators completed the same difficulty evaluation tests as the first translators.

Once the back-translations had been obtained they were compared with the original version of the questionnaire by the research team and sent to the original author for assessment. Fig. 1 summarises all phases of the cross-cultural adaptation process.

### Applicability of the tool

A pilot scheme was used to estimate feasibility and viability of the tool, along with its cultural suitability. This was based on the identification of ambiguous items, possible errors and comprehension conflicts in the items. Response completion time was also assessed. The participant professionals were chosen through non probabilistic convenience sampling at the convenience of the research team criteria. A total of 20 professionals (10 gynaecologists and 10 midwives) took part in this pilot study, and the questionnaire was sent to them

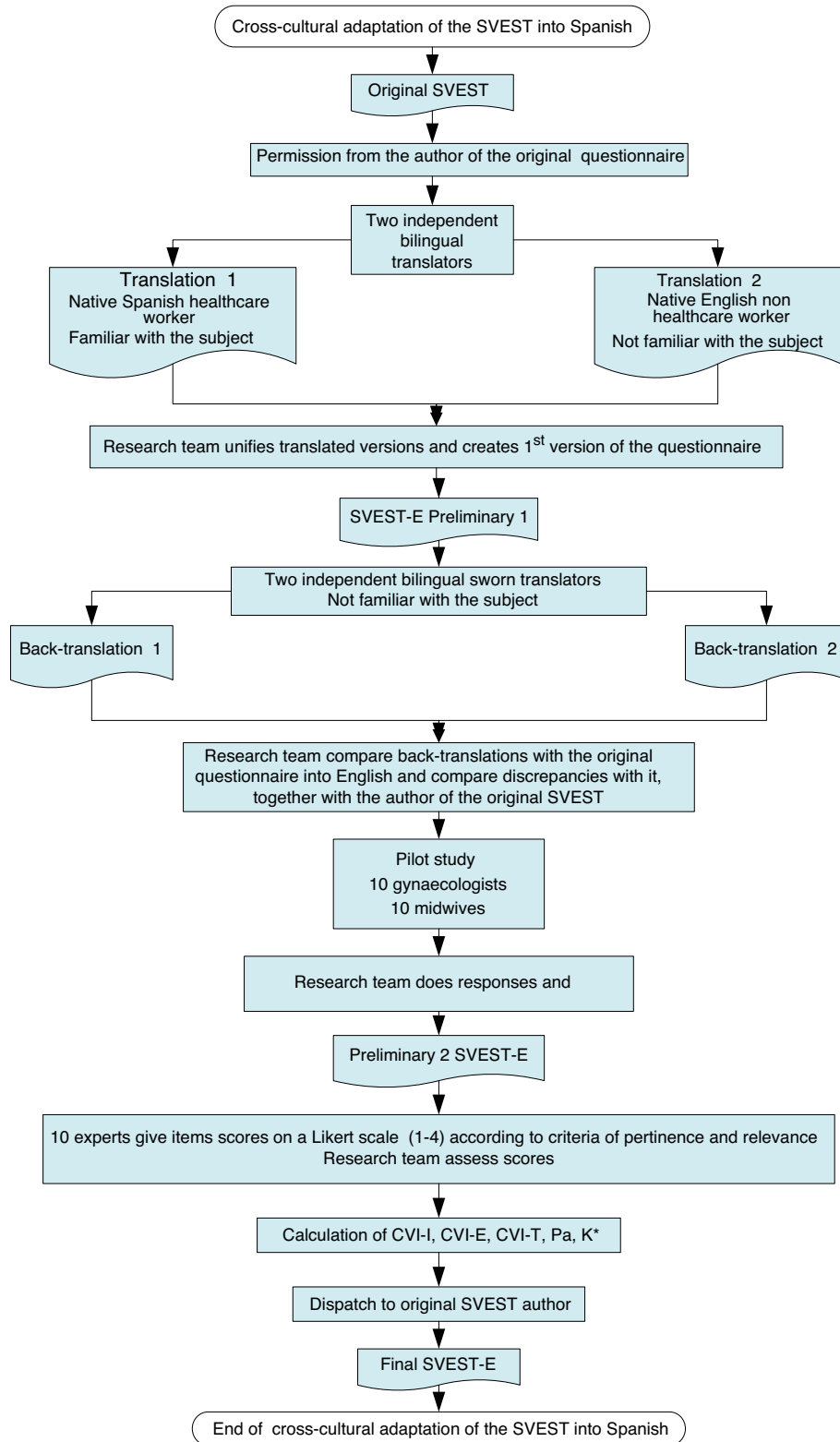


Figure 1 Diagram of the cross-cultural adaptation process of the SVEST.

**Table 1** Occupation, years of experience, area and academic level of the experts.

	Position they occupy	Years of professional experience	Area	Academic level
Expert 1	Hospital quality coordinator	31 years	Care Manager	Medical and surgical graduate Postgraduate in hospital emergencies Master graduate in quality management Doctorate in medicine
Expert 2	Gynaecologist Area Director	22 years	Care Manager Teaching	Medicinal and surgical graduate Specialist in obstetrics and gynaecology
Expert 3	Gynaecologist Area Director	30 years	Care Manager Teaching	Medical and surgical graduate Bioethical Master Doctorate in Medicine
Expert 4	Midwife	31 years	Care	Nursing diploma Specialist in obstetrics and gynaecology
Expert 5	Full University professor	21 years	Teaching	Nursing diploma Doctorate in health sciences
Expert 6	Anaesthetist	11 years	Care Manager Teaching	Medicinal and surgical graduate Specialist in anaesthesiology and resuscitation Doctorate in Medicine
Expert 7	Midwife	4 years	Care	Nursing diploma Specialist in obstetrics and gynaecology
Expert 8	General supervisor midwife	40 years	Manager	Nursing diploma Specialist in obstetrics and gynaecology
Expert 9	Paediatrician Associate university professor	30 years	Care Teaching	Medicinal and surgical graduate Specialist in paediatrics Doctorate in medicine
Expert 10	Gynaecologist Area Director Head of University Department	38 years	Care Manager Teaching	Medicinal and surgical graduate Specialist in obstetrics and gynaecology Doctorate in medicine University professor

via email. For this an electronic formula was designed, using a safe online survey platform (*Google Forms*) in keeping with the recommendations of the CHERRIES<sup>21</sup> regulations. This pre-test was carried out during April 2020.

The preliminary version 2 of the SVEST-E was created using suggestions from this process.

### Content validity

To study content validity the experts test described by Polit and Beck,<sup>22</sup> was used. This is based on the systematic use of intuitive judgement issued by a group of experts, to highlight convergences of opinions and reach eventual consensus. The panel of experts comprised 10 professionals, who were chosen by non probabilistic convenience sampling by the research team. The selection criteria sought diversity in aspects such as: academic level, years of experience, environment, professional category and knowledge on the issue of second victims.

Each one of them was given a code known only to the research team members to preserve anonymity. Each expert gave a score to the items of the preliminary version 2 of the VEST-E, according to three criteria of pertinence and relevance, with the use of a Likert scale from 1 to 4 (from

lesser to greater importance). The same platform as that used in the previous pilot phase was used to collect scores.

With the scores from the experts, the following was calculated: content validity of each item (CVI-I); content validity index by expert (CVI-E), and total content validity (CVI-T). To ensure validity of the items in the calculation of the content validity index correction of random chance agreement was made (Pa) using the formula =  $[N! / (A!(N-A)!)] * 0.5^N$ , where N = n° Expert and A = n of agreement with good relevance and the statistical calculation of modified Kappa ( $K^* = (CVI-i-Pa)/(1-Pa)$ ) for each item of the tool. The evaluation criteria of the K\* were described by Polit et al. (Poor: K\* values < .39; Moderate: K\* values = .40-.59; Good: K\* values = .60-.74; Excellent: K\* values > .74).<sup>23</sup> lastly, the original author of the questionnaire was again contacted, and informed of the values obtained in this phase and of the final version obtained (SVEST-E).

### Ethical considerations

The study protocol was assessed and approved by the Research Ethics Committee/Research Medication Ethics Committee (CEI/CEIm) HUGC Dr. Negrín with code 2020-140-

**Table 2** Content validity analysis by item.

Items	Number of experts who score 3 or 4	CVI-I <sup>a</sup>	Pa <sup>b</sup>	K* <sup>c</sup>	Evaluation <sup>d</sup>
1.1	8	.80	.044	.79	Excellent
1.2	10	1.00	.001	1.00	Excellent
1.3	10	1.00	.001	1.00	Excellent
1.4	8	.80	.044	.79	Excellent
2.1	10	1.00	.001	1.00	Excellent
2.2	10	1.00	.001	1.00	Excellent
2.3	8	.80	.044	.79	Excellent
2.4	9	.90	.010	.90	Excellent
3.1	10	1.00	.001	1.00	Excellent
3.2	10	1.00	.001	1.00	Excellent
3.3	9	.90	.010	.90	Excellent
3.4	9	.90	.010	.90	Excellent
4.1	10	1.00	.001	1.00	Excellent
4.2	10	1.00	.001	1.00	Excellent
4.3	6	.60	.205	.50	Moderate
4.4	9	.90	.010	.90	Excellent
5.1	9	.90	.010	.90	Excellent
5.2	9	.90	.010	.90	Excellent
5.3	8	.80	.044	.79	Excellent
6.1	10	1.00	.001	1.00	Excellent
6.2	8	.80	.044	.79	Excellent
7.1	9	.90	.010	.90	Excellent
7.2	10	1.00	.001	1.00	Excellent
7.3	9	.90	.010	.90	Excellent
7.4	7	.70	.117	.66	Good
8.1	8	.80	.044	.79	Excellent
8.2	10	1.00	.001	1.00	Excellent
9.1	7	.70	.117	.66	Good
9.2	8	.80	.044	.79	Excellent
10.1	6	.60	.205	.50	Moderate
10.2	6	.60	.205	.50	Moderate
10.3	10	1.00	.001	1.00	Excellent
10.4	9	.90	.010	.90	Excellent
10.5	10	1.00	.001	1.00	Excellent
10.6	8	.80	.044	.79	Excellent
10.7	7	.70	.117	.66	Good

<sup>a</sup> CVI-I: Content validity per each item.

<sup>b</sup> Pa: random likelihood agreement.

<sup>c</sup> K\*: modified Kappa.

<sup>d</sup> K\*applied evaluation criteria.

1. Also, each participant professional was informed about the whole project and their informed consent was obtained.

## Results

### Translation and cross-cultural adaptation

The initial translators coincided in their scores regarding the difficulty of the translation, giving it the ‘‘easy’’ level. The research team’s review of the first translation version did not reveal any major faults or errors.

The unified version compared with that adapted in Argentina showed a similarity above 80% in content, with a few minor linguistic and conceptual differences. The two professional translators who did the back-translations also

classified it as ‘‘easy’’. The research team compared the original questionnaire with the two back-translations, finding no significant differences between the two versions. The original author also examined them and although one of them appeared to be clearer (Back translation 2), they confirmed that neither of them veered too much from the original questionnaire and that semantic and conceptual equivalence existed, being faithful to the original SVEST.

### Tool applicability

The participants (10 gynaecologists and 10 midwives) were mostly women (18/90%) with a mean of 38.4 years (SD = 2.7 years), 100% with Spanish nationality and care professionals from the Complejo Hospitalario Universitario Insular

**Table 3** Content validity index for each expert.

Experts	Individual content validity index for each expert (CVI-E)
Expert 1	.77
Expert 2	1
Expert 3	.83
Expert 4	1
Expert 5	1
Expert 6	.91
Expert 7	1
Expert 8	.58
Expert 9	.86
Expert 10	.75

Materno-Infantil in Palmas de Gran Canaria (tertiary level hospital).

The pilot study detected the need for changes to syntax in 11 items to improve their comprehension and these were agreed by the research team, with no major substantial changes to the same. No ítem was added or removed.

Average duration of the survey in the pre-test was 10.3 min (SD = 1.4 min).

### Content validation

The group of experts comprised 6 physicians and 4 nurses. Other characteristics of the experts are contained in [Table 1](#). [Table 2](#) contains the CVI-I scores for each item. Thirty items (83.3%) of the thirty six in the SVEST questionnaire -E had an Excellent CVI-I with scores above  $\geq .79$ , three items had good validity of CVI-I content with scores between  $\leq .79$  and  $\geq .70$  (items 7.4, 9.1, 10.7) and another three items had a lower content validity with scores below  $\leq .70$  (items 4.3, 10.1, 10.2). The CVI-I scores for each item may be consulted in [Table 2](#). The CVI-E for each expert range between scores of 1 (four experts) and .58 (one expert) ([Table 3](#)).

### Final tool

The final tool obtained called SVEST-E has a CVI-Total of .87 and consists of a total of 36 items, subdivided into seven dimensions (25 items), two outcome variables (four items) and one support section (seven items of support response), maintaining the same item structure and sections as the original questionnaire. The final questionnaire obtained may be consulted in [Table 4](#).

### Discussion

The SVEST is the only currently existing tool for measuring the phenomenon of second victims.<sup>15</sup> It has been validated and used previously in different contexts and countries,<sup>16-19,24</sup> except in Spain.

Although there is a version in Spanish, this version was validated in a different country, in Argentina.<sup>16</sup> Today's recommendation is to carry out a cross-cultural adaptation of any tool of measurement since there may be linguistic

aspects, cultural connotations or variations which affect the feasibility of the tool.<sup>20,25</sup>

Due to the fact that this study fits in with a wider project on the phenomenon of second victims in Spain, a complete cross-cultural adaptation was undertaken, starting off from the original questionnaire<sup>15</sup> without the use of the Argentinean version,<sup>16</sup> although the latter was used as a comparative element.

There is no standardized method for cross-cultural adaptations of measuring tools such as questionnaires. Depending on the source consulted, several methodologies abound.<sup>20,25</sup> In this research we used a method which fitted in with the general recommendations proposed.<sup>20</sup>

CVI calculation provides evidence of content validity of the tool and is frequently used because calculation is easy and it is simple.<sup>22</sup> This test has also been used in previous validations of the SVEST, including the Korean<sup>17</sup> or Chinese,<sup>18</sup> but not in the Argentinean version.<sup>16</sup>

Despite having been widely used, CVI has been the object of debate since several authors criticise it as being a system which is highly sensitive to the number of experts and because they dispute the opinions of experts on the suitability or representativeness of the tool's content, suggesting they should not be interpreted as being synonymous with validity.<sup>26</sup>

For this reason, the recommendation is to recruit between 8-12 carefully selected experts, and to apply corrective measures in analysis, such as the chance-corrected agreement (Pa) and the modified Kappa statistical ( $K^*$ ).<sup>23,26</sup> In this research both approaches were used, since apart from the calculation of these parameters, 10 experts were recruited. In contrast, in the study by Kim et al. only seven experts were recruited<sup>17</sup> and in that of Chen et al.<sup>18</sup> there were nine.

Even so, the total CVI obtained (CVI-Total = .87) suggests a content validity similar to that of the previous cited studies (CVI-Total = .95 for Kim et al.<sup>17</sup> and CVI-Total = .99 for Chen et al.<sup>18</sup>) and higher than the minimum score recommended by Polit and Beck (CVI-total with score above .80 for adequate content validity of the tool).<sup>22,23</sup>

Although the panel of experts comprised professionals of different disciplines and specialities, the pre-test only involved care professionals of two different professional categories (gynaecologists and midwives). This may be considered a potential limitation, although it should be said that both the original SVEST and its other versions were validated and used to date exclusively in nursing professionals,<sup>16-18,24</sup> and we believe this may provide an added value to this research, since physicians present with the same risk of suffering from the second victim phenomenon. In addition, the speciality of obstetrics and gynaecology is particularly vulnerable to this phenomenon.<sup>27-29</sup>

Although in Spain the study of the second victims is still low, several recent studies powered by the Research Group of Second and Third Victims have been undertaken and provide approaches and strategies for confronting this issue in Spain.<sup>30-32</sup> In its macro study for analysis on this phenomenon, this group estimated the high prevalence in the healthcare population, since over half of the professionals who participated in the study (727 of 1087/66.9%) had experienced being a second victim either directly or indirectly.<sup>30</sup>

**Table 4** Questionnaire on the experience of the second victims and means of support (SVEST-E).

	1	2	3	4	5
<i>Dimension 1 – Psychological distress</i>					
I have experienced embarrassment from these instances.					
1.2 My involvement in these types of instances has made me fearful of future occurrences.					
1.3 My experiences have made me feel miserable.					
1.4 I feel deep remorse for my past involvements in these types of events.					
<i>Dimension 2 – Physical distress</i>					
2.1 The mental weight of my experience is exhausting.					
2.2 My experiences with these occurrences can make it hard to sleep regularly.					
2.3 The stress from these situations has made me feel nauseous or dizzy.					
2.4 Thinking about these situations can make it difficult to have an appetite.					
<i>Dimension 3 – Colleague support</i>					
3.1 I appreciate my co-workers attempts to console me, but their efforts can come at the wrong time.					
3.2 Discussing what happened with my colleagues provides me with a sense of relief. <sup>a</sup>					
3.3 My colleagues can be indifferent to the impact these situations have had on me.					
3.4 My colleagues help me feel that I am still a good healthcare provider despite any mistakes I have made. <sup>a</sup>					
<i>Dimension 4 – Supervisor support</i>					
4.1 I feel that my supervisor treats me appropriately after these occasions. <sup>a</sup>					
4.2 My supervisor’s responses are fair. <sup>a</sup>					
4.3 My supervisor blames individual members of the team when these cases occur.					
4.4 I feel that my supervisor evaluates these situations in a manner that considers the complexity of patient care practices. <sup>a</sup>					
<i>Dimension 5 – Institutional support</i>					
5.1 My organisation understands that those involved may need help to process and resolve any effects they may have on care providers. <sup>a</sup>					
5.2 My organisation offers a variety of resources to help me get over the effects of involvement with these instances. <sup>a</sup>					
5.3 The concept of concern for the wellbeing of those involved in these situations is not very strong at my organisation.					
<i>Dimension 6 – Non work-related support</i>					
6.1 I look to close friends and family for emotional support after one of these situations has happened. <sup>a</sup>					
6.2 The love from my close friends and family help me get over these occurrences. <sup>a</sup>					
<i>Dimension 7 – Professional self-efficacy</i>					
7.1 Following my involvement I experienced feelings of inadequacy regarding my patient care abilities.					
7.2 My experience makes me wonder if I am not really a good healthcare provider.					
7.3 After these experiences I become afraid to attempt difficult or high-risk procedures.					
7.4 These situations don’t make me question my professional abilities. <sup>a</sup>					
<i>8-Outcome Variable 1 – Turnover intentions</i>					
8.1 My experience with these occurrences has made me want to get a job outside patient care.					
8.2 The stress of being involved in these situations sometimes makes me want to leave my job.					
<i>9-Outcome Variable 2 - Absenteeism</i>					
9.1 My experience with an adverse event or medical error has led me to take time off for my mental health and to be able to recover.					



Table 4 (Continued)

	1	2	3	4	5
9.2 I have taken time off work after some of these occurrences.					
10 – Desired support options					
10.1 The ability to immediately take time away from my unit for a little while.					
10.2 A specified peaceful location that is available to recover and recompose after one of these types of event.					
10.3 A respected peer to discuss the details of what happened.					
10.4 An employee assistance programme that can provide free counselling to employees outside work.					
10.5 A discussion with my manager supervisor about the incident.					
10.6 The opportunity to schedule a time with a counsellor at my hospital to discuss the event.					
10.7 A confidential way to get in touch with someone 24 h a day to discuss how my experience may be affecting me.					
Dimensions 1–7 and the 2 outcome variables were given a score with the following Likert scale:					
1 – Totally disagree 2 – Disagree 3 – Neither agree nor disagree 4 – Agree 5 – Totally agree.					
The support options were given a score with the following Likert scale:					
1 – Not desired 2 – Not desired much 3 – Neither desired nor undesired 4 – Desired 5 – Strongly desired.					
<sup>a</sup> Inverted items.					

According to the result obtained, these professionals had suffered from anxiety, feelings of guilt, doubts about how to report what was happening to the patient, their colleagues and their superiors, fear of the legal consequences and concern for the loss of professional prestige.<sup>30</sup> The researchers used a questionnaire created by means of consensus from the research team, not reporting on the psychometric characteristics and properties of this tool.<sup>30</sup>

To conclude, and pending its application in healthcare professionals to confirm other psychometric properties of the questionnaire, this study confirms that the SVEST-E is a tool with suitable content validity for measuring the experience of second victims in healthcare professionals in Spain.

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## Conflict of interests

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