Cross-cultural adaptation of safety culture tool for Primary Health Care

Adaptação transcultural de instrumento de cultura de segurança para a Atenção Primária

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Abstract

Objective: Translate, adapt and validate the Medical Office Survey on Patient Safety Culture (MOSPSC).
Methods: Methodological study for the cross-cultural adaptation of the MOSPSC, elaborated by the Agency for Healthcare and Research in Quality. The following steps were undertaken: translation, back-translation, expert analysis, target population group and pretest, in a sample of 37 professionals.
Results: In the expert analysis, the tool reached a general content validity score of 0.85. Six professionals performed the assessment by the target population group, and the adaptation suggestions were analyzed and modified by consensus. The pretest involved 37 professionals, who assessed the tool as easy to understand. Cronbach's alpha coefficient corresponded to 0.95.
Conclusion: The tool was translated and adapted to Brazilian Portuguese with a satisfactory content validity and high reliability.

Resumo

Objetivo: Traduzir, adaptar e validar o instrumento de pesquisa *Medical Office Survey on Patient Safety Culture* (MOSPSC).
Métodos: Estudo metodológico de adaptação transcultural do instrumento MOSPSC elaborado pela *Agency for Healthcare and Research in Quality*. Seguiram-se as etapas de tradução, retrotradução, análise de especialistas, grupo de população meta e pré-teste com amostra de 37 profissionais.
Resultados: Na análise dos especialistas, o instrumento atingiu índice de validade de conteúdo geral de 0,85. A avaliação pelo grupo de população meta foi realizada por seis profissionais, e as sugestões de adaptação foram analisadas e modificadas por consenso. O pré-teste foi realizado com 37 profissionais, que avaliaram o instrumento como de fácil compreensão. O coeficiente alfa de Cronbach foi de 0,95.
Conclusão: O instrumento foi traduzido e adaptado para a língua portuguesa do Brasil com nível satisfatório de validade de conteúdo e alta confiabilidade.

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Introduction

The importance of discussing the patient safety culture and establishing safer care that does not cause harm is beyond doubt, with a view to establishing a safety culture at health institutions and offering quality care. Patient safety is neither an individual's nor a professional category's problem, but a process that involves an institutional transformation.

The patient safety culture is a multifactorial structure, intended to promote an approach of the system to prevent and reduce damage for the patients, essentially referring to a culture in which all stakeholders are aware of their role and contribution to the organization, being responsible for the consequences of their actions.[1,2] The frailty aspects include the existence of the culture of fear that errors are registered in their job records, the clear lack of communication and the reporting culture of adverse events.[3]

Adverse event management involves identification, registering, analysis, discussion and prevention, in a culture of accountability instead of blame.[1] Cultural transformation is thus a complex process with multiple factors that influence its success.[4]

The assessment of the safety culture is considered the starting point to understand the current scenario and start the planning of actions aimed at changes to reduce the incidence of adverse events.[5] It permits the identification and prospective management of relevant safety issues in the work routines, aiming to guarantee safe health care in general practice.[6]

It is important for the organizational culture to support learning and development since, if it is based on punishment and guilt, it can cause the omission of adverse events, hampering the construction of an institutional culture aimed at patient safety.[3] The careful analysis of error triggers evidences a series of incidents that, even in a safe practice, when influenced by the work environment and organizational culture, can produce bad results. Hence, human error should be faced in two different ways: the individual mode and the organizational mode.[1] The factors that knowingly affect the patient safety outcomes include the number of nurses at a service, the nurses' level of education and a favorable work environment.[7]

Thus, it is fundamental to adopt solutions applicable to all members of the organizations, which should be easily integrated in the routine and work flow, in order to increase the adherence and sustainability.[4] Teamwork should be strengthened as a basic core, since is may contain a decisive potential for the efficacy of the current Primary Health Care model.[8] The institutions should critically reflect on the role the managers should play, as their strategic decisions include personnel management, demanding professional encouragement and training for the effective prevention, reporting and management of these risks during the performance and assessment of the care delivered, the planning of the facilities, the elaboration of the operating procedures, the choice of the equipment and all other decisions that define the structure of the system.[3]

In recente years, patient safety research in primary care has considerably evolved.[9] Adverse events are common also in Primary Care, where most services are provided. Therefore, there has been increasing interest in patient safety factors also beyond the hospital contexto.[10] Thus, the safety culture needs to be explored from the perspective of the multidisciplinar teams, inserted in an organizational context, to constitute a body of knowledge, identifying the professionals' view on patient safety and, thus, arousing debate and reflection on the theme to support the implementation of actions that improve the safety culture and the quality of care at Primary Health Care services.

The qualification of Primary Care in the Unified Health System (SUS), adopted by the Brazilian government, intends to rescue the universal tone of the Declaration of Alma-Ata, emphasizing the reorientation role of the care model towards a universal and integrated health care system. In that sense, the Family Health Strategy is one of the proposals for the reorganization of Primary Care, being considered an alternative action to achieve the objectives of universalization, equity and integrality.[11]

Based on the above, the objective in this study was to translate, adapt and validate the research tool *Medical Office Survey on Patient Safety Culture*

(MOSPSC) to assess the patient safety culture in Primary Health Care in Brazil.

Methods

A methodological study was undertaken for the translation and cultural adaptation of the MOSP-SC,[12] an assessment tool the Agency for Health Care Research and Quality (AHRQ) developed in 2007. This tool has shown its usefulness as a form of scientific research. The cross-cultural adaptation and validation was undertaken for use in Primary Health Care in Spain.[13] It was also validated in Arabic and recently applied in a study in Al Mukalla, Yemen.[14] In a study developed by the LINNEAUS project, published in November 2015, in which 15 experts from the United Kingdom, the Netherlands, Denmark, Germany, Poland and Austria analyzed the tool, the results show that it is useful and applicable to assess the patient safety culture at Primary Health Care services in Europe.[15]

The original assessment tool consists of 51 questions that measure 12 dimensions of the patient safety construct, including: (1) open communication; (2) error communication; (3) information exchange with other sectors; (4) work process and standardization; (5) organizational learning; (6) general perceived patient safety and quality; (7) management support in patient safety; (8) follow-up of patient care; (9) aspects of patient safety and quality; (10) team training; (11) teamwork; and (12) pressure at work and rhythm.

To achieve the study objective, initially six steps were followed (Figure 1), strictly monitored and registered in reports, according to a guideline for validation studies in health, which are: Step 1 – translation of original tool to target language by two independent translators, (versions T1 and T2), native speakers of Brazilian Portuguese and bilingual in English/Portuguese, experienced in this method and knowledgeable about the research objective; Step 2 - in synthesis I, versions T1 and T2 were compared with the original version of the tool and summarized; Step 3 – back translation by two independent translators (R-T1 and R-T2), bilingual
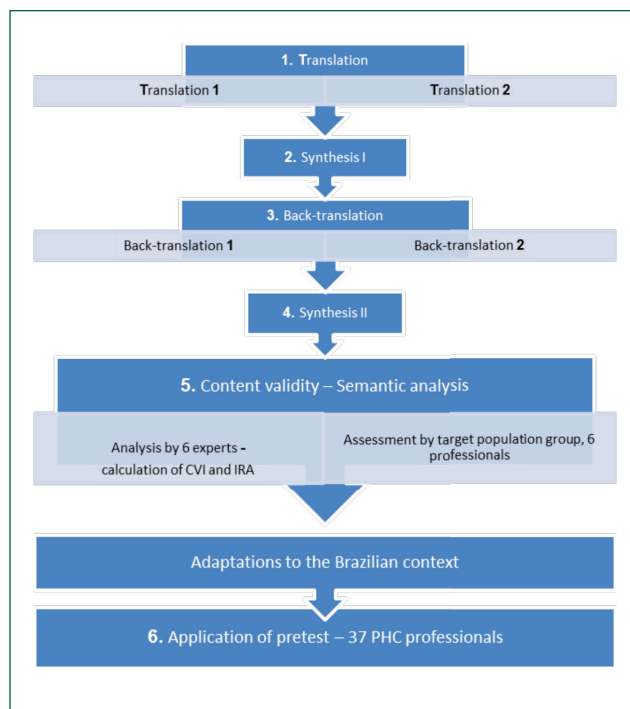

Figure 1. Steps of the method; CVI – Content Validity Index; IRA – inter-rater agreement; PHC – Primary Health Care

native North Americans, who were unfamiliar with the original version of tool and not knowledgeable about the study objectives; Step 4 - in Synthesis II, the cross-cultural adaptations were undertaken after assessing for discrepancies; Step 5 - Content validity and semantic analysis undertaken in two phases.

In Phase 1 of Step 5, the expert analysis was undertaken. Six experts participated, selected based on the following criteria: be a researcher (M.Sc. or Ph.D.) and author of scientific research on the theme patient safety or methodological advice for tool adaptation. Curricula were analyzed on the Lattes Platform of the Brazilian Scientific and Technological Development Council and, beyond the criteria established, five out of six experts have expertise in collective health.

The invitation and instructions were forwarded to the experts by e-mail. For the sake of analysis, the research program *SurveyMonkey*® was used, which contained the items for individual assessment in terms of clarity, pertinence and content form, using a Likert scale with the following scores: 1 unclear, 2 hardly clear, 3 clear and 4 very clear. At the end of each item, there was space for suggestions and observations.

To measure the proportion or percentage of inter-rater agreement, the collected data were analyzed concerning the Content Validity Index,[16,17] according to the following formula:

- Number of "3" and "4" answers divided by total number of answers.

In addition, the inter-rater agreement level was calculated for each section, using the following formula:

- Number of items with Content Validity Index ≥80% divided by total number of items in each section.

The inter-rater agreement serves to assess the extent of the experts' reliability in the assessments of the items in view of the study context.[18] Finally, the Content Validity Index of the tool was calculated by adding up the Content Validity Indices, divided by the total number of items.

Phase 2 of Step 5 referred to the assessment by a group from the target population, aiming to verify whether all items were understandable to the target population of the tool. In this phase, six professionals from the target population participated, representing the main professional categories active in Primary Health Care, ranging from the lowest to the highest education level. Each item was assessed interactively and its understanding was analyzed during a brainstorming.[19] For the questions whose interpretation aroused doubts, suggestions were requested for adaptations, which were registered in a report and later analyzed.

In Step 6, the pretest was applied, which was aimed at assessing whether the questionnaire was understandable to a larger number of people in the target population and the reliability analysis of the tool was processed.

The data were collected in March and April 2005 in a sample of 37 multidisciplinary team professionals from three health centers and one family clinic (service with eight family health teams) in a regional health department of the State Health Secretary in the Federal District. The understanding was scored on a five-point Likert scale, as follows: 1 I did not understand; 2 I hardly understood; 3 I understood more or less; 4 I understood; and 5 I fully understood. To an-

alyze the reliability, Cronbach's alpha coefficient was used.

The study was registered in Brazil under the Platform Presentation of Certificate number to Ethics Assessment (CAEE) 31787314.0.0000.5553.Initially, tbe AHRQ was consulted, which authorized the study.

Results

The adaptations of the assessment tool started with the title, "Medical Office Survey on Patient Safety", originally translated as "*Pesquisa de Consultório Médico sobre Segurança do Paciente*". The goal was to adapt a tool that could be used in the different forms of Primary Health Care. Therefore, the title was modified to "*Pesquisa sobre Cultura de Segurança do Paciente para Atenção Primária*" ("Research on Patient Safety Culture for Primary Health Care"). In addition, the term "medical office" was changed to "health service", and the term "provider" to "physician". The professionals included in the health team were also adapted, as there is no equivalent for some professional categories in Brazil.

Attachment 1 displays the final version of the translation and cross-cultural adaptation applied in the pretest.

Expert analysis

The items in the assessment tool that received more than 20% of score 1 (unclear) or 2 (hardly clear) were considered unsatisfactory. They were then modified based on the suggestions while maintaining the general concept. Hence, the minimum inter-rater agreement level was set at 80% to avoid any need for adaptations.

In section A, only three items (questions 1, 3 and 8) reached a Content Validity Index of 0.8; questions 4, 5 and 6 reached index 0.7 and the remainder below 5. In section B, the Content Validity Index was unsatisfactory because the alternative answers were maintained in a single question. In Section C, most items reached an index between 0.8 and 1.0; the index was inferior to 0.7 in only three items (questions 3, 12 and 14), requiring adaptations. In section D, only one item (question 6) did

not reach a satisfactory Content Validity Index; the remainder continued between 0.8 and 1.0. In sections E, F, G and H, all questions obtained indices superior to 0.8.

As regards the inter-rater agreement, the coefficients obtained in sections A (0.3) and B (0.0) were unsatisfactory, demanding further adaptations. In section C, the inter-rater agreement corresponded to 0.8; in D, 0.9; and the remaining sections reached a score of 1.0.

Although some sections required further adaptations, the calculation of the Content Validity Index for the general tool was satisfactory, corresponding to 0.85.

Assessment by target population group

In this pahse, six professionals participated in the research, one from each category: nurse, physician, dentist, nursing technician, community health agent and oral health technician. As for education, one held a secondary education degree, one was taking a higher education program and one held a higher education degree, two held a specialization degree and one a Master's degree.

The researchers analyzed the group's suggestions and the items considered relevant were modified by consensus. In Section A, question number 8 was included, suggested by the group and accepted, so that this section consisted of ten questions (Attachment 1).

Pretest

Fifty-two questionnaires were distributed, 37 of which were returned (71%). In the distribution by professional category, the collection was done to include the widest possible range, as follows: nursing technicians (n=11; 29.7%), nurses (n=7; 19.0%), physicians (n=4; 10.8%), dentists (n=3; 8.1%), administrative team (n=3; 8.1%), laboratory technicians (n=2; 5.4%), nutritionist (n=1; 2.7%), oral health technician (n=1; 2.7%), administrator (n=1; 2.7%), manager (n=1; 2.7%), head nurse (n=1; 2.7%), head of registration sector (n=1; 2.7%), and community health agent (n=1; 2.7%).

The Portuguese version of the MOSPSC showed a Cronbach's alpha coefficient of 0.95, expressing high reliability.

Discussion

This study was limited by the fact that, to reach a satisfactory level with only six experts in the calculation of the Content Validity Index, five experts had to assess the item with a minimum score of 3 (clear) or 4 (very clear). Another aspect was that, in section B, the subitems were maintained in a single question, which interfered in the assessment, because the experts suggested that the answered should be divided. Despite these limitations, the Content Validity Index of the general tool reached a satisfactory level (0.85). To check the validity of new tools in general, some authors suggest a minimum agreement coefficient of 0.80.[17]

In the internal consistency analysis, Cronbach's alpha coefficient corresponded to 0.95, similar to the coefficient found in the validation of the tool for Spanish (0.96).[13]

The use of a consistent method for the translation, cross-cultural adaptation and validation of a research tool is essential.[12] In this study, the steps were carefully monitored, analyzed and documented to achieve a better consistency level. A robust and well-developed tool, with validity and reliability of the data in the original version, strictly adapted and translated in different languages, permits the comparison of the results on an international scale, in different cultures.[20]

The research steps were used to support the conceptual, semantic and content equivalence of the tool to be translated. Experts performed the content analysis step. According to the methodological framework used, six experts are sufficient to obtain content validity.[13,19] Therefore, they were carefully selected to guarantee the quality of the evaluation.

The semantic analysis was undertaken through the target population group, assessing the understanding and face validation. The items were reviewed and modified to enhance the understanding and clarity in accordance with the suggestions. A project to translate, adapt and validate a cross-cultural research tool can take several years and is normally developed based on more than one study as

a methodological framework. The initial target can be defined as the translation, adaptation and validation of a tool using steps 1 to 5, followed by the full psychotechnical test of the prefinal version of the translated tool in a sample of the target public.[16]

The largest number of suggested adaptations were related to section A, in the expert analysis phase as well as in the assessment by the target population. One factor that contributed to reduce the Content Validity Index of the section was one expert's assessment, who scored all items as "hardly clear", not related to the question, but to the answer frequency. Replacing the alternative answers "weekly" or "monthly" by "at least once a week" and "at least once a month" was suggested, respectively.

In section H, the professional categories active at Primary Health Care services in Brazil were adapted, considering that the theme covers the organizational structure and the multiprofessional team. Similarly, another instrument translation and validation study for use in hospitals developed this adaptation.[6]

None of the items was excluded from the assessment tool; on the opposite, item 8 was added in section A, suggested by the target population group. The item refers to the access to medical exams as, in the Brazilian reality, the necessary exams are not always offered to the patients freely and in due time. Access is defined as the user's capacity to obtain health care whenever necessary, easily and conveniently,[11] and this dimension of quality in health interferes directly in the safety, as it makes appropriate diagnosis and treatment impossible. The large number of questions in the tool may interfere in the adherence to the research and, in another study, it was equally suggested that a lesser number of items would be more appropriate.[13]

Hence, the challenge of adapting a tool cross-culturally, and the limitations of assessing a complex theme like the patient safety culture, containing items that target managers, the administrative team and the multiprofessional team, its reliability can be confirmed. Nevertheless, subsequent steps need to be pursued, aimed at the operational and measuring equivalence, in order to prove its psycho-

metric properties.[6] The application of a validated questionnaire in studies compared among different contexts in the country and among other countries from different continents will permit understanding the multifaceted phenomenon of safety culture at several Primary Health Care services.

Conclusion

The research tool Medical Office Survey on Patient Safety Culture was translated, cross-culturally adapted and validated, including the semantic analysis and assessment of the clarity and understanding of the items. In the expert analysis, the results demonstrated satisfactory content validity. In the pretest, the Brazilian Portuguese version showed high reliability, according to Cronbach's alpha, and was considered easy to understand by the target population.

Collaborations

Timm M and Rodrigues MCS declare that they contributed to the conception of the study, analysis, interpretation of the data, writing of the article, relevant critical review of the intellectual content and final approval of the version for publication.

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Attachment 1. Adapted and validated tool

Research on Patient Safety Culture for Primary Health Care

RESEARCH INSTRUCTIONS

Think about the way things are done in your health service and provide your opinions on issues that affect the safety and quality of the care provided to patients.

If a question does not apply to you or you don't know the answer, please check "Does Not Apply or Don't Know."

If you work in more than one health service, when answering this survey, answer only about the location where you received this survey—do not answer about your practice in general.

If you work in a building with other health services, answer only about your own place of work.

SECTION A: List of questions on patient safety and quality

The following items describe things that can happen at health services that affect patient safety and quality of care. According to you, how often did the facts listed below happen at your place of work OVER THE PAST 12 MONTHS?

	Daily	At least once a week	At least once a month	Several times in the past 12 months	Once or twice over the last 12 months	Did not happen over the past 12 months	Does not apply or I don't know
1. A patient was unable to get an appointment within 48 hours for an acute/serious problem.	☐1	☐2	☐3	☐4	☐5	☐6	☐9
Patient identification 2. When attending a patient, a chart/medical record from another patient was used.	☐1	☐2	☐3	☐4	☐5	☐6	☐9
Charts/medical records 3. The chart/medical record of a patient was unavailable when necessary.	☐1	☐2	☐3	☐4	☐5	☐6	☐9
4. Clinical information from one patient was filed, scanned or entered into the chart/medical record of another patient.	☐1	☐2	☐3	☐4	☐5	☐6	☐9
Equipment 5. Equipment needed for care was not working properly or was in need of repair or replacement.	☐1	☐2	☐3	☐4	☐5	☐6	☐9

SECTION A: List of questions on patient safety and quality (continued)

How often did the facts listed below happen at your place of work OVER THE PAST 12 MONTHS?

Medication	Daily	At least once a week	At least once a month	Several times in the past 12 months	Once or twice over the last 12 months	Did not happen over the past 12 months	Does not apply or I don't know
6. The patient returned to the health service to clarify or correct a prescription	☐1	☐2	☐3	☐4	☐5	☐6	☐9
7. The health professional did not review the medicaiton a patient used during his/her appointment.	☐1	☐2	☐3	☐4	☐5	☐6	☐9
Diagnostics & testes							
8. The lab or imaging tests were not done when necessary.	☐1	☐2	☐3	☐4	☐5	☐6	☐9
9. The lab or imaging test results were not available when needed.	☐1	☐2	☐3	☐4	☐5	☐6	☐9
10. An abnormal result of a lab or imaging test was not followed up in due time.	☐1	☐2	☐3	☐4	☐5	☐6	☐9

SECTION B: Information exchange with other institutions

Over the past 12 months, how often has this health service had problems exchanging accurate, complete, and timely information with:

	Problems daily	Problems at least once per week	Problems at least once per month	Several problems over the last 12 months	One or two problems over the last 12 months	No problem over the last 12 months	Does not apply or I don't know
1. Imaging centers/labs from the health care network?	☐1	☐2	☐3	☐4	☐5	☐6	☐9
2. Other health services/physicians from the health care network?	☐1	☐2	☐3	☐4	☐5	☐6	☐9
3. Pharmacies?	☐1	☐2	☐3	☐4	☐5	☐6	☐9
4. Hospitals?	☐1	☐2	☐3	☐4	☐5	☐6	☐9
Others? Please specify: _____	☐1	☐2	☐3	☐4	☐5	☐6	☐9

SECTION C: Working at this health service

How much do you agree or disagree with the following statements?	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Does not apply or don't know
1. When someone in this service gets really busy, other colleagues help out	☐1	☐2	☐3	☐4	☐5	☐9
2. In this service, there is a good working relationship between the physicians and other professionals	☐1	☐2	☐3	☐4	☐5	☐9
3. In this service, we often feel rushed when taking care of patients	☐1	☐2	☐3	☐4	☐5	☐9
4. This service trains the team when new processes are put into place	☐1	☐2	☐3	☐4	☐5	☐9
5. In this service, we treat each other with respect	☐1	☐2	☐3	☐4	☐5	☐9
6. We have too many patients for the number of physicians in this service	☐1	☐2	☐3	☐4	☐5	☐9
7. This service makes sure the team gets the training they need for care delivery	☐1	☐2	☐3	☐4	☐5	☐9

	Never	Rarely	Sometimes	Almost always	Always	Does not apply or I don't know
8. This service is more disorganized than it should be	□1	□2	□3	□4	□5	□9
9. In this service, there are procedures in place to check that work in this service was done correctly	□1	□2	□3	□4	□5	□9
10. The professional in this service are asked to do tasks they haven't been trained to do	□1	□2	□3	□4	□5	□9
11. We have enough professionals to handle the number of patients	□1	□2	□3	□4	□5	□9
12. We have problems with workflow in this service	□1	□2	□3	□4	□5	□9
13. This service values teamwork in taking care of patients	□1	□2	□3	□4	□5	□9
14. This service has too many patients to be able to attend to them effectively	□1	□2	□3	□4	□5	□9
15. The team in this service follows standardized processes to get its activities done	□1	□2	□3	□4	□5	□9

SECTION D: Communication and Follow-up

How often do the following facts happen in this service?	Never	Rarely	Sometimes	Almost always	Always	Does not apply or I don't know
1. The physicians at this service are open to the ideas of the other team members on how to improve the work processes.	□1	□2	□3	□4	□5	□9
2. At this service, the team is encouraged to express other points of view.	□1	□2	□3	□4	□5	□9
3. At this service, the patients are warned when they need to make an appintment for preventive or routine care.	□1	□2	□3	□4	□5	□9
4. At this service, the team is afraid to ask questions when something does not seem right.	□1	□2	□3	□4	□5	□9
5. This service keeps records of how chronic patients follow the treatment plan.	□1	□2	□3	□4	□5	□9
6. This service follows up when it does not receive an expected report from another service.	□1	□2	□3	□4	□5	□9
7. The team at this servisse believes that its erros can be used against the team.	□1	□2	□3	□4	□5	□9
8. The team talks openly about problems at this service.	□1	□2	□3	□4	□5	□9
9. This service monitors patients who need follow-up.	□1	□2	□3	□4	□5	□9
10. At this servisse it is difficult to express different opinions.	□1	□2	□3	□4	□5	□9
11. In this service we discuss ways to prevent errors from happening again.	□1	□2	□3	□4	□5	□9
12. Employees are willing to report bugs to observe this service.	□1	□2	□3	□4	□5	□9

SECTION E: Management/administration/leadership support

A. **Are you a manager/administrator or** do you have a leading function with responsibility to make financial decisions for the service?

□1 Yes → *Move on to Section F*

□2 No → ***Continue below***

How much do you agree or disagree with the following statements about the managers/ leaders of your service?	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Does not apply or don't know
1. They aren't investing enough resources to improve the quality of care in this service	□1	□2	□3	□4	□5	□9
2. They overlook patient care mistakes that happen over and over	□1	□2	□3	□4	□5	□9
3. They place priority on improving patient care processes	□1	□2	□3	□4	□5	□9
4. They frequently make decisions based on what is best for the office instead of what is best for patients	□1	□2	□3	□4	□5	□9

SECTION F: Your health service

How much do you agree or disagree with the following statements?	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	Does Not Apply or Don't Know
1. When there is a problem in our servisse, we asses whether the way we do things needs to change.	☐1	☐2	☐3	☐4	☐5	☐9
2. Our work processes are appropriate to prevent errors that could affect the patients.	☐1	☐2	☐3	☐4	☐5	☐9
3. At this service, mistakes happen more often than they should.	☐1	☐2	☐3	☐4	☐5	☐9
4. It is just by chance that we don't make more mistakes that affect our patients.	☐1	☐2	☐3	☐4	☐5	☐9
5. This service is good at changing work processes to make sure that problems do not happen again.	☐1	☐2	☐3	☐4	☐5	☐9
6. At this service, how much work is done is more important than the quality of the care provided.	☐1	☐2	☐3	☐4	☐5	☐9
7. At this service, after making changes to improve the patient care process, we check to see whether they work.	☐1	☐2	☐3	☐4	☐5	☐9

SECTION G: Overall assessment

Overall quality assessment

1. In general, how would you rank this health service in each of the following health care quality areas?

		Bad	Reasonable	Good	Very good	Excellent
a. Patient centered:	Is sensitive to the patients' individual preferences, needs and values.	☐1	☐2	☐3	☐4	☐5
b. Effective:	Is based on scientific knowledge.	☐1	☐2	☐3	☐4	☐5
c. Punctual:	Minimizes potentially harmful waiting times and delays.	☐1	☐2	☐3	☐4	☐5
d. Efficient:	Guarantees care with a good cost-benefit relation (avoids waste, excessive and incorrect service use).	☐1	☐2	☐3	☐4	☐5
e. Impartial:	Offers the same quality of care to all patients, independently of sex, ethnic origin, socioeconomic status, language etc.	☐1	☐2	☐3	☐4	☐5

Overall patient safety assessment

2. Overall, how would you rank the systems and clinical processes this service uses to prevent, identify and correct problems that may affect patients?

Bad	Reasonable	Good	Very good	Excellent
☐1	☐2	☐3	☐4	☐5

SECTION H: Questions about professional practice

1. How long have you worked at this service?

☐ a. Less than 2 months   ☐ d. Between 3 years to less than 6 years

☐ b. Between 2 months to less than 1 years   ☐ e. Between 6 years to less than 11 years

☐ c. Between 1 years to less than 3 years   ☐ f. 11 years or more

2. Normally, how many hours per week do you work at this service?

☐ a. 1 to 4 hours per week   ☐ d. 25 to 32 hours per week

☐ b. 5 to 16 hours per week   ☐ e. 33 to 40 hours per week

☐ c. 17 to 24 hours per week   ☐ f. 41 hours per week or more

3. What is your function at this service? Check ONE category that best applies to your job.

☐ a. Physician

☐ b. Nurse

☐ c. Management

    Administrator

    Nurse Manager

    Laboratory Manager

    Another manager _____

☐ d. Administrative team

Medical records   In charge of scheduling (appointments, exams, surgery etc.),

Reception   Another administrative function: _____

Receptionist

☐ e. Nursing Technician

☐ f. Other clinical staff:

Laboratory Technician

Oral Health Technician

    ☐ Odontologist   ☐ Physiotherapist   ☐ Nutritionist

    ☐ Pharmacist   ☐ Psychologist   ☐ Occupational Therapist

    ☐ Social Worker   ☐ Community Health Agent

    ☐ Another function. Please specify: _____

SECTION I – Your comments

Please feel free to write any comments you may have about safety and quality of care at the service where you work.

THANK YOU FOR COMPLETING THIS RESEARCH.