

CONTINUING EDUCATION IN THE DEVELOPMENT OF COMPETENCES IN NURSES¹

Nádia Chiodelli Salum², Marta Lenise Prado³

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² PhD in Nursing Philosophy. Professor at the Professional Master Degree Program in Care Management, UFSC, SC, Brazil. E-mail: nchiodelli@gmail.com

³ PhD in Nursing Philosophy. Professor of the Undergraduate Course in Nursing (Department of Nursing) and GPN, UFSC, SC, Brazil. Researcher of the Brazilian Council for Technological and Scientific Development (CNPq). E-mail: mpradop@ccs.ufsc.br

ABSTRACT: This study aimed at characterizing the potential of continuing education to develop technical, relational/communicational, and ethical/political competences in nurses. This is a qualitative study undertaken with 12 nurses. Data collection was performed through documental analysis, interviews, and observation. Data were analysed on the basis of pre-determined categories: technical, communicational/relational, and ethical/political competences. Our results show that continuing education significantly contributes to the development of professional competences and indicate a predominance of the technical dimension as a way of ensuring security and professional recognition. However, relational/communicational and ethical/political competences are consolidating. They contribute to the interpersonal relationships and to the way of organizing work. Continuing educational processes, which include multiple dimensions of competences, potentiate the process, favoring integration among professionals in a changing world.

KEYWORDS: Nursing. Continuing education. Professional competence.

A EDUCAÇÃO CONTINUADA PERMANENTE NO DESENVOLVIMENTO DE COMPETÊNCIAS AOS PROFISSIONAIS DE ENFERMAGEM

RESUMO: Este estudo teve por objetivo identificar o potencial da educação permanente no desenvolvimento de competências técnicas, relacionais/comunicacionais e éticas/políticas dos profissionais de enfermagem. Trata-se de uma pesquisa qualitativa realizada com 12 profissionais de enfermagem. A coleta de dados foi realizada por meio de análise documental, entrevistas e observação. Os dados foram analisados a partir de categorias pré-determinadas: competência técnica, competência relacional/comunicacional e competência ética/política. Os resultados revelam que a educação permanente contribui significativamente para o desenvolvimento das competências dos profissionais. Apontam a predominância da dimensão técnica como forma de garantir segurança e reconhecimento profissional. Entretanto, as competências relacionais/comunicacionais e éticas/políticas estão se consolidando e trazem contribuições no relacionamento interpessoal e na forma de organização do trabalho. O processo de educação permanente que inclua as várias dimensões da competência favorece a integração dos profissionais no mundo em transformação e é um dos aspectos que potencializam esse processo.

PALAVRAS CHAVE: Enfermagem. Educação continuada em enfermagem. Competência profissional.

LA EDUCACIÓN PERMANENTE EN EL DESARROLLO DE COMPETENCIAS DE LOS PROFESIONALES DE ENFERMERÍA

RESUMEN: Este estudio tuvo por objetivo reconocer el potencial de la educación permanente en el desarrollo de competencias técnicas, relacionales/comunicacionales y ética/políticas de los profesionales de enfermería. Tratase de una investigación cualitativa realizada con doce profesionales de enfermería. La recolección de datos se llevó a cabo a través de análisis de documento, entrevista y observación. Los datos fueron analizados con base en categorías predeterminadas: competencia técnica, competencia relacional/comunicacional y competencia ética/política. Los resultados demuestran que la educación permanente contribuye de manera significativa al desarrollo de competencias de los profesionales. Apuntan para el predominio de la dimensión técnica como modo de garantizar seguridad y reconocimiento profesional. Las dimensiones relacionales/comunicacionales y ético/políticas también son consideradas y contribuyen en el relacionamiento interpersonal y en la forma de organización del trabajo. El proceso de educación permanente que incluye las diversas dimensiones favorece la integración de los profesionales en el mundo de cambios e es uno de los aspectos que potencializan dicho proceso.

PALABRAS CLAVE: Enfermería. Educación continuada en enfermería. Competencia profesional.

INTRODUCTION

The need for investment in training professionals to meet the health care needs of the population is one of the crucial aspects regarding the constant changes in the health work. Work education in the health context has been regarded as an instrument of change in a society that indicates alternative ways for quality health production and greater satisfaction for users and professionals. Accordingly, continuing education has been a determining factor in building professional competences for work.¹

Continuing education should be a part of thinking and doing of professionals in order to provide their personal and professional growth and to contribute to organizing the work process, as² it develops from daily problems identified in reality.

Competence is an overall skill that professionals develop to work safely, following the technological changes and improvements and the diversity of the contemporary world, and recognizing that knowledge cannot be exhausted neither during formal training nor in the everyday life. Thus, competence is recognized as “an ability to cope with a set of similar situations, which mobilizes various cognitive resources, knowledge, skills, microcompetences, information, values, attitudes, schemes of perception, evaluation and reasoning in a correct, fast, relevant, and creative manner, providing ability to move in the work and social life areas “.^{3:19}

In this view, competences are equivalent to a synergistic combination of knowledge, skills, and attitudes, which are expressed during the professional activity, to produce ethical, safe, and quality care to human beings and their communities within a given organizational context.⁴ Previously, work was seen as an activity for life. Currently, work has a new configuration that requires more than qualification. It has characteristics of transience, and the worker is required to show skills such as initiative, cooperation, mastering the process, ability to predict and eliminate failures, communicate, and interact, not only in his own work, but also with other professionals and especially with patients. These trends, which are observed worldwide, express that investment in human resources must revert to quality of health care and organizational competitiveness, requiring continuous training of skills, which are necessary for the nurse to act as a professional in the working world. Thus, establishment of Continuing Educa-

tion in Health is highlighted as a national policy for education and training of health workers, with regard to the articulation between two possibilities: developing professional education and increasing the resolving capacity of health services.¹

Personal or professional competences are actions taken to articulate knowledge (knowing), skills (doing), values (being), and attitudes (living) with regard to “flexibility, interdisciplinarity, and contextualization of health services”.^{4:284} Given multiple components of competence, only the set of technical, relational/communicational, and ethical/political competences determines professional competence,⁵ noting that they are always provisory and must be constantly evaluated and rebuilt.

The technical dimension indicates the way or skill required to do something. The relational competence indicates the behavior, emotions, and feelings that arise in relationships.⁵ The communicational dimension is closely related to relational dimension since both are based on relationships with other people. The ethical and political dimensions indicate the values that guide the conduct of professionals.

The subject of continuing education has served as an “area” where we reflect and put in practice education and development for persons, professionals, and health teams, working the elements that give completeness to health care. Continuing education is a feasible alternative to change the workspace, as it proposes differentiated ways of educating and learning, through which we transcend technicism and punctual training, instigating active participation of students during the process as well as developing their critical and creative ability,⁶ thus contributing to the work environment, transforming it and being transformed.

Development of competences, enabling professionals to live with diversity and [high] speed of knowledge production in the modern world, has been the keynote of continuing education for multidimensional education of professionals in new views of health work. Accordingly, the study aimed at identifying the potential of continuing education for the development of technical, relational/communicational and ethical/political competences of nurses.

METHODOLOGY

This paper reports a qualitative-case study, in which the authors aimed at a deep approach of

the problem, for a broad and detailed knowledge of the subject.⁷ The study was carried out at the University Hospital (UH, UFSC), since it is the place of work of the researcher, where the Center for Education and Research in Nursing (CEPEn, for *Centro de Educação e Pesquisa em Enfermagem*) is structured since 1988. CEPEn is responsible for training of nurses, being highlighted as a reference in the state scenario.

Data collection was performed through triangulation of data: document analysis, interviews, and systematic observation. Making a first approximation to the subject was the aim of the strategy. It has allowed surveying aspects of training courses conducted at the CEPEn such as objectives, themes developed, number of participations, and identification of competences included in these courses. Data were extracted from program documents and teaching plans, including attendance lists and annual reports of the CEPEn.

Semi-structured interviews were conducted for identification of the perception of professionals on the influence of continuing education on their personal and professional life and non-participant systematic observation as a strategy for direct observation, assuming that "phenomena of interest are not only those of historical character; some relevant behaviors or environmental conditions are available for observation".^{7:119-120} In this sense, they were carried out to complement specific information, using an observation guide that included objective and subjective aspects identified during nursing care by professionals interviewed. This occurred in several instances of health care, such as wound dressing, administration of medication, assistance in personal hygiene, turndown, information given, visit to patients, and shift change. Twelve interviews were conducted with nursing professionals (six nurses and six nursing technicians, representatives of the various inpatient units of the UH, UFSC. Participation in at least ten training courses at CEPEn in the period 2000-2005 was the criterion for inclusion in the sample. All professionals who met this criterion were invited. Anonymity of the participants was maintained using letters (N: Nurse; NT: nursing technician) and numbers (1, 2, 3, etc) to identify respondents, who signed the Term of Free and Informed Consent.

Data collected in September 2006 were analyzed following the steps of thematic analysis.⁸ Data were organized into three categories: technical, relational/communicational, and ethical/political dimensions of competence.

This study followed the guidelines of Resolution No. 196/96 for research involving human subjects, being registered in the Brazilian Committee for Ethics in Research (CONEP, for *Comissão Nacional de Ética em Pesquisa*) under Protocol No. 06133404.

RESULTS AND DISCUSSION

The nursing service of the UH, UFSC, has shown a vision of continuing education, with an analytical pedagogical view, along its history. The Department of Nursing recognizes meaningful learning, including the development of various dimensions of competence in its training courses. This process, which was developed by CEPEn, has been strengthened. At the beginning, its training courses were organized with focus on development of technical skills. Recently, they have been extended with emphasis on more problematic and comprehensive situations, which include relational/communicational and ethical/political competences.

During the study, 367 training courses were conducted. Among them, only the technical (33.2%), relational (18.0%), communicational (12.8%), and ethical (13.6%) dimensions have been met; 22.3% of the training courses meet one or more dimensions simultaneously. Continuing education for nursing professionals shows to be very active, structured, continuous, and consolidated in the UH, UFSC. This does not represent the majority of health care institutions, which has continuing education relegated to a secondary position due to lack of planning and difficulties with lack of staff.² Although continuing education at the UH (UFSC) shows to be differentiated in relation to most of the health services, it is still heavily based on the technical dimension of nursing work. Such predominance is attributed to the higher number of requests from professionals that emphasize the technical dimension (eg, hospital infection control, biosafety, wounds, cardiopulmonary arrest, blood glucose monitoring) to obtain information about innovations that support quality work.

Perception of professionals on competence development due to continuing education encompasses knowledge, skills, and attitudes they assimilated during their experience.

The technical dimension of competence

The technical dimension indicates the manner or skill to do something.⁵ In nursing, the technical dimension is related to the correct performance

of nursing techniques and procedures so that a safe and quality care is performed.

Mastery of technical knowledge is perceived as a factor that brings security to both planning and execution of patient care and relationship with other professionals. Domain of knowledge allows nurses to expose their assistance view to other professionals and defend their management view. In health care institutions, this aspect favors development of practice because knowing his/her profession is essential for interdisciplinary practice; moreover, a professional cannot do exchanges involving what he/she does not know. This vision is strongly perceived by nurses, who require security to plan care and to coordinate their teams.

Having [technical] knowledge is what gives you tranquility to provide assistance to the patient to the team you coordinate and to yourself. How are you going to question something you don't know? You do not question, you just do it. That's the difference between being able or not for the service you're developing (N3).

Systematic observation allowed realizing the frequency with which the middle-level professionals ask the nurse clarification on conduct and information or guidance to perform complex procedures. Ignorance by the nurse of alterations presented by patients causes insecurity, because it hampers giving the guidelines that must be given to the team for care continuity. In this context, the labor market requires from the nurse knowledge and application of leadership in care coordination.⁹ Accordingly, greater participation in training courses addressing technical issues is justified because they reflect the everyday work and support the development of team leadership and quality work.

Things from our surgical clinic unit, because I think learning is even more cemented because it is our practice. Things that go unnoticed and there, in the course, we can make a bridge with practice. I think it is these little things that stay, because sometimes we are in practice, on the everyday routine and remember: ah! But do you remember the course when they talked such thing? (NT4).

At various times of observation, professionals concerned with the correct performance of the technique were witnessed doing antisepsis, following the steps of the procedure, exchanging needle, which is certainly essential to quality care. However, other subjective aspects of care, such as attention and information, were often not highlighted. It is noteworthy that patients feel a lack of information because they do not know the

scientific aspects of care and, thus, the technical aspect is not their main concern. For patients, quality of care is frequently assessed by the degree of attention and information they receive from professionals.¹⁰

Adherence of continuing education to technical competence is perceived by the professionals as potentiator of growth. The reason is that the technique is more tangible and practical, different from the relational and ethical competences, which are more subjective and perceptible only in the long term, through gradual changes in attitudes.

The relational/communicational dimension of competence

Interpersonal competence indicates ability to deal efficiently/effectively with behavior, emotions and feelings which are manifested in relationships with others adequately to the needs of each.^{5,10} Learning to live "is one of the greatest challenges of education".^{11,96} High competitiveness has led human beings to individuality and generation of many relational conflicts. Overcoming these conflicts in the work is obtained practicing participation, working in teams, recognizing diversity, and accepting individuality of people.

The nursing professionals realize that training courses for development of relational/communicational dimensions can be a space for reflection on interpersonal relationships at work. Accordingly, they report the need for investment in relationship between members of the team, as conflicts and relationship difficulties at work are evidenced there.

I think investing in companionship and teamwork is necessary. I think it's quite different from those persons who never attend to any course, never do anything, only live in their own little world, come here, arrive, do their work, go there, have their little snack, and continue their service. There is no that talk, that companionship, helping those who need help. There is no that (NT2).

It is in the context of improving relationships that Habermas¹² advocates a reason that dialogues and acts in the intersubjectivity of subjects. For this author, there is a mood of the subjects to reach a consensus through dialogue since language allows understanding to be established, not only about goals, but also about the moral-practical and aesthetic-expressive elements in which understanding is sought. It is impossible to think outside human relationships that are established with the other.¹¹ In this sense, discussions in daily

work allow individual subjectivity to be expressed. Moreover, the necessary solidarity can be created in these spaces to do the collective work in health, decentralizing and socializing information that, until then, is often centered on the head.¹³

The way work is organized can affect the maintenance of harmonious relationships. Daily division of tasks to perform the care and personnel deficit in the work scale are perceived as discouraging, creating situations of dissatisfaction at work. They argue that little attention paid by them to patients is related to unequal division of activities among the mid-level professionals. Little attention paid to patients due to the uneven division of tasks and non-inclusion of middle-level professionals in the registration and planning for nursing actions are expressions rated as unsatisfactory. However, they recognize that they could devote more attention to patients at their moment of fragility, if the day-to-day were less busy.

You cannot give sufficient attention to the patient, you have six hours to take care of eight patients and have to do everything, sometimes two patients bedridden, six ambulating, with medication care and everything, sometimes you cannot stop to listen to the patient. It becomes a mechanical thing (NT6).

Nurses emphasize that distribution of tasks should be negotiated daily through a process of open communication in which both parties could be heard:

[...] division of tasks is strongly perceived as a conflict-generating factor in the staff. As we can predict that and not let it happen, we better distribute the number and severity of patients, but we do not always get that. This must be negotiated daily (N3).

The expectation to overcome this form of work organization has been built by the nursing staff, increasing participation of nursing professionals in decision-making processes involving their category. Thus, although the interpersonal relationships are often marked by conflict situations, relatively harmonious relationship is observed between the groups. Perception of positive feelings, of sympathy and help, increase the possibility of a better and more pleasurable work. On the other hand, negative feelings of antipathy and rejection tend to decrease the interactions, taking to separation and smaller communication. All this affects daily activities, with a probable reduction in productivity and making the work less pleasurable.

We succeed in working in harmony, the service is well divided, and everybody helps each other; it is

important. The division is made by the number of dependent patients, you divide not to overload only one [professional]. So we divide, who gets neuro does not get hemato; we have these internal divisions, or who is in isolation does not get who is much contaminated. This vision, we have a lot, and it helps in our relationships (NT3).

During the observations, it was also found that more casual relations prevailed during the act of caring, with an intensive communication between professionals. However, this seemed somewhat excessive at some times, because it shifted the focus of attention from the patient. Particular issues were discussed between laughs while they were performing their activities. This is a frequent practice in nursing teams, as they stay more time at work than at home. Thus, they strengthen relationships and divide with each other personal matters, of satisfaction and dissatisfaction with life, solving problems and making decisions with the help of colleagues. However, we must think about the inappropriateness of such excesses before patients, because they expect the professional to be attentive to the care he/she performs and meet their needs, mainly in his/her attention and way of looking at him.

While recognizing the importance of harmonious relationships at work, nurses express their difficulties in the power relations held in the workplace, understanding that it is only possible to work in the health team if there are respect and participation in the care decisions. For some of them, consolidation of their space in the staff must be conquered daily even though this is not an easy task.

The difference is that I realize that our relationship with the medical team is also fully differentiated when you give yourself respect and the due value, because if you show that you have competence in what you're talking about, they learn to respect you, and it requires no cry, aggression, nothing. It's just showing this in your day-to-day work (N1).

Another aspect appointed as a contribution of continuing education is related to the change in attitude before his/her colleagues, learning to respect and recognizing the limits of each one to maintain a harmonious environment.

I think I've changed regarding respect with my colleagues! I was very short tempered, do you understand? It was my way and full stop! Now, with the courses, I could be more, how will I tell you, respect, tolerate. I got seeing the difference of each person, each one is the way he/she is. Recognizing that each one has his/her own way

of doing. I think I've changed a lot [in the sense of better understanding other people] (NT2).

The continuous training courses conducted at the UH (UFSC), addressing relational/communicational competences, create opportunities for discussion and reflection on the process of nursing work and its relationships, expanding the existential repertoire and awareness of the contact of each person with his/herself in its multiple interactions with the social environment. It is in this network of interactions, which occur daily, that human beings assess and build themselves and change their practice.

Communicational dimension is closely related to relational dimension since both are based on relationships held with other people. Communicative competence is the ability to express and communicate with your cooperation, work, dialogue, bargaining exercise, or interpersonal communication group.¹⁴ The way by which communication occurs is a determining factor in relationships and care, being recognized as important for the humanized care to be provided. In this sense, forms of communication (and how it occurs in the working environment), noise in communication, and importance of feedback are frequently discussed, allowing a form of opening for dialogue and sharing experiences, feelings, and thoughts. They recognize that the way they communicate with the patient determines their assistance.

Usually, both communication and technique are important at work, because the way you communicate with the patient determines your assistance (N5).

Communicational, relational, and ethical aspects in the conduct of professionals are valued in the vision of humanization, sense of looking each subject in their specificity and life history, and appreciation of subjectivity in this relationship.

Ethical/political dimension of competence

The ethical/political dimension indicates the values that guide the professional conduct. Ethics characterizes the way of thinking and acting, which is the imprint of a group, people, or society.⁵ In this sense, ethics is the way professionals act inside and outside their work. It is also the set of values that support and guide their actions, whether technical, relational, or communicational. The posture of professionals in situations experienced during nursing labor indicates that their praxis is supported by ethical values.

Acceptance of differences between professionals implies accepting the diversity in the ways of thinking and acting of each of them, recognizing the other's competence and accepting it even though different from his/hers.

When one discusses the issue of ethics, it is punctual; there is a lot the question about comparison between behaviors. Discussions are: why the guy always does that and never changes? Is he not learning as we are? He was also at the course. Then, when comes the question on the behavior of each person, of his/her concepts of life, then it becomes more complicated. It is not so easy! So, this is much of the concept of life of each one. But, inside here is a professional institution; you must have ethical respect. Then, it facilitates requiring the standard behavior, but we know that behind the default behavior there is the person, and that person will not change if he/she does not want (N4).

Experiences lived in health institutions are permeated by limits, rights, and duties that are changed within a proper and complex dynamics. The routine of the work, most times stressful, and the way work is organized end up creating in the professional a sort of damping of his/her sensitivity, a mechanization of care, which is characterized by a routinized care, provided by "that professional who does not look into the eyes of the other, is no longer touched by a death or birth".^{4:287}

Rupture in this practice has been the subject of studies on humanization of care, advocated by public policies for humanization,¹⁵ bringing a major contribution and allowing visualization of another health care practice that occurs by interdisciplinarity, meaningful learning, and comprehensive care. In this regard, it involves a new organization of work, in a more flexible and participative way, so that new knowledge and practices are added to the group of professionals.

Being ethical at work involves having commitment, shared responsibility, participation in decision-making level, respect (to the other and to the rules approved and established democratically), and pursuit of autonomy. Although the assumptions are not explicit in speech, they are implicit in the practice of professionals. They perceive a philosophy of humanized assistance at the UH (UFSC), which makes the institution different from others.

Nursing care [in the institution] is differentiated. It may be that the same person works here and in another hospital; here, it's different. His/her posture [here] is different: he/she respects more the patient. I think it is

the issue of our philosophy, of the assistance we value, and of the director [of nursing] not being subordinated to [that of] medicine (N5).

The ethical reflection of care, even though little expressed by the professionals, is reflected in the conduct adopted by them when they recommend providing a safe care and adopt an attitude of valuing interpersonal relationships.

When we're there [in training], listening that [something] has to be so, that the ethical part should be so, we realize the mistakes that we commit, we rethink and seek to change (NT1).

Ethics favors autonomous elaboration of critical thinking and formulation of his/her own value judgments in order to decide by him/herself how to act in the life in different circumstances.¹⁶

Development of competences in nursing professionals by contribution of continuing education can be recognized through different indicators in specific situations of the everyday work. Regarding skills and competences expected from the nursing professional, some of them can be mentioned, such as having specific technical ability, ability to approach, welcome, listen to, and communicate with the patient, work in a team, have initiative, organize both him/herself as a person and his/her work environment, seek data and information to support arguments and decisions, ability to use the technology currently available to citizens and professionals.¹⁷ Given the complexity of the model of health care, flexibility, proactivity, resilience, respect, bonding, and commitment are also included as fundamental attitudes for health care professionals. Competence must be understood not only as an individual attribute for acquisition and construction of knowledge by subjects, but contextualized with basis on demands for concrete situations at work.³ In practice, development of ethical, political and technical competences enables the professional to become an agent of social transformation, fundamental to every free and independent human being.

FINAL CONSIDERATIONS

Professional competence is built from practice, from concrete and contextualized action of professionals. On the other hand, a social construction must meet the challenge of proposing alternatives to the current model of education that can respond to the dynamics and transformation of the working world. Thus, one can realize that competence in a constantly changing society can-

not be restricted to knowledge about the work, but must have a broad knowledge of the context, using general, ethical, and political knowledge and showing his/her competence as a set of interdependent and complementary knowledge, skills, and attitudes necessary for a responsible acting. In view of the above considerations, we defend the idea that the task of education must always be develop the human being to his/her full potential, from a work that requires multiple knowledge, considering that an overall development of the human being is directly related to the quality of life he enjoys in his/her everyday life.

In the perception expressed by the professionals, one can see that continuing education, as held by the Department of Nursing at UFSC, has contributed not only for the development of technical competence but also for relational/communicational and ethical/political competence, although each competency has been perceived differently by the professionals.

Technical competence is admittedly the most valued competence among nurses, since they believe to be recognized and valued as competent professionals through it, feeling safety to both practice the care and serve as a reference in the social groups to which they belong. Without this ability, they feel devalued before the staff. For middle-level professionals, technical competence is also the most valued competence, but they do not feel threatened without this knowledge.

Relational competence is a new perspective, magnified by the need for an interdisciplinary practice of both team work and participative management. It contributed to substantiate an internal relationship in which work issues are discussed in the sense that each one must consider his/her individuality and specificity.

The ethical/political dimension of competence permeates other dimensions. It is revealed in care actions, values that guide conducts, and reflections on how daily care occurs.

Development of competences that allow professionals to coexist with diversity and technological progress in the modern world is the keynote supported by continuing education for current training of professionals, and this has been perceived as a potential transformer of the professional subject in his/her personal, professional, and institutional dimensions. However, continuing education still has a long way to go at UFSC until training courses contemplating competencies in a more balanced way are implemented.

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