

EVALUATION OF THE PATIENT SAFETY CULTURE IN PRIMARY HEALTH CARE

AVALIAÇÃO DA CULTURA DE SEGURANÇA DO PACIENTE NA ATENÇÃO PRIMÁRIA À SAÚDE

EVALUACIÓN DE LA CULTURA DE LA SEGURIDAD DEL PACIENTE EN LA ATENCIÓN PRIMARIA DE LA SALUD

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Objective: to evaluate the patient safety culture in the perspective of the multiprofessional team working in Primary Health Care and its relation with the labor characteristics. **Method:** cross-sectional study, conducted with 188 professionals from 17 Family Health Units in a city in Rio Grande do Sul, Brazil, in the period from December 2017 to April 2018. Data collection occurred through the Brazilian version of the questionnaire Primary Health Care Survey on Patient Safety Culture. Descriptive and inferential analysis was performed. **Results:** the overall score was considered positive (3.64±0.84). Most dimensions obtained clearly positive perception and positive perception, except Work pressure and pace, which was negative (2.38±0.76). There was statistically significant difference in the variables working time, position and being coordinator. **Conclusion:** the patient safety culture in the surveyed institution was considered positive in most dimensions, except in pressure and pace.

Descriptors: Primary Health Care. Organizational Culture. Patient Safety.

Objetivo: avaliar a cultura de segurança do paciente na perspectiva da equipe multiprofissional atuante na Atenção Primária à Saúde e sua relação com as características laborais. Método: estudo transversal, realizado com 188 profissionais de 17 Unidades de Saúde da Família de um município do Rio Grande do Sul, Brasil, no período de dezembro de 2017 a abril de 2018. Coleta por meio da versão brasileira do questionário Pesquisa sobre Cultura de Segurança do Paciente para Atenção Primária à Saúde. Realizada análise descritiva e inferencial. Resultados: o escore geral foi considerado positivo (3,64±0,84). Obteve-se percepção claramente positiva e percepção positiva na maioria das dimensões, exceto Pressão e ritmo de trabalho, que foi negativa (2,38±0,76). Evidenciou-se diferença estatisticamente significativa nas variáveis tempo de trabalho, cargo e ser coordenador. Conclusão: a cultura de segurança do paciente na instituição investigada foi considerada positiva na maioria das dimensões, exceto na pressão e ritmo.

Descritores: Atenção Primária à Saúde. Cultura Organizacional. Segurança do Paciente.

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Objetivo: evaluar la cultura de la seguridad del paciente en la perspectiva del equipo multiprofesional actuante en la Atención Primaria de la Salud y su relación con las características laborales. Método: estudio transversal, realizado con 188 profesionales de 17 Unidades de Salud Familiar de una ciudad del estado de Rio Grande do Sul, Brasil, en el período comprendido entre diciembre de 2017 a abril de 2018. La recogida de datos ocurrió por medio de la versión brasileña de la Encuesta sobre la Cultura de Seguridad del Paciente a la Atención Primaria de Salud. Se realizó análisis descriptivo e inferencial. Resultados: la puntuación global fue considerada positiva ($3,64 \pm 0,84$). La mayoría de las dimensiones obtuvieron percepción claramente positiva y percepción positiva, excepto Presión y el ritmo de trabajo, el cual fue negativo ($2,38 \pm 0,76$). Hubo una diferencia estadísticamente significativa en las variables tiempo de trabajo, posición y ser coordinador. Conclusión: la cultura de la seguridad del paciente en la institución investigada fue considerada positiva en la mayoría de las dimensiones, excepto en la presión y el ritmo.

Descriptores: Atención Primaria de Salud. Cultura Organizacional. Seguridad del Paciente.

Introduction

Patient safety (PS) comprises a set of actions and attitudes that aim to manage and prevent strategically and continuously the risks to which patients are exposed during health care⁽¹⁾. A riskless patient care is synonymous with quality in health services and prominence in the discussions for improving the care process⁽²⁾.

Despite the efforts of health organizations to improve the care process, unsafe practices that put at risk the patient integrity continue to happen at all care levels. In this scenario, among the strategies adopted in health institutions focusing on the safe care, there stands out the strengthening of the PS culture as conditioning factor to improve the quality of care and reduce incidents⁽³⁾.

In this sense, the PS culture is defined as the set of values, attitudes, skills and behaviors that determine the commitment with the health and safety management, replacing the guilt and punishment by the opportunity to learn from failures⁽¹⁾. Its implementation requires the understanding of beliefs, values and norms appreciated by the institution, in addition to defining the expected actions and behaviors directed to the PS⁽⁴⁾.

In Brazil, investigations on PS have focused on hospital environments, but incidents and adverse events (AE) occur in all levels of assistance. As an example, a Brazilian study found an incident ratio of 1.11% in Primary Health Care (PHC), in which 82% resulted in damage to the patients⁽⁵⁾.

Since most of the follow-up of patients and/or users of the Unified Health System (UHS) occur in

the PHC, which performs the longitudinal care of patients linked to its unit over time, the inclusion of this scenario in investigations involving PS is justified⁽⁵⁾. In this context, one expects to contribute with evidences that collaborate to improving the safe care, promoting the quality assistance and establishing a PS culture, which implies a process of institutional transformation⁽⁶⁾.

Considering the health care demand in outpatient services, including the PHC, and the estimates of public policies that the basic attention should be the care coordinator⁽⁷⁾, it is important to evaluate and discuss the PS culture. Thus, those services are expected to enable the accomplishment of studies on this theme aiming to assist in identifying gaps and plan actions to improve the quality of health care, since there is a gap of knowledge in this health context⁽⁸⁾. In Brazil, studies evaluating the PS culture in the PHC are still incipient^(6,8), which denotes the necessity and importance of this study.

Thus, the objective of this study was to evaluate the patient safety culture in the perspective of the multiprofessional team working in Primary Health Care and its relation with the labor characteristics.

Method

Cross-sectional study, conducted in 17 Family Health Units (FHUs) in a municipality in the state of Rio Grande do Sul, Brazil. The municipality has offered the multiprofessional residency program in family health since the year 2010.

The inclusion criteria were: belong to the multiprofessional team; work in the unit for 30 days; and work 20 hours a week, at least. These criteria were established because, from a month, the professionals realize the values, attitudes, perceptions and individual and group skills that determine the commitment, the style and proficiency on the issues of patient safety in the health institution⁽⁹⁾. There was exclusion of those on health leave or another type of leave in the data collection period.

Initially, a nominal list of workers and their working shifts was requested to the City Health Department (SMS). Later, the managers of the units were contacted to set the time and date for application of the questionnaire. After the definition of the dates by managers, the main researcher (the first author) went to the units and invited the workers to participate, explaining the study. In the sequence, she presented and read the Informed Consent Form (ICF), which was delivered within an envelope, in two copies, along with the research instrument. After the consent and signature of the ICF, a copy remained with the interviewee and the other, with the researcher. After this step, the interviewees answered the instrument, which was delivered in a sealed envelope and returned to the researcher, who remained in the unit, awaiting the completion of the instrument.

Data collection occurred from December 2017 to April 2018. Of the 228 professionals from the SMS list, after applying the inclusion criteria, there were 34 losses; 24 professionals were on maternity or health leave and 10 did not have the expected service time (30 days). There were also six refusals. In this way, the participants were 188 professionals, namely: 11 doctors, 25 nurses, 42 nursing technicians, 20 administrative staff, 45 Community Health Workers, 26 other health professionals (dental auxiliary, dentist, speech pathologist, pharmacist, occupational therapist, social worker, nutritionist, psychologist, physical educator), 19 workers of endemics.

The data collection instrument used was the version of the questionnaire PHC Survey on PS Culture, translated, adapted and validated

semantically⁽⁶⁾ and psychometrically⁽¹⁰⁾ for use in Brazil, based on the original version Medical Office Survey on Patient Safety Culture (MOSPSC), developed in the United States of America in 2007⁽⁴⁾. The instrument consists of dimensions of the PS construct, which include: Aspects related to the PS and quality; Exchange of information with other institutions; Teamwork; Work pressure and pace; Staff training; Working process and standardization; Communication Openness; Patient care follow-up; Communication about mistakes; Support from managers in patient safety; Organizational Learning; Overall perceptions of PS and quality; Overall assessment of PS; and Overall assessment of quality.

The data were entered twice on the Epi-Info® 6.04. After correction of inconsistencies and/or errors, the data were analyzed using the Statistical Package for the Social Sciences (SPSS®), version 21.0 for Windows. The quantitative variables are described through measures of central tendency (mean and dispersion), according to the normality distribution assessed by the Kolmogorov-Smirnov test. The authors developed the variables used, which contemplated working time, position and being the unit coordinator.

The data analysis, through the Patient Safety Synthetic Index (PSSI), was defined as the average of all the questions that make up the analyzed dimensions. In all cases, the range was 1 through 5. The relative frequencies of each question were calculated, and the composite indicators for each dimension were measured by the following formula⁽¹¹⁾:

$$\frac{\sum \text{responses (positive, neutral and negative)} \\ \text{in the dimension items}}{\text{Number of total responses in a dimension items}}$$

To perform a comparative analysis of all dimensions that compose the questionnaire, the scale of the original response to sections A and B, which have six categories of response, was transformed into a rating scale ranging from 1 to 5, as the rest of the sections, applying the score formula given in the original scale (OSS) x (4/5) + 0.2. In all cases, the range was 1 through 5. The dimension was considered "positive

perception” when the PSSI was >3 and “clearly positive perception” when the PSSI was ≥ 4 ⁽¹¹⁾.

The ethical aspects were observed according to precepts established in Resolution n. 466/2012 of the National Health Council⁽¹²⁾, which establishes parameters for researches involving human beings. The project was approved by the Research Ethics Committee (REC) of the Regional University of Western Rio Grande do Sul, under CAAE 78621917.5.0000.5350 and Consubstantiated Opinion n. 2.413.567, 4 December 2017.

Results

Of the 194 participants, there was a response rate of 97% (n=188). Most participants were in the age range 31-50 years (58%), females reported greater number (87.8%), with a partner (55.3%), secondary education (42.8%), income over three minimum wages (31.9%), time since graduation ranged from 5 years and 1 day to 10 years (30.4%), work in the service for 11 years or more (27.8%), with 33 through 40 working hours per week (79.3%), government worker (79.3%), with no other employment (95.7%), and Community Health Workers (CHW) as the prevalent category(30.3).

In the investigated units, the overall score of the PS culture was considered positive (3.64 ± 0.84). The following dimensions obtained clearly positive perception: Patient care follow-up (4.32 ± 0.58); Teamwork (4.31 ± 0.48); Aspects related to PS and quality (4.12 ± 0.77); Exchange of information with other institutions (4.11 ± 0.75); and Communication openness (4.07 ± 0.66).

The following dimensions obtained positive perception: Communication about mistakes (3.89 ± 0.65); Organizational Learning (3.87 ± 0.70); Overall assessment of PS and quality (3.72 ± 0.61); Work process and standardization (3.64 ± 0.63); Overall assessment of patient safety (3.48 ± 0.73); Overall assessment of quality (3.45 ± 0.66); Staff training (3.40 ± 0.75); and Support from managers (3.19 ± 0.77). The dimension Work pressure and pace (2.38 ± 0.76) had negative perception.

Table 1 shows the mean and standard deviation for the dimensions of the MOSCPC instrument, compared to labor variables. In the dimension Work pressure and pace, there was statistically significant difference ($p \leq 0.05$) between the mean (2.7 ± 0.8) of working time, from 6 to less than 11 years, when compared to the mean (2.1 ± 0.5) of the age from 3 to less than 6 years.

Table 1 – Distribution of mean and standard deviation (mean \pm standard deviation) for the dimensions of the Medical Office Survey on Patient Safety Culture (MOSPSC) scale in comparison with the labor variables. Rio Grande do Sul, Brazil – 2018 (continued)

Profile	Medical Office Survey on Patient Safety Culture (MOSPSC) dimensions				
	Aspects related to patient safety and quality	Exchange of information with other institutions	Teamwork	Work pressure and pace	Staff training
Working time (p)¶	0.431	0.069	0.768	0.023	0.376
Less than 2 months	3.9 \pm 1.3	3.5 \pm 1.5	4.4 \pm 0.5	2.3 \pm 0.7	2.9 \pm 1.2
From 2 months to one year	4.4 \pm 0.8	4.3 \pm 0.8	4.3 \pm 0.6	2.4 \pm 0.7	3.4 \pm 0.6
From 1 year to less than 3 years	4.5 \pm 0.6	4.5 \pm 0.7	4.4 \pm 0.6	2.3 \pm 0.9	3.3 \pm 0.7
From 3 years to less than 6 years	4.5 \pm 0.9	4.5 \pm 0.7	4.3 \pm 0.5	2.1 \pm 0.5b	3.3 \pm 0.8
From 6 years to less than 11 years	4.5 \pm 0.8	4.6 \pm 0.6	4.2 \pm 0.4	2.7 \pm 0.8a	3.5 \pm 0.7
11 years or more	4.6 \pm 0.6	4.6 \pm 0.7	4.4 \pm 0.4	2.3 \pm 0.7	3.4 \pm 0.8

Table 1 – Distribution of mean and standard deviation (mean±standard deviation) for the dimensions of the Medical Office Survey on Patient Safety Culture (MOSPSC) scale in comparison with the labor variables. Rio Grande do Sul, Brazil – 2018 (conclusion)

Profile	Medical Office Survey on Patient Safety Culture (MOSPSC) dimensions				
	Aspects related to patient safety and quality	Exchange of information with other institutions	Teamwork	Work pressure and pace	Staff training
Position (p)¶	0.776	0.390	0.063	0.094	0.323
Physician	4.6±0.4	4.2±0.5	4.5±0.4	2.6±0.9	3.8±0.5
Nurse	4.5±0.8	4.5±0.7	4.4±0.4	2.2±0.8	3.4±0.9
Administrative staff / Community Health Worker	4.4±1.0	4.4±0.9	4.2±0.6	2.6±0.7	3.4±0.8
Nursing technician	4.5±0.6	4.6±0.7	4.4±0.4	2.2±0.7	3.3±0.7
Other health professionals	4.6±0.8	4.5±0.9	4.4±0.4	2.3±0.7	3.2±0.9
Other positions	4.6±0.5	4.8±0.2	4.3±0.4	2.5±0.9	3.4±0.5
Unit coordinator (p)§	0.041	0.170	0.043	0.535	0.011
Yes	4.9±0.2	4.8±0.4	4.6±0.4	2.5±1.0	3.9±0.7
No	4.5±0.8	4.5±0.8	4.3±0.5	2.4±0.7	3.4±0.7

Source: Created by the authors.

In approach of the position, in comparison with the scale, there was significant difference in the dimension Patient care follow-up ($P=0.007$), in which the position of other health professionals ($4.1±0.7$) showed significantly lower mean when compared to the positions of physician ($4.5±0.4$) and administrative staff ($4.5±0.5$).

The representative difference was present in the dimension Communication about mistakes ($P=0.017$), in which the professionals with less

than two months obtained smaller average ($3.4±0.6$) in comparison to the ranges from two months to one year ($4.0±0.8$), from six years to less than 11 months ($4.1±0.6$) and more than 11 years ($4.0 ± 0.5$).

In the dimension Support from managers in PS, the difference ($p=0.021$) was between the positions of other health professionals ($2.9±0.9$) and administrative staff/CHW ($3.4±0.7$).

Table 2 – Distribution of mean and standard deviation (mean±standard deviation) for the dimensions of the Medical Office Survey on Patient Safety Culture (MOSPSC) scale in comparison with the labor variables. Rio Grande do Sul, Brazil – 2018 (continued)

Profile	Medical Office Survey on Patient Safety Culture (MOSPSC) dimensions				
	Work process and Standardization	Communication openness	Patient care follow-up	Communication about mistakes	Support from managers in patient safety
Working time (p)¶¶	0.127	0.678	0.197	0.017	0.645
Less than 2 months	3.6±0.7	4.2±0.5	4.1±0.6	3.4±0.6c	2.9±1.0
From 2 months to one year	3.7±0.4	4.0±0.7	4.2±0.6	4.0±0.8 ^a	3.3±0.9
From 1 year to less than 3 years	3.4±0.7	3.9±0.7	4.2±0.6	3.7±0.7	3.1±0.7

Table 2 – Distribution of mean and standard deviation (mean±standard deviation) for the dimensions of the Medical Office Survey on Patient Safety Culture (MOSPSC) scale in comparison with the labor variables. Rio Grande do Sul, Brazil – 2018 (continued)

Profile	Medical Office Survey on Patient Safety Culture (MOSPSC) dimensions				
	Work process and Standardization	Communication openness	Patient care follow-up	Communication about mistakes	Support from managers in patient safety
Working time (p)¶	0.127	0.678	0.197	0.017	0.645
From 3 years to less than 6 years	3.7±0.8	4.0±0.7	4.4±0.6	3.8±0.7	3.3±0.6
From 6 years to less than 11 years	3.8±0.5	4.1±0.6	4.5±0.6	4.1±0.6 ^a	3.2±0.7
11 years or more	3.6±0.7	4.2±0.6	4.3±0.6	4.0±0.5 ^a	3.2±0.8
Position (p)¶¶	0.647	0.630	0.007	0.279	0.021
Physician	3.7±0.4	4.4±0.5	4.5±0.4 ^a	4.0±0.7	3.2±0.9
Nurse	3.5±0.6	4.1±0.7	4.2±0.5	3.8±0.7	3.3±0.7
Administrative staff / Community Health Worker	3.7±0.8	4.0±0.7	4.5±0.5 ^a	4.0±0.7	3.4±0.7 ^a
Nursing technician	3.6±0.5	4.1±0.7	4.2±0.6	3.9±0.5	3.0±0.6
Other health professionals	3.6±0.5	4.1±0.6	4.1±0.7 ^b	3.7±0.7	2.9±0.9 ^b
Other positions	3.8±0.4	4.1±0.6	4.4±0.6	4.0±0.6	3.1±0.9
Unit coordinator (p)§	0.006	0.001	0.527	0.445	0.066
Yes	4.1±0.4	4.6±0.3	4.4±0.5	4.0±0.5	4.3±0.9
No	3.6±0.6	4.0±0.7	4.3±0.6	3.9±0.7	3.7±0.7

Source: Created by the authors.

There was significant difference in the dimension Overall perceptions of PS and quality ($P=0.026$), in which the professionals with working time from two months to one year ($3.9±0.6$) and from six years to less than 11 years ($3.9±0.5$) showed higher averages than those professionals with up to two months of work ($3.3±0.4$).

In the Overall assessment of quality, the results showed that the professionals with other functions ($3.2±0.6$) and administrative staff ($3.3±0.7$) showed significantly lower average in comparison to positions of Physician ($3.8±0.6$), Nurses ($3.7±0.6$) and Other health professionals ($3.7±0.7$) with a value of $p=0.009$.

Table 3 – Distribution of mean and standard deviation (mean±standard deviation) for the dimensions of the Medical Office Survey on Patient Safety Culture (MOSPSC) scale in comparison with the labor variables. Rio Grande do Sul, Brazil – 2018 (continued)

Profile	Medical Office Survey on Patient Safety Culture (MOSPSC) dimensions			
	Organizational learning	Overall perceptions of patient safety and quality	Overall assessment of patient safety	Overall assessment of quality
Working time (p)¶¶	0.113	0.026	0.965	0.326
Less than 2 months	3.2±1.5	3.3±0.4 ^b	3.3±1.0	2.9±0.7
From 2 months to one year	3.9±0.9	3.9±0.6 ^a	3.6±0.9	3.6±0.8

Table 3 – Distribution of mean and standard deviation (mean±standard deviation) for the dimensions of the Medical Office Survey on Patient Safety Culture (MOSPSC) scale in comparison with the labor variables. Rio Grande do Sul, Brazil – 2018 (continued)

Profile	Medical Office Survey on Patient Safety Culture (MOSPSC) dimensions			
	Organizational learning	Overall perceptions of patient safety and quality	Overall assessment of patient safety	Overall assessment of quality
Working time (p)¶	0.113	0.026	0.965	0.326
From 1 year to less than 3 years	3.9±0.6	3.6±0.7	3.5±0.8	3.4±0.6
From 3 years to less than 6 years	3.8±0.5	3.7±0.6	3.5±0.7	3.4±0.6
From 6 years to less than 11 years	4.0±0.7	3.9±0.5a	3.5±0.6	3.5±0.7
11 years or more	3.9±0.5	3.6±0.6	3.5±0.7	3.5±0.6
Position (p)¶	0.251	0.597	0.548	0.009
Physician	4.1±0.4	4.0±0.7	3.5±0.5	3.8±0.6 ^a
Nurse	4.0±0.5	3.7±0.7	3.5±1.0	3.7±0.6 ^a
Administrative staff / Community Health Worker	3.9±0.7	3.7±0.6	3.4±0.7	3.3±0.7
Nursing technician	4.0±0.4	3.7±0.6	3.4±0.6	3.4±0.6
Other health professionals	3.7±1.0	3.6±0.6	3.7±0.8	3.7±0.7 ^a
Other positions	3.7±1.0	3.7±0.4	3.4±0.6	3.2±0.6 ^b
Unit coordinator (p)§	0.016	0.007	0.171	0.011
Yes	4.3±0.3	4.1±0.4	3.7±0.6	3.9±0.6
No	3.8±0.7	3.7±0.6	3.5±0.7	3.4±0.7

Source: Created by the authors.

The MOSPSC scale presented the largest number of dependency relationships with the professional characteristic of unit coordinator, pointing to higher means among professionals who reported being unit coordinators. There were significant differences in the dimensions: Aspects related with PS and quality (0.041), Teamwork (0.043), Staff training (0.011), Work process and standardization (0.006), Communication openness (0.001), Organizational learning (0.016), Overall perceptions of PS and quality (0.007) and Overall assessment of quality (0.011).

Discussion

A study assessing the PS culture recommends the highest possible number of professionals participating in the evaluations, therefore, the higher the response rate, the more appropriate its representation⁽⁴⁾. The present study revealed

positive results of PS culture in the PHC. This finding indicates that the culture is established between workers from health services in the research place. Health organizations with this profile boost organizational learning based on the occurrence of incidents. The strengthening of the culture occurs with professionals' engagement, in order to intensify the moments of discussions of mistakes and collective learning, aiming at the safe care⁽¹³⁾.

The patient care follow-up has been a guideline in the PHC. It constitutes the patient follow-up over time, involving relationship of care continuity, construction of bond and responsibility between professionals and users, monitoring the effects of health interventions and other elements in people's life⁽¹⁴⁾.

A study infers that workers from the same health unit tend to perceive more positively the teamwork, because they share moments

and develop attachment to their workplace⁽¹⁴⁾. Teamwork is essential regarding aspects related to SP and quality of the care provided. The unit coordinator that acts as a leader, being an advisor and information mediator, facilitates the incorporation of professionals who feel excluded from the team activities⁽¹⁵⁾.

In order to cope with the AEs during patient care, a study⁽³⁾ and normative⁽¹⁶⁾ were published, aiming to assist health managers and professionals to ensure health care quality. In this sense, the exchange of information between the team and other sectors has been pointed out as an important aspect, because it aims at the safe care continuity and how the service performs the exchange of complete and accurate information with other health services related to PS⁽⁴⁾.

The positive outcome in this study indicates that the professionals performed users' referral and counter-referral and that there was communication between the different points in the health care network in the patient care. In contrast to this finding, a study showed negative evaluation in this dimension, comprising an area that needs improvement, because it uses information technology of different levels of assistance and should have greater involvement of professional assistants⁽¹¹⁾.

Related to the position of unit coordinator, a study shows that one of the most important characteristic of PHC health managers is communication openness, in addition to leadership, organization, planning, agility, good relationship, knowledge, creativity and motivation ability. It also shows the benefits provided by the training directed to this work line for the process of health management⁽¹⁷⁾.

A study that evaluated the challenges of teamwork in the PHC showed that the multiprofessional team realized communication openness as a facilitating aspect of the work, and needs to be carried out directly, sincerely, respectfully and collaboratively, even with divergence of ideas among professionals. The form of narrowing relations and encouraging communication openness in daily work is through team meetings, which are seen as

moments of integration and construction for a harmonious working environment, an occasion to strengthen relations between the team and the planning of actions⁽¹⁸⁾.

Concerning the communication about mistakes, a study conducted with Arab population indicated that it can be improved, if there is inclusion of team professionals to report incidents, ask questions and point concerns when something does not seem right, in addition to motivating employees to express their opinions directed to the improvement of PS⁽¹⁸⁾. Carrying out actions for improvements through systemic approach of error and organizational learning may, in the long term, decrease turnover of professionals in labor sectors and provide autonomy regarding safe care, which collaborates to PS⁽¹⁹⁾.

The staff learning, in the organizational perspective, is still incipient in the health area. This requires a collective and effective learning, which facilitates the development of a culture directed to develop educational interventions, aiming to change individual opinions and practices related to the interactions occurring in the workplace⁽²⁰⁾. A study⁽²¹⁾ assesses that health care with the user can weaken if there is no support for a learning related to care and PS, which guides the manager's decision with a view to enhance his/her teamwork.

The dimension "Overall perceptions of PS and quality" showed a statistical difference for the variable related to working time. The best perception of professionals with more time working in the service may relate to the fact they accompany the process of the organizational structure remodeling in PHC services. In this, the implementation of new policies and work processes related to health care has been gradually improving. This result was also found in another study⁽¹⁸⁾.

Related to the position of unit coordinator, a study⁽²¹⁾ shows that the support for learning offered by the immediate boss is perceived as negative by the professionals, when the boss tends to inhibit new skills and ignore proposed changes based on knowledge acquired in training. Concerning being coordinator and obtaining

positive average in comparison to other positions in the work process and standardization, it is directly related to the position occupied, of team leadership.

For this purpose, during the work process and standardization, a good management of conflicts and problems is essential, as well as the availability of information for decision-making and adequate supervision, since these factors allow for better performance and productivity at work⁽²²⁾. The professional autonomy can also be evidenced based on the health care coordination, in the perspective of the communication between professionals and services, focusing on a more effective organizational environment⁽²²⁾.

A study⁽⁷⁾ shows that PHC professionals are often unable to meet the spontaneous demand of the unit, requiring directing the patients to seek care in emergency care units. This fact highlights the fragility in the work process and the standardization of the team tasks. The lack of service to users who seek the PHC goes against the UHS principles, which preach the reception at the primary level as an important strategy to reorganize the teamwork, not restricted to a screening for medical care. Teamwork is essential to the positive results of the PS culture, since the lack of consensus between all can harm the common goals.

A study⁽¹¹⁾ performed with medical interns shows that the culture results are lower in the final years of their specialty training than at the beginning, which indicates that PS must be one of the knowledge areas that interns must acquire. This result may be related to the fact that the professionals more recently graduated time have less training and qualifications, if compared to workers who graduated long before and have more professional performance. In this way, develop training, continuing education, qualifications, courses, seminars, surveys, periodic meetings for the team discuss and arrange the work process and have a feedback of the performed activities, are ways to improve the PS culture in the PHC, as stated in a study⁽⁸⁾.

A research that evaluated the relationship between education and PS informs that the

participants still had a traditional view of what was taught in the past and understood what training and continuing education were important strategies to qualify the organizational culture. It also points to the need for changes in the professional training related to current issues, and that the qualifications through lectures, courses and training during the work period were effective strategies to know the patient safety theme⁽²³⁾, which could be facilitated by the coordinator acting in the team.

In this way, the management's support for professionals' daily work is essential, as well as encouraging communication and exchange of information at appropriate time, related to adverse events that might impair the professional activities. Also importantly, managers should underscore safety-related issues, receive criticism and different opinions positively, encourage feedback, determine safety standards and encourage workers' qualification⁽¹⁹⁾.

In this study, work pressure and pace achieved the lowest values and were related to the impact of the workload in the carelessness with the patient. A similar result was found in other studies^(11,18). The work overload may be due to the high demand of users' call, demand for production by managers, turnover or absence of workers, which directly influence the provision of service, implying in the provided care. Furthermore, some teams experience high rates of violence and social vulnerability, a fact that influences the way they organize their routine work to meet the care demand, causing fatigue and displeasure⁽²⁴⁾.

As years pass by, the higher work pressure and load should be observed and modified by the health service, for the continuous improvement during the work process⁽¹⁸⁾. When workers feel satisfied with their work, there should be less professional turnover⁽¹⁹⁾. In this study, the low average in this dimension may be related to the excessive demand of users who seek treatment at the health unit, which contributes to the professionals showing work pressure and overload. As established by the PNAB, with respect to the peculiarities of family health, each

team should be responsible for no more than four thousand people, with a recommended average of three thousand people, respecting the criteria of equity for this definition⁽⁷⁾.

Another issue related to the dimension Work pressure and pace may be the fact that the service has joined the reception of users, abolishing the queue for access to appointments. This fact facilitates access, as the service extends the ability to listen to people's demands⁽⁷⁾. A study that investigated the factors that influence the access to health service stresses that the practice of reception in the PHC is many times identified as a failure in the professionals' perspective, because a portion of users use the service unnecessarily, due to the easy access. This, however, hinders the identification of other patients' real needs, causing professional disinterest to ask about the problem that brought the user to the unit⁽²⁵⁾.

A limitation of the study constitutes the fact of its development in a single municipality. As contributions, there stands out the fact of being one of the pioneers in Brazilian studies that portray the PS culture in the PHC. For this reason, it can constitute a starting point for future investigations.

Conclusion

This study shows that the surveyed professionals express a positive PS culture, except in the Work pressure and pace dimension. The result shows that workers and service managers should focus on the negative dimension and think about strategies that can improve the routine and the workload experienced on a daily basis. The user daily uses the various technologies available at the PHC and the Pressure and work pace directly affect the quality of the provided care, requiring dialog between the team and the agreement of ideas, with a view to coping with errors in health care.

There was statistically significant difference for the variable Working time in the dimensions Work pressure and pace, Communication about mistakes, Overall perceptions of PS and quality. For the Position variable, there was statistically

significant difference in the dimensions Patient care follow-up, Support from managers in PS and Overall quality assessment. In the variable Unit coordinator, there was statistically significant difference in the dimensions Aspects related to PS and quality, Teamwork, Staff training, Work process and standardization, Communication openness, Organizational learning, Overall perceptions of PS and quality and Overall quality assessment.

The results of this research can signify health managers and workers to observe and reflect on profiles and ways to improve the work process within their health unit, expressing a positive culture.

Further studies should be developed to evaluate the PS culture in the PHC, relating it to the number of people registered in the unit, considering the finding of this study.

Collaborations:

1 – conception, design, analysis and interpretation of data: Sandra Dal Pai, Daiane Fernanda Brigo Alves and Adriane Cristina Bernat Kolankiewicz;

2 – writing of the article and relevant critical review of the intellectual content: Sandra Dal Pai, Daiane Fernanda Brigo Alves, Pâmella Pluta, Vanessa Dalsasso Batista Winter and Adriane Cristina Bernat Kolankiewicz;

3 – final approval of the version to be published: Sandra Dal Pai, Daiane Fernanda Brigo Alves, Pâmella Pluta, Vanessa Dalsasso Batista Winter and Adriane Cristina Bernat Kolankiewicz.

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