Journal of Nursing
Revista de Enfermagem
UFPE On Line
ISSN: 1981-8963

ORIGINAL ARTICLE

PERCEPTION OF COMMUNITY HEALTH AGENTS ABOUT PATIENT SAFETY

PERCEPÇÃO DE AGENTES COMUNITÁRIOS DE SAÚDE SOBRE SEGURANÇA DO PACIENTE

PERCEPCIONES DE AGENTES COMUNITARIOS DE SALUD SOBRE LA SEGURIDAD DEL PACIENTE

Luiz Henrique Fernandes Musmanno[1], Ana Lúcia Queiroz Bezerra[2], Maria Aparecida de Souza Melo[3], Thatianny Tanferri de Brito Paranaguá[4], Gabriela Camargo Tobias[5], Cristiane Chagas Teixeira[6]

ABSTRACT

Objective: to analyze the perception of community health agents about patient safety. ***Method:*** This is a qualitative, descriptive, exploratory study with 51 Family Health Strategy teams, involving 169 agents. Data were collected through a questionnaire preceded by workshops, and then submitted to descriptive and thematic analysis. ***Results:*** the following categories were created in the thematic analysis: << Understanding the meaning of patient safety >> and << Co-responsibility for patient safety >>. ***Conclusion:*** it was evidenced that the agents have a limited knowledge about patient safety, but they are able to identify the occurrence of incidents sensitive to primary care, and they represent important actors in the continuity of safe care. Systematic continued education is considered to be the way to be followed by managers to develop a safety culture and improvements in care for users assisted in regional and national health services. ***Descriptors:*** Primary Health Care; Community Health Agents; Patient Safety; Quality of Health Care; Risk Management.

RESUMO

Objetivo: analisar a percepção dos agentes comunitários de saúde sobre segurança do paciente. ***Método:*** trata-se de estudo qualitativo, descritivo, exploratório, com 51 equipes da Estratégia Saúde da Família, envolvendo-se 169 agentes e coletaram-se os dados por meio de questionário, precedida de oficinas. Submeteram-se os dados a técnica de Análise de Conteúdo na modalidade Análise Temática. ***Resultados:*** obtiveram-se da análise temática as categorias: << Compreensão sobre o significado de segurança do paciente >> e << Corresponsabilização pela segurança do paciente >>. ***Conclusão:*** evidenciou-se que os agentes possuem conhecimento limitado sobre segurança do paciente, porém conseguem identificar a ocorrência de incidentes sensíveis à atenção primária, constituindo importantes atores na continuidade de cuidados seguros. Considera-se que a educação permanente sistemática pode ser o caminho a seguir pelos gestores para o desenvolvimento de uma cultura de segurança e de melhorias no cuidado aos usuários atendidos nos serviços de saúde da família regional e nacional. ***Descritores*:** Atenção Primária à Saúde; Agentes Comunitários de Saúde; Segurança do Paciente; Qualidade da Assistência à Saúde; Gestão de Riscos.

RESUMEN

Objetivo: analizar la percepción de los agentes comunitarios de salud sobre seguridad del paciente. ***Método:*** se trata de estudio cualitativo, descriptivo, exploratorio, con 51 equipos de la Estrategia Salud de la Familia, envolviendo 169 agentes y con recolección de datos por medio de un cuestionario, precedida de talleres. Se sometieron al análisis descritivo y temático. ***Resultados:*** las siguientes categorías surgieron del análisis: << Comprensión sobre el significado de seguridad del paciente >> y << Corresponsabilización por la seguridad del paciente >>. ***Conclusión:*** se evidenció que los agentes poseen conocimiento limitado sobre seguridad del paciente, sin embargo consiguen identificar incidentes sensibles a la atención primaria, constituyendo importantes actores en la continuidad de cuidados seguros. Se considera que la educación permanente sistemática puede ser el camino a seguir por los administradores para el desarrollo de una cultura de seguridad y de mejorías en el cuidado a los usuarios atendidos en los servicios de salud de la familia regional y nacional. ***Descriptores*:** Atención Primaria de Salud; Agentes Comunitarios de Salud; Seguridad del Paciente; Calidad de la Atención de Salud; Gestión de Riesgos; Humanización de la Atención.

[1]Master, Professor, School of Medicine of the Pontifical Catholic University of Goiás, Goiânia (GO), Brazil. E-mail: musmanno@gmail.com ORCID iD: https://orcid.org/0000-0003-4837-4864; [2]PhD, Associate Professor, School of Nursing, Federal University of Goiás Goiânia (GO), Brazil. E-mail: analuciaqueiroz@uol.com.br ORCID iD: https://orcid.org/0000-0002-6439-9829; [3]PhD, Associate Professor, State University of Goiás Goiânia (GO), Brazil. E-mail: cida.souza.melo@gmail.com ORCID iD: https://orcid.org/0000-0002-2282-2350; [4]PhD, Adjunct Professor, College of Health Sciences, University of Brasília. Brasília (DF), Brazil. E-mail: ttb.paranagua@gmail.com ORCID iD: https://orcid.org/0000-0003-0562-8975; [5]Master, PhD student in the Graduate Program in Tropical Medicine at the Federal University of Goiás Goiânia (GO), Brazil. E-mail: gabicamargo22@gmail.com ORCID iD: https://orcid.org/0000-0003-0607-4687; [6]Master, PhD student of the School of Nursing, Federal University of Goiás Goiânia (GO), Brazil. E-mail: cc-teixeira@hotmail.com ORCID iD https://orcid.org/0000-0002-4752-0439

INTRODUCTION

Discussions about patient safety in health services are a relevant topic and a world debate, due to its relation with the improvement of work processes and quality of care to the population. It is worth noting that, despite the discussions, human errors still call attention in the media due to the diversity and magnitude of their consequences to professionals, institutions and users of the health system.[1-3]

Emphasis is placed on the occurrence of errors in health care, such as problems in the actions developed by professionals, in the different practice scenarios, including Primary Health Care (PHC), and specifically the Family Health Strategy (FHS) which is considered the gateway for the network of the Unified Health System (SUS)[4]. Improvement of errors has been a focus in the planning of actions that may occur through the adoption of educational techniques, efficient communication of norms and protocols to guarantee the systematization of care to users.[1-4]

There is a shortage of studies developed in PHC contemplating aspects discussed for the systematization of a safe work process that involves FHS teams. In view of the diversity of structures and processes, it is possible to create opportunities for the occurrence of failures; it is necessary to motivate the realization of studies on the theme that will certainly contribute to the qualification of Primary Health Care services.[4]

It is understood that, in the context of the FHS, the work of Community Health Agents (CHAs) involves actions of direct care and transmission of guidelines. This close relationship between health services and the community makes it possible to implement sensitive listening, a way of embracement the proactive insertion in the production of care.[5]

It is seen that CHAs are the professionals of the FHS team who are at the same time part of the team and of the community. It is worth noting the possibility of CHAs establishing a relationship of embracement and bond with the families with which they work and, grounded on this bond, they can make it possible to create a relationship of trust between the community and the health team, which is usually appreciated by the community. This allows the development of their assignments in a more effective and affective way, and awakens to the construction of citizenship.[5-6]

It is understood that the proximity of CHAs to the local reality and the importance of their actions along with the team to plan the health actions justify the importance of qualifying these professionals in the identification of the risks, damages and health needs of the population.[5,7] No studies have been identified that relate patients' safety and quality of care performed by these professionals. This reality justifies the need to investigate the understanding of these important professionals about patient safety, in order to subsidize the direction of educational actions with the population.

OBJECTIVE

- To analyze the perception of community health agents about patient safety.

METHOD

This is a qualitative, descriptive and exploratory study having as scenario the Family Health Strategy of the Northwest Sanitary District of Goiânia, Goiás, Brazil, involving all the 51 teams distributed in 18 Family Health Centers. The population that participated in the research corresponded to 169 CHAs out of a total of 242 CHAs who worked in the FHS. The inclusion criteria were: be working for at least 3 months in one of the FHS teams in the research scenario, thus excluding those who were officially removed from the service, such as those on vacations, on leave; and professionals who did not have availability of time to attend the workshop.

Data were collected through workshops held in December 2013. The researchers went to the Northwest District on a date previously scheduled with the local head office and the CHAs.

The workshops were held in an auditorium of one of the Health Centers with space for all participants. The CHAs were divided according to their availability of schedule, not interfering in their working hours. Four workshops were held with different groups, each lasting two hours. The workshops were conducted by the researcher himself with the assistance of the nurse from the health unit.

Conceptual aspects of patient safety, incidents and risk situations based on the practice in the health units and in the home context were discussed as a programmatic content. Illustrative slides and daily simulations were strategies used. The workshops were designed as a way to offer the Community Health Agents support for them to respond the instrument, recalling in their memory situations in which they identified risks to patient safety in cases assisted at the

health units.

After each workshop, the CHAs were invited to participate in the research. In the moment of the invitation, the objectives were clarified and the participants were invited to sign the Informed Consent Form. A self-administered instrument was used for data collection, consisting of eight closed questions to characterize the participants' profile and 14 open questions to investigate their perception about patient safety and risk situations that occurred during the community service.

In the analysis phase, data were descriptively transcribed and analyzed, presenting absolute and relative frequencies. The responses were categorized through Content Analysis in the Thematic Analysis modality in order to condense the context units to favor understanding.[8]

The results were distributed in tables containing the registration units (words and phrases) that had been more frequently mentioned and that could be grouped according to similarities of sense; and the context units that make up the communication, excerpts from speeches, a story whose frequency of appearance may present a meaning, with the chosen analytical objective. The thematic categories emerged from the content analysis were: "Understanding the meaning of patient safety" and "Co-responsibility for patient safety".

This study was preceded by the approval of the research project by the Research Ethics Committee of the Clinical Hospital of the Federal University of Goiás/UFGO. All ethical precepts recommended by National Health Council CNS/MS Resolution 466/12 that addresses aspects related to research with human beings were observed.[9] Informed Consent Forms were signed by participants and, to ensure anonymity, the reports were identified through a coding of the team.

RESULTS

A total of 169 CHAs were selected, corresponding to 70% of the total population, 46 (20%) were on vacation or on leave and 27 (10%) CHAs did not come to the workshops on their own will.

Women (158; 93.5%), with ages between 29 and 38 years (77; 45.6%), complete secondary education (107; 63.3%) and with a time between 11 and 15 years in the profession (97, 57.4%) were predominant characteristics in the study. It was seen that the majority (119; 70.4%) had been trained to perform their function and reported that they perform between 21 and 40 home visits per week. It was observed that the time acting as a CHA in the assigned area was 1 to 5 years in 43 cases (25.4%) and 5 to 15 years in the case of 60 (35.5%). Regardless of the time of action as a CHA or the period of performance in the assigned area, it was reported by all the 169 CHAs a weekly workload of 40 hours.

In the category "Understanding the meaning of patient safety", the concept is in general limited to damage control, where a large proportion (81; 47.9%) of CHAs associated safety with Standard Operating Procedures (SOPs):

> *Care to prevent accidents and minimize harm to patients (CHA 10); It is the care that the patients should receive, when seeking medical care, without offering risks or damages to their health or their family (CHA 15); Patient Safety is to follow the rules to avoid errors (CHA 18); Prevent that the patient suffers damage (CHA 77).*

Regarding the understanding of the occurrence of incidents, it was noticed that two CHAs confused the term with work accident; however, it was evident that the occurrence of patient safety incidents in the FHS context is a reality and 63 (37.3%) CHAs reported association with the medication, communication, falls and misdiagnoses. The service seems not to be prepared to proactively act in cases of incidents, interfering in the continuity of important programmatic actions:

> *I was responsible for a walking group from my micro area, we did the activity in an improper place, but to keep the group, we would go for a walk once a week. On one particular day, an old woman stumbled and fell. I took the elderly woman to the unit and gave up keeping the group (CHA 31); Patient with the same name, resident of the same neighborhood. One is obese and hypertensive, the other hypertensive and diabetic. In the home visit to the obese patient, we had the medical record of the diabetic patient. I informed the new CHA about this confusion involving the two persons, I told not to confuse again and I informed the physician (CHA 150); On a home visit, I met a lady who was going to medicate a child with the powder of amoxicillin (CHA 24).*

Regarding the aspects that facilitate the occurrence of incidents, it was noticed that 56.8% (96) of the CHAs failed to describe the contributing factors. The reports of other professionals highlighted the lack of professional knowledge, lack of attention to patients, failure in communication, and problems with the structure of the service:

> *Lack of knowledge about risks and responsibility in the lack of structure, adequate place (CHA 31); Lack of training*

(ACS 109); The simple lack of attention and consideration with patients (CHA 18).

It was also highlighted the patient's ability to understand the guidelines and give continuity to the treatment in the correct form and the heavy demand of activities:

Because he is illiterate, he does not have a person who can help him (CHA 57); The patient is elderly and does not understand (CHA 72); The rush and lack of attention (CHA 73).

Regarding the notification of incidents, the importance attributed to this action by the CHAs for the educational purposes and for prevention of new occurrences was evident:

Only in this way it will be possible to undertake measures so that they do not recur in the future (CHA 112); To prevent similar new cases from occurring and also to register them (CHA 143).

However, there was unanimous ignorance about the guidelines of the Sanitary Surveillance Notification System as the official monitoring system for incidents and lack of information regarding the correct flow of the notification:

Work Team and Sanitary District (CHA 9); To the Head Office of the Unit (CHA 14); To the Head Office, the Sanitary District and the Municipal Health Department (CHA 20); The ombudsman's office (CHA 23); To the Municipal Health Department (CHA 133).

In the category "Co-responsibility for patient safety", the CHAs were considered mediators of the health education process, being predominant the appearance of records about the personal commitment of these professionals to pass information/guidelines correctly. This way they contribute to safe care.

Regarding the feeling of safety of CHAs during the home visit, it was noticed that 122 (72%) felt safe and 162 (96%) recognized that the visited users have confidence and credibility in their work and are satisfied with the guidelines received.

The responsibility of CHAs to provide correct guidance to patients is associated with the need for a program of continued qualification, as strongly reported by the participants:

Because my job is to guide the patient and for this we must always seek new knowledge (CHA 27); I try to update myself by studying and acquiring new knowledge (CHA 31); I was trained to provide guidance on prevention and health (CHA 36).

Regarding the doubts presented by users during home visits, it was evidenced that 106 (62.7%) CHAs reported situations involving from issues related to the operation of the unit up to more complex issues such as technical-scientific knowledge:

Regarding the hours of operation of the unit, the diseases that may occur in the family (CHA 145); About examinations and referrals (CHA 149).

In cases when they did not know the answers, 91 (53.8%) CHAs had as main conduct to ask the user for a time to search for information and 72 (42.6%) CHAs went to the team to find out the information:

I take the question to the team, I look for an answer, and then I go back to that family to answer it (CHA 4); I go after the team, if I can't, I look to the district's team supporter or the NASF team (CHA 20); I tell him that I will take the case to the nurse or physician and then return with the answer to his question (CHA 40).

In these reports, the fundamental role of the CHA as a link between the multiprofessional team and the community is clear, involving everyone in the collaboration and contribution in the process of developing patient autonomy for self-care. It is highlighted that as a result of this, 61.5% (104) of the CHAs emphasized the need to develop technical-scientific knowledge to more assertively respond to patients' demands, using a variety of strategies such as support for organizational learning, although they recognize the need for systematizing the process of continued education in the service:

I try to find out with the nurse or physician, and I take the requested information to the patient (CHA 10); Because the information changes a lot and more training was necessary (CHA 71); From my information/knowledge gained throughout life (CHA 3).

In this perspective of co-responsibility for patient safety, it was evident in the reports the need to involve the patients and the families, as well as to find strategies that facilitate the communication process between these actors:

To inform family members to accompany the elderly in the consultations (CHA 51); Taking notes, speaking slowly, even when you are in a hurry (CHA 72); Improving communication, use of the board, scrapbook and meetings (CHA 117).

DISCUSSION

Women (93.5%) were predominant in this study, corroborating the changes that occurred in the last decades, in which a growing insertion of women in the labor market took place, increasing the number of economically active women in relation to a discrete increase of males.[10-13]

It should be noted that the age group of the CHAs was 29 to 38 years, followed by 39 and 48

years, demonstrating the maturation of this population as to emotional coping in the performance of their activities in the community.[14] The requirement established by the Ministry of Health of Brazil on the minimal professional level to work as CHA is limited to complete elementary education. However, the knowledge required and experienced in the course of professional activities within the work process of the CHAs requires a higher level of knowledge due to the complexity and the diversification of situations presented to them in the community.[16]

It was observed in the assigned area that the time of action of the CHAs was an important indicator as reflects the performance and creation of links between these professionals and the local community. It is recommended that recognizing the needs of a given area, identifying problems and bringing solutions to the community, is something that promotes the bonding between community and health units and strengthens the bonds of trust and credibility in the proposals offered by the FHS teams. Moreover, living in the community where they work can be a facilitating aspect for the development of CHAs' actions, especially for the knowledge of culture and language that should be used for communication effectiveness in the context of health practice.[6,17]

It was evident that the meaning of patient safety in the minds of the CHAs showed limitations. It is recognized that there is a need to control damages and follow operating standards, but safety must also be analyzed from the perspective of a continuous process of improvement. It was observed the occurrence of incidents reported by the CHAs that also showed the need to broaden the management's view of these situations and systematize the flow of the registry/notification to support the consolidation of data for decision making.

The lack of standardization of care procedures, the lack of norms and routines can motivate a feeling of lack of safety in the professionals during care provision. This is due to the lack of applicability of the procedures. Such situation shows little organization in the service offered, due to the different ways of conducting the cases.[18-19]

It was observed that 72% of the CHAs displayed confidence about the information and guidelines that are transmitted by them to the community. It was seen that when they eventually feel insecure about some specific question, they seek answers from professionals in their work team. According to the National Policy of Primary Care, continued education should be a pedagogical process that contemplates from the acquisition and updating of knowledge and skills to the learning that arise from the problems and challenges faced in the work process; this process involves practices to be defined by multiple factors.[20-21]

Favoring the process of transfer of knowledge among team members is extremely important for the quality of care and standardization of actions. Promoting learning opportunities to evaluating the results obtained is necessary in order to estimate the relationship between the time invested and the contribution to the improvement and transformation of the processes for the welfare of people in the environment of health practice.[22]

Regarding the main doubts presented by the users during home visits, when the CHAs feel insecure, they seek the health team and advise the families about the use of the available services, according to the attributions of the CHAs established by the National Policy of Primary Care.[5,20]

It was understood that physicians and nurses are the professionals most sought after by the CHAs, since they are directly related to the care and, through the scientific knowledge acquired in their training, can reliably transmit a response to the demands presented. This, in some way, enables closer professional relationships among team members, establishes trust and credibility bonds and strengthens teamwork.[20,22]

It calls attention that patients often present difficulty to understand the information offered, requiring the team's creativity to ensure that when they receive the CHAs in their residence and/or return to their home, they have no doubts as to the use of the medication, schedules, dosage, and other guidance on daily life.[6] it is considered that this reality can be exacerbated because 43% of all CHAs believe they do not have enough technical knowledge to properly guide users. It is highlighted that the justifications range from the lack of skills, short experience as a CHA, lack of communication within the unit or the Health Department, up to the lack of time for individualized study.

It is necessary to systematize the process of continued education in the work environment, as a technical and educational tool in the continuity of training and qualification of these professionals. The linking of the processes of continued education to the strategy of institutional support can enhance the development of management and care competences in Primary Health Care, as they proportionally increase learning through exchanges of experiences and discussion of real

situations, becoming an alternative for coping with difficulties experienced by workers in their daily lives.[20,23]

Legally, the roles of medical and nursing professionals in PHC include the contribution to, carry out, and participate in the ongoing education activities of all team members, as well as to plan, manage and evaluate the actions developed by the CHAs together with the other team members and contribution to the quality of care and patient safety.[2,20,24-26]

It should be emphasized that the commitment to resolve the demands brought by patients and this movement of attachment between patients, CHAs and the team are fundamental for the development of actions that stimulate the relationship of trust, favoring an environment of change promotion, where the main actor must be the patients.[4]

There is a trend to ignore personal preferences about the traditional and paternalistic approach to health care and to promote patient dependence; a shift towards patient-centered care is therefore necessary.[27] In this perspective, it is necessary that patients be engaged in care; patients should be guided to develop autonomy to take control over their health situation, having initiative, solving problems and making decisions. Considering the proximity of CHAs to the community and the health team, these professionals can play a fundamental role in the development of patients' autonomy in relation to self-care.[16,27]

It is known that damage to patients may increase the need for health care. Therefore, it becomes elementary to identify these occurrences as soon as possible, in order to mitigate their effects. The diagnosis about the perception of CHAs in relation to the patient safety can support the preparation of these professionals for a more critical and comprehensive view, which allows to guarantee the safety of care even at the home of the patients, and to increase the resolution of health care.

CONCLUSION

This study evidenced that the CHAs have a limited knowledge about patient safety, but they are able to identify the occurrence of incidents sensitive to primary care, constituting important actors in the continuity of safe care. It was highlighted that the risks to patient safety are not actions isolated from the care provided by health professionals; they rather represent flaws of a whole system that presents weaknesses and gaps. It is observed that the construction of knowledge through continued education can help overcome the weaknesses in the perception of CHAs on the subject of patient safety, in recognizing the health needs of users and anticipating the possible damages and errors to be generated as a result of the assistance.

It is proposed that the monitoring, evaluation of incidents and the systematization of continued education for CHAs in the FHS context may be the path to be taken by managers, to generate information with a view to expanding the qualification of these professionals in order to develop safety culture in the work environment, aiming at improvements in care for users served in the regional and national context of family health.

REFERENCES

1. Rigobello MCG, Carvalho REFL, Cassiani SHB, Galon T, Capucho HC, Deus NN. The climate of patient safety: perception of nursing professionals. Acta Paul Enferm [Internet]. 2012 [cited 2017 Apr 10];25(5):728-35. Available from: http://www.scielo.br/pdf/ape/v25n5/en_13.pdf

2. Verbakel NJ, Bont AA, Verheij TJ, Wagner C, Zwart DL. Improving patient safety culture in general practice: an interview study. Br J Gen Pract [Internet]. 2015 [cited 2017 Apr 13];65(641):822-28. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4655736/

3. Tobias GC, Bezerra ALQ, Paranaguá TTB, Silva AEBC. Safety culture in a teaching hospital: strengths and weaknesses perceived in nurses. J Nurs UFPE on line [Internet]. 2016 [cited 2017 Mar 11];10(3):1063-071. Available from: https://periodicos.ufpe.br/revistas/revistaenfermagem/article/view/11059/12479

4. Marchon SG, Junior WVM. Patient safety in primary health care: a systematic review. Cad Saúde Pública [Internet]. 2014 [cited 2017 Apr 12];30(9):1815-835. Available from: http://www.scielo.br/pdf/csp/v30n9/0102-311X-csp-30-9-1815.pdf

5. Jesus AS, Santos FPA, Rodrigues VP, Nery AA, Machado JC, Couto TA. Atuação do agente comunitário de saúde: conhecimento de usuários. Rev enferm UERJ [Internet]. 2014 [cited 2017 Apr 11];22(2):239-44. Available from: http://www.facenf.uerj.br/v22n2/v22n2a15.pdf

6. Machado LM, Mattos KM, Colomé JS, Freitas NQ, Sangoi TP. Family health strategy: the perception of community health agents concerning their work. Cienc Cuid Saude [Internet]. 2015 [cited 2017 Apr 12];14(2):1105-112. Available from:

http://periodicos.uem.br/ojs/index.php/CiencCuidSaude/article/view/22612/pdf_361

7. Kebian LVA, Acioli S. A visita domiciliar de enfermeiros e agentes comunitários de saúde da Estratégia Saúde da Família. Rev Eletr Enf [Internet]. 2014 [cited 2017 Apr 10];16(1):161-69. Available from: https://www.fen.ufg.br/fen_revista/v16/n1/pdf/v16n1a19.pdf

8. Bardin L. Análise de conteúdo. 4ª ed. Lisboa, Portugal: Edições 70; 2010.

9. Ministério da Saúde (BR). Resolução nº 466, de 12 de dezembro de 2012. Aprova as diretrizes e normas regulamentadoras de pesquisas envolvendo seres humanos [Internet]. Brasília: Ministério da Saúde; 2012 [cited 2017 Mar 26]. Available from: http://bvsms.saude.gov.br/bvs/saudelegis/cns/2013/res0466_12_12_2012.html

10. Médici AC. Mulher brasileira: muito prazer. In: Mulher, Saúde e Sociedade no Brasil, Petrópolis: Vozes. Rio de Janeiro: Abrasco; 1989.

11. Palmezoni VP, Miranda FJS. A identificação da violência intrafamiliar contra crianças e adolescentes pelos ACS. Saúde Coletiva [Internet]. 2011 [cited 2017 Apr 11];08(49):88-92. Available from: https://www.researchgate.net/publication/237040938_A_identificacao_da_violencia_intrafamiliar_contra_criancas_e_adolescentes_pelo_agente_comunitario_de_saude

12. Oliveira DT, Ferreira PJO, Mendonca LBA, Oliveira HS. Percepções do agente comunitário de saúde sobre sua atuação na estratégia saúde da família. Cogitare Enferm [Internet]. 2012 [cited 2017 Mar 13];17(1):132-37. Available from: https://revistas.ufpr.br/cogitare/article/view/26386/17580

13. Baptistini RA, Figueiredo TAM. Agente comunitário de saúde: desafios do trabalho na zona rural. Ambiente e Sociedade [Internet]. 2014 [cited 2017 Apr 10];17(2):53-70. Available from: http://www.scielo.br/pdf/asoc/v17n2/a05v17n2.pdf

14. Ferraz L, Aerts DRGC. O cotidiano do trabalho do agente comunitário de saúde no PSF em Porto Alegre. Ciênc Saúde Coletiva [Internet]. 2005 [cited 2017 Mar 12];10(2):347-55. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1413-81232005000200012&lng=pt&nrm=iso&tlng=pt

15. Ministério da Saúde (BR). Portaria nº 2.488 de 21 de outubro de 2011. Aprova a Política Nacional de Atenção Básica, estabelecendo a revisão de diretrizes e normas para a organização da Atenção Básica, para a Estratégia Saúde da Família (ESF) e o Programa de Agentes Comunitários de Saúde (PACS) [Internet]. Brasília: Ministério da Saúde; 2011 [cited 2017 Mar 28]. Available from: http://bvsms.saude.gov.br/bvs/saudelegis/gm/2011/prt2488_21_10_2011.html

16. Mendonça MHM. Profissionalização e regulação da atividade do agente comunitário de saúde no contexto da reforma sanitária. Trab Educ Saúde [Internet]. 2004 [cited 2017 Apr 11];2(2):353-65. Available from: http://www.scielo.br/pdf/tes/v2n2/09.pdf

17. Fontoura MD, Almeida AP, Marques CMS, Prado MM, Portilho JAC. Dilemas bioéticos no cotidiano do trabalho do Agente Comunitário de Saúde. Rev Saúde Dist Fed [Internet]. 2004 [cited 2017 Mar 13];15(3):66-77. Available from: http://bases.bireme.br/cgi-bin/wxislind.exe/iah/online/?IsisScript=iah/iah.xis&src=google&base=LILACS&lang=p&nextAction=lnk&exprSearch=420733&indexSearch=ID

18. Guerrero GP, Beccaria LM, Trevisan MA. Standard operating procedure: use in nursing care in hospital services. Rev Latino-Am Enfermagem [Internet]. 2008 [cited 2017 Apr 13];16(6):966-72. Available from: http://www.scielo.br/pdf/rlae/v16n6/05.pdf

19. Capucho HC, Cassiani SHB. The need to establish a national patient safety program in Brazil. Rev Saúde Pública [Internet]. 2013 [cited 2017 Mar 10];47(4):1-8. Available from: http://www.scielo.br/pdf/rsp/v47n4/en_0034-8910-rsp-47-04-0791.pdf

20. Ministério da Saúde (BR). Secretaria de Atenção à Saúde. Departamento de Atenção Básica. Política Nacional de Atenção Básica [Internet]. Brasília: Ministério da Saúde; 2012 [cited 2017 Mar 28]. Available from: http://189.28.128.100/dab/docs/publicacoes/geral/pnab.pdf

21. Peixoto LS, Gonçalves LC, Costa TD, Tavares T, Melo CM, Cavalcanti ACD, et al. Educación permanente, continuada y de servicio: desvelando sus conceptos. Enfermería Global [Internet]. 2013 [cited 2017 Apr 10];12(29):307-22. Available from: http://scielo.isciii.es/scielo.php?script=sci_arttext&pid=S1695-61412013000100017

22. Paranaguá TTB, Bezerra ALQ, Tobias GC, Ciosak SI. Support for learning in the perspective of patient safety in primary health care. Rev Latino-Am Enfermagem [Internet]. 2016 [cited 2017 Mar 13];24:e2771. Avaliable from: http://www.scielo.br/pdf/rlae/v24/pt_0104-1169-rlae-24-02771.pdf

23. Bomfim ES, Araújo IB, Oliveira BG, Moreira RM, Rocha RM, Boery RNRSO. Continuing health

education: discussion of educational practices in the family health strategy. J Nurs UFPE on line [Internet]. 2016 [cited 2017 Apr 13];10(8):2833-337. Available from: https://periodicos.ufpe.br/revistas/revistaenfermagem/article/viewFile/11350/13067

24. Carson-Stevens A, Hibbert P, Williams H, Evans HP, Cooper A, Rees P, et al. Characterising the nature of primary care patient safety incident reports in the England and Wales National Reporting and Learning System: a mixed-methods agenda-setting study for general practice. Health Serv Res [Internet]. 2016 [cited 2017 Mar 13];4(27):1-108. Available from: https://www.ncbi.nlm.nih.gov/books/NBK385186/

25. Durgun H, Kaya H. The attitudes of emergency department nurses towards patient safety. Int Emerg Nurs [Internet]. 2017 [cited 2017 Mar 13];1(16):30113-116. Available from: https://www.ncbi.nlm.nih.gov/pubmed/29174645

26. Boamah SA, Spence Laschinger HK, Wong C, Clarke S. Effect of transformational leadership on job satisfaction and patient safety outcomes. Nurs Outlook [Internet]. 2018 [cited 2017 Mar 13];66(2):180-89. Available from: https://www.ncbi.nlm.nih.gov/pubmed/29174629

27. European Network on Patient Empowerment (ENOPE). Editorial: patient empowerment - Who empowers whom? The Lancet [Internet]. 2012 [cited 2018 Mar 06];379(9827):1677. Available from: https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(12)60699-0.pdf

Submission: 2018/03/01
Accepted: 2018/08/17
Publishing: 2018/11/01

Corresponding Address

Gabriela Camargo Tobias
Instituto de Patologia Tropical e Saúde Pública - IPTSP
Universidade Federal de Goiás/UFG
Rua 235 - s/n - Setor Universitário
CEP: 74605-450 – Goiânia (GO), Brazil