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Violence against nursing workers: repercussions on patient access and safety

Violência contra o trabalhador de enfermagem: repercussões no acesso e segurança do paciente

Violencia contra trabajadores de enfermería: repercusiones en el acceso y seguridad de los pacientes

Grasiele Fatima Busnello[I]
ORCID: 0000-0002-2027-0089

Letícia de Lima Trindade[I]
ORCID: 0000-0002-7119-0230

Daiane Dal Pai[II]
ORCID: 0000-0002-6761-0415

Carmem Lúcia Colomé Beck[III]
ORCID: 0000-0001-9060-1923

Olga Maria Pimenta Lopes Ribeiro[IV]
ORCID: 0000-0001-9982-9537

Elisabete Maria das Neves Borges[IV]
ORCID: 0000-0002-6478-1008

Maiara Daís Schoeninger[I]
ORCID: 0000-0002-0095-1485

[I]*Universidade Comunitária da Região de Chapecó. Chapecó, Santa Catarina, Brazil.*
[II]*Universidade Federal do Rio Grande do Sul. Porto Alegre, Rio Grande do Sul, Brazil.*
[III]*Universidade Federal de Santa Maria. Santa Maria, Rio Grande do Sul, Brazil.*
[IV]*Universidade de Porto. Porto, Portugal.*

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Corresponding author:
Grasiele Fatima Busnello
E-mail: grasibusnello@gmail.com

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ABSTRACT

Objectives: to analyze the repercussions of violence against nursing professionals, in the access and safety of patients in Family Health Strategy. **Methods:** a mixed study, with 169 nursing professionals. We used a socio-labor questionnaire, Survey Questionnaire Workplace Violence in the Health Sector, a patient safety instrument and interviews. **Results:** verbal aggression was related to support (p=0.048), respect (p=0.021), hours of care (p=0.047) and patient safety behaviors (p=0.033) among professionals. Suffering from bullying was related to fear of questioning when something is wrong (p=0.010) and lack of support from management (p=0.016). Victims of physical violence felt that their mistakes could be used against them. Mixed data converge and confirm that violence affects professional behavior and puts Primary Health Care attributes at risk. **Conclusions:** violence affects workers' behavior, interferes with the care provided, weakens the access and safety of patients.
Descriptors: Workplace Violence; Health Services Accessibility; Patient Safety; Nursing; Primary Health Care.

RESUMO

Objetivos: analisar as repercussões da violência contra o profissional de enfermagem no acesso e na segurança dos pacientes da Estratégia Saúde da Família. **Métodos:** estudo misto, com 169 profissionais de enfermagem. Utilizamos questionário sociolaboral, *Survey Questionnaire Workplace Violence in the Health Sector*, instrumento de segurança do paciente e entrevistas. **Resultados:** agressão verbal teve relação entre apoio (p=0,048), respeito (p=0,021), horas de cuidado (p=0,047) e condutas de segurança do paciente (p=0,033) entre os profissionais. Sofrer assédio moral relacionou-se ao medo de questionar quando algo está incorreto (p=0,010) e à falta de apoio da gestão (p=0,016). Vítimas de violência física consideraram que seus erros podem ser usados contra elas. Os dados mistos convergem e confirmam que a violência repercute nas condutas profissionais e coloca em risco atributos da Atenção Primária à Saúde. **Conclusões**: a violência repercute no comportamento do trabalhador, interfere no cuidado realizado, fragiliza o acesso e a segurança dos pacientes.
Descritores: Violência no Trabalho; Acesso a Serviços de Saúde; Segurança do Paciente; Enfermagem; Atenção Primária à Saúde.

REUMEN

Objetivos: analizar las repercusiones de la violencia contra el profesional de enfermería en el acceso y seguridad de los pacientes en la Estrategia Salud de la Familia. **Métodos:** estudio mixto, con 169 profesionales de enfermería. Se utilizó un cuestionario sociolaboral, *Survey Questionnaire Workplace Violence in the Health Sector*, instrumento de seguridad del paciente y entrevistas. **Resultados:** la agresión verbal se relacionó con conductas de apoyo (p=0,048), respeto (p=0,021), horas de atención (p=0,047) y seguridad del paciente (p=0,033) entre los profesionales. Sufrir bullying se relacionó con el miedo a ser cuestionado cuando algo anda mal (p=0,010) y la falta de apoyo por parte de la dirección (p=0,016). Las víctimas de violencia física sintieron que sus errores podrían usarse en su contra. Datos mixtos convergen y confirman que la violencia afecta el comportamiento profesional y pone en riesgo atributos de la Atención Primaria de Salud. **Conclusiones:** la violencia afecta el comportamiento del trabajador, interfiere en la atención brindada, debilita el acceso y la seguridad de los pacientes.
Descriptores: Violencia Laboral; Accesibilidad a los Servicios de Salud; Seguridad del Paciente; Enfermería; Atención Primaria de Salud.

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INTRODUCTION

Studies confirm that Primary Health Care (PHC) contributes significantly to increasing users' access to health services, as well as to achieving positive results in health indicators[1-4].

Safer PHC is central to the United Nations Sustainable Development Goals, particularly those related to ensuring healthy lives and promoting well-being for all at all ages[5].

In Brazil, this level of care is considered the originator of the Unified Health System (SUS - *Sistema Único de Saúde*) services, with Family Health Strategy (FHS) being fundamental in the performance of actions to effectuate access to users, with actions in the scope of health promotion, treatment, rehabilitation and harm reduction[1,3,6].

The Family Health team (FHt) has nursing professionals as indispensable members of the multidisciplinary team, working throughout the territory covered by FHS[1], in health units, as well as in open environments, in community spaces and in the users' own homes, which potentially exposes these professionals to violence[7-8]. In this sense, the conditions under which workers carry out their work stand out, with interfaces in quality of access to health services.

According to the International Labor Organization (ILO), violence in the work environment is any incidental action or behavior by a person against another that leads to aggression, offense, harm or humiliation in their work or as a consequence[8-9].

In this context, nursing professionals are highly exposed to the risk of suffering violence[7-8], since they are the first to contact service users[7], perform reception, care, clinical care and often manage teams in PHC.

Repercussion of violence on nursing workers' health in PHC have been recorded in national[7,10] and international studies[8-9]. However, most investigations are focused on the hospital context, and PHC research has gained more visibility in recent years[11-12]. Still, in this scenario, there are few studies that deal with the relationship between violence against nursing workers, access and safety in user care.

Thus, the question was: what are the repercussions of violence against nursing professionals on FHS user access and safety?

Thus, the research took access to health as an element of quality of the services offered, with interfaces in professional competence, in the promotion of a patient safety culture, in the effective offer/use of resources, in user satisfaction and in favorable results for the population[2-4]. On the other hand, patient safety was anchored in the complexity of clinical and care practice, whose praxis is based on the consequences that affect the health and well-being of individuals who receive health care[13]. In this direction, it is understood that nursing professionals are directly involved in patient access and safety[13].

OBJECTIVES

To analyze the repercussions of violence against nursing professionals on FHS patient access and safety.

METHODS

Ethical aspects

The study development complied with all ethical standards in research involving human subjects. All participants signed the Informed Consent Form.

Study design, period and place

This is an explanatory sequential mixed study[14], guided by the STROBE, carried out in 53 FHt in a municipality in southern Brazil, from September 2018 to March 2019.

Population and sample; inclusion and exclusion criteria

In the quantitative stage (QUAN) of the study, the following inclusion criteria were used for the participants: having training in the area of nursing and having been working at FHS for at least 12 months. Workers on leave for any reason during the data collection period were excluded. To define the sample, a sample calculation was performed by category, considering 95% confidence and 5% error. The population of workers in the scenario studied consisted of 53 nurses and 159 nursing technicians/assistants and all who met the criteria agreed to participate in the study, with those who were not included those who were on leave for some reason during the data collection period.

In the qualitative (QUAL) stage, workers who participated in the previous stage were invited, being intentionally selected. Participants were 18 nursing workers who made themselves available, considering their availability to participate in a semi-structured interview, including 18 workers. Of these, ten responded that they had suffered different types of violence, and eight, workers who had not suffered violence, seeking more perspectives on the phenomenon. Thus, the study sample consisted of 169 nursing professionals, 47 nurses and 122 nursing technicians/assistants. The number of participants in this stage could not reach 20% of this category, given the discomfort in remembering situations of violence, opting for the criterion of data saturation to define the participants of this stage.

Study protocol

The QUAN stage participants answered a questionnaire to survey socio-occupational characteristics (sex, skin color, number of children, marital status, years of experience in nursing, working hours, satisfaction, recognition and concern about violence in the workplace), the Survey Questionnaire Workplace Violence in the Health Sector[15], translated and adapted into Portuguese[16], which measures the occurrence of physical violence (with 18 questions) and psychological (with 13 questions) in the last 12 months, covering characteristics of the victim, aggression and offender, as well as three questions about institutional measures to control violence. Psychological violence is subdivided into verbal aggression, moral harassment, sexual harassment and racial discrimination, considering characteristics of the victim, aggression and offender, as well as institutional measures to control violence. A questionnaire on patient safety was used, validated and translated into Brazilian Portuguese[17], adapted for the PHC scenario, which includes questions about patient safety, errors associated with care and reporting of events during care, assessed using a five-point Likert scale (strongly disagree, disagree, neither agree nor disagree, agree and strongly agree).

In the QUAL stage, two interviews were used to understand the origin and situations in which workplace violence occurred,

adapted for those who suffered and for those who did not suffer workplace violence. The semi-structured instrument had eight open-ended questions that allowed reporting episodes of workplace violence, conduct in the face of events, repercussions on the way of attending, teamwork, communication, protective measures and how the phenomenon was managed in the work context. They were carried out in a private environment, audio-recorded and transcribed.

Also at this stage, non-participant observation was carried out in 14 Family Health Units (FHUs), intentionally chosen, seeking representation of the different territories of the municipality. A total of 56 hours of observation were carried out, recorded in a field diary. Observations took place during the two shifts of care, observing situations of violence, the flow of care, waiting periods, different procedures performed, the division of tasks, meetings and work organization strategies.

Analysis of results and statistics

QUAN data were tabulated and analyzed using the Statistical Package for the Social Sciences, version 21.0. Descriptive variables were presented in the form of mean, standard deviation, medians and interquartile ranges, relative and absolute frequencies. After the Shapiro-Wilk normality test, the Mann-Whitney was used to analyze differences between medians in the groups. For the statistical analysis, a significance level of $p \leq 0.05$ was adopted.

QUAL findings were subjected to thematic analysis[18], gathered in the thematic category "Relationship between violence against nursing professionals and the repercussions on patient access and safety", and its three subcategories.

The speech excerpts were coded as: nurse (N), nursing technician/nursing assistant (NTA), followed by the serial number of the interviews. Field diary entries were identified by the initials (FD).

RESULTS

The study had a representative sample of 169 nursing workers who worked at PHC, being 47 nurses (27.8%) and 122 technicians or nursing assistants (72.2%). Of these, most were female (93.5%), white (91.1%), married or living with a partner (70.4%), had, on average, one child (±1.1) and had a mean age of 41.1 years (± 8.8). Participants had, on average, 15.4 years of study (± 2.8), 14 years (± 8.6) of work in the health area, five years (± 6.7) of work at FHS, in which worked 40 hours a week and, mostly, 94.1% had physical contact with users.

The study revealed that 83.4% (n=141) of nursing workers reported having suffered violence in the last year, and in total, 221 episodes of violence were identified. Verbal aggression (75.7%) was the most prevalent type of violence, followed by bullying (39.1%), sexual harassment (8.9%), racial discrimination (4.1%) and physical violence (3.0%).

Users were the main offenders of violence against FHS nursing workers (71.4%). Leadership (20.8%) was also found to be the offender of violence, followed by co-workers (7.8%).

The study related situations of violence (physical, verbal, bullying/intimidation and sexual harassment) against nursing workers with the safety of patients assisted in PHC, as shown in Table 1.

The QUAL stage provided more information on the "Repercussions of violence on patient access and safety", and the macrocategory consists of three subcategories of analysis: "Modification of workers' behavior in care"; "Repercussions of violence against nursing workers on users' access to Primary Health Care services"; and "Interferences of these events in comprehensive care for Family Health Strategy users".

The first subcategory gathers reports from nursing workers about how their behavior has changed after suffering aggressions in their workplaces, directly interfering with emotions, creating barriers to patient care, caused by suffering and emotional exhaustion, as well as interfering with the quality of the procedures performed.

> *So, you lose some of that focus that you need, because I thought, I'm going to have to go back to the vaccine room, I'm going to have to pay attention, it's a child, it's a vaccine, there are four vaccines, many times, you have to take a deep breath.* (NTA09)

> *Often, that simplicity of opening the office door and smiling at the patients, these little details, we end up blocking.* (N04)

Table 1 - Significant association between nursing workers, patient safety and occurrence of different types of violence, Chapecó, Santa Catarina, Brazil, 2020 (n=169)

	Suffered violence	n (%)	Mean (SD)	Median	*p**
Physical violence Patient safety dimensions					
Professionals consider that their mistakes, mistakes or failures can be used against them.	Yes	5 (2.95)	4.00 (+0.00)	4.00	0.037
	No	164 (97.05)	3.78 (+0.40)	4.00	
It is just by chance, mistakes, mistakes or more serious failures do not happen around here.	Yes	5 (2.95)	2.00 (+0.00)	2.00	0.017
	No	164 (97.05)	2.22 (+0.39)	2.00	
Verbal aggression Patient safety dimensions					
People support each other.	Yes	128 (75.74)	3.80 (+0.36)	4.00	0.048
	No	41 (24.26)	3.95 (+0.14)	4.00	
People treat each other with respect.	Yes	128 (75.74)	3.75 (+0.43)	4.00	0.021
	No	41 (24.26)	3.98 (+0.10)	4.00	
Professionals work longer hours than would be best for patient care.	Yes	128 (75.74)	2.43 (+0.67)	2.00	0.047
	No	41 (24.26)	2.15 (+0.26)	2.00	

To be continued

Table 1 (concluded)

	Suffered violence	n (%)	Mean (SD)	Median	*p**
We have patient safety issues.	Yes	128 (75.74)	3.13 (+0.92)	4.00	0.033
	No	41 (24.26)	2.76 (+0.89)	2.00	
Professionals receive information about changes implemented from event reports.	Yes	128 (75.74)	4.27 (+0.69)	4.00	0.005
	No	41 (24.26)	4.66 (+0.48)	5.00	
Professionals are free to say something they see and can negatively affect patient care.	Yes	128 (75.74)	4.21 (+0.65)	4.00	0.040
	No	41 (24.26)	4.66 (+0.65)	5.00	
Professionals are informed about the errors that happen in the unit.	Yes	128 (75.74)	3.90 (+0.65)	4.00	0.003
	No	41 (24.26)	4.37 (+0.68)	5.00	
Professionals feel comfortable questioning the decisions or actions of their superiors.	Yes	128 (75.74)	3.64 (+0.77)	4.00	0.005
	No	41 (24.26)	4.12 (+0.69)	4.00	
Bullying/intimidation					
Patient safety dimensions					
Professionals work longer hours than would be best for patient care.	Yes	66 (39.05)	2.18 (+0.37)	2.00	0.014
	No	103 (60.95)	2.48 (+0.69)	2.00	
We used more temporary/outsourced professionals than would be desirable for patient care.	Yes	66 (39.05)	2.00 (+0.03)	2.00	0.037
	No	103 (60.95)	2.15 (+0.27)	2.00	
Professionals are afraid to ask when something seems not right.	Yes	66 (39.05)	2.95 (+0.50)	3.00	0.010
	No	103 (60.95)	2.52 (+0.96)	3.00	
The unit management only seems interested in patient safety when an adverse event occurs.	Yes	66 (39.05)	2.86 (+0.42)	3.00	0.016
	No	103 (60.95)	2.65 (+0.54)	3.00	
Sexual harassment					
Patient safety dimensions					
Professionals work in a crisis situation trying to do the tasks quickly.	Yes	15 (8.87)	2.33 (+0.53)	2.00	0.007
	No	154 (91.13)	2.99 (+0.82)	3.00	

*SD - standard deviation; *Mann-Whitney test.*
Note: Although the normality test showed a non-parametric distribution and, therefore, the Mann-Whitney test was used, it was decided to also keep the presentation of means and standard deviation in the table in order to facilitate the interpretation of the findings.

> *The conducts* [...] *we become more closed off, we have less empathy for the other, we no longer put ourselves in the other's shoes, we put a barrier between patient and professional, and a very big barrier, and this mischaracterizes everything that is the work of nursing* [...] *from the moment I'm putting up several barriers and I don't take care of patients, I can't look at them as a whole. So, I think it harms my job and modifies me as a professional, for sure.* (N02)

Regarding the subcategory "Repercussion of violence against nursing workers on users' access to Primary Health Care health services", workers reported restriction or limitation of care provided to aggressor users, as illustrated by the statements:

> *The patient who assaulted us, when he entered the unit, everyone ran from him. Then, when he entered, everyone was afraid to answer, afraid that he would commit another aggression.* (N10)

> *There was an employee who came to tell me that she will no longer visit a particular patient, will no longer attend, nor visit him, because she was assaulted, felt humiliated* [...]. (N13)

In the subcategory "Interference of these events in comprehensive care for Family Health Strategy users", the episodes that generate disorders in the care have repercussions on the need for other professionals in the care for aggressor users, as a criterion for safety and coping with violence. This causes delay in the care of other users and even less availability of time for teams to perform care activities. Participants revealed that the lack of professionals working at FHS and the presence of user aggressors in the work environment can weaken comprehensive care, as the reports below illustrate:

> *There are professionals who no longer want to attend and do not attend. They turn their backs and leave it to another colleague to answer, because, normally, they remember the user who attacked them. They are afraid of being attacked again, or they work with another colleague together in the room, they work in pairs.* (NTA14)

> *We try not to answer. The service is fast, only what the patient really needs* [...]. (NTA09)

> *During observation at the FHU, it was noticed that a nurse who had suffered violence asked another colleague from the nursing team to accompany her to the office, to care for an aggressor patient. Both assisted the patient with the office door open.* (FD)

It is observed that, when episodes of violence occur, professionals provide care more quickly, because they feel pressured by users, often making comprehensive care difficult (FD).

> *When we realize that the user who entered the unit is used to attacking professionals, we communicate, and the professional who attends speeds up the service to release him* [user] [...] *sometimes, there is not even time to ask many questions or to listen to him, to prevent him from staying in the unit for a long time and being able to attack professionals.* (NTA06)

DISCUSSION

It was evidenced that the highest prevalence of nursing workers exposed to violence in PHC was women, young people and with less professional experience. A study carried out in the hospital setting differs on the most exposed professional category, but it coincides

with the findings of this study with regard to the time of work, gender and the higher prevalence among young workers[19]. In research carried out at the FHU, victims of violence were also younger workers in the nursing field. Moreover, violence was associated with a worse evaluation of relationships at work with colleagues and bosses[20].

Regarding offenders, most were related to users, demonstrating proximity to other investigations[7,19-20].

The results of the analysis of violence in the context of nursing work that works at FHS revealed that 83.4% of workers were victims of violence in the last year, in 221 episodes of aggression, which corroborates the results of other studies[8-12]. The prevalence of verbal psychological aggression found in this investigation was similar to other studies[8,19-21].

In FHS, the nursing work process is directly related to patients, as these professionals are the first to contact those who seek care in PHC, promoting care for the most diverse health needs on a daily basis. However, users in pain or seriously ill also manifest verbal abuse, intimidation or other types of violence. It is also considered that distrust and lack of effective communication with workers can contribute to violence[22]. In a study carried out in the reception sector of a regional hospital in the state of Rio Grande do Norte, it was confirmed that nursing professionals predominantly suffer verbal violence from users and other professionals[19]. Regarding users, the lack of information on where to look for the appropriate care for their problem in health services was identified as one of the main causes[23].

Nursing workers are prepared for care[7]; however, some situations can change the way workers develop their work activities. For instance, situations of violence stand out, which interfere with workers' quality of life, health and safety, impacting on the care provided to patients[24].

In line with the literature and considering the findings of this study, it was noticed that problems with patient safety can also occur in the PHC setting. When associated with patient safety and the occurrence of different types of violence, significant differences are evidenced in psychological and physical violence. It was observed that workers who suffered physical violence considered that errors, mistakes or failures during their care, although they occasionally occur, can be used against them, and this encourages the failure to notify the error. International guidelines reinforce that, on average, one in ten patients suffers an adverse event while receiving hospital care in developed countries[5], a potentially serious aspect in Brazil.

Workers mentioned that there was a lack of support and, in order to promote better patient care, there was a need to work beyond the contractual workload. It is reinforced that the lack of support and support in professional relationships, as well as disrespect, significantly affect, which can compromise the quality of care provided[4], with the potential occurrence of errors in patient care[10].

Work overload is considered the main cause of incidents that result in errors caused by nursing workers[24], significantly influencing the quality of care provided to users[24-25]. In this direction, flaws in personnel dimensioning cause work overload and deficiency in the pace of work, also impacting on the reduction of the frequency with which incidents are reported[20].

Studies reveal that the types of incidents in the context of patient safety that occur most frequently in PHC are associated with errors in medication administration and patient diagnosis, with communication failures between members of the health team as contributing factors[12,24]. Communication failures between workers and patients were also related to low adherence to treatment and the exchange of wrong or mistaken information, lack of integration between team professionals and other sectors of the Health Care Network[26].

It is essential, in the PHC work routine, that workers are co-responsible for recognizing errors and other incidents, planning strategies that solve them, so that they participate in all stages of the work process and feel part of it[13]. Moreover, the way errors are handled can also be a differential to qualify patient safety measures[12].

International guidelines reinforce that the cause of error does not potentially depend on just one individual, but rather on a complex network of actions, interactions, processes, relationships between the team, communication, human behavior, available technology, organizational culture, rules and policies, as well as the operating environment[5].

Although users, in most care at this level of care, have contact with nursing workers, with violence permeating the teams' daily lives, sometimes care is provided faster, less empathically, redirected to another team worker, requiring one more professional to perform care or even being denied. Thus, it can be inferred that workers, after exposure to violence, start to establish barriers in accessing users[24] and have difficulties in complying with some of the PHC attributes, such as continuity and coordination of comprehensive care for users, as well as imposing barriers to their access. It is added that each worker is unique and experiences situations of violence in their own way, depending on their life path and their skills to handle complex situations. In this sense, the repercussions of violence in the workplace are different among professionals and, although they can trigger consequences for the entire team, they are experienced in different intensity[20,27]. Therefore, the Brazilian National Primary Care Policy (*Política Nacional de Atenção Básica*) recommends that FHS should guarantee coordination of care, expanding access and resolution to users of this service[1-3].

An investigation carried out in two hospital institutions, with 282 nursing workers, is similar to this study in that workers consider that their incidents can be used against them[27]. The researchers refer that this situation also indicates the perspective of underreporting of incidents by nursing workers, due to fear and insecurity of suffering penalties in their work environments. However, notifications of these events need to be encouraged, so that they are investigated and promote learning with a view to preventing future incidents[12,20].

In PHC, teamwork must be planned and prioritized, bringing together knowledge to solve the population's demands, making all workers co-responsible for care strategies. Thus, health demands will not be directed only to some workers, causing overload, but will be shared with the entire team[13].

Nursing workers should be encouraged to practice patient safety in PHC, as well as its constant improvement so that they can produce safe health care and increase the reliability and effectiveness of the care offered to patients[13]. Patient safety is an important dimension of the quality of health services, which directly influences mortality rates, which points to financial, social and psychological impacts[27].

Restricting workers' access to how the phenomenon of violence occurred or how it was conducted reveals flaws in the communication process between nursing workers and management. Communication failures can result in insecurity in patient care, causing incidents. In this sense, management support to workers must also provide intersectoral actions to promote a culture of peace, respect and tolerance, through the fight against violence and the formation of conflicts. The culture of peace, when established in services, encourages and stimulates communication, dialogue, education and citizenship construction[28].

Also, in another investigation, nursing workers who are victims of sexual harassment change their attitude towards users[7]. In this situation, a positive aspect regarding the safety of the care provided is perceived, but an aggravating factor for workers' health.

Disagreements against superiors are often interpreted as guilt or imminent confrontation with superiors, which can lead to problems in interpersonal relationships, so that most workers tend to avoid them[27].

Nurses, as they occupy central positions in coordination of care in PHC, understand that they are mostly responsible for ensuring safe care in health services, as well as supporters of the nursing team and other professionals, developing strategies and practices in order to solve or minimize problems identified in work processes[13].

The practice of patient safety in PHC has been measured as a challenge, in such a way that solutions have been proposed, such as the incorporation of patients and families in a strategic planning of safety promotion and assessment of these aspects, implementation of information technologies for care assistance, use of electronic medical records, monitoring bulletins, interpersonal relationships and continuing education, as well as encouraging the use of soft technologies, such as reception, bonding and accountability. From this perspective, the exchange of information and knowledge between FHS workers, holding meetings for debate and reflection on the work process and clinical cases, training workers and encouraging improvements in the management of primary care units are considered essential[11-26].

In Brazil, FHS aims to guide families' care practice, contributing to the population's access to health services without restrictions, with comprehensiveness and fullness of individual and collective actions, in addition to continuity and coordination of care[1]. Due to its close contact with the population, nursing plays an important role in this context, providing greater understanding of needs and providing better quality of care to individuals[7].

In this direction, a Latin American study[29] points to universal health coverage as a strengthening focus for health care delivery systems, aiming at promoting access to care and improving populations' health outcomes. It highlights nursing care as a foundation to meet health priorities, as well as the introduction of advanced practices to improve the outcomes of this workforce and promote PHC to users of these services[29].

In research carried out at the FHS of a municipality in southern Brazil, it was observed that, in order to guarantee access to users, it is essential to welcome and recognize the main demands. The FHS implementation expanded users' access to the services offered by PHC, which promote integrated and humanized actions, reflecting greater safety in patient care[12]. However, in a context of violence, nursing professionals expressed insecurity, fear and suffering, which can influence their psychic health and the quality of their care, especially as they seek to avoid contact with offenders, sometimes changing the way they care for. These changes potentially impose barriers to access and continuity of care, interfering with coordination of comprehensive care for aggressor users. Still, as a consequence of this routine, the nursing team is more likely to develop unsafe care, permeated by incidents or injuries that can interfere with patient safety.

Study limitations

As a limitation of this study, it is considered that aspects of violence may not have been revealed in its total occurrence, considering the naturalization bias among nursing workers and because it is veiled in the context of this scenario. There is still a possible memory bias of the participants reflected by the research instrument, in which the situations of the phenomenon are measured in the last 12 months.

Contributions to workers' health and collective health

The findings of this study contribute to the advancement of knowledge in the workers' health area, since they show exposure of nursing to violence in PHC, presenting unique aspects that can help in the primary prevention of violence and favor a culture of peace. Still, aspects for the management scope that can support developing instruments to monitor repercussions of violence on workers' health, but also on patient safety, potentially, to define conducts for each type of violence, stand out.

CONCLUSIONS

It is concluded that violence affects nursing professionals' behavior, precarious interpersonal relationships and changes individual behavior in the face of error, which weakens access and patient safety. As a result, professionals are more likely to avoid aggressors, develop fast and unsafe care, potentially permeated by incidents or injuries, which can interfere with safe patient care.

In this regard, the set of findings, convergent in the mixed method study, indicates that nursing care changes with violence, potentially compromising some PHC attributes, as it imposes barriers in access and comprehensive care to users.

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