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Patient Safety Climate in Healthcare Organizations: translation and adaptation to the Brazilian culture

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Patient Safety Climate in Healthcare Organizations: tradução e adaptação para a cultura brasileira

Patient Safety Climate in Healthcare Organizations: traducción y adaptación a la cultura brasileña

Marcia Raquel Panunto Dias Cunha[a]
Edinêis de Brito Guirardello[b]

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ABSTRACT

Objective: To translate and adapt the Patient Safety Climate in Healthcare Organizations - PSCHO questionnaire to the Brazilian culture.

Methods: Methodological study, which followed the stages of translation; synthesis; back-translation; evaluation by an experts committee, composed of one doctor and six nurses; and pretest with 40 subjects, among them nurses, nursing technicians, physiotherapists and physicians.

Results: The translation and back-translation steps were appropriate. In the synthesis step, the author of the questionnaire was consulted to adapt the equivalence of some terms. The analysis of the experts committee showed a content validity rate above 80% for most items regarding semantic, idiomatic, cultural and conceptual equivalence. In the pretest, it was observed appropriate content validity, items easy to understand, with an average application time of 15 minutes.

Conclusion: The translation and cultural adaptation of the PSCHO questionnaire was considered satisfactory, resulting in an easily understandable tool.

Keywords: Nursing. Validation studies. Patient safety.

RESUMO

Objetivo: Traduzir e adaptar o instrumento Patient Safety Climate in Healthcare Organizations–PSCHO para a cultura brasileira.

Métodos: Estudo metodológico, o qual seguiu as etapas de tradução; síntese; retrotradução; avaliação por um comitê de juízes, composto por uma médica e seis enfermeiras; e pré-teste com 40 sujeitos, entre eles enfermeiros, técnicos de enfermagem, fisioterapeutas e médicos.

Resultados: As etapas de tradução e retrotradução foram apropriadas. Na síntese, consultou-se a autora do instrumento para ajustar a equivalência de alguns termos. A análise do comitê de juízes demonstrou um índice de validade de conteúdo acima de80% para a maioria dos itens quanto às equivalências semântica, idiomática, cultural e conceitual. No pré-teste, observou-se adequada validade de conteúdo, facilidade de compreensão dos itens, com um tempo médio de preenchimento de 15 minutos.

Conclusão: A tradução e adaptação cultural do instrumento PSCHO foram consideradas satisfatórias, resultando em uma ferramenta de fácil compreensão.

Palavras-chave: Enfermagem. Estudos de validação. Segurança do paciente.

RESUMEN

Objetivo: Traducir y adaptar el instrumento Patient Safety Climate in Healthcare Organizations - PSCHO a la cultura Brasileña.

Métodos: Estudio metodológico que siguió las etapas: traducción; síntesis; retrotraducción; evaluación por un comité de expertos, compuesto por una médica y seis enfermeras; y prueba previa con 40 sujetos, entre ellos enfermeros, técnicos de enfermería, fisioterapeutas y médicos.

Resultados: Las etapas de traducción y retrotraducción fueron apropiadas. En la síntesis, se consultó la autora del instrumento para ajustar la equivalencia de algunos términos. El análisis del comité de expertos demostró un índice de validez de contenido superior al80% en la mayoría de los ítems, en cuanto a las equivalencias semánticas, idiomáticas, culturales y conceptuales. En el pre-test, se observó una adecuada validez de contenido, facilidad de comprensión de los ítems, con un tiempo medio de llenado de 15 minutos.

Conclusión: La traducción y adaptación cultural del instrumento PSCHO se consideró satisfactoria, lo que resulta en una herramienta de fácil compresión.

Palabras clave: Enfermería. Estudios de validación. Seguridad del paciente.

[a] Universidade Estadual de Campinas (UNICAMP), Colégio Técnico de Campinas, Departamento de Enfermagem. Campinas, São Paulo, Brasil.

[b] Universidade Estadual de Campinas (UNICAMP), Faculdade de Enfermagem. Campinas, São Paulo, Brasil.

INTRODUCTION

Healthcare events are the third leading cause of death in the United States and millions of incidents have been reported around the world, which highlights the need to understand the factors that put the patient at risk and to incorporate measures that contribute to safer health organizations[1-2]. The search for systematic interventions may contribute to the reduction of these events and requires the construction of a work process based on a safety culture model[3].

The safety culture is defined as the product of values, attitudes, perceptions, skills and individual and collective behavior patterns[3], which can be measured through the climate, a temporal measure, in which it is considered the perception of the professionals in relation to the behavior and actions that prioritize the safety in their work environment[4].

There is evidence of the relationship between work environments with a positive safety culture and the reduction of mortality rates, falls, infection and better patient satisfaction[5-6] and the use of climate assessment tools makes it possible to identify gaps in health organizations to implement strategies that strengthen safety. In Brazil, there are available the Hospital Survey on Patient Safety Culture (HSOPSC)[7] and the Safety Attitudes Questionnaire (SAQ) [8]. However, while the HSOPSC presents changes in its dimensional structure pointed out in other countries, which makes it difficult to compare[7], studies using the SAQ lack instrument reliability data.

Another instrument that has the same purpose, the Patient Safety Climate in Healthcare Organizations[9], not yet validated for our culture, is a tool capable of measuring the safety climate of health organizations based on the perception of professionals, both of those who work in direct patient care and those who manage the organization[10].

Its construction is based on the theory related to the characteristics of High Reliability Organizations - HRO, which operate in hazardous conditions and have a minimum percentage of adverse events[11]. Among the main attributes of these organizations are: well-articulated and resilient work processes; concern about failures; reluctance to accept the simplification of interpretations, focusing on understanding the true causes of errors; sensitivity to early recognize indicators that threaten the organizational performance; and decision-making by individuals with the most expertise about work processes, independent of the role or position they occupy within the organization[11].

Despite the availability of instruments in our culture to assess the safety climate, the PSCHO is a tool that, in addition to this purpose, makes it possible to identify the percent problematic response in issues that influence the perception of the professionals, both in the unit of work and in the institution, which allows the manager to implement improvement actions according to their demand. Thus, the present study aimed at translating and adapting the Patient Safety Climate in Healthcare Organizations instrument to the Brazilian culture.

METHOD

It is a methodological study, characterized by processes of development and evaluation of instruments of data collection, originated from the thesis entitled "*Adaptação cultural e avaliação das propriedades de medida do instrumento* Patient Safety Climate in Healthcare Organizations"[12]. The following step was carried out between June 2015 and May 2017, in a public teaching hospital in the countryside of the state of São Paulo.

Patient Safety Climate in Healthcare Organizations – PSCHO

The PSCHO has 51 items, six related to professional characteristics and 45 about the safety climate, of which 42 are distributed in 12 dimensions that measure the overall organizational, the work unit and interpersonal aspects of the safety climate. The dimensions related to organizational level include the senior managers' engagement (items 1, 3, 4, 7, 11 and 24), organizational resources for safety (items 2, 16, 30, 39) and overall emphasis on patient safety (items 12 and 23)[10].

The aspects related to the unit of work includes unit managers' support (items 25, 29 and 34), unit safety norms (items 5, 8, 18, 32 and 40), unit recognition and support for safety efforts (items 10, 21, 22 and 31), collective learning (items 26, 35, 38 and 41), psychological safety (items 27, 33 and 37) and problem responsiveness (items 28 and 36)[10].

The interpersonal level involves the dimensions of fear of shame (items 6, 9, 43 and 44) and fear of blame and punishment (items 15, 17 and 42). Another important aspect for the safety climate was considered, but not classified in the previous categories, which consists of the dimension of safe care provision, assessed by items 14 and 19[10].

The scale of response to the statements is of the Likert type with five points, whose options are: strongly disagree (1), disagree (2), neither agree nor disagree (3), agree (4) and strongly agree (5). The professional may also consider the option "not applicable" (6)[9]. Nine items (6, 9, 14, 15, 17, 34, 42, 43 and 44) have negative connotations and therefore should be reversed for analysis.

The score is obtained in such a way as to highlight the answers that oppose the safety (1) strongly disagree and (2) disagree, called problematic responses. The measurement can be obtained for items, dimensions and for the overall safety climate. First, the mean percent problematic response for each item among all the respondents is calculated. Then, the mean of all item means in a dimension, and the mean of all items means in the survey is calculated. A lower mean of percent problematic response indicates a better perception of the safety climate in the organization.

Translation and cultural adaptation

After the formal permission of the author of the instrument, professor and researcher Dr. Sara Singer, the methodological procedures of translation and adaptation of the PSCHO recommended by the literature started, with the purpose of maintaining the same equivalence between the original and the adapted version[13].

Initially, the instrument was translated by two independent translators, fluent in the English language, whose mother tongue was Brazilian Portuguese. One of the translators was informed about the concepts and objectives of the instrument and the other did not have access to this information.

The two versions (T1 and T2) were analyzed by a third independent translator, which allowed the comparison and the consensus of discrepancies, obtaining a synthesis version (T12). The T12 was back-translated to English by two translators fluent in Portuguese, whose mother tongue was English, producing two versions (RT1 and RT2). These professionals were independent translators, who were not part of the first step of the translation and were not informed about the concepts measured by the PSCHO.

After obtaining the back-translations, an experts committee was composed of seven professionals: a physician, with experience in intensive care and who had lived in the country of origin of the instrument; a nurse, PhD student and with care experience; a nurse, PhD student and professor with administration focus and graduated in Languages; a nursing manager, with experience in the area of quality and patient safety; two nursing professors, researchers in the area of patient safety; and a nursing professor with experience in translating and adapting instruments.

In order to analyze the content validity and to develop the pre-final version of the PSCHO, all the versions of the instrument (VO, T1, T2, T12, RT1 and RT2) were made available to the experts for a quantitative and qualitative evaluation. Each judge received an invitation letter and specific instructions requesting the evaluation of the semantic, idiomatic, cultural and conceptual equivalence of each item of the instrument.

The semantic equivalence evaluation refers to the meaning of the words, in which it is observed if the translated words have the same meaning used in the original version[13-14]. The idiomatic evaluates whether the translated item preserves the meaning of the expression in the original version[13]. The cultural equivalence refers to the adequacy of situations or activities addressed that correspond to the situations experienced in the cultural context of Brazil, while the conceptual one concerns the analysis of words with different concepts between the cultures[13-14].

The quantitative evaluation of the instrument occurred in an individual way, in which the members of the committee assigned a score for the equivalence of each item (1=not equivalent, 2=impossible to evaluate the equivalence before the item is revised, 3=equivalent, but it requires minor changes, 4=rightly equivalent) for the calculation of the Content Validity Index (CVI). This calculation is done taking into account the number of experts who scored 3 or 4, divided by the total number of experts. The items with CVI lower than 0.80 were considered eligible for revision[15]. The qualitative evaluation was carried out through a meeting with the majority of the members of the committee, in which suggestions were made on some aspects of the instrument.

With the adjustments discussed in this meeting, the pre-final version of the PSCHO was obtained, which was submitted to the pre-test in May 2017 with 40 subjects, among them nurses, nursing technicians, physiotherapists and physicians. The criterion for this selection was to assume that these professionals are part of the majority of those who are included both in direct patient care and in managerial positions of a hospital institution.

The subjects were given the pre-final version of the PSCHO and were asked to evaluate the instrument regarding the ease of understanding of the items and instructions, ease of checking the questions and time spent filling them.

The study was approved by the Research Ethics Committee of Unicamp (CAAE: 54036116.0.0000.5404) and all the subjects signed the Free and Informed Consent Term.

RESULTS

The translation process of the PSCHO instrument was adequate and allowed the elaboration of the synthesis of the T1 and T2 versions, which was later submitted to back-translation. In the synthesis step (T12), the author of the instrument was consulted to clarify the meaning of some terms, which presented different semantic equivalence, but which could be synonyms in the original language

(disciplined, punished and corrected). After clarification, for the terms "**disciplined**" and "**punished**" it was considered the translation "***punido***" and, for "**corrected**", "***corrigido***". Then, the VO, T1, T2, T12, RT1 and RT2 versions were submitted to the evaluation by the experts committee.

In the quantitative evaluation, most of the items had an agreement above 80% among the experts, which demonstrated semantic, idiomatic, cultural and conceptual equivalence among the versions of the instrument, as presented in Table 1.

Table 1 - Index of content validity of the items of the Brazilian version of the Patient Safety Climate in Healthcare Organizations. Campinas, SP, 2017

Items	Average CVI
Instructions, section I, section II, definition, options, items 1, 2, 3, 4, 5, 6, 7, 8, 10, 11, 12, 13, 14, 15, 19, 20, 22, 24, 25, 27, 32, 33, 35, 37, 38, 39, 40, 41, 44, 45, 49, 50 and 51.	1.00
Title, items 9, 21, 23, 34, 43 and 46	0.96
Items 29, 30 and 42	0.93
Item 17	0.92
Items 28, 31 and 48	0.89
Item 18	0.86
Item 36	0.83
Items 16 and 26	0.79
Item 47	0.75

Source: Research data, 2017.

During the meeting with the members of the experts committee, moment when it was possible to carry out the qualitative evaluation of the items of the instrument, there were suggestions for altering the items to suit the semantic, idiomatic, cultural and conceptual equivalence.

Among items that had an agreement rate lower than 80%, the item 47 "***Meu cargo é***" presented disagreement on the cultural, semantic and conceptual equivalence and, because it is a statement that addresses professional categories, it has undergone alterations to suit the Brazilian reality. In item 16 "***Eu tenho tempo suficiente para realizer procedimentos com o paciente de forma segura***" the experts pointed out a lower agreement rate for semantic and cultural equivalence, having as a suggestion the substitution of the word "***procedimentos***" to "***cuidado***".

For item 26 "***Os erros ocorridos em minha unidade têm levado a mudanças positivas no setor***", it was pointed out the need to subtract the term "***ocorridos em minha unidade***" for better semantic and idiomatic equivalence, since the original version did not specify where the errors occurred, but whether they encouraged changes in the unit. In this way, the alterations suggested by the experts were accepted and the item assumed the version "***Os erros têm levado a mudanças positivas em minha unidade/setor***".

In addition to the items with an agreement rate below 80%, other statements have been modified. Items 46 and 48 have undergone changes to suit the cultural equivalence, because they address positions and hospital work areas, respectively, that should be adapted to the cultural reality of the country.

Amongst the standardized terms, "***administração/direção***" was used whenever the statement referred to the management of the institution (items 3, 4, 7 and 11), while "***gerência/coordenação***" was inserted in items related to the unit, (items 25, 28, 29, 34 and 37). The word "**facility**" presented divergence in items 23 and 39, assuming the translation "***unidade***". After consensus, the meaning of "***instituição***" was assumed for this term, because it is present in items that represent organizational dimensions rather than unit.

In addition to these affirmations, the verbal tense was modified in item 9 "***Se eu cometer um erro que tenha consequências significativas e ninguém perceber, eu não irei revelar a ninguém sobre o ocorrido***", assuming the present tense in "***eu não revelo a ninguém sobre o ocorrido***", and in item 30 "***Eu recebi treinamento adequado para resolver problemas relacionados à segurança do paciente***", whose alteration occurred in "***Eu tenho recebido***".

Regarding the word substitution, in item 17 "***Profissionais da área clínica que cometem erros graves, geralmente são punidos***" the term "***área clínica***" was replaced by "***assistência***". In item 21 "***Eu sou recompensado(a)***

pela rápida intervenção ao identificar um erro grave" the expression "***rápida intervenção***" was altered for "***agir rapidamente***".

The remaining items that obtained equivalence lower than one and that have undergone substantial modifications (in bold) are described in Chart 1.

Items	Original version	Synthesis	Pre-test Version
18	In my unit, there is significant peer pressure to discourage unsafe patient care.	Há uma pressão significativa dos colegas na minha unidade para desencorajar práticas que não sejam seguras ao paciente.	Na minha unidade, há uma pressão significativa dos colegas para desencorajar práticas inseguras ao paciente.
28	Bringing patient safety problems to management's attention usually results in the problem being addressed.	Alertar o gestor sobre problemas com a segurança do paciente geralmente leva à resolução do problema.	Alertar a gerência/coordenação da minha unidade sobre problemas com a segurança do paciente geralmente leva à discussão sobre o problema.
31	My performance is evaluated against defined safety standards.	Meu desempenho é avaliado de acordo com os padrões estabelecidos para a segurança do paciente.	Meu desempenho é avaliado de acordo com padrões de segurança definidos.
36	When I take time to communicate about patient safety problems there is appropriate follow up.	Quando dedico algum tempo para notificar os problemas relacionados à segurança do paciente, há um acompanhamento apropriado aos pacientes.	Quando dedico algum tempo para notificar os problemas relacionados à segurança do paciente, há um seguimento apropriado.
42	I will be blamed if I make an error.	Serei responsabilizado se eu cometer um erro.	Serei considerado culpado se eu cometer um erro.

Chart 1 - Description of items modified after evaluation by the experts committee

Source: Research data, 2017.

After the modifications suggested by the members of the experts committee, the pre-test stage was carried out in a university hospital with 40 professionals, among them nurses (12.5%), nursing technicians (45%), physiotherapists (2.5%), resident physicians (17.5%), professor physicians and assistants (22.5%), whose areas of work were: ambulatory, emergency room (ER), intensive care unit (ICU), central sterile services department (CSSD), operating room (OR), ward and other areas. Most of the professionals were between 31 and 50 years old (72.5%), were female (62.5%), having more than five years working at the institution (70%).

The mean PSCHO filling time was 15.3 minutes (SD±6), with a minimum of seven and a maximum of 34 minutes. Although 67.5% of subjects rated it as easy to fill, some suggested altering the formatting of the spine to mark them, with the intention of highlighting the existing options and making the fulfillment faster. Regarding the instructions and questions of the PSCHO, 85% indicated that it is easy to understand.

Item 40 "***Violações deliberadas dos procedimentos operacionais padrões são raras na minha unidade***" presented agreement of 100%, however, it was considered by some subjects without cultural equivalence by the use of the term "***deliberadas***". In order to modify this item, it was decided to consult again the experts and the return of the majority was obtained, who agreed to subtract the term. For item 47, which deals with the professions, it was suggested to change the statement "***Meu cargo é***" for "***Minha função é***", since question 46 already deals with the job or position occupied by the professional in the institution.

With the changes made after the pre-test, the translated and adapted version of the PSCHO for the Brazilian culture (Appendix) was obtained.

DISCUSSION

The process of translation, synthesis and back-translation of the PSCHO instrument to the Brazilian culture was carried out in a systematic way, according to the literature[13]. Although it is an already well-established process, each stage has specific characteristics that must be detailed by the researcher. The translation of the instrument is the first step to

a well-executed work, so it is relevant to carefully select the professionals who will be part of this step[16].

The synthesis of translations requires a specialist in linguistics to ensure that the semantic equivalence of the concepts of the instrument, both in the original language and in the target language, is respected. Two aspects should be considered at this stage, the referential meaning (denotative) and the general (connotative) meaning. The literal correspondence between a word in its original language and its translation provides denotative meaning, however, from the connotative point of view a word may have a different impact on the cultural context of the target population[16].

This reflection was necessary in the present study, since in the patient safety culture, the "punishment" of the professional is understood as unfair and harmful, because it does not analyze the organizational factors for the occurrence of the error[17]. The use of this term indiscriminately could reverse the meaning of the item of the instrument. Thus, the term "corrected" did not assume the punitive meaning, but rather of redirection of the action, aligned to the learning culture[18].

The evaluation step by the experts committee was essential for the adaptation and validity of the content, because it considered the experience of each specialist, which contributes to the standardization of the terms, making the items clearer and easier to understand in the Brazilian context[14,19].

In the equivalences evaluation of the PSCHO by the experts committee, it was possible to observe greater divergence regarding the semantic equivalence. As in the study of cross-cultural adaptation of the HSOPSC instrument[20], some words were modified and some terms standardized with the purpose of facilitating the understanding of the items by the subjects and keeping them with the original meaning.

The analysis of the equivalences showed that the cultural adaptation steps were adequate. Although there is no consensus about the number and qualification of the experts[13-14], it is crucial that these professionals are able to assess the quality of translations, make critical decisions, reach a consensus on discrepancies and consolidate all versions of the instrument[14]. The contribution of a professional with care experience in the country where the instrument was originated facilitated the consensus when the cultural equivalence of several items was discussed, mainly between the options of professions and work areas ("***Minha função é***" and "***Área de trabalho***", respectively) of the PSCHO.

Although the instrument is built for application among the different professionals in the hospital setting, during the sample selection for the pre-test it was decided to invite subjects that represented the target population of the study, composed of the nursing team, physiotherapists and physicians. Each of them contributed in a qualitative way to a better understanding of the instrument and, in general, the subjects evaluated in a positive way the answer options, understanding of the items and instructions of the Brazilian version of the PSCHO. Of the 51 items, only item 40 was described as difficult to understand, indicating an adequate process of cross-cultural adaptation.

The mean answering time of 15 minutes may have been influenced by the layout of the scale response options. A part of the subjects suggested modifications in this aspect, in order to facilitate the reading of each item and the location of the answer option, which was accepted to facilitate the filling of the instrument. Another modification suggested and approved was the replacement of the item's statement "***Meu cargo é***" for "***Minha função é***", since job is a position, not someone's profession.

CONCLUSION

The translation and adaptation process of the PSCHO to the Brazilian culture followed the steps recommended internationally and presented satisfactory results in relation to its understanding by the subjects. As a limitation, it was difficult to compare the data with other studies, since the instrument is translated only in China.

The version of PSCHO obtained in this study corresponds to the first stage of the process of making an instrument available in a culture that is different from the original one in which it was developed. Future studies should be developed to validate the questionnaire for research purposes. In the professional practice environment, the use of the PSCHO may contribute to the understanding of the patient's safety climate and, thus, it will help identify the organizations gaps. Therefore, it is expected that this will be a useful tool for managers to address changes that effectively reduce the care risks to a minimum acceptable.

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Corresponding author:
Edinêis de Brito Guirardello
E-mail: guirar@unicamp.br

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APPENDIX

CLIMA DE SEGURANÇA DO PACIENTE EM INSTITUIÇÕES DE SAÚDE

PARTE I

Este conjunto de afirmativas corresponde às suas experiências relacionadas à segurança do paciente na sua unidade de trabalho e na sua instituição atualmente, salvo as observações em contrário.

Algumas afirmativas referem-se à "minha unidade". Médicos e outros prestadores de cuidados que não estão alocados em uma única unidade devem respondê-las com base nas experiências adquiridas por meio de seus serviços prestados, tais como assistência clínica ou cirúrgica. Todos os outros profissionais devem responder essas afirmativas segundo suas experiências na unidade de trabalho em que passam a maior parte do tempo, como em uma Unidade de Terapia Intensiva, Centro Cirúrgico ou Ambulatório.

DEFINIÇÃO: Segurança do Paciente - *Ações para evitar, prevenir ou corrigir eventos adversos que podem ser decorrentes do processo de prestação de cuidados de saúde.*

INSTRUÇÕES: Para as afirmações a seguir, por favor, assinale se você "discorda totalmente", "discorda", "não concorda nem discorda", "concorda" ou "concorda totalmente". Caso você queira alterar alguma resposta, preencha o quadrado que corresponde à sua nova opção e faça um círculo em volta dele.

PREENCHIMENTO CORRETO ☐☐☐☒☐☐

	Discordo totalmente	Discordo	Não concordo nem discordo	Concordo	Concordo totalmente	Não se aplica
1. Existe um bom fluxo de comunicação entre os níveis hierárquicos, ascendente e descendente, sobre os assuntos relacionados à segurança do paciente.	☐	☐	☐	☐	☐	☐
2. Tenho à minha disposição recursos adequados (pessoal, orçamento e equipamento) para prestar cuidado seguro ao paciente.	☐	☐	☐	☐	☐	☐
3. A administração/direção da instituição apoia um clima que promove a segurança do paciente.	☐	☐	☐	☐	☐	☐
4. A administração/direção da instituição tem uma visão clara dos riscos associados ao cuidado do paciente.	☐	☐	☐	☐	☐	☐
5. Minha unidade empenha-se em identificar e avaliar os riscos para garantir a segurança do paciente.	☐	☐	☐	☐	☐	☐
6. Pedir ajuda é um sinal de incompetência.	☐	☐	☐	☐	☐	☐
7. A administração/direção da instituição tem conhecimento dos tipos de erros que realmente ocorrem nesta instituição.	☐	☐	☐	☐	☐	☐
8. Minha unidade faz um bom trabalho de gerenciamento de riscos para garantir a segurança do paciente.	☐	☐	☐	☐	☐	☐
9. Se eu cometer um erro que tenha consequências significativas e ninguém perceber, eu não revelo a ninguém sobre o ocorrido.	☐	☐	☐	☐	☐	☐
10. Minha unidade reconhece as conquistas individuais relacionadas à segurança por meio de recompensas e incentivos.	☐	☐	☐	☐	☐	☐
11. A administração/direção da instituição considera a segurança do paciente quando são discutidas mudanças nos processos internos.	☐	☐	☐	☐	☐	☐
12. Comparada com outras instituições na área, esta instituição preocupa-se mais com a qualidade do serviço que presta ao paciente.	☐	☐	☐	☐	☐	☐
13. Eu tenho aprendido como melhorar meu próprio trabalho ao tomar conhecimento dos erros cometidos pelos meus colegas.	☐	☐	☐	☐	☐	☐
14. No último ano, eu presenciei um colega de trabalho fazer algo que me pareceu ser inseguro para o paciente.	☐	☐	☐	☐	☐	☐
15. Se as pessoas descobrirem que eu cometi um erro, eu serei punido.	☐	☐	☐	☐	☐	☐
16. Eu tenho tempo suficiente para realizar os cuidados ao paciente de forma segura.	☐	☐	☐	☐	☐	☐
17. Profissionais da assistência que cometem erros graves, geralmente são punidos.	☐	☐	☐	☐	☐	☐
18. Na minha unidade, há uma pressão significativa dos colegas para desencorajar práticas inseguras ao paciente.	☐	☐	☐	☐	☐	☐
19. Eu nunca presenciei um colega de trabalho fazer algo que me parecesse inseguro para o cuidado do paciente.	☐	☐	☐	☐	☐	☐
20. No último ano, eu fiz algo que não foi seguro para o paciente.	☐	☐	☐	☐	☐	☐
21. Eu sou recompensado (a) por agir rapidamente ao identificar um erro grave.	☐	☐	☐	☐	☐	☐
22. Minha unidade oferece treinamento sobre o trabalho em equipe, a fim de melhorar o desempenho no cuidado e segurança do paciente.	☐	☐	☐	☐	☐	☐
23. Em geral, o nível de segurança do paciente nesta instituição está melhorando.	☐	☐	☐	☐	☐	☐
24. As decisões relacionadas à segurança do paciente são tomadas pelas pessoas mais qualificadas, independentemente do cargo ou hierarquia.	☐	☐	☐	☐	☐	☐
25. A gerência/ coordenação da minha unidade me ajuda a superar problemas que dificultam a prestação de cuidado seguro ao paciente.	☐	☐	☐	☐	☐	☐

INSTRUÇÕES: Para as afirmações a seguir, por favor, assinale se você "discorda totalmente", "discorda", "não concorda nem discorda", "concorda" ou "concorda totalmente".

Caso você queira alterar alguma resposta, preencha o quadrado que corresponde à sua nova opção e faça um círculo em volta dele.

PREENCHIMENTO CORRETO ☐☐☐☒☐☐

	Discordo totalmente	Discordo	Não concordo nem discordo	Concordo	Concordo totalmente	Não se aplica
26. Os erros têm levado a mudanças positivas em minha unidade/ setor.	☐	☐	☐	☐	☐	☐
27. A equipe sente-se confortável para questionar as ações daqueles com maior autoridade quando a segurança do paciente está em risco.	☐	☐	☐	☐	☐	☐
28. Alertar a gerência/ coordenação da minha unidade sobre problemas com a segurança do paciente geralmente leva à discussão sobre o problema.	☐	☐	☐	☐	☐	☐
29. Na minha unidade, a gerência/ coordenação coloca a segurança em um nível mais elevado de importância do que o cumprimento do cronograma e da produtividade.	☐	☐	☐	☐	☐	☐
30. Eu tenho recebido treinamento adequado para abordar problemas relacionados à segurança do paciente.	☐	☐	☐	☐	☐	☐
31. Meu desempenho é avaliado de acordo com padrões de segurança definidos.	☐	☐	☐	☐	☐	☐
32. Na minha unidade, qualquer pessoa que intencionalmente viole os padrões ou regras de segurança é corrigida.	☐	☐	☐	☐	☐	☐
33. A equipe manifesta-se com liberdade caso observe algo que pode afetar negativamente o cuidado ao paciente.	☐	☐	☐	☐	☐	☐
34. Sempre que a pressão aumenta, a gerência/coordenação da minha unidade quer que trabalhemos mais rápido, mesmo que isso implique em abreviar tarefas, o que pode afetar a segurança do paciente de forma negativa.	☐	☐	☐	☐	☐	☐
35. Na minha unidade, identificamos e resolvemos problemas de segurança antes que o incidente de fato ocorra.	☐	☐	☐	☐	☐	☐
36. Quando dedico algum tempo para notificar os problemas relacionados à segurança do paciente, há um seguimento apropriado.	☐	☐	☐	☐	☐	☐
37. Eu me sinto confortável em informar minhas preocupações em relação à segurança, sem medo de ser punido pela gerência/coordenação da minha unidade.	☐	☐	☐	☐	☐	☐
38. Nosso processo de investigação de acidentes e incidentes é efetivo na identificação das causas-raízes.	☐	☐	☐	☐	☐	☐
39. Essa instituição dispõe de recursos suficientes para o acompanhamento dos problemas de segurança identificados.	☐	☐	☐	☐	☐	☐
40. Violações dos procedimentos operacionais padrões são raras na minha unidade.	☐	☐	☐	☐	☐	☐
41. Na minha unidade, os problemas e erros relacionados à segurança do paciente são comunicados às pessoas certas para que o problema seja corrigido.	☐	☐	☐	☐	☐	☐
42. Serei considerado culpado se eu cometer um erro.	☐	☐	☐	☐	☐	☐
43. As pessoas duvidarão das minhas habilidades se eu fizer perguntas.	☐	☐	☐	☐	☐	☐
44. Meus colegas de trabalho perderão o respeito por mim se eles souberem que cometi um erro.	☐	☐	☐	☐	☐	☐
45. Eu me sinto envergonhado quando cometo um erro na frente dos meus colegas de trabalho.	☐	☐	☐	☐	☐	☐

PARTE II

Por favor, complete as seguintes informações. Lembre-se de que suas respostas são anônimas.

46. Eu sou: ☐ Administrador/ Diretor da instituição. ☐ Gerente/ Coordenador da unidade. ☐ Não ocupo nenhum dos cargos.

47. Minha função é:

☐ Médico ☐ Aux. Enfermagem ☐ Terapeuta Ocupacional ☐ Nutricionista ☐ Auxiliar de limpeza
☐ Residente ☐ Assistente Social ☐ Fonoaudiólogo ☐ Técnico em nutrição ☐ Técnico de radiologia
☐ Enfermeiro ☐ Farmacêutico ☐ Odontologista ☐ Técnico de laboratório ☐ Auxiliar administrativo
☐ Téc. Enfermagem ☐ Fisioterapeuta ☐ Psicólogo ☐ Profissional do transporte de pacientes (Escolta/ Maqueiro) ☐ Outros

48. Área de trabalho (Assinale apenas UMA, aquela que você passa a maior parte do tempo)

☐ Ambulatório ☐ Centro de Material ☐ Recuperação pós-anestésica ☐ Cuidado domiciliar
☐ Pronto-Socorro/ Unidade de Emergência Referenciada ☐ Centro cirúrgico ☐ Centro Obstétrico e Maternidade ☐ Farmácia
☐ Unidade de terapia intensiva ☐ Laboratório ☐ Enfermaria/ Unidade de Internação ☐ Áreas não-clínicas

49. Idade ☐ 18 – 25 anos ☐ 26 – 30 anos ☐ 31 – 40 anos ☐ 41 – 50 anos ☐ 51 – 60 anos ☐ + de 60 anos

50. Sexo ☐ Feminino ☐ Masculino

51. Há quanto tempo você trabalha nesta instituição? ☐ 0 - 6 meses ☐ 6 meses - 1 ano ☐ 1 - 3 anos ☐ 3 - 5 anos ☐ 5 - 10 anos ☐ + de 10 anos

Obrigada por sua participação.