Adaptation of the protective nursing advocacy scale for nursing in primary health care: validity evidence

Adaptação da protective nursing advocacy scale para a enfermagem na atenção primária à saúde: evidências de validade

Adaptación de la escala de defensa de la enfermería protectora para la enfermería en la atención primaria de salud: evidencias de validez

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REVISA

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RESUMO

Objetivo: Adaptar e validar a Protective Nursing Advocacy Scale-versão brasileira para a enfermagem na Atenção primária à saúde. Método: Trata-se de um estudo metodológico, seguindo as etapas do processo de adaptação: adaptação do instrumento, avaliação com especialistas, teste piloto e teste psicométricos. A população deste estudo foi constituída por técnicos de enfermagem e enfermeiros da Atenção Primária à Saúde, os quais preencheram os instrumentos de caraterização sociodemográfica e laboral e a Protective nursing advocacy scale – versão brasileira. A análise dos dados foi realizada por meio dos testes psicométricos e estatística descritiva. A organização dos dados foi realizada no Excel e as análises no programa R. Resultados: Na etapa de validação, a comunalidade variou de 0,42 a 0,89. Todas as cargas foram maiores que 0,4, variando de 0,418 a 0,827, indicando um padrão claro do instrumento. O alfa de Cronbach (0,81) e a análise confirmatória demonstraram a adequação do modelo com cinco fatores e 20 itens validados.vConclusão: evidenciou-se que a Protective nursing advocacy scale – versão brasileira é um instrumento válido e confiável para ser empregado na Atenção Primária à Saúde.

Descritores: Advocacia em saúde; Enfermagem; Ética em enfermagem; Estudos de validação.

ABSTRACT

Objective: To adapt and validate the Protective Nursing Advocacy Scale-Brazilian version for nursing in primary health care. Method: This is a methodological study, following the stages of the adaptation process: adaptation of the instrument, evaluation with experts, pilot test and psychometric test. The population of this study consisted of nursing technicians and nurses from Primary Health Care, who completed the sociodemographic and work characterization instruments and the Protective nursing advocacy scale – Brazilian version. Data analysis was performed using psychometric tests and descriptive statistics. Data organization was performed in Excel and analyses were performed in the R program. Results: In the validation stage, commonality ranged from 0.42 to 0.89. All loadings were greater than 0.4, ranging from 0.418 to 0.827, indicating a clear pattern of the instrument. Cronbach's alpha (0.81) and confirmatory analysis demonstrated the adequacy of the model with five factors and 20 validated items. Conclusion: it was shown that the Protective nursing advocacy scale – Brazilian version is a valid and reliable instrument to be used in Primary Health Care.

Descriptors: Health advocacy; Nursing; Nursing ethics; Validation studies.

RESUMEN

Objetivo: Adaptar y validar la Protective Nursing Advocacy Scale-versión brasileña para la enfermería en la Atención primaria de la salud. Método: Se trata de un estudio metodológico, siguiendo las etapas del proceso de adaptación: adaptación del instrumento, evaluación con expertos, prueba piloto y pruebas psicométricas. La población de este estudio estuvo constituida por técnicos de enfermería y enfermeros de la Atención Primaria de Salud, quienes completaron los instrumentos de caracterización sociodemográfica y laboral y la Protective Nursing Advocacy Scale – versión brasileña. El análisis de los datos se realizó mediante pruebas psicométricas y estadística descriptiva. La organización de los datos se realizó en Excel y los análisis en el programa R. Resultados: En la etapa de validación, la comunalidad varió de 0,42 a 0,89. Todas las cargas fueron mayores que 0,4, variando de 0,418 a 0,827, indicando un patrón claro del instrumento. El alfa de Cronbach (0,81) y el análisis confirmatorio demostraron la adecuación del modelo con cinco factores y 20 ítems validados. Conclusión: se evidenció que la escala de defensa de enfermería protectora - versión brasileña es un instrumento válido y confiable para ser empleado en la Atención Primaria de Salud.

Descriptores: Defensa en salud; Enfermería; Ética en enfermería; Estudios de validación.

ORIGINAL

Introduction

The promotion of patient rights refers to the support and representation offered to individuals within healthcare settings. This involves ensuring respect for patients' rights, needs, and preferences, and guaranteeing that they receive appropriate care and support[1]. Patient advocates play an essential role by bridging the gap between patients and healthcare professionals, assisting them in navigating the healthcare system and empowering them to make informed decisions about their care[2–3].

Patient advocacy remains a little-discussed topic, and a large proportion of patients are unaware of this concept and of their rights in this context. It is important to emphasize that patient advocacy exists to strengthen human rights, particularly those related to health. Advocacy should be a tool accessible to all healthcare professionals, supporting the maintenance and promotion of public health policies[4].

Patient advocacy has gained relevance as a subject of discussion, being an essential ethical component in nursing practice. This movement in defense of patients' rights has brought greater recognition to the nursing role as patient advocates, especially considering the close relationship between nurses and patients[4–5].

To assess patient advocacy, the Protective Nursing Advocacy Scale (PNAS) was used. This instrument aims to understand how nurses exercise advocacy in their work settings, including the influence of knowledge related to personal values, confidence, and ethical beliefs[6].

In Brazil, the need to adapt the PNAS for nurses in hospital settings was identified, with the goal of evaluating the advocacy performed by these professionals. Of the 43 items in the original instrument, 37 were analyzed and validated, and the Brazilian version (PNAS-VB) consists of 20 items[7]. The final stage of the instrument's validation was conducted in two hospitals in the southern region of the country—one public, serving exclusively through the Brazilian Unified Health System (SUS), and the other philanthropic, providing private, insurance, and SUS-covered services[7].

There is a clear need to adapt the PNAS for use in Primary Health Care (PHC), as this setting represents the first point of contact for patients, where initial care and interaction with the medical and nursing teams take place[8]. Until now, the PNAS-Brazilian Version (PNAS-VB) has only been applied among hospital-based nurses[6], making its extension to PHC—along with the inclusion of nursing technicians, in addition to nurses—highly relevant. A study involving 153 nurses from two hospital institutions in southern Brazil confirmed the validity and reliability of the scale in measuring Brazilian nurses' actions and beliefs regarding patient advocacy[6].

Patient advocacy is a critical issue for improving the quality of care provided to patients; however, there remains a shortage of studies and tools tailored to the Brazilian context. Therefore, adapting the PNAS-VB to the PHC setting will assist in measuring the extent to which nurses and nursing technicians act as advocates for their patients, as well as their willingness to defend patients' rights.

Thus, the objective of this study was to adapt and validate the Protective Nursing Advocacy Scale – Brazilian Version (PNAS-VB) for nursing professionals working in Primary Health Care.

Method

This is a methodological study aimed at adapting and validating the PNAS-VB for Primary Health Care (PHC). Methodological studies are essential to fully conduct the instrument validation process, ensuring maximum reliability and fidelity to the original version.[9]

The study was conducted in PHC, which includes 18 family clinics, all located in a municipality in the interior of Goiás, three of which are situated in rural districts. PHC services operate from Monday to Friday, from 7:00 a.m. to 7:00 p.m.

The target population of the study consisted of nursing professionals, including nurses and nursing technicians working in PHC. On average, PHC has 175 nursing professionals, comprising 70 nurses and 105 nursing technicians. All nursing professionals actively working in their respective units were invited to participate. Considering a 5% margin of error, 95% confidence level, and an estimated proportion of 50%, the minimum sample size was calculated to be 103 participants.[10] The sample was non-probabilistic and selected by convenience. Inclusion criteria were nurses and nursing technicians with at least one month of experience in the healthcare services. Professionals who were on leave for any reason during data collection were excluded.

Data collection was conducted online. The forms were made available in PHC units through QR codes or links provided on flyers. The sociodemographic and occupational characterization questionnaire and the validated instrument were applied in a virtual environment using Google Forms®, an electronic survey tool created and managed by Google®, which allows for the structuring of questionnaires and storage of data in Excel® spreadsheets. Internet access was required, offering participants the convenience of completing the survey at any time (online) with immediate submission.

A Data Confidentiality Agreement and an Informed Consent Form (ICF) containing the study's objectives, risks, and benefits were provided. Each participant accessed the electronic form via QR code or link, read the consent form, and upon agreement, the data collection began.

Stages of the PNAS-VB adaptation process

This process was conducted based on the methodological framework proposed by Reichenheim & Moraes (2007)[12] and Sousa & Rojjanasrirat (2011)[13], and was organized into four stages:

Stage 1: Instrument adaptation

The PNAS was developed and validated[6] for hospital nurses, including in Brazil.[7] However, to be used in PHC, minor content adjustments were necessary. Before beginning this process, the researchers who validated the PNAS for Brazil were contacted to obtain authorization for its use and

adaptation to PHC. The PNAS-VB was adapted by two researchers responsible for the study, according to the needs and context of PHC.

Stage 2: Expert panel analysis of the adapted instrument

The clarity and relevance of the PNAS were evaluated by seven experts in ethics and patient advocacy, working in PHC in various regions of Brazil. Each member rated the items using the following scale: 1 = not relevant; 2 = unable to assess relevance; 3 = relevant but needs minor revision; 4 = very relevant and concise, and a dichotomous clarity scale: clear or unclear.

Items rated as unclear by at least 80% of the participants were reassessed. Then, the Content Validity Index (CVI) was calculated using the formula: CVI = number of responses rated 3 or 4 / total number of responses. A satisfactory level of agreement should be at least 0.80 or higher than 0.90.[11] The pre-final adapted version of the PNAS-VB emerged from this step. This stage was conducted through Google Forms®, and the ICF was sent to each expert.

Stage 3: Pilot testing of the PNAS-VB scale

The pilot test took place in three Family Clinics that were part of the study sample, with an average of 30 nursing professionals working on-site. Inclusion criteria included nurses and nursing technicians working in PHC. Professionals on leave during the data collection period were excluded. Data collection occurred in January 2024.

A convenience sampling method was adopted. Each participant was asked to classify the clarity of the instrument items using a dichotomous scale (clear or unclear). Participants were also encouraged to suggest alternative wording and provide comments. Items rated as unclear by at least 80% of participants were reassessed. The lead researcher conducted the data collection alone, as her involvement in the instrument adaptation process allowed for better understanding of the difficulties and suggestions raised during this stage. Each pilot test participant received and signed the ICF, with a copy retained by both the participant and the researcher.

Stage 4: Psychometric testing of the final translated version of the instrument

This stage aimed to establish the psychometric properties of the PNAS-VB. The following psychometric analyses were conducted: internal consistency reliability and factor analyses. The scale was administered to an average of 103 nursing professionals, each assigned a number from 1 to 103, from which 20% (n = 21) were randomly selected to participate in the retest.[12] The PNAS-VB was re-administered between seven to fifteen days after the initial data collection to assess test-retest reliability.[13]

Afterward, data were organized in an Excel® spreadsheet and analyzed using R software. Descriptive statistics were applied, with absolute and relative frequency distributions for categorical variables and measures of central tendency and dispersion for quantitative variables. Cronbach's alpha values were calculated to examine internal consistency reliability, with values above 0.70 considered satisfactory.[14–16]

Test-retest reliability was assessed using the weighted quadratic Kappa coefficient, with the following interpretation: <0.40 = poor; 0.40–0.75 = fair to

good; >0.75 = excellent; and the Intraclass Correlation Coefficient (ICC): <0.4 = poor; 0.4 ≤ to <0.75 = satisfactory; ≥0.75 = excellent.[17–18]

Factor analysis, a psychometric technique for assessing construct validity, was also performed. Before conducting factor analysis, sample adequacy was assessed using the Kaiser-Meyer-Olkin (KMO) test, which ranges from 0 to 1, with higher values indicating greater sample adequacy. KMO values are classified as follows: <0.5 = unacceptable; 0.5–0.6 = poor; 0.6–0.7 = fair; 0.7–0.8 = average; 0.8–0.9 = good; 0.9–1 = very good.[19] The Bartlett's sphericity test should yield a p-value <0.001.[20] For component extraction in exploratory analysis, the exact number of instrument factors was used. The orthogonal Varimax rotation with Kaiser normalization was applied.[20–21]

Confirmatory factor analysis (CFA) was conducted using R software. The following fit indices were calculated, considering population sizes over 250: Comparative Fit Index (CFI) > 0.92; Tucker-Lewis Index (TLI) > 0.92; Standardized Root Mean Square Residual (SRMR) ≤ 0.08 (with CFI > 0.92); Root Mean Square Error of Approximation (RMSEA) < 0.07 (with CFI ≥ 0.92).[20]

The study followed the guidelines and regulations for research involving human beings, as established by Resolution No. 466/12.[22] The project was submitted and approved by the Research Ethics Committee under opinion number 6.573.385.

Results

When adapting the PNAS-VB instrument for APS, both linguistic and cultural adjustments were made to fully preserve the original meanings of the items, ensuring effective understanding by the target population. Table 1 shows the adapted version for the Brazilian context and the adapted version for APS.

Table 1 - Adapted version of the Protective Nursing Advocacy Scale for the Brazilian context and the adapted version for primary health care.

PNAS – Brazilian Version	PNAS – Brazilian Version for PHC
Nurses who speak for patients may face retaliation from their employers.	Nurses and/or nursing technicians who speak for patients may face retaliation from their employers.
Nurses who speak on behalf of vulnerable patients may be labeled as disruptive by employers.	Nurses and/or nursing technicians who speak on behalf of vulnerable patients may be labeled as disruptive by employers.
When nurses inform and educate patients about their rights in the clinical setting, they may put their jobs at risk.	When nurses and/or nursing technicians inform and educate patients about their rights in the clinical setting, they may put their jobs at risk.
I am speaking on behalf of the patient when I act as their advocate.	I am acting on behalf of the patient when I perform as their advocate.
I am acting as the patient's representative when I act as their advocate.	I am acting as the patient's representative when I perform as their advocate.

Nurses who are committed to providing good patient care are better patient advocates.	Nurses and/or nursing technicians who are committed to providing good patient care are better patient advocates.
Greater commitment to nursing increases the nurse's ability to be a patient advocate.	Greater commitment to nursing increases the ability of the nurse and/or nursing technician to be a patient advocate.
Greater nursing qualifications improve the nurse's effectiveness in patient advocacy.	Greater nursing qualifications improve the effectiveness of the nurse and/or nursing technician in patient advocacy.
Nurses who understand the benefits of patient advocacy are better patient advocates.	Nurses and/or nursing technicians who understand the benefits of patient advocacy are better patient advocates.
Nurses who provide patients with information about their care are acting as their advocates.	Nurses and/or nursing technicians who provide patients with information about their care are acting as their advocates.
Because I do not like working as a nurse, I am less willing to act as a patient advocate.	Because I do not like working as a nurse and/or nursing technician, I am less willing to act as a patient advocate.

Source: Authors, 2024. *The changes are in italics.

Among the changes, it is noteworthy that in almost all items, the term "nursing technicians" was included, as they are also a target audience of this research, alongside nurses. In items 6, "I am speaking on behalf of the patient when I act as their advocate," and 9, "I am acting as the patient's representative when I act as their advocate," the term "acting" was changed to "I perform" to improve fluency and participant comprehension. The remaining items of the instrument remained unchanged and, therefore, are not included in Table 1.

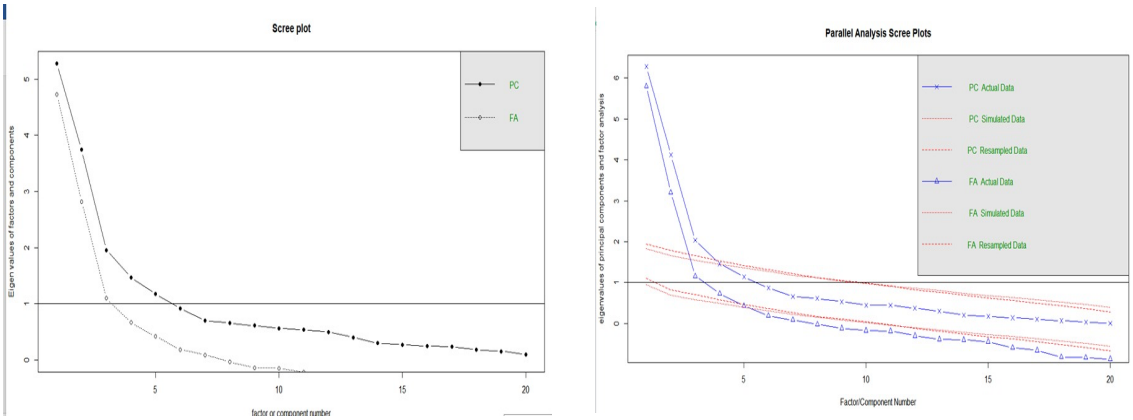
Regarding the instrument's validity, the expert panel demonstrated unanimous agreement on all items of the scale, evaluating them as relevant and ensuring semantic, cultural, idiomatic, and conceptual cohesion. All items were consistently understood in line with their original wording, resulting in only minor modifications, mainly related to phrasing, with a CVI of 0.97, indicating an acceptable level of agreement.

Instrument validation stage of the PNAS for PHC

The study population consisted of 38% (n=43) nurses and 62% (n=69) nursing technicians. Most participants were female (87%, n=97) with a mean age of 40 years.

In Figure 1, the factor analysis shows that no item needs to be excluded from the instrument, indicating that all items should be retained.

Figure 1 - Factor analysis demonstrating the exposure of the factors of the instrument.



Regarding the communalities of the PNAS-VB, they ranged from 0.42 to 0.89. All loadings were greater than 0.4, varying from 0.418 to 0.827, indicating a clear pattern of the instrument.

Table 1 - Factor loadings, communality, and specificity of the Protective Nursing Advocacy Scale-Brazilian Version for the primary health care context.

Variables	Communality	Specificity	Factorial Load
P_1	0.44	0.55	0.546
P_2	0.89	0.10	0.718
P_3	0.58	0.41	0.572
P_4	0.59	0.40	0.683
P_5	0.56	0.43	0.712
P_6	0.49	0.50	0.418
P_7	0.42	0.57	0.530
P_8	0.62	0.37	0.646
P_9	0.52	0.47	0.571
P_10	0.53	0.46	0.586
P_11	0.60	0.39	0.750
P_12	0.77	0.22	0.816
P_13	0.63	0.36	0.620
P_14	0.82	0.17	0.827
P_15	0.50	0.49	0.670
P_16	0.56	0.43	0.414
P_17	0.40	0.59	0.568
P_18	0.50	0.49	0.492
P_19	0.59	0.40	0.417
P_20	0.47	0.52	0.526

The KMO sample measure supported the adequacy of the sample for analysis, with a value of 0.73. The Bartlett's test of sphericity ($\chi^2 = 1161.074$, df = 190, $p < 0.000$) indicated that the strength of the relationship between the variables is medium to good, allowing for the factorial analyses to proceed. The confirmatory factor analysis was tested for the instrument with 20 items and five factors with a sample of 43 nurses and 69 nursing technicians, following the

original model of questions and factors, where the CFI was 0.95, TLI 0.95, RMSEA 0.079, and SRMR 0.08 with a 90% confidence interval (0.080 to 1.000) and with a significant p-value ≤ 0.05, as shown in Table 2.

Table 2 - Confirmatory Analysis of the Protective Nursing Advocacy Scale - Brazilian version for the context of Primary Health Care.

Variables*	Confirmatory analysis
Comparative Fit Index	0,95
Tucker-Lewis Index	0,95
Root Mean Square Error of Approximation	0,079
Standardized Root Mean Square Residual	0,08

* Significant for p<0.01

The reliability of internal consistency measured by Cronbach's alpha coefficient was 0.81 for the total PNAS-VB and varied among the five factors from 0.70 to 0.84.

Table 3. Alpha of the factors of the Protective Nursing Advocacy Scale - Brazilian version.

Variables	Cronbach's alpha
General score	0,81
Negative implications of practicing law	0,84
Advocacy actions	0,79
Facilitators for the practice of law	0,78
Perceptions that favor the practice of law	0,70
Barriers to the practice of law	0,75

Discussion

The translation and adaptation process of the PNAS-VB questionnaire was conducted with respect to the original meaning of the items; however, some adjustments were necessary to preserve the intended meaning of the terms, including those applicable to nursing technicians. The translation and adaptation process aimed to maintain the semantic integrity of the items, ensuring the preservation of word meanings—an essential aspect highlighted in the literature[23].

This meticulous process sought to achieve semantic equivalence and preserve the core essence of the questionnaire, a critical factor in cross-cultural adaptations[24]. The involvement of experts in the adaptation process was fundamental to ensure a high level of understanding and relevance of the questionnaire, aligning with their contributions to content validation and semantic equivalence assessments, as emphasized in the literature[25].

The clarity of the instrument during the pilot testing phase was satisfactory, demonstrating that it is easily understood by nursing professionals[26]. The PNAS-VB, adapted and validated for Brazilian nurses, underwent a rigorous evaluation by a panel of experts, pretesting, and factor

analysis, resulting in the identification of five constructs related to advocacy practice, including barriers and facilitators[27]. Furthermore, studies emphasize the importance of patient advocacy in nursing, highlighting its role in promoting patient safety and quality care, as well as serving as the patient's voice[28]. The concept of patient advocacy is crucial in healthcare professions, with codes of ethics guiding professionals to engage in the defense of patients' rights and the assurance of quality care[6].

The validity of the PNAS-VB instrument was considered satisfactory based on evaluations by a panel of experts and pilot testing. The factor analysis of PNAS-VB identified five key constructs for understanding the legal aspects of nursing practice: "negative implications of advocacy practice," "legal actions," "facilitators of advocacy practice," "perceptions that support advocacy," and "barriers to advocacy practice." These constructs provide a robust framework for assessing and improving advocacy practice in nursing[29].

The confirmatory analysis of PNAS-VB was deemed appropriate, indicating that the scale is valid and reliable for measuring nurses' engagement in patient advocacy within the context of Primary Health Care (PHC). This scale was developed to evaluate the involvement of frontline healthcare professionals in advocacy practices, encompassing various issues such as patients' rights, quality of care, and access to healthcare services. The scale aims to identify factors affecting nurses' performance in patient advocacy, emphasizing the understanding of patient needs, individualized care, and collaborative decision-making[30].

While the Patient Advocacy Scale focuses specifically on advocacy within the nursing profession, other studies highlight the importance of communication skills and organizational resources for safety and quality in improving nurses' intention to remain in their jobs and enhancing the patient safety climate[31–33]. A comprehensive assessment of nurses' actions and benefits in advocating for patients contributes to a holistic understanding of the role of nursing professionals in ensuring patients' rights, quality care, and access to healthcare services[31–33].

Patient advocacy in PHC is still a novel topic, which, until now, has primarily been applied in hospital settings. PHC is an environment that serves users, families, and communities—many of whom often lack awareness of their rights and responsibilities within the public health system. The PNAS-VB is an instrument designed to support nursing professionals and other healthcare providers in acting as patient advocates, aiming to promote the implementation and practice of public policies within these services[31–33].

Conclusion

The results obtained demonstrate that the PNAS-VB for nursing in APS is a valid and reliable instrument for evaluating beliefs and actions related to patient advocacy among nurses and nursing technicians. This not only guides the practice of advocacy in nursing but also provides a solid foundation for future research in this area. It is identified that the five constructs and the 20 items that broadly explain the exercise of patient advocacy: negative implications of advocacy, advocacy actions, facilitators for advocacy, perceptions that promote advocacy, and barriers to advocacy.

One of the limitations of the study relates to the size and composition of the sample. As a suggestion for future research, it would be interesting to compare the PNAS-VB with other scales and assessment tools to verify the consistency of results, and to explore possible additions that could provide a more comprehensive view.

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