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Original

Primary Health Care as a scenario for assessing the patient's safety culture

Atenção Primária a Saúde como cenário de avaliação da cultura de segurança do paciente

Atención Primaria a la Salud como escenario de evaluación de la cultura de seguridad del paciente

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ABSTRACT

Objective: To evaluate attitudes and perceptions about the culture of patient safety by professionals working in primary health care. **Method:** A cross-sectional study, developed with professionals from the multiprofessional team, who work in basic and family health units of a municipality in the northwest of the State of Rio Grande do Sul. For data collection from June to December 2016, the Safety Attitudes Questionnaire - Outpatient version. Responses follow the Likert scale, and scores were considered positive when ≥7.5. **Results**: 172 professionals from the multiprofessional team participated in the study. The domains that showed positive results were patient safety and unit management. The lowest scores occurred in the error and working conditions domains. **Conclusion**: We identified weaknesses in the results, and the need for investments in structure, training and awareness of professionals, managers and users in order to consolidate safe care.
Descriptors: Primary health care; Health services; Patient Assistance Team; Assistance; Patient safety.

RESUMO

Objetivo: Avaliar atitudes e percepções sobre a cultura de segurança do paciente por profissionais que atuam na atenção primária a saúde. **Método:** Estudo transversal, desenvolvido com profissionais da equipe multiprofissional, que atuam em unidades básicas e de saúde da família de um município do noroeste do Estado do Rio Grande do Sul. Para coleta de dados realizadas nos meses de junho a dezembro de 2016, utilizou-se o Questionário de Atitudes de Segurança - Versão ambulatorial. As respostas seguem a escala de Likert, e escores foram considerados positivos quando ≥7,5. **Resultados**: Participaram do estudo 172 profissionais da equipe multiprofissional. Os domínios que apresentaram resultado positivo foram segurança do paciente e gerência de unidade. Os menores escores ocorreram nos domínios erro e condições de trabalho. **Conclusão**: Identificou-se fragilidades nos resultados, e a necessidade de investimentos em estrutura, capacitação e conscientização dos profissionais, gestores e usuários a fim de consolidar o cuidado seguro.
Descritores: Atenção Primária à Saúde; Serviços de Saúde; Equipe de Assistência ao Paciente; Assistência; Segurança do Paciente.

RESUMÉN

Objetivo: Evaluar actitudes y percepciones sobre la cultura de seguridad del paciente por profesionales que actúan en la atención primaria a la salud. **Método:** Estudio transversal, desarrollado con profesionales del equipo multiprofesional, que actúan en unidades básicas y de salud de la familia de un municipio del noroeste del Estado de Rio Grande do Sul. Para la recolección de datos realizadas en los meses de junio a diciembre de 2016, utilizó - el Cuestionario de Actitudes de Seguridad - Versión ambulatoria. Las respuestas siguen la escala de Likert, y los escores se consideraron positivos cuando ≥7,5. **Resultados**: Participaron del estudio 172 profesionales del equipo multiprofesional. Los dominios que presentaron resultado positivo fueron seguridad del paciente y gerencia de unidad. Los menores escores ocurrieron en los dominios error y condiciones de trabajo. **Conclusión**: Se identificaron fragilidades en los resultados, y la necesidad de inversiones en estructura, capacitación y concientización de los profesionales, gestores y usuarios a fin de consolidar el cuidado seguro.
Descriptores: Atención Primaria a la Salud; Servicios de Salud; Equipo de Asistencia al Paciente; Asistencia; Seguridad del paciente.

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INTRODUCTION

The Patient Safety (PS) has been gaining ground in health, especially after the publication of the report To err is human,[1] which widely advertised on Adverse Events (AE) related to health care. Since then, advances have been made, however PS remains a public health problem, since avoidable damages still occur in the different levels of health care that pay attention to the various populations with their demands and complexities.[2] Faced with this reality, in the year 2016, the National Patient Safety Foundation issued a report stating that the assistance should be harmless.[2]

In Brazil, actions aimed at this issue are taken from the National Patient Safety Program (PNSP), which aims to qualify care in all health care settings in the national territory.[3] It also aims to consolidate a culture with values, attitudes and behaviors that prioritize SP, and substitute punishment for the opportunity to learn from mistakes to qualify care,[4] and decrease the occurrence of AE and mortality.

Health care occurs in several places in the health care network (HCN) and Primary Health Care (PHC) is one of the main levels that promotes patient care, especially in countries where this system is consolidated.5 This fact demonstrates the need for the patient to be treated safely in all environments, as well as when they pass through them. 2 Even though part of the health care of the population is provided in PHC, the investigations related to PS are little explored in this context, with greater focus on hospital care.[6-7]

In order to identify the safety culture in an institution, it is necessary to quantify the professionals' perceptions about the issue quantitatively.[8] Among the instruments that evaluate the safety culture are the Safety Attitudes Questionnaire Ambulatory Version Safety - outpatient version, SAQ-AV), created in Texas, translated and adapted into Brazilian Portuguese.[9]

From this context, it was outlined as a question of the study: How is the safety culture of the patient in the APS of a municipality of Rio Grande do Sul, from the perspective of health professionals? Aiming to evaluate attitudes and perceptions about patient safety by professionals working in Primary Health Care.

METHODS

A cross-sectional study, which analyzes the patient's safety culture at the time, developed in Primary Health Care in a municipality in the southern region of Brazil, with an estimated population of 83,300 inhabitants in 2017.[10] A study developed in 15 Family Health Strategies (FHS), five Basic Health Units (BHU) and a Family Health Support Center (FHSC), in which multiprofessional teams work.

The following inclusion criteria were used: being a health professional and manager, who had been in the unit for at least one month. Workers who were on health leave or any other leave during the data collection period were excluded. Data collection took place from June to December 2016, by four previously trained nursing academics.

The training of the collectors was carried out through reading activities of articles using Safety Attitudes Questionnaire Ambulatory Version (SAQ-AV), pre-tests with the instrument

for familiarization, enumerations of doubts about the questionnaire and subsequent clarification. For data collection, initially, the Municipal Health Department (MHD) was asked to list the names of the workers, positions and the unit of action. Afterwards, a working scale was drawn up for the collectors in order to organize the collection of data.

The SMS reviewed in the month prior to the beginning of the collection, a list of 247 professionals who worked in Primary Health Care (APS). Nineteen (7.7%) professionals were excluded because they were on maternity leave, 15 (6.1%) professionals for working less than one month in the unit, totalizing an eligible population of 213 professionals. The losses were due to not filling all the questions (4, 2.0%), and (37; 17.3%) did not accept to participate in the study. To verify the statistical representativeness of the number of professionals under study, the following criteria were adopted: estimated proportion of 50%, sampling error of 5% and level of significance of 5%. From the calculation of the sample size, at least 152 professionals would be needed.

The initial approach to the workers was carried out with the managers of the FHS, BHU and FHSC and the objectives of the study were explained, the best moment was defined to carry out the data collection, which in the majority of the FHS occurred during the shift intended for the team meeting. In the other areas, BHU and FHSC, time is scheduled, subject to availability of each professional. At the time of collection, each participant received the instrument of data collection and two copies of the Informed Consent Term. The privacy of the worker was respected to answer the questionnaire. The collectors remained in place in order to assist in case of doubts, and to receive the completed questionnaire.

As a research tool used the SAQ-AV, developed at the University of Texas.[11] The questionnaire consists of four blocks: the first with questions related to sociodemographic and labor data; the second evaluates collaboration and communication among team professionals; the third is the evaluation of the patient safety climate in the PHC, composed of 63 questions divided into nine attitudes: work satisfaction, communication, working conditions, patient safety, teamwork culture, center management health, stress recognition, continuing education and error. The fourth block is a space for research participants to cite key recommendations for improving PS in their workspace.[9]

Each question follows the five-point Likert scale and the final score ranges from 0 to 10. Zero is the worst perception of the security climate and 10 is the best. A positive patient safety culture is considered when presenting a score ≥7.5. The options and values of each response were: A "do not agree strongly", B "do not agree slightly", C "neutral", D "slightly agree "And E" strongly agree ". The values assigned to each option were from two to 10, where A = 2, B = 4, C = 6, D = 8, E = 10, to quantitatively measure the patient's safety climate.[7]

We performed double independent typing, subsequent inconsistency corrections, and statistical analysis was performed in the Statistical Package for the Social Sciences (SPSS) program. For the analysis of the variables, we

used the descriptive statistics represented by the measure of central tendency and dispersion (standard deviation). Categorical variables are described by gross (N) and relative (%) frequencies.

A descriptive analysis of the total SAQ-AV and domains was carried out. The calculation was performed by summing the answers and dividing by the number of questions. The analysis of the safety attitudes scores was dichotomized, considered as negative/high score culture (<7.5) and positive culture/high score (≥7.5). The frequency (N) of each analyzed domain can present a different number, according to the number of answers "not applicable" of each item of the instrument.

Research approved by the Research Ethics Committee (CEP) of the Regional University of the Northwest of the State of Rio Grande do Sul (UNIJUÍ), under CAAE 54069616.6.0000.5350 and contemplates the guidelines of Resolution n. 466/2012.

RESULTS

172 professionals participated, corresponding to the response rate of 80.7%. Among the participants, 18 were nurses (10.5%), 16 doctors (9.3%), seven nutritionists (4.1%), nine dentists (5.2%), six dental assistants (45.9%), 18 nursing assistants (10.5%), a physiotherapist, a health manager, a psychologist and an assistant (2.3%).

Table 01 shows the sociodemographic characterization of the study participants, in which 83.1% of the workers work in FHS, with a predominance of women (84.9%), most aged 31 to 50 years, 69.2% married/stable union, 46.5% with complete secondary education and 28.5% have graduation. The duration of APS was 5 to 10 years, and the length of stay in the same workplace obtained the highest percentage of up to 5 years.

Regarding the labor characterization of the workers, 98.8% are civil servants, 95.3% work full-time, 79.7% opted to work in the unit, 70.4% said they received some type of training, 84.3% if dedicated exclusively to the institution, 94.8% have direct contact with the patient.

Table 02 shows results of the domains evaluated, presents a dichotomous analysis of these data, according to professionals from the multidisciplinary team working in the PHC.

Table 01: Sociodemographic and work profile of professionals working in Primary Health Care. Rio Grande do Sul, 2017, Brasil.

Variable	N (%)
Sex	
Male	26(15.1)
Female	146(84.9)
Age group*	
18 to 40 years	78(45.8)
41 to 60 years	83(48.8)
More than 60 years	9(5.4)

Marital status	
Married/Stable relationship	119(69.2)
Single	35(20.3)
Widow/Divorced	18(10.5)
Schooling	
Primary or secondary school	3(1.7)
High school	80(46.5)
University graduate	49(28.5)
Postgraduate	40 (23.3)

The SP domains and unit management had positive means, and the others (job satisfaction, communication, teamwork culture, working conditions, permanent education, perception of stress and error) presented weaknesses in the scores.

Table 02: Analysis of the domains of the Safety Attitudes Questionnaire - Ambulatory Version in Primary Health Care. Rio Grande do Sul, 2017, Brasil.

General score	Medium ± dp	Positive culture	Negative culture	Participants
		N(%)	N(%)	N(%)
SAQ AV total	6.9±0.74	32 (20.3)	126(80.8)	158 (91.9)
Work satisfaction	7.4± 1.13	100(58.8)	70 (41.2)	170 (98.8)
Culture of teamwork	6.6± 1.21	35(21.1)	131(78.9)	166 (96.5)
Work condition	5.5±1.24	8(4.8)	160(95.2)	168(97.7)
Communication	7.4 ±1.11	89(53.6)	77(46.4)	166 (96.5)
Patient safety	8.7 ±1.44	132(77.6)	38(22.4)	170 (98.8)
Permanent education	6.6± 1.99	58(34.5)	110(65.5)	168 (97.7)
Unit Management	7.8 ±1.9	121(71.6)	48(28.4)	169 (98.3)
Stress Recognition	6.5±1.06	32(19.2)	135(80.8)	167 (97.1)
Error	5.2 ±1.2	9(5.3)	161(94.7)	170 (98.8)

DISCUSSION

The study evaluated patient safety in Primary Health Care (PHC) and showed that the duration of PHC professionals' experience was 5 to 10 years, and in the unit up to 5 years, a positive fact because it is important that the professional stay in the to recognize and know the territory in which it operates. To build a bond with the population, which positively favors the patient's safety, since it favors the knowledge of the

users' demands. A study carried out with Community Health Agents (CHA) about the perception about Patient Safety (PS) showed that the professional's time with the community reflects positively to identify problems, recognize needs and bring solutions to the demands of the community.[13] Regarding the domains evaluated, patient safety obtained higher score, while domain error, the lowest mean, data corroborated by other Brazilian research.[7]

International studies performed in the APS with the Safety Attitudes Questionnaire Ambulatory Version (SAQ-AV) obtained divergent results. In Slovenia, the study showed a total SAQ-AV score of 56.6 ± 16.0 points, with a higher average for the domain of teamwork and the lowest mean of job satisfaction.[14] In Texas, the culture domains of teamwork, job satisfaction, and the security climate were positive.[12] In contrast, a survey carried out in the Netherlands showed a negative score in all analyzed domains.[14]

In this sense, analyzing the safety culture in PHC is necessary, considering its positive relation with the improvement of the work process and quality of care. In the present study, the domain of job satisfaction encompasses aspects such as liking or feeling frustrated with work, agreeing with the conduct of the unit, recognizing the unit as a good workplace, presented negative mean for safety culture. A study developed by Dorigan and Guirardello,[15] showed a significant correlation by nursing professionals in the perception of organizational performance, job satisfaction and safety climate.

Factors such as management problems, established relationships in the practice of care practice and overwork are contributing factors to the dissatisfaction of workers in the PHC,[16] and can hamper work attendance, work performance, well being and health.[17] Authors report that job satisfaction has a strong influence on the permanence of health workers in the institution where they work.[15]

Also, in a study carried out with nursing professionals to evaluate the reasons that lead to job dissatisfaction, it was pointed out that political issues established in relations between voters and elected officials hinder the progress of the activities of the units and result in dissatisfaction.[18] To improve work satisfaction, authors suggest that leaderships increase the bond with workers, consider their visions, with the objective of making participatory management.[19]

Work satisfaction is linked to the conditions that the professional has to carry out their activities,[19] it is evident the need for changes due to the low score found in the working conditions domain. In a study that analyzed the context of work in the APS, it was concluded that the conditions were considered critical by professionals, especially those related to inadequate furniture, excessive noise, lack of instruments, materials,[20] beyond the scarcity of human resources.[18]

Regarding the culture of teamwork, the score was also negative. In this sense, in the contemporaneity, it is important to look at the multiprofessional in the care process because it is necessary the construction and interaction of all professionals to expose their abilities,

longings, difficulties in order to improve the quality of teamwork.[21]

A study shows that peer orientation towards the challenges of applying new skills and praise enhances teamwork. If this is necessary, it must be cultivated in an integrated and articulated way, since the teams increase their capacity of care and problem solving, favoring the quality of assistance to the population.[22]

The mean score related to the communication was negative, which can be characterized as a challenge for PS, since of the AE that occur, it is estimated that 70% are related to communication failures.[23]

One of the positive domains was unit management, which indicates approval by the team about management work, that leaders support the daily efforts of professionals, who are committed to SP, and that professionals express their disagreements with coordination.

Management is perceived as challenging in different contexts and in PHC it is no different, since the leader must have a link with the team, negotiation capacity, political knowledge, territory, in addition, they need to have initiative, to recognize the importance of consolidating the positive security culture with its team, with open dialogue and assistance that prioritizes PS. In order to favor improvements in care by health managers, systematic permanent education is a way to strengthen and strengthen progress in the care of the users of family health services.[13]

In relation to the patient safety domain, the same presented a positive score and is related to the care performed by the professionals, the importance of the theme to unity. It is perceived the importance of this result, because the PS permeates the safety culture established by the institution. However, respect for diverse opinions, collective interaction and harmony are indispensable to maintain the work environment favorable to PS and professionals.[24]

The recognition of stress evaluates how much the professional recognizes that stressful situations affect his performance in the work. In the present study, the mean of the domain was negative. The perception of stress can be associated with the professional category and the time of the work of the workers.[25] In this way, each professional in their own individuality, has a perception related to the stressors factors. However, the professional needs to understand their limitations and take care of themselves, to avoid negative feelings that result in abandonment of their tasks.[24]

During this period, permanent education is an important tool to qualify care. However, it presented a negative score in the present study and may show low participation of workers in these spaces. It is also worth noting that permanent education must start from the fragile points of the service, in order to concretize changes in practice and, consequently, to improve the quality of health care.[26]

In this sense, the domain that addresses issues related to errors obtained lower scores, among those evaluated. One of the alternatives to transforming error into learning opportunity and collective growth is to work in teams a non-punitive culture of dialogue to prevent further adverse events from occurring.[3,7] The literature also points out that working a "no-fault" culture

in favor of patient safety has been complex, fear of punishment can cause tensions and difficulties to discuss incidents between those involved.[22]

SP initiatives in the APS are still incipient and limited, professionals perceive culture as negative in most domains. Since the year 2013, in Brazil, discussions on the subject have gained prominence due to the legislation that came into force, but the consolidation of safe care is still far.

The difficulties to recognize patient safety as relevant to professional practice originate from the training in the health area, where the subject is approached in a fragmented way, not sensitizing much of the students. Thus, it is necessary that the theme be based on the curriculum in order to train professionals with exclusive skills to prevent and reduce adverse events related to health care.[22]

It is important to note that during the data collection, some professionals expressed that the topic is relevant to be worked in hospitals, an aspect that highlights the need to address these issues with an emphasis on PHC, considering the amount of care that is performed at this location.

CONCLUSION

From the perspective of professionals from the multiprofessional team working in PHC, the positive scores were in the areas of patient safety and unit management. The lowest averages were related to error domains and working conditions.

Results of this research allow us to infer that due to the lower averages found, the error is still worked in a punitive way, with no possibility to learn and take initiatives to avoid them. As well as the working conditions, which presented weaknesses and need to be rethought, because in order for the care provided to be performed safely, a favorable and safe environment is necessary, both for the professional and for the patient.

There are weaknesses in the patient's safety culture in APS. Therefore, the theme needs to be worked on, and be on the agenda of managers, professionals, and users, in order to recognize the environment as a potential cause of harm to the patient, the importance to be involved in the cause, so that initiatives aimed at consolidating a positive culture can be taken.

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All authors have contributed to the conception and design of the work; in the collection, analysis and interpretation of data; in the writing of the article and in its critical revision; and the final version to be published. All authors agree and are responsible for the contents of this version of the manuscript to be published.

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CONFLICTS OF INTEREST

The authors declare that no have conflicts of interest.

AVAILABILITY OF DATA

Available upon request to the authors

FUDING SOURCE

Does not apply.

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