Cross-cultural adaptation of the Team Member Perspectives of Person-Centered Care (TM-PCC) in institutionalized older adults

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Abstract

Objective: To carry out the translation and back-translation into Brazilian Portuguese, and the cross-cultural adaptation of the instrument called Team Member Perspectives of Person-Centered Care (TM-PCC), as well as its construct validity. The objective of the TM-PCC is to assess the frequency of behaviors and care practices centered on the individual according to professionals who work in Long-Term Care Facilities for Older Adults (ILPIs). *Method:* The process of translation, back-translation, and cross-cultural adaptation was followed through semantic, idiomatic, experiential, and conceptual equivalence carried out by five expert judges in the field of Geriatrics and Gerontology, with the pilot instrument being administered to 49 professionals from four ILPIs in three Brazilian states. *Results:* After the assessment was conducted by the expert judges, disagreement was found regarding the terms "previous associations," "fulfilling relationships," and "incorporate this caring into my daily routine," which were replaced by"histórias pregressas" (past stories), "relações satisfatórias" (satisfactory relationships), and "incorporar esse cuidado na minha rotina diária" (incorporate this care into my daily routine). After these corrections and revisions, the questionnaire was sent back to the judges, who were in total agreement. Good understanding of the questions was observed during the pilot application and good internal consistency through Cronbach's alpha (0.78). *Conclusion*: The TM-PCC can be a useful tool for assessing individual-centered care in ILPIs in Brazil, according to the assessment of professionals. This will enable patient care managers or supervisors to plan and develop educational and management interventions aimed at promoting individual-centered care in ILPIs.

Keywords: Long Term Care Facility for the Elderly. Health Service for the Elderly. Humanization of Assistance. Patient Assistance Team. Validation Study.

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INTRODUCTION

The humanization of long-term care for older adults represents one of the greatest challenges of the 21st century[1,2]. Professionals, public managers, and scholars are faced with the accelerated aging of the population and, at the same time, with the need to plan interventions aimed at the living and health conditions of the long-lived population[3,4]. Within the alternatives of long-term care in Brazil, *Instituições de Longa Permanência para Idosos* (ILPIs, Long-Term Care Facilities for Older Adults) represent the most prevalent care model, after domiciliary care[5].

ILPIs have a residential character, in the form of collective home for people aged 60 years or older, with or without family support, housing residents with different health characteristics[6]. Until 2010, according to the *Instituto de Pesquisa Econômica Aplicada* (IPEA, Institute of Applied Economic Research), there were 3,548 institutions in the Brazilian territory, which encompassed only 0.5% of the total number of older adults in Brazil[5]. After the proliferation of SARS COV 2 in Brazilian institutions and the high mortality rates among institutionalized older adults, the National Front for the Strengthening of ILPIs (an organized civil society group composed of experts, scholars, and professionals) has strived to follow up, support, guide, and gather information from Brazilian ILPIs in order to have a more up-to-date overview of how care is organized in these institutions[7]. According to a survey carried out by the group, Brazil has 7,029 institutions, of which 4,232 are located in the Southeast, 1,874 in the South, 493 in the Northeast, 351 in the Midwest, and 79 in the North of Brazil[7]. Most of these institutions are private non-profit/philanthropic companies, followed by private and public institutions (a small number) [7].

Among the observed needs, there is a shortage of instruments to measure care practices centered on the individual in the Brazilian reality, especially to measure care practices according to the view of professionals working in ILPIs. Care centered on the individual comprises a set of initiatives aimed at promoting decent and quality care, whose targets are: the autonomy of residents in care and activities; team training; shared decision-making; shared choice; meaningful social interactions; and home spaces, based on the relationships between older adults and the environment, as well as with professionals, residents, and the community[8-10].

In the study conducted by Boscart et al.[8], it was observed that the literature has 20 instruments for the assessment of care centered on the individual, but most of them have not yet been validated. Among these instruments, only two are the most used, the Person-Centered Care Assessment tool (PCCA-t) and the Person-Directed Care Measure (PDCM). However, the PDCM was adapted because it has high internal consistency, reliability, and has already been used in the North American context. Thus, from the 64 original items, in a panel that brought together experts, managers, administrators, family members, and residents, the 11 most important items were chosen based on the relevance to measure care centered on the individual and on the individual psychometric performance of each item. Additionally, based on the literature review and the assessment conducted by the panelists, the authors included three other domains to capture the subjective assessment of relationships between staff and residents. After the adjustments, the Team Member Perspectives of Person-Centered Care (TM-PCC) was proposed. The questionnaire was applied to 461 Canadian professionals and the existence of three components was observed: Support for social relationships; Familiarity with the residents' preferences; and Significant relationships between residents and staff.

The TM-PCC, compared to the original survey, had fewer components (i.e., it did not address the resident's autonomy, personality, or comfort, the work with the residents, their personal environment, and the administrative structure), but included a new component (Relationships with staff). The TM-PCC had an internal consistency similar to the original PDCM (Cronbach's alpha coefficient 0.82 vs. 0.74-0.91). Based on these findings, Boscart et al.[8] concluded that the TM-PCC can be used to assess the PCC from the perspective of the team of professionals working in ILPIs. The advantage of this version is the speed of application and completion (5 to 10 minutes) and for detecting items that are sensitive to the humanization of care, such as communication, relationships, knowledge about residents, and emotional support.

In view of the above, this study aims to carry out a cross-cultural adaptation of the TM-PCC instrument, which was proposed by Boscart et al.[8], in order to assess the practices of the team of professionals working in ILPI regarding individual-centered care[11].

METHOD

This is a cross-cultural adaptation study of the Team Member Perspectives of Person-Centered Care (TM-PCC) instrument developed by Boscart et al.[3]. It is a questionnaire composed of 11 questions that ask professionals to assess, using a Likert scale from 1 to 5, how much they practice or not items related to individual-centered care, including knowledge about residents' habits, foods, and favorite music, their availability to help residents when they need to go to the toilet (with and without the residents' request), support in case they get agitated, social support, interaction with families, and relationships with residents. Altogether, the questions are organized into three domains: *Support for social relationships* (items 1, 2, 3, and 4); *Familiarity with residents' preferences* (items 5, 6, 7, and 8); and *Meaningful relationships between resident and staff* (items 9, 10, and 11).

First stage - adaptation

In this study, the cultural adaptation processes already described in the literature by Beaton, Bombardier, Guillemin, and Ferraz[11], and Guillemin[12] were followed, which included obtaining semantic, idiomatic, experiential, and conceptual equivalence in the translation through back-translation techniques (from Portuguese to English, with subsequent assessment by a native English-speaking translator); and assessment by expert judges on the matter for semantic and construct adequacy; and, finally, pilot application.

In this approach, semantic equivalence refers to the assessment of grammatical and vocabulary similarities between languages since there are some words in languages that do not have the equivalent translation in another language. The idiomatic equivalence identifies the existence of difficulties in translating colloquial expressions used in different countries. Experimental equivalence, also defined as cultural equivalence, assesses the consistency of translated terms with the experiences of the target population. Finally, conceptual equivalence verifies the adequacy of the concepts before the terms or expressions used, since the terms or expressions can have different meanings[12].

The cultural adaptation process consisted of obtaining semantic equivalence through translation, synthesis, and back-translation techniques. Initially, an independent translation into Portuguese of the original English-language questionnaire was prepared with the participation of two independent and qualified English translators with proficiency in the English language and culture, and only one of the translators knew the purpose of the study. At the end of this phase, there was translation 1 (T1) and translation 2 (T2). Then, the synthesis between T1 and T2 was performed by three researchers of this study and the translators, resulting in a version called T12 after adjustments and consensus.

Subsequently, in order to verify whether the T12 version was similar to the original version, a back-translation was performed by two other English translators with fluent Brazilian Portuguese.

After the back-translation, the original version of the scale and the translated version were again compared and discussed between the three researchers and the translators to eliminate flaws that could compromise the meanings and consistency of the instrument.

Finally, the judgment of conceptual and item, semantic, idiomatic, and cultural equivalence between the versions was carried out by a panel of judges.

This panel of judges was made up of five experts working in the areas of Geriatrics and Gerontology, with clinical, technical and research experience in the context of caring for institutionalized older adults. The sample was obtained by convenience and based on their expertise related to the topic. Initially, 15 researchers working in the Southeastern, Southern, and Northeastern regions of Brazil were invited by e-mail. The inclusion criterion of the judges was being a health professional, researching or working in the field of long-term care and having experience with the adaptation of instruments. The exclusion criterion

was unavailability to respond to the assessment sheet in a timely manner. Five judges agreed to participate in this study. After acceptance, the assessors received a letter with the instrument questions.

For each expert, the necessary material for the content validation process was available in Google Form. Thus, the judges received the research project of this study, the original instrument manual, the adapted instrument, and instructions for filling out the form for later calculation of the Content Validity Index (CVI). For each question of the instrument, the judges should assess, using a scale: "-1 disagree"; "0 neither disagree nor approve"; "+1 approve"; and others". This configuration was chosen in order to encompass all suggestions and adjustment possibilities, according to the study of Zukeran et al.[13]. A scale from -1 to 1 was assigned to assess the agreement index between the assessors. A score of -1 was assigned to "others."

The agreement was calculated using the frequency of agreement regarding the items of the questionnaire. The CVI, corresponding to an accuracy rate of ≥80% for each item, was considered as a criterion for adequacy[14]. Questions with CVI scores lower than 80% were reviewed, following possible suggestions from the judges, and sent again for assessment, in order to obtain the maximum agreement between the examiners and the final consensus. After this consensus, the final and adapted version of the scale was created. Finally, after the assessment of the judges and the verification of the CVI, changes were made to the questions and, at the end, the judges received the amended questionnaire to obtain the final agreement.

Second step - Pilot application

Sample

To complete the cultural adaptation process, completing the pre-test phase, the instrument was applied to a convenience sample composed of 49 professionals who worked in direct care of older adults (caregivers, nursing staff, technical staff professionals, and professionals who offered care to institutionalized older adults) from four ILPIs, located in the cities of Brasília (FD), Pontalina (GO), and two in São Paulo (SP). All institutions were philanthropic with subsidies from the *Sistema Único de Assistência Social* (SUAS, Unified Social Assistance System), had been operating for more than three years and were registered with the city's *Supervisão de Vigilância Sanitária* (SUVIS, Health Surveillance Supervision). The professionals who were assessed had worked at the institution for at least six months and were available to answer the questions via an online form. Exclusion criteria were being temporarily away from work, being on vacation and/or health conditions that made participation unfeasible, such as self-reported mental disorders without treatment and/or medical follow-up.

Data collection took place from December 2021 to January 2022 and was carried out using a Google Forms questionnaire. The questionnaire link and the invitation letter were sent by e-mail to the managers of the institutions and, later, retransmitted to their staff via online form. In the invitation letters, all participants were clarified about the objectives of the study and, later, oriented about signing the Informed Consent Form (ICF), respecting the ethical principles of research according to Ordinance 466/2012 of the *Ministério da Saúde* (MS, Ministry of Health).

To characterize the sociodemographic profile of the residents, data were collected regarding age (years), length of service (years), gender (male and female), occupation (caregiver, technical, higher education or support professional), and educational level (elementary or high school, technical or higher education). Data were analyzed quantitatively through descriptive analysis (frequency, mean, standard deviation) and description of Cronbach's Alpha to assess the internal consistency of the questionnaire.

The Ethics Committee of the Catholic University of Brasília approved this study (Opinion Number: 3.621.190), in accordance with the attributions defined in Resolution 466/2012 of the National Health Council.

RESULTS

Adaptation of the questionnaire

After using the stages of translation, back-translation and assessment by the judges, a detailed analysis of the suggestions for semantic adequacy was performed, as shown in Chart 1.

Chart 1. Translation and cross-cultural adaptation of the TM-PCC, 2022.

Original version	Initial Agreement Index	Final version: Portuguese language	Suggestions
I know the preferred habits for __ of my residents	75%	*Eu __ (nunca/ quase nunca / às vezes / quase sempre /sempre) conheço os hábitos preferidos dos meus residentes*	Insert alternatives in a Likert scale: never, sometimes, almost always, and always.
I know __ of my residents' favorite foods	100%	*Eu __ (nunca/ quase nunca / às vezes / quase sempre /sempre) conheço a comida favorita dos meus residentes*	No suggestions
I know ___ of my residents' favorite music	100%	*Eu__ (nunca/ quase nunca / às vezes / quase sempre /sempre) conheço a música favorita dos meus residentes*	No suggestions
I quickly help __ of my residents to the toilet when they request or need help	50%	*Eu __ (nunca/ quase nunca / às vezes /quase sempre /sempre) ajudo meus residentes com rapidez, quando pedem minha ajuda ao banheiro*	Replace the verb "request" with "ask".
I help __ of my residents stay connected to their families	75%	*Eu__ (nunca/ quase nunca / às vezes /quase sempre /sempre) ajudo meus residentes a manterem contato com seus familiares*	Replace "stay connected" with "keep in touch."
I help __ of my residents stay connected to previous associations	75%	*Eu __ (nunca/ quase nunca / às vezes /quase sempre /sempre) ajudo meus residentes a manterem contato com suas histórias pregressas*	Translate "previous associations" as "past stories"
I help __ of my residents keep family members as part of their life	100%	*Eu __ (nunca/ quase nunca / às vezes /quase sempre /sempre) ajudo meus residentes a manterem os membros da família como parte da sua vida*	No suggestions.
I help __ of my residents spend time with people they like	100%	*Eu __ (nunca/ quase nunca / às vezes /quase sempre /sempre) ajudo meus residentes a passarem tempo com as pessoas que eles gostam*	No suggestions.
I __ look after the same residents from day to day	100%	*Eu __ (nunca/ quase nunca / às vezes / quase sempre /sempre) cuido dos mesmos residentes todos os dias*	no suggestions
I am __ able to build fulfilling relationships with residents	75%	*Sou __ (nunca/ quase nunca / às vezes / quase sempre /sempre) capaz de construir relações satisfatórias com os residentes*	Translate "fulfilling relationships" as "satisfying relationships"
I __ can learn from residents and their family members and incorporate this caring into my daily routine	50%	*Posso __ (nunca/ quase nunca / às vezes /quase sempre /sempre) aprender com os residentes e suas famílias e incorporar esse cuidado na minha rotina diária*	Translate "incorporate this caring into my daily routine" as "incorporate this care into my daily routine"

The assessment of the back-translation showed that, of the total of 11 items, two showed good correspondence between the original and the back-translated versions. In the others, different degrees of divergence were identified by at least one (six items) and two judges (three items). Most of the suggestions corresponded to problems of agreement and/or verb conjugation, followed by difficulties in understanding the original question and problems involved in the translation or back-translation. In item 6, one of the judges suggested translating "previous associations" as "past stories." In item 10, one of the judges suggested that the term "fulfilling relationships" be translated as "deep relationships." After discussions between the authors, it was decided to translate the term as "satisfying relationships."

In item 11, we chose to translate "incorporate this caring into my daily routine" as "incorporate this care into my daily routine." After these corrections and revisions, the questionnaire was sent back to the judges, obtaining 100% agreement after the necessary adjustments. The final version of the questionnaire corresponds to the right-hand column of Table 1.

Pilot application

Of the 49 participants in the pilot application, 40 were female and 9 were male. Their mean age was 40.2 years (+9.81), with a mean length of service of 5.37 years (+4.82). As for the cities in which they are located, 20 participants work in the Brasília (FD) ILPI, 14 in the Pontalina (GO) ILPI, and 15 participants in the São Paulo (SP) ILPI. The most common occupation was caregiver (n=37), followed by professionals with technical certification or college degree (n=9), and supporting staff (n=3). Only three participants studied up to elementary school, with the others having completed high school or higher education.

The pilot application of the instrument indicated that the participants had a good understanding of the questions. Most participants reported that the instrument was easy to understand (77.6%), with others reporting it was okay (20.4%) or difficult to understand (2%).

According to Table 1, of the TM-PCC items, the highest frequencies of "Always" were questions 10 "building satisfying relationships with residents" (75.5%), 9 "I take care of my residents every day" (69, 4%), and 11 "I can learn from residents and their families and incorporate this care into my daily routine" related to the *Meaningful relationships* domain; question 4 "I help my residents quickly when they ask me for help when they need to go to the toilet" (65.3%) concerning the *Familiarity with residents' preferences* domain. The lowest prevalence of "Always" were questions 6 "I help my residents to keep in touch with past stories" (6.1%) regarding *Support for Social Relationships* and question 3 "I know my residents' favorite music" (16.3%) regarding the *Familiarity with residents' preferences* domain.

The instrument's internal consistency, the overall Cronbach's alpha, was 0.78, which indicates good internal consistency. The consistency values for each domain ranged from 0.65 to 0.72 as shown in Table 2.

Table 1. Results of the pilot application of the TM-PCC (cross-culturally adapted to Brazil) to 49 ILPI professionals, 2022.

TM_PCC questions	Never	Almost never	Sometimes	Almost always	Always
	N (%)				
I know my residents' favorite habits	0	2 (4.1)	5 10.2)	19 (38.8)	23 (46.9)
I know my residents' favorite food	0	2 (4.1)	14(28.6)	12 (24.5)	21 (42.9)
I know my residents' favorite music	2 (4.1)	2 (4.1)	14 (28.6)	23 (46.9)	8 (16.3)
I help my residents quickly when they ask me for help when they need to go to the toilet	1 (2.0)	2 (4.1)	5 (10.2)	9 (18.4)	32 (65.3)
I help my residents keep in touch with their families	3 (6.1)	1 (2.0)	12 (24.5)	10 (20.4)	23 (46.9)
I help my residents keep in touch with past stories*	22 (44.9)	7 (14.3)	10 (20.4)	7 (14.3)	3 (6.1)
I help my residents keep family members a part of their lives	2 (4.1)	2 (4.1)	12 (24.5)	11 (22.4)	22 (44.9)
I help my residents spend time with people they like	4 (8.2)	2 (4.1)	8 (16.3)	18 (36.7)	17 (34.7)
I take care of my residents every day	1 (2.0)	1 (2.0)	0	13 (26.5)	34 (69.4)
I can build satisfying relationships with residents	0	0	3 (6.1)	9 (18.4)	37 (75.5)
I can learn from residents and their families and incorporate this care into my daily routine	2 (4.1)	1 (2.0)	6 (12.2)	13 (26.5)	27 (55.1)

* Although the judges chose the term "previous stories," it is suggested to add the word "relationships" to the term in order to encompass the semantic aspects of the term "previous associations," referring to the relational aspects associated with reminiscences and autobiographical stories. Therefore, the final question would be "Do I help my residents keep in touch with past relationships and stories?"

Table 2. Cronbach's alpha values for each domain of the TM-PCC questionnaire, 2022.

Domain	Number of questions	Mean	Standard deviation	Cronbach's alpha
Familiarity with residents' preferences	4	3.91	0.780	0.672
Support for social relationships	4	3.52	0.892	0.726
Meaningful relationships between resident and staff	3	4.52	0.767	0.652

DISCUSSION

In the present study, the process of translating and transcultural adaptation of the TM-PCC instrument into Brazilian Portuguese is described, considering the methodological rigor recommended in the international literature[11,12]. At this stage, health professionals working in the areas of Geriatrics and Gerontology participated as expert judges, who were essential for the success of this research. Also, in the pilot application of the instrument, evidence was presented to support the adequacy of the psychometric properties of this version of the instrument to be used with professionals from Brazilian ILPIs, as recommended by its creators[8].

In the present study, there was good internal consistency of the questionnaire, with values similar to those observed in the study by Boscart et al.[8] (Cronbach's alpha of 0.78 versus 0.82 in the scale construction study). Cronbach's alpha values for each domain were also similar to the original study (0.65 to 0.72 in the present study versus 0.62 to 0.83 in the study by Boscart et al.8). In both studies, the lowest consistency was observed in the *Meaningful relationships between resident and staff* domain (0.65 versus 0.62) and the highest in the *Support for social relationships* domain (0.72 versus 0.83). The lower consistency in this last domain may have been mediated by the sample size, which was smaller in the present study, or by cultural, socioeconomic, and educational issues that can be better elucidated in other studies.

With regard to the adaptation of the instrument, adaptations were developed in item 6 in the item "previous associations," translated as "past stories," in item 10 in relation to the term "fulfilling relationships" translated as "satisfying relationships," and in item 11 in relation to the term "incorporate this caring into my daily routine" translated by "incorporate this care into my daily routine." It is observed that the adaptation involved adjustments that considered idiomatic, semantic, and grammatical aspects, necessary for the understanding of the instrument. After the final adjustments, there was 100% agreement with the proposed changes. In this context, the TM-PCC can be a useful tool for assessing individual-centered care.

However, as discussed by Boscart et al.[8], the domains of management and autonomy of residents were removed from the original PDCM to prepare the TM-PCC, which can be considered one of the main limitations of the scale. On the other hand, the authors' strategy was to choose items that were more sensitive to individual-centered care and compose a leaner scale that could be answered quickly. The domains assessed using the TM-PCC comprise *Familiarity with the Residents' Preference* (item 1, 2, 3, and 4), *Support for Social Relationships* (items 5, 6, 7, and 8), and *Meaningful Relationships between Staff and Older adults* (Item 9, 10, and 11).

The cross-cultural adaptation of the TM-PCC proved to be successful. Given the scarcity of standardized assessments to measure individual-centered care in Brazil, the TM-PCC offers professionals, scholars, and experts the opportunity to assess the adoption of humanized practices in the context of professionals working in ILPIs. The instrument focuses on aspects related to the relationships between professionals and older adults, as well as the interaction, communication, and knowledge that professionals have regarding the residents' preferences[8].

The results of the pilot application indicated that the questionnaire was well understood by the

participants. Of the questions analyzed, the following items had the lowest scores: item 3 "I know my residents' favorite music," relative to the *Familiarity with the residents' preferences* domain; and item 6 "I help my residents to keep in touch with past stories" of the *Support for social relationships* domain. Item 6 stands out in the responses, indicating that maintaining contact with past stories is a challenge in the context of care, as it highlights the exchange between living in a collective space and keeping in touch with contacts and the previous stories.

Another aspect that may have supported the low frequency of professionals in question 6 is a possible difficulty in understanding the question. Despite the agreement of the judges on the term "previous stories," the English term "previous associations" carries with it a greater semantic range, related both to reminiscences and autobiographical memory as well as to relational, personal issues and related to the social contacts that older people accumulated throughout their lifespan. Therefore, it is suggested to complement the question with terms that can help the understanding of this semantic variety in the context of the Portuguese language, such as "previous/preceding/antecedent relationships and stories." Respect for the residents' uniqueness and life story is a sensitive issue that should be further explored by studies, in order to instrumentalize the technical and social work of ILPIs and workers.

Oliveira and Rozendo[15] in a qualitative study with institutionalized older adults highlighted that the institution is seen as an ambiguous place by them, because while it welcomes, shelters, and meets their needs, it is an environment that can make independent and autonomous life impossible due to routines or daily care. Michel[16], when interviewing the meanings of the experience of older adults in ILPIs, observed that for residents, the institution means the possibility of care as a way of maintaining life and optimizing their well-being, and given the norms and routines of the institution, they develop their own strategies against the mortification of the self. Thus, it is possible that these results are supported by the confluence of the context in which older adults were institutionalized, often marked by broken homes and the absence of long-term care alternatives that keep older adults in their households, to the development of technical work that dialogues between the challenges of maintaining individuality, privacy and active social life even in the presence of a collective space such as ILPIs.

In this context, care centered on the individual is aimed at improving the quality of life and care, in an integral way, anchored in a biopsychosocial approach, with individualized and humanized treatment, since the focus is on the person[17-19].

It was observed, in the present study, that the investigated professionals had high scores in the questions related to *Meaningful Relationships with Residents* (items 9, 10, and 11), which indicates that the operationalization of care that meets the domains of *Support for Social Relationships* and *Familiarity with Residents' Preferences* could be more easily operationalized through educational actions, sensitization of professionals and survey of internal and external resources related to work, in order to promote structural and organizational changes necessary for the well-being of older adults and the staff. Thus, it is essential to have professionals who work in ILPIs in dimensions such as family distance, the functional decline of older adults and the resistance of older adults on these issues[20].

One of the limitations of the present study is the need to verify all the psychometric properties of the instrument so that it can be used with professionals. It is necessary to design studies to adjust the internal structure, reliability, and accuracy as a situational diagnosis instrument. In addition, it is suggested to compare the findings of the TM-PCC with studies that use observational techniques or other assessment scales in professionals working in ILPIs regarding care focused on individuals.

CONCLUSION

The TM-PCC can be a useful tool for assessing individual-centered care in the context of care for older adults in ILPIs in Brazil. It proves to be successful, both for the acceptance of expert judges and to facilitate the understanding of professionals, as well as for the adequate assessment of the analysis

of *Familiarity with Residents' Preference*, *Support for Social Relations*, and *Meaningful Relationships between Staff and Older Adults*. The instrument, when validated, will make it possible to identify the situational diagnosis on how familiar these professionals are with the residents' preferences and to verify the social work and the relationships that are established between older adults and staff. The translated and cross-culturally adapted proposal presented in the present study may support future studies aimed at validating and analyzing the psychometric components of the instrument.

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