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Patients safety as practices of health care: a theoretical reflection on literature

La seguridad del paciente como práctica de la atención sanitaria: uma reflexão teórica sobre la literatura

Segurança do paciente como práxis da atenção à saúde: uma reflexão teórica sobre a literatura

ABSTRACT

Objective: To analyze, from a theoretical reflection, the context of patient safety in health care. **Method:** This is a qualitative, descriptive study of the theoretical-reflective type developed from the narrative review approach with national and international scientific articles available in the LILACS, BDENF, SciELO and MEDLINE databases. **Results:** The concept of patient safety has evolved among health professionals, as well as in other areas of hospital health institutions, including senior leadership, which encourages the involvement of the institution as a whole. In Brazil, there is still a high incidence of the occurrence of adverse events that could be avoided. **Conclusion:** There is a need to expand investigations on adverse events at other levels of care regarding the adoption of strategies related to health safety patient needs to be better developed.

DESCRIPTORS: Patient safety; Primary health care; Quality of health care.

RESUMEN

Objetivo: Analizar, desde una reflexión teórica, el contexto de la seguridad del paciente en el cuidado de la salud. **Método:** Se trata de un estudio cualitativo, descriptivo de tipo teórico-reflexivo desarrollado a partir del enfoque de revisión narrativa con artículos científicos nacionales e internacionales disponibles en las bases de datos LILACS, BDENF, SciELO y MEDLINE. **Resultados:** El concepto de seguridad del paciente ha evolucionado entre los profesionales de la salud, así como en otras áreas de las instituciones de salud hospitalaria, incluyendo la alta dirección, lo que incentiva la participación de la institución en su conjunto. En Brasil, todavía existe una alta incidencia de eventos adversos que podrían evitarse. **Conclusión:** Es necesario ampliar las investigaciones sobre eventos adversos en otros niveles de atención, ya que la adopción de estrategias relacionadas con la seguridad del paciente debe desarrollarse más.

DESCRIPTORES: Seguridad del paciente; Atención primaria de salud; Calidad de la atención de salud.

RESUMO

Objetivo: Analisar, a partir de uma reflexão teórica, o contexto da segurança do paciente na atenção à saúde. **Método:** Trata-se de um estudo qualitativo, descritivo do tipo teórico-reflexivo desenvolvido a partir da abordagem de revisão narrativa com artigos científicos nacionais e internacionais disponíveis nas bases de dados LILACS, BDENF, SciELO e MEDLINE. **Resultados:** O conceito de segurança do paciente tem evoluído entre os profissionais de saúde, bem como em outras áreas das instituições de saúde hospitalares, inclusive na alta liderança, o que estimula o envolvimento da instituição como um todo. No Brasil, ainda há uma elevada incidência de ocorrência de eventos adversos que poderiam ser evitados. **Conclusão:** Tem-se a necessidade de ampliar as investigações sobre eventos adversos em outros níveis de atenção quanto a adoção de estratégias relacionadas à segurança do paciente precisa ser melhor desenvolvida.

DESCRIPTORES: Segurança do paciente; Atenção primária à saúde; Qualidade da assistência à saúde.

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INTRODUCTION

Patient safety has been one of the main targets of discussion and concern in recent decades by health professionals, managers and researchers due to the impact that adverse events can have on the quality of healthcare.¹⁻²

This became more present in the agendas of the agendas of public and private health services after the publication, in 1999, of the North American report "To err is human: building a safer health system" by the Institute of Medicine (IOM).³⁻⁵

The document presents the results of the study of medical records that indicated the occurrence of iatrogenic events in a little more than 3% of the total analyzed. In addition, from 44 to 98.000 patient deaths per year have been documented in the United States of America (USA). A large portion of them could have been avoided with the adoption of practices aimed at promoting safe care.³

Thus, after the dissemination of these data, health agencies aroused greater interest in the topic, which made it possible to adopt measures to improve the quality of health services and to reduce the incidence of adverse events.⁶

To achieve this care, said to be safe, health institutions have made efforts to improve the care processes offered to users, recognizing in the first instance the need to establish a culture of patient safety as a routine in the health service.⁷⁻⁸ The institution's understanding of this scenario based on

the analysis of the safety culture becomes, therefore, the starting point for outlining actions in favor of changes to reduce incidents and guarantee safe health care.⁹⁻¹⁰

Given this reality, the safety assessment is seen as the starting point to understand the current scenario and start planning actions that seek changes to reduce the incidence of adverse events.¹¹ It allows the identification and prospective management of issues relevant to safety in work routines, with a view to ensuring safe healthcare in general practice.¹²

Therefore, this article aims to analyze, from a theoretical reflection, the context of patient safety in health care.

METHODS

This is a qualitative, descriptive, theoretical-reflective study developed from the narrative review approach with national and international scientific articles that address the context of patient safety in health care.

To search for the productions, the following research question was asked: "What is the production, in the literature, about patient safety in the context of health care?". Thus, articles that addressed patient safety and health care were selected.

The articles were searched from January to March 2020 through the databases Latin American and Caribbean Literature in Health Sciences (LILACS), Medical Literature Analysis and Retrieval System Online (MEDLINE), Database in Nursing (BDENF) and

Scientific Electronic Library Online (SciELO), refining the search for the period 2009 to 2020 and using the following inclusion criteria: articles available online; in Portuguese, English or Spanish; and original research or literature review.

The study was divided into stages: search of articles in databases; reading the titles and abstracts to verify the convergence of the material to the study theme and the inclusion criteria; reading the entire article; search and reading of original studies found through the final references of articles from the search in the databases. After all the readings, the materials were compiled, followed by the analysis and identification of the context of patient safety in health care for reflection and, finally, the elaboration of the reflective summaries of the study.

With the selected articles, the narrative synthesis was used for data analysis and discussion.

RESULTS

Thirteen articles were used in this narrative review (Chart 1), and the results were interpreted and synthesized through a comparison of the data evidenced in the analysis of the articles.

DISCUSSION

Patient satisfaction with health-care has been questioned for a long time. Although public health has advanced significantly in the last 30 years,

Chart 1 – Distribution of articles according to journal, year of publication, author(s), title, design and results. Brasília, Federal District, Brazil, 2021.

	JOURNAL AND YEAR OF PUBLICATION	AUTHOR(S)	TITLE	OUTLINE	RESULTS
Article 1	Revista Bioética, 2018	Romero MP, González RB, Calvo MSR, Fachado AA	Patient safety, quality of care and ethics of health systems	Theoretical reflection	The ethical obligations around preventing medical errors and promoting patient safety are shaped by the four principles of bioethics. These obligations are not only personal duties of each professional, but also of health institutions as a whole.

Article 2	Cadernos de Saúde Pública, 2018	Rech RS, Hugo FN, Giordani JMA, Passero LG Hilgert JB	Contextual and individual factors associated with dissatisfaction with public emergency health services in Brazil, 2011-2012	Multilevel transversal	The prevalence of perceived dissatisfaction was 48,1%. The variables that maintained a significant association with the outcome were: age > 20 years, education ≥ 16 years, Midwest Region, unmet demands, longer waiting times and access to emergency care in primary care services. The prevalence of perceived dissatisfaction is predominantly related to the waiting time and the time needed to resolve the demand.
Article 3	Int J Nurs Stud, 2016	Rosse FV, Bruijne M, Suurmond J, Essink-Bot ML, Wagner C	Language barriers and patient safety risks in hospital care: A mixed methods study	Mixed	Situations in hospital care where a language barrier threatened patient safety included daily nursing tasks, ie, medication administration, pain control, fluid balance management and doctor-patient interaction regarding the diagnosis, communication of risk and acute situations.
Article 4	Revista Gaúcha de Enfermagem, 2019	Reis GAX, Oliveira JLC, Ferreira AMD, Vituri DW, Marcon SS, Matsuda LM	Difficulties in implementing patient safety strategies: perspectives from nurse managers	Qualitative	The nurses listed the insufficiency of nursing staff, the deficit in support from senior management, and the lack of adherence of care workers as important difficulties for the implementation of patient safety strategies.
Article 5	Ciência & Saúde Coletiva, 2013	Reis CT, Martins M, Laguardia J	Patient safety as a dimension of health care quality: a look at the literature	Literature review	Patient safety research does not yet have the benefit of having its approaches well established; and also, that multiple barriers and challenges need to be faced when designing study designs and using research techniques..
Article 6	Saúde em Debate, 2016	Silva AT, Alves MG, Sanches RS, Terra FS, Resck ZMR	Nursing care and the focus on patient safety in the Brazilian scenario	Integrative literature review	It was identified the existence of low knowledge of health professionals about adverse events and how to notify them, fear of health professionals to expose errors due to the institutions' punishment policy and low adherence to the hand hygiene technique.
Article 7	Cadernos de Saúde Pública, 2016	Gama ZAS, Saturno-Hernández PJ, Ribeiro DNC, Freitas MR, Medeiros PI, Batista AM et al	Development and validation of indicators of good patient safety practices: ISEP-Brasil Project	Validation of measuring instruments	75 indicators of good practices were approved (39 of structure; 36 of process) for 31 of the 34 recommendations. The indicators were considered valid, reliable and useful for monitoring patient safety in Brazilian hospitals.
Article 8	Revista Brasileira de Terapia Intensiva, 2009	Beccaria LM, Pereira RAM, Cotrin LM, Lobo SMA, Trajano DHL	Adverse events in nursing care in an intensive care unit	Quantitative	A total of 550 adverse events related to the five medication administration rights were recorded; to medications not administered; inadequate medication notes; to failures in the installation of drugs in an infusion pump; not performing the inhalation; mishandling of syringes and needles; to nursing procedures not performed; incorrect handling of therapeutic and diagnostic artifacts; to incorrectly used equipment alarms; and failures in nursing notes.

Article 9	Texto & Contexto Enfermagem, 2017	Reis GAX, Hayakawa LY, Murassaki ACY, Matsuda LM, Gabriel CS, Oliveira MLF	Implementation of patient safety strategies: perceptions of nurse managers	Qualitative	The process of implementing patient safety strategies is perceived in a contradictory way by the participants, but despite this, they expressed feelings of satisfaction.
Article 10	BMJ Qual Saf, 2013	Jha AK, Larizgoitia I, Audera-Lopez C, Prasopa-Plaizier N, Waters H, Bates D	The global burden of unsafe medical care: analytic modelling of observational studies	Observational study	It is estimated that there are 421 million hospitalizations worldwide annually and approximately 42,7 million adverse events. Approximately two-thirds of all adverse events take place in low- and middle-income countries.
Article 11	Revista da Associação Médica Brasileira, 2013	Mendes Júnior W, Pavão ALB, Martins M, Moura MLO, Travassos C	Characteristics of preventable adverse events in hospitals in Rio de Janeiro	Retrospective Cohort	Sixty-five preventable adverse events were identified from the 56 patients who experienced preventable adverse events. Infections associated with health care accounted for 24,6%; surgical and/or anesthetic complications, 20%; damage resulting from delay or failure in diagnosis and/or treatment, 18,4%; pressure ulcers, 18,4%; damage from complications in venipuncture, 7,7%; damage from falls, 6,2%; damage as a result of the use of medications, 4,6%. Preventable adverse events accounted for an additional 373 days of hospital stay.
Article 12	Int J Qual Health Care, 2009	Mendes Júnior W, Martins M, Rozenfeld S, Travassos C	The assessment of adverse events in hospitals in Brazil	Retrospective Cohort	The incidence of patients with adverse events was 7,6%. The overall proportion of preventable adverse events was 66,7%. The incidence density was 0,8 adverse events per 100 patient-days. The patient's ward was the most frequent location for adverse events. Regarding classification, adverse surgical events were the most frequent (35,2%).
Article 13	Acta Paulista de Enfermagem, 2013	Paranaguá TTB, Bezerra ALQ, Silva AEB, Azevedo Filho FM	Prevalence of undamaged incidents and adverse events in a surgical clinic	Cross-sectional	It was evident that 615 hospitalizations were exposed to the incident without harm and 140 to the adverse event. Of the 5.672 incident records, 218 were characterized as an adverse event for causing harm to the patient. The others did not show damage, however they pointed out the need to adapt the work processes.

Elaboration: AGUIAR; SALMAZO (2021).

ars, some researches reveal a decrease in satisfaction with the perception of personal health or an apparent mismatch between the technological health apparatus and the subjective parameters, based on the self-assessment of the health status of the users in the services.¹³⁻¹⁵

Therefore, four factors that support the discrepancy between subjective perception and objective health indicators were proposed, namely: 1) reduction in mortality rates and increased prevalence of chronic non-communicable diseases (NCDs); 2) greater po-

pulation awareness of symptoms and diseases, promoted by greater awareness of the population about health; 3) widespread commodification of health and the role of the media in disseminating health issues combined with the creation of a climate of insecurity and alarm about the disease, and finally, 4) the progressive medicalization of daily life, with implications for the development of unrealistic expectations about curing certain pathologies.¹⁶

The recognition of this problem and the possible damage caused by health care triggered multiple reflections,

17 mainly from the publication of the document "To Err is Human: Building a Safer Health System" by the Institute of Medicine (IOM), in 1999, which identified the deaths of 44 to 98 thousand Americans resulting from adverse events, largely, avoidable.³

However, previously, throughout history, patient safety has been approached as a minimum element for the quality of care. Hippocrates, more than two thousand years ago, enunciated: "primum non nocere", that is, "first not to hurt". Later, Florence Nightingale, precursor of Modern Nursing,

reinforced: "it may seem like a strange principle to announce as a basic requirement, that the patient should not be harmed".¹⁸

Part of these reflections and mobilizations were brought about by the observation that the occurrence of adverse events involves considerable social and economic costs, in addition to implying irreversible damage to patients and their families. From the year 2000, patient safety entered the agenda of researchers around the world and began to be internationally recognized as a fundamental dimension of quality in health.¹¹

Thus, in 2004, the World Health Organization (WHO), recognizing the global magnitude of the patient safety problem, launched the World Alliance for Patient Safety. The purpose of this initiative was to define and identify priorities in the area in order to contribute to a global agenda for field research. Among the priority issues, the following stand out: health care for mothers and newborns; healthcare for the elderly; adverse events related to medication errors; fragile safety culture, focused on the process of accountability for the error; inadequate skills and abilities among health professionals; and healthcare-associated infections.¹⁹

Thus, patient safety was defined by WHO as reducing the risk of unnecessary harm associated with health care to an acceptable minimum. This acceptable minimum refers to what is feasible given current knowledge, available resources and the context in which care was provided, given the risk of not treating or other treatment.²⁰

Despite advances in health care, patient safety is influenced by the iatrogenics committed by professionals, which directly reflect on the quality of life of patients, causing unpleasant consequences for both patients, their families, professionals and the health system.²¹ Thus, safety was the last dimension explicitly included in the

multidimensional concept of quality in health services.²²

In this context, health quality is understood as the degree to which the services offered to the patient decrease the probability of the occurrence of unfavorable results and increase the probability of favorable results. In this understanding, unfavorable results can be understood as adverse events.³

Thus, it should be considered that the quality of healthcare is the sum of several factors, such as: health provision according to current scientific knowledge; care directed to the needs of patients; adequate provision of the health care that one is capable of and care that satisfies the patient. As for the dimensions that make up the quality of care, there are professional competence or technical-scientific quality, effectiveness, efficiency, accessibility, satisfaction, adequacy, equity and patient safety.¹³

Different from the traditional dimensions of quality, centered on making the right and timely decisions to achieve health outcomes and patient satisfaction, patient safety is primarily focused on reducing adverse events, but also on errors, negligence, failures and omissions of the care process that do not cause damage, but that could have caused.²²⁻²³

Thus, adverse events are incidents likely to occur during the provision of health care and can result in harm(s) to the patient that can be of a physical, social and/or psychological nature, which includes illness, injury, suffering, disability or death.²⁴⁻²⁵

Adverse events are commonly associated with individual human error, but working conditions, structural aspects and the complexity of the activities performed should be considered as triggers. Situations that predispose to the risk of adverse events include technological advances with deficient improvement of human resources, lack of motivation, delegation of unsupervised care and service overload.²⁶

Therefore, adverse events arising from health care are present in institutions generally due to work overload, often combined with inadequate staff dimensioning and lack of training of its workers. In addition, the authors point out other factors, such as ineffective communication, difficulty in interpersonal relationships between health professionals and the leadership's lack of knowledge about the weaknesses and strengths of their team.²⁷

Lack of patient safety causes an estimated 42,7 million adverse events with harm around the world each year. Of this total, about two-thirds are in developing countries and countries in transition.²⁸ According to the WHO, it is estimated that about 10% of patients suffer damage related to hospital care in Western countries.²⁹

In Brazil, there is still a high incidence of occurrence of adverse events that could be avoided, according to the results shown in the study by Mendes Júnior et al.³⁰: healthcare-associated infections accounted for 24,6%; surgical and anesthetic complications, 20%; damage resulting from delay or failure in diagnosis and treatment, 18,4%; pressure injuries, 18,4%; damage from complications in venipuncture, 7,7%; damage from falls, 6,2%; damage as a result of the use of medications, 4,6%. These events accounted for 373 additional days of hospital stay.

Still on this aspect, other studies indicate that the prevalence of adverse events in Brazil is around 6 to 18,7%³⁰⁻³² and the incidence is 38,4%.³⁰ However, about 66,7% of these events are considered preventable.³¹

In view of these alarming data, in 2013 the National Patient Safety Program (PNSP - Programa Nacional de Segurança do Paciente) was instituted in Brazil through Ordinance GM/MS No. 529, of April 1st, 2013, with the purpose of supporting and implementing targeted initiatives to patient safety. In this same direction, the National Health Surveillance Agency (Anvisa) published

Resolution Collegiate Board of Directors (RDC) No. 36, of July 25th, 2013, in which it established concrete actions to promote safe care, namely: correct identification of the patient; effective communication between health professionals; safety in the prescription, use and administration of medications; safe surgery; hand hygiene to prevent infections; prevention of pressure injury (PI) and falls.^{18,25,27,33}

Despite the evolution in the approach to the subject, investigations on adverse events at other levels of care, such as primary health care (PHC), are still scarce in Brazil. The adoption of safety-related strategies needs to be better developed at this level of care, in order to identify the opportunities and challenges of health professionals in providing resolute, effective and quality health care in PHC.¹¹

Finally, a study developed by Andrés et al.³⁴ in 48 PHC centers in 16 autonomous communities in Spain, identified a prevalence of 11,8% of adverse events, with 54,7% considered mild, 38% moderate and 7,6% severe. In this sense, the high prevalence of adverse events at this level of care justifies the need to consider as a priority the promotion of measures for safe care also in the context of PHC.

The adoption of safety-related strategies needs to be better developed at this level of care, in order to identify the opportunities and challenges of health professionals in providing resolute, effective and quality health care in PHC.

Finally, the literature portrays that the concept of patient safety has evolved among health professionals, as well as in other areas of hospital health institutions, including senior leadership, which encourages the involvement of the institution as a whole,³⁵ but that both investigations into adverse events at other levels of care, particularly in PHC, and the adoption of strategies related to patient safety need to be better developed at this level of care.¹¹

CONCLUSION

The literature portrays that the concept of patient safety has evolved among health professionals, as well as in other areas of hospital health institutions, including senior leadership, which encourages the involvement of the institution as a whole, but that both investigations on adverse events at other levels of care, particularly in PHC, as the adoption of strategies related to patient safety need to be better developed at this level of care.

Therefore, the results of this study can support discussions between PHC managers and health professionals in order to identify the needs and limitations to promote patient safety. ■

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