

CROSS-CULTURAL ADAPTATION AND VALIDATION OF THE “HEALTH SCIENCES EVIDENCE-BASED PRACTICE QUESTIONNAIRE” INTO BRAZILIAN PORTUGUESE

ADAPTAÇÃO TRANSCULTURAL E VALIDAÇÃO DO “HEALTH SCIENCES EVIDENCE-BASED PRACTICE QUESTIONNAIRE” PARA O PORTUGUÊS DO BRASIL

ADAPTACIÓN TRANSCULTURAL Y VALIDACIÓN DEL “HEALTH SCIENCES EVIDENCE-BASED PRACTICE QUESTIONNAIRE” AL PORTUGUÉS BRASILEÑO

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ABSTRACT

Introduction: the instrument “Health Sciences Evidence-Based Practice Questionnaire” assesses the different dimensions of building evidence-based practice as a process to respond to situations arising from daily clinical practice. **Objectives:** culturally adapt the instrument “Health Sciences Evidence-Based Practice Questionnaire” to the Brazilian Portuguese language and evaluate its psychometric qualities. **Method:** methodological study. The first step comprised the process of translation and cross-cultural adaptation of the instrument. In the second step, the instrument Evidence-Based Practice and Clinical Effectiveness Questionnaire was applied for convergent validation, using Pearson's correlation index, significance level 0.05, and Confirmatory Factor Analysis (CFA) was performed, according to the structural equation model. Reliability was assessed by test-retest using Pearson's r correlation coefficient. Internal consistency was obtained using Cronbach's alpha coefficient. **Results:** content validity obtained in the third round, final title: HS-EBP Questionnaire - Health Sciences Evidence-Based Practice, applied to 305 healthcare professionals. Reliability was verified using Cronbach's alpha coefficient (0.970), similar to the original version, and test-retest stability was verified using Pearson's r correlation index ($r = 0.766$), which indicated a strong correlation. For convergent validation, Pearson's correlation index ($r = 0.683$) was applied, positive and with moderate correlation between the instruments. The chi-square test was significant (<0.001) for all models obtained, in all models tested. **Conclusion:** the instrument proved to be valid and reliable for reproducibility in the Brazilian version.

Keywords: Evidence-Based Practice; Validation Studies; Psychometrics; Education, Continuing; Health Services Administration; Quality of Health Care.

RESUMO

Introdução: o instrumento “Health Sciences Evidence-Based Practice Questionnaire” avalia as diferentes dimensões da construção da prática baseada em evidência como um processo para responder às situações decorrentes da prática clínica diária. **Objetivos:** adaptar culturalmente o instrumento “Health Sciences Evidence-Based Practice Questionnaire” para a língua portuguesa do Brasil e avaliar suas qualidades psicométricas. **Método:** estudo metodológico. A primeira etapa compreendeu o processo de tradução e adaptação transcultural do instrumento. Na segunda etapa, o instrumento Questionário de Prática Baseada em Evidências e Efetividade Clínica foi aplicado para a validação convergente, utilizando-se o índice de correlação de Pearson, nível de significância 0,05 e realizada Análise Fatorial Confirmatória (AFC), de acordo com o modelo de equações estruturais. A confiabilidade foi avaliada pelo teste-reteste, utilizando o coeficiente de correlação r de Pearson. A consistência interna foi obtida por meio do coeficiente alfa de Cronbach. **Resultados:** validade de conteúdo obtida na terceira rodada, título final: Questionário HS-EBP - Prática Baseada em Evidências nas Ciências da Saúde, aplicado a 305 profissionais da saúde. A confiabilidade foi verificada por meio do coeficiente alfa de Cronbach (0,970), similar à versão original, e da estabilidade teste-reteste pelo índice de correlação r de Pearson ($r = 0,766$) que indicou uma correlação forte. Para a validação convergente foi aplicado o índice de correlação de Pearson ($r = 0,683$) positivo e com correlação moderada entre os instrumentos. O teste qui-quadrado foi significativo ($<0,001$) para todos os modelos obtidos, em todos os modelos testados. **Conclusão:** o instrumento se mostrou válido e confiável para a reprodutibilidade na versão brasileira.

Palavras-chave: Prática Clínica Baseada em Evidências; Estudos de Validação; Psicometria; Educação Continuada; Administração de Serviços de Saúde; Qualidade da Assistência à Saúde.

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RESUMEN

Introducción: el instrumento “Health Sciences Evidence Based Practice Questionnaire” evalúa las diferentes dimensiones de la construcción de la práctica basada en la evidencia como un proceso para responder a las situaciones derivadas de la práctica clínica diaria. **Objetivos:** adaptar culturalmente el instrumento Health Sciences Evidence Based Practice Questionnaire al portugués de Brasil y evaluar sus cualidades psicométricas. **Método:** estudio metodológico. La primera etapa comprendía el proceso de traducción y adaptación transcultural. En la segunda etapa, se aplicó el instrumento Cuestionario de Práctica Basada en la Evidencia y Efectividad Clínica para la validación convergente, utilizando el índice de correlación de Pearson, nivel de significación 0,05 y el Análisis Factorial Confirmatorio (AFC), según el modelo de ecuaciones estructurales. La fiabilidad se evaluó mediante una prueba y una segunda prueba, utilizando el coeficiente de correlación r de Pearson. La consistencia interna se obtuvo mediante el coeficiente alfa de Cronbach. **Resultados:** validez de contenido obtenida en la tercera ronda, título final: Cuestionario HS-EBP - Práctica Basada en la Evidencia en Ciencias de la Salud, aplicado a 305 profesionales sanitarios. La fiabilidad se verificó mediante el coeficiente alfa de Cronbach (0,970), similar al de la versión original, y la estabilidad de una prueba y una segunda prueba mediante el índice de correlación r de Pearson ($r = 0,766$), que indicaba una fuerte correlación. En cuanto a la validación convergente, el índice de correlación de Pearson ($r = 0,683$) fue positivo y con una correlación moderada entre los instrumentos. La prueba Chi-Cuadrado fue significativa ($<0,001$) para todos los modelos obtenidos, en todos los modelos probados. **Conclusión:** el instrumento demostró ser válido y confiable para la reproducibilidad en la versión brasileña.

Palabras clave: Práctica Clínica Basada en la Evidencia; Estudios de Validación; Psicometría; Educación Continua; Administración de los Servicios de Salud; Calidad de la Atención de Salud.

INTRODUCTION

Currently, discussions about the importance of health practices and behaviors based on the best available scientific evidence are present in academia, in the clinical environment and in the formulation of public policies in several countries. Thus, the results of scientific production arising from rigorous research processes have guided conduct, both in the clinical sphere and in health management.^{1,2}

Evidence-Based Practice (EBP) is based on the premises that care decisions are the result of patients' values, clinical circumstances and the conscious, explicit and judicious use of the best current, valid and reliable evidence for decision-making about the best possible care for the patient. Thus, the EBP integrates the users' desire, the professional's individual clinical skills and the findings generated by methodologically rigorous research.^{3,4}

It is important to emphasize that the implementation of EBP improves the quality of care provided and intensifies clinical judgment. For the implementation of EBP, healthcare professionals must be able to obtain, interpret and integrate the best scientific evidence with the patient's wishes and with data from clinical observations.^{1,3}

In this way, an important and real gap can be incurred in the contemporary world, due to the high performance

of scientific production and the poor ability of the professional to keep up to date and, primarily, to transpose the best evidence into daily professional practice.^{1,5}

For EBP to be effective, it is necessary to develop individual and organizational strategies aimed at the factors that interfere with its use by healthcare professionals.^{5,6} In the search for diagnoses that contribute to solutions, measuring instruments have been developed to assess, in judiciously the practice, knowledge, skills and attitudes of healthcare professionals, as well as the existing barriers to the adoption of EBP.^{7,8}

The instrument “Health Sciences Evidence-Based Practice Questionnaire” (HS-EBP) appears in the literature as a reliable instrument to assess the potential of professionals for work based on EBP. The HS-EBP questionnaire includes the assessment of different components for the clinical reasoning process before decision making. Results of scientific research, clinical experience and professional skill in clinical judgment include other sources of information that can become part of a healthcare professional's reasoning process, such as those related to the opinions of co-workers. It also allows for the assessment of health outcomes as a final component of the process.

Likewise, the HS-EBP makes it possible to reflect on the main factors at the individual and organizational levels that influence the clinical reasoning process and decision-making - including the beliefs and attitudes of professionals in relation to EBP -, allowing to infer the impact of specific interventions to improve EBP.⁶ The HS-EBP questionnaire published in 2017 is a tool that allows evaluating the different dimensions of the construction of EBP; however, to date, no articles have been found with translated and validated versions in other languages.

Considering the scarcity of instruments in Brazilian Portuguese for the assessment of EBP, the present study aims to adapt the instrument “Health Sciences Evidence-Based Practice Questionnaire” (HS-EBP) cross-culturally and validate it for Brazilian Portuguese.

METHOD

This is a methodological development study of translation and cross-cultural adaptation of the instrument “Health Sciences Evidence-Based Practice Questionnaire” (HS-EBP) and its validation from English to Portuguese in the Brazilian context. The HS-EBP questionnaire consists of 60 items, with a Likert scale ranging from 1 to 10 for all items according to the degree of agreement. The higher the score, the greater the degree of agreement in a structure composed of: Dimension 1. BELIEFS - ATTITUDES, with 12 items; Dimension 2. PRACTICES, with

36 items; and Dimension 3. BARRIERS - FACILITATORS, with 12 items.⁶

After obtaining consent from the author of the original instrument and due approval from the research ethics committees of the institutions involved (Opinion Report No. 3,063,730 and Opinion Report No. 3,195,150), the essential steps were followed to carry out the cross-cultural adaptation of the instrument. Recommendations proposed by the World Health Organization (WHO [2015]) were adopted, due to the fact that they are similar to what is advocated by Herdman and/or Guillemin, relevant authors on this topic.^{9,10} The adaptation process consists of the following phases: i) translation; ii) back translation; iii) evaluation by the expert committee; and iv) carrying out a pre-test of the instrument to obtain the final version.^{9,12}

The translations were made by two bilingual translators. One is a specialist in the area in question and knew the objectives and concepts that involve the instrument, so that the peculiarities of the subject studied are respected in the translation (T1). The other was unaware of the theme, so that his translation (T2) offers the language used by the population in general. The two translated versions (T1 and T2) were compared, obtaining a consensus version (T3), reflecting the agreement of the translators involved.^{10,13,14}

To assess whether, after translation, the instrument remained faithful to the original, the T3 version was reverted back to English by translators who did not participate in the previous step, as well as did not know the instrument or the objectives of the work and whose native language is the same as the original instrument, thus obtaining back translation 1 (BT1) and back translation 2 (BT2).^{12,15}

It is essential to evaluate the measurement properties of the questionnaire to guarantee the quality of the results. This evaluation is due to the reliability and validity of the instrument.^{3,16} Reliability was evaluated through stability and internal consistency, and stability was verified through Pearson's correlation index with the application of the test-retest method and internal consistency by Cronbach's alpha coefficient.¹³ Validity was verified using the following methods: content validity and construct validity.^{13,17}

To carry out all the validation steps, the tool was made available via an access link to the Survey Monkey® platform via e-mail. To carry out content validity, the selection of judges to compose the experts committee was made by *Plataforma Lattes* (<http://lattes.cnpq.br>), whose classification of professionals was made according to the criteria proposed by Fehring, considering a minimum score of five points.^{18,19} The Informed Consent Form (ICF) was applied, presenting the objectives and ethical aspects of the research to the expert committee, emphasizing that participation was voluntary and that they could stop participating at any time.

Content validation was performed using the Delphi technique, obtaining the consensus of the expert committee, which assessed the semantic, idiomatic, cultural, and conceptual equivalences of the instrument. After the evaluation rounds, a single version was consolidated, in Portuguese, to obtain a pre-final version. This version was used in the pre-test and aimed to make adjustments to improve the understanding of the instrument.¹⁰

For construct validity, the assessment of convergent validity was performed, tested by correlating the scores of two instruments that assess a similar construct;^{13,20} therefore, in this study, the HS-EBP Questionnaire (Health Sciences Evidence-Based Practice) was correlated, focus of this research, with the Evidence-Based Practice and Clinical Effectiveness Questionnaire (EBPQ).²¹ For structural or confirmatory validity, confirmatory factor analysis (CFA) was performed to verify whether the theoretical factor structure fits the results observed;¹³ cross-cultural validity has been previously described.

Site

The study was carried out in a private institution, composed of health care units that have hospitals considered reference centers of great complexity and with complementary units in two Brazilian capitals, São Paulo/SP and Brasília/DF.²²

Population and sample

Participants were healthcare professionals from the following areas: Medicine, Nursing, Physiotherapy, Speech Therapy, Psychology, Pharmacy, Biomedicine and Nutrition. For construct validation, the sample was randomly obtained by drawing lots, with the aim of reaching at least 300 participants, as recommended for validation studies: having at least five subjects per number of instrument variables.^{12, 23}

Data analysis

Data collection for instrument construct validation took place from December 2019 to March 2020. Data were collected after obtaining the Free and Informed Consent Form (ICF), in accordance with the rules of Council Resolution 466/2012 National Health. For the statistical analyses, the *Statistical Package for the Social Sciences* (SPSS) software, version 22 and the JASP 0.13.0.0 software, which is based on Lavaan, an R package for modeling structural equations, were used.

The validity of the construct was performed through the approach of hypothesis testing through convergent validity, using Pearson's correlation index, adopting a significance level of 0.05 and through Confirmatory Factor

Analysis (CFA), according to the structural equation model. For this, the following statistical tests were considered: Comparative Fit Index (CFI); Tucker-Lewis Index (TLI); Bentler-Bonett Normed Fit Index (NFI); Standardized root mean square residual (SRMR).

Values above 0.90 for the CFI and TLI indices, values above 0.80 for the NFI, and values below 0.05 for the SRMR indices were considered satisfactory as criteria for model adjustment. Reliability was assessed by stability, applying the test-retest, using Pearson's *r* correlation coefficient; internal consistency was performed using Cronbach's alpha coefficient.

RESULTS

In the process of translating the HS-EBP questionnaire, there were not many discrepancies between the two translations (T1 and T2), requiring only a few adjustments to obtain the summary version (T3). This was again reverted to English (back translation), and after translation, it was observed that the instrument remained faithful to the original.

With the completion of the steps aforementioned, version 2 was prepared and submitted to content validation by the expert committee, carried out using the Delphi technique in three rounds. As in this technique there is a

risk of losing participants, more than one participant per profession was selected. In the first round, 15 experts participated; in the second and third rounds, only 10 and 8 experts responded, respectively. Table 1 shows the items that did not reach statistically significant agreement ($p \leq 0.05$) in the first round.

In the second round, in addition to the 7 items that did not obtain satisfactory equivalence in the first round, the title and item 14 of the practical dimension were also included. This is because, after analyzing the notes made by the specialists, they were modified and needed another evaluation. Table 2 depicts that the item referring to the title did not obtain conceptual equivalence; therefore, a third round was made, with alternatives to choose the title that best represented the fidelity of the original title.

In the third round, the alternative titled HS-EBP Questionnaire (Health Sciences Evidence-Based Practice) was the option with the most votes. After content validation, the version for the pre-test was obtained, applied between October and November 2019. Fifteen healthcare professionals were invited to this step, but only 12 completed the questionnaire.

As for the instructions for completing the instrument, 100% of the participants reported that they were clear enough to understand the items and their respective

Table 1 - Items that did not obtain statistically significant agreement between the components of the expert committee. São Paulo, SP, 2020

Items	Assessment Criteria	%	Sig.
Item (P) 8 - Idiomatic	Not Equivalent or Not Relevant	30.0%	0.206
	Equivalent or Relevant	70.0%	
Item (P) 8 - Cultural	Not Equivalent or Not Relevant	27.3%	0.132
	Equivalent or Relevant	72.7%	
Item (P) 16 - Cultural	Not Equivalent or Not Relevant	20.0%	0.058
	Equivalent or Relevant	80.0%	
Item (P) 24 - Cultural	Not Equivalent or Not Relevant	20.0%	0.058
	Equivalent or Relevant	80.0%	
Item (P) 26 - Semantics	Not Equivalent or Not Relevant	45.5%	0.763
	Equivalent or Relevant	54.5%	
Item (P) 26 - Idiomatic	Not Equivalent or Not Relevant	33.3%	0.317
	Equivalent or Relevant	66.7%	
Item (P) 26 - Cultural	Not Equivalent or Not Relevant	40.0%	0.527
	Equivalent or Relevant	60.0%	
Item (P) 26 - Conceptual	Not Equivalent or Not Relevant	36.4%	0.366
	Equivalent or Relevant	63.6%	
Item (BF) 2 - Semantics	Not Equivalent or Not Relevant	27.3%	0.132
	Equivalent or Relevant	72.7%	

Table 2 - Items that did not reach agreement among the 10 judges of the expert committee in the second round of evaluation of the HS-EBP Questionnaire São Paulo, SP, 2020

Binomial test		Category	N	Observed proportion	Test proportion	Exact Sig. (bilateral)
Title - Conceptual	Group 1	Concordant	6	0.75	0.50	0.289
	Group 2	Discordant	2	0.25		
	Total		8	1.00		

answers, 3 of the participants (25%) rated the questionnaire as very adequate and 9 (75%) rated it as adequate. There were only two observations regarding the similarity between some items, but without impact on their understanding. Two participants evaluated that the questionnaire is long, and most reinforced that the instrument was clear and without difficulties to be answered.

For the evaluation of the psychometric properties, a total of 1,000 participants were drawn and the survey link was sent to all. This link was accessed by 403 participants, of which 18 refused to participate in the research; the others who matched (358) agreed to participate, but the collection instrument was entirely completed by only 305 participants. Internal consistency was verified by Cronbach's alpha coefficient, which was high, with a minimum of 0.969 and a maximum of 0.971. Although Cronbach's alpha coefficient is the most used in the evaluation of internal consistency, there is still no consensus regarding its interpretation: some studies determine that values greater than 0.7 are ideal, but some studies consider values close to 0.60 as satisfactory.¹³ As all items had Cronbach's alpha greater than 0.9, no item was excluded. For the stability assessment, a sample of 108 healthcare professionals who agreed to perform the test-retest was used. The relationship between the instruments was calculated using Pearson's correlation index (significance 0.05), which indicated a strong correlation²⁴ (Table 3).

For the analysis of the convergent validity of the HS-EBP Questionnaire with the Evidence Based Practice and Clinical Effectiveness Questionnaire (EBPQ) instrument, Pearson's correlation index was used (significance 0.05). The correlation coefficient ($r = 0.683$) was positive and statistically significant, with a moderate correlation between the instruments.²⁴ The data are presented in Table 4.

The goodness of fit of the HS-EBP Questionnaire was assessed by the AFC using the structural equation model. The chi-square test was significant (<0.001) for all models obtained, as well as all items were significant for the studied factors (Factor loadings), and for all residual variances (Residual variances) in all tested models. The full

model (with all the original items of the evaluated instrument) did not perform well according to the adjustment criteria, with values above 0.90 for the Comparative Fit Index (CFI) and Tucker- Lewis Index (TLI).

For the Bentler-Bonett Normed Fit Index (NFI), a value above 0.80 was adopted, and for the Standardized Root Mean Square Residual Index (SRMR), values below 0.05 were adopted. To try to reach a better fit, the correlation matrix of the models was taken into account, as well as the items that individually most affected the models' adjustment criteria, trying to remove the smallest possible number of items.

Table 3 - Pearson's correlation coefficients and significance level for assessing the reliability of the HS-EBP Questionnaire (Evidence-Based Practice in Health Sciences). São Paulo, 2021

	Pearson correlation	Sig. (2 extremities)	N
HS-EBP Questionnaire (test) X HS-EBP Questionnaire (retest)	$r = 0.766$	0.000	108

Table 4 - Pearson's correlation coefficient and significance level for convergent validation of the HS-EBP Questionnaire with EBPQ - São Paulo, 2020

	Pearson correlation	Sig. (2 extremities)	N
HS-EBP Questionnaire X HS-EBPQ Questionnaire	$r = 0.683$	0.000	111

In Table 5, the indices of adjustments of the full model (with all the original items of the evaluated instrument) and of the models that presented a better adjustment are

Table 5 - Adjustment adequacy measures by the AFC of the HS-EBP Questionnaire (Health Sciences Evidence-Based Practice). São Paulo, 2020

Models	Comparative Fit Index (CFI)	Tucker-Lewis Index (TLI)	Bentler-Bonett Normed Fit Index (NFI)	Standardized root mean square residual (SRMR)
HS-EBP complete	0.671	0.659	0.607	0.088
Model 1	0.748	0.737	0.681	0.078
Model 2	0.924	0.913	0.868	0.056
	>0,9	>0,9	>0,8	<0,05

presented, with the withdrawal of the smallest possible number of items.

All models took into account the highest covariances between items. The HS-EBP questionnaire in the Brazilian version is found in full in Appendix 1.

DISCUSSION

To carry out the cross-cultural adaptation, the steps recommended in the literature were followed.^{9,10} It was observed that there were few discrepancies between the two translations, requiring only a few adjustments to obtain the synthesis version. In the back translation process, when comparing the versions produced, similarities were identified that proved that the instrument remained faithful to the original. According to the consensus obtained by the expert committee, all items that make up the instrument obtained statistically significant agreements, reinforcing the adequacy of the translated version into Brazilian Portuguese.

Analyzing the psychometric statistical results with the specialized technical literature, it can be stated that the HS-EBP Questionnaire is reliable, as it presented adequate stability in the test-retest and obtained an excellent degree of internal consistency with high Cronbach's alpha. Furthermore, when compared with the Cronbach's alpha of the HS-EBP instrument of the original and Brazilian versions, both obtained a similar result of approximately 0.9.⁶ It was only possible to correlate with the original version due to the unavailability of the instrument validated in other languages.

In the CFA, which aims to confirm the instrument's structural model, the chi-square test was significant (<0.001) for all models obtained and tested. However, the model with all the original items of the evaluated instrument did not perform well according to the adjustment criteria used.^{13,25}

The original HS-EBP Questionnaire was developed using a five-dimensional structure, but the instrument made available by the authors for this study was structured in 3 dimensions. Such a structure must have

influenced the behavior presented in the CFA; therefore, other studies for validation are necessary to evaluate the structure of the questionnaire with five dimensions.

In the convergent validation, a satisfactory result was obtained since the HS-EBP Questionnaire was positively correlated with the EBPQ questionnaire. That is, the research focus instrument correlated positively with another validated instrument that measures the same construct.^{13,24}

The results of the psychometric tests of the HS-EBP Questionnaire (Health Sciences-Evidence Based Practice) were promising to ensure its use in the assessment of EBP at the individual level, as well as the impact of specific interventions for the implementation of EBP. However, there is a need to carry out new studies produced with other samples representative of the Brazilian reality, in order to guarantee greater validity through other methodological approaches and expansion of locations and samples of healthcare professionals. Furthermore, it is considered that other sociodemographic variables and those related to behavior and attitudes can be added to verify the associations of these variables with the domains of the HS-EBP Questionnaire (Health Sciences Evidence-Based Practice).

The HS-EBP Questionnaire (Health Sciences-Evidence Based Practice) can be used for diagnostic and interventional approaches, favoring the unveiling of data that may lead to individual and collective changes in favor of the operationalization of EBP. Another important utility is the opportunity to compare realities regarding the use of the instrument by other researchers in different institutions in the country and in different geographic regions. The national diagnosis could encourage a national policy to favor EBP.

Like other validation studies, this one has limitations regarding the validity of self-reported measures due to the impossibility of incorporating direct EBP measures through observation. This would be able to confirm whether the daily practice of healthcare professionals is in accordance with the results of the instrument.

CONCLUSION

The process of cross-cultural adaptation of the instrument “Health Sciences-Evidence Based Practice Questionnaire” (HS-EBP) to the Brazilian culture followed the methodological steps recommended internationally and was successfully completed.

The assessment of the psychometric properties of the Brazilian version of the instrument was carried out by measuring its reliability and validity. Reliability was evaluated through internal consistency and stability (test-retest), demonstrating that the instrument is capable of consistently reproducing a result.

The validation of the instrument was carried out by methods, content validity and construct validity, showing that the instrument's concepts measure exactly what they are intended to measure.

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APÊNDICE 1 - QUESTIONÁRIO HS-EBP (PRÁTICA BASEADA EM EVIDÊNCIAS NAS CIÊNCIAS DA SAÚDE)

O questionário que você está prestes a responder destina-se a coletar informações sobre o uso da Prática Baseada em Evidências (PBE) nas Ciências da Saúde.

Não há respostas certas ou erradas. As respostas devem ser as mais sinceras possíveis. Leia cada uma das afirmações com atenção e escolha a opção que melhor representa sua opinião, situação ou comportamento. Considerando a natureza multiprofissional do questionário, tente adaptar as expressões ao seu próprio contexto profissional.

O tempo estimado para responder ao questionário inteiro é de 10 a 12 minutos.

Crença-attitudes

Esta parte do questionário tem como objetivo coletar a sua OPINIÃO sobre os diferentes aspectos relacionados ao paradigma da Prática Baseada em Evidências (PBE).

Marque, em uma escala de 1 a 10, o seu grau de concordância com as seguintes afirmações, no qual 1 corresponde ao menor grau e 10 ao maior grau.

Crença-attitudes

Item 1.	Utilizar resultados de pesquisas é importante para o desenvolvimento da minha/nossa prática profissional.									
	1	2	3	4	5	6	7	8	9	10
Item 2.	A prática baseada em evidências (PBE) tem um grande impacto na minha prática individual.									
	1	2	3	4	5	6	7	8	9	10
Item 3.	A PBE deve ter um papel positivo na minha prática profissional.									
	1	2	3	4	5	6	7	8	9	10
Item 4.	Eu acredito que a PBE melhora a qualidade e os resultados das intervenções.									
	1	2	3	4	5	6	7	8	9	10
Item 5.	Na prática profissional, a PBE é uma ferramenta útil para a tomada de decisões.									
	1	2	3	4	5	6	7	8	9	10
Item 6.	A PBE implica obter resultados mais eficientes.									
	1	2	3	4	5	6	7	8	9	10
Item 7.	A PBE nos ajuda a prestar cuidados às pessoas da mesma forma e com a mesma eficiência.									
	1	2	3	4	5	6	7	8	9	10
Item 8.	Eu considero os resultados das pesquisas importantes para a minha prática diária.									
	1	2	3	4	5	6	7	8	9	10
Item 9.	Aplicar a PBE está entre minhas prioridades profissionais.									
	1	2	3	4	5	6	7	8	9	10
Item 10.	Considero a aplicação da PBE como algo motivador.									
	1	2	3	4	5	6	7	8	9	10
Item 11.	Eu estaria interessado em melhorar as habilidades necessárias para aplicar a PBE.									
	1	2	3	4	5	6	7	8	9	10
Item 12.	Estou disposto a mudar as rotinas da minha prática quando estas se mostrarem inadequadas.									
	1	2	3	4	5	6	7	8	9	10

Prática

Esta parte do questionário destina-se a coletar informações sobre conhecimentos, habilidades e, principalmente, sobre o uso da Prática Baseada em Evidências entre os profissionais da área de Ciências da Saúde.

Portanto, nesta parte, nós estamos interessados no USO que você faz das evidências científicas e das diferentes fontes de informações disponíveis em sua prática.

Assim, pedimos que você responda às afirmações da maneira mais sincera possível.

Marque o nível de frequência com o qual você realiza as seguintes ações e/ou seu grau de concordância com as seguintes afirmações (quando apropriado), usando a escala de 1 a 10 (no qual 1 corresponde ao menor grau e 10 ao maior grau).

Prática

Item 1.	Eu resolvo as dúvidas ou questões decorrentes da minha prática, procurando por resultados científicos atualizados.									
	1	2	3	4	5	6	7	8	9	10
Item 2.	Eu me faço perguntas de tal forma que elas possam ser respondidas através de resultados de pesquisas.									
	1	2	3	4	5	6	7	8	9	10
Item 3.	Eu uso informações de pesquisas científicas para responder às questões decorrentes da minha prática profissional.									
	1	2	3	4	5	6	7	8	9	10
Item 4.	Eu uso as principais fontes de informações científicas na minha área.									
	1	2	3	4	5	6	7	8	9	10
Item 5.	Eu sou capaz de executar uma busca eficaz na literatura científica em bases de dados eletrônicas.									
	1	2	3	4	5	6	7	8	9	10
Item 6.	Eu estou atualizado sobre resultados de pesquisa relacionadas a minha prática usual.									
	1	2	3	4	5	6	7	8	9	10
Item 7.	Eu conheço os diferentes delineamentos de estudos científicos que me permitirão responder às minhas dúvidas ou perguntas.									
	1	2	3	4	5	6	7	8	9	10
Item 8.	Eu normalmente uso algum classificador de qualidade para avaliar a literatura científica.									
	1	2	3	4	5	6	7	8	9	10
Item 9.	Eu geralmente avalio a qualidade da metodologia utilizada nos estudos de pesquisas que encontro.									
	1	2	3	4	5	6	7	8	9	10
Item 10.	Eu reconheço os possíveis vieses ou fatores de confusão e limitações dos estudos selecionados.									
	1	2	3	4	5	6	7	8	9	10
Item 11.	Eu sou capaz de interpretar as implicações práticas dos resultados estatísticos.									
	1	2	3	4	5	6	7	8	9	10
Item 12.	Eu avalio a relevância dos resultados da pesquisa em futuras intervenções.									
	1	2	3	4	5	6	7	8	9	10
Item 13.	Eu uso pesquisa atualizada para tomar decisões rotineiras na minha prática profissional.									
	1	2	3	4	5	6	7	8	9	10
Item 14.	Eu uso documentação proveniente da literatura científica para orientar minhas intervenções para a PBE.									
	1	2	3	4	5	6	7	8	9	10
Item 15.	Eu incorporo os resultados mais atualizados de pesquisas científicas para resolver problemas relacionados à minha prática profissional.									
	1	2	3	4	5	6	7	8	9	10
Item 16.	Quando a minha prática usual não está de acordo com os resultados da pesquisa, eu altero a minha prática para incorporá-los.									
	1	2	3	4	5	6	7	8	9	10

Continue...

...continuation

Item 17	Eu repito intervenções que têm me proporcionado bons resultados em situações que não são respaldadas por resultados de pesquisas.									
	1	2	3	4	5	6	7	8	9	10
Item 18	Eu troco opiniões com outros profissionais na minha prática cotidiana.									
	1	2	3	4	5	6	7	8	9	10
Item 19	Ao lidar com situações não resolvidas por pesquisas, eu pergunto a opinião de profissionais renomados.									
	1	2	3	4	5	6	7	8	9	10
Item 20	As necessidades e preocupações imediatas dos pacientes e/ou seus familiares envolvem uma parte importante da minha intervenção.									
	1	2	3	4	5	6	7	8	9	10
Item 21	Eu informo meus pacientes para que eles possam considerar as diferentes alternativas de intervenção que podemos aplicar.									
	1	2	3	4	5	6	7	8	9	10
Item 22	Eu levo em consideração as informações fornecidas pelos meus pacientes sobre sua evolução para avaliar minhas intervenções.									
	1	2	3	4	5	6	7	8	9	10
Item 23	Eu incorporo as preferências, os valores e as expectativas do paciente nas minhas intervenções.									
	1	2	3	4	5	6	7	8	9	10
Item 24	Minhas ações profissionais são acordadas conforme as preferências, os valores e as expectativas dos pacientes.									
	1	2	3	4	5	6	7	8	9	10
Item 25	Conheço as medidas objetivas de avaliação de resultados mais utilizadas na área específica da minha prática.									
	1	2	3	4	5	6	7	8	9	10
Item 26	Eu uso algum classificador, baseado em evidências científicas, para avaliar os resultados das minhas intervenções.									
	1	2	3	4	5	6	7	8	9	10
Item 27	As medidas de avaliação que eu uso foram confirmadas por evidências científicas.									
	1	2	3	4	5	6	7	8	9	10
Item 28	Eu avalio criticamente os instrumentos/ferramentas disponíveis para realizar a análise dos resultados.									
	1	2	3	4	5	6	7	8	9	10
Item 29	Eu uso um procedimento padronizado para coletar e armazenar informações sobre os meus pacientes.									
	1	2	3	4	5	6	7	8	9	10
Item 30	Eu registro sistematicamente os resultados obtidos a partir da aplicação dos instrumentos ou técnicas de avaliação em meus pacientes.									
	1	2	3	4	5	6	7	8	9	10
Item 31	Eu registro informações referentes a possíveis mudanças na evolução de um caso ou durante uma intervenção.									
	1	2	3	4	5	6	7	8	9	10
Item 32	Eu analiso sistematicamente e continuamente as informações coletadas nas intervenções com meus pacientes.									
	1	2	3	4	5	6	7	8	9	10
Item 33	Eu avalio os efeitos da minha prática usando os registros dos resultados.									
	1	2	3	4	5	6	7	8	9	10
Item 34	Eu avalio os resultados das minhas decisões em termos da eficiência delas.									
	1	2	3	4	5	6	7	8	9	10
Item 35	Eu considero os resultados inesperados após avaliar minha prática.									
	1	2	3	4	5	6	7	8	9	10
Item 36	Quando os resultados não são os esperados, reviso todo o processo aplicado para analisar possíveis situações que possam explicá-los.									
	1	2	3	4	5	6	7	8	9	10

Barreiras ou facilitadores

Esta parte final do questionário tem como objetivo coletar informações sobre aspectos relacionados ao seu local de trabalho ou às características das próprias evidências que você percebe como BARREIRAS OU FACILITADORES para a adoção da Prática Baseada em Evidências em sua prática diária.

Marque o seu grau de concordância com as seguintes afirmações em uma escala de 1 a 10 (no qual 1 corresponde ao menor grau e 10 ao maior grau).

Barreiras ou facilitadores

Item 1.	Eu posso acessar recursos relacionados à evidência científica no meu local de trabalho.									
	1	2	3	4	5	6	7	8	9	10
Item 2.	No meu local de trabalho existem documentos que orientam as intervenções relacionadas à PBE.									
	1	2	3	4	5	6	7	8	9	10
Item 3.	Manter-se atualizado com resultados de pesquisas é uma prioridade no meu local de trabalho.									
	1	2	3	4	5	6	7	8	9	10
Item 4.	No trabalho, há espaços para compartilhar e discutir os resultados de pesquisas científicas com outros colegas.									
	1	2	3	4	5	6	7	8	9	10
Item 5.	A maioria dos meus colegas de profissão com os quais eu me relaciono tem uma atitude favorável em relação ao uso de resultados de pesquisas em sua prática.									
	1	2	3	4	5	6	7	8	9	10
Item 6.	Meus pacientes exigem que seus tratamentos sejam baseados em evidências científicas.									
	1	2	3	4	5	6	7	8	9	10
Item 7.	Meus pacientes exigem que seus tratamentos sejam baseados em evidências científicas.									
	1	2	3	4	5	6	7	8	9	10
Item 8.	Meus supervisores incentivam a PBE ou, no caso de profissional independente, eu mesmo incentivo o uso de PBE.									
	1	2	3	4	5	6	7	8	9	10
Item 9.	Há recomendações ou demandas suficientes em meu ambiente de trabalho para o uso de PBE.									
	1	2	3	4	5	6	7	8	9	10
Item 10.	A distribuição de tempo na minha jornada diária de trabalho facilita a busca e aplicação de evidências científicas.									
	1	2	3	4	5	6	7	8	9	10
Item 11.	No meu local de trabalho, a aplicação de PBE é incentivada/recompensada.									
	1	2	3	4	5	6	7	8	9	10
Item 12.	No meu local de trabalho, é fácil mudar práticas de trabalho estabelecidas como padrão.									
	1	2	3	4	5	6	7	8	9	10