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# Public health policies oriented towards patient safety: a theoretical reflection

Políticas de salud pública orientadas hacia la seguridad del paciente: una reflexión teórica

Políticas públicas de saúde orientadas para a segurança do paciente: uma reflexão teórica

## ABSTRACT

The concern with the quality of the health service offered is a concern already described by Hippocrates in the early days of medicine and that emerged with the passing of the years after the realization of studies that pointed to the number of health damage and deaths related to errors During care. Public policies were instituted internationally, with the concern to ensure the safety of the patient attended in the health services. The objective of this study was to reflect on the implementation of public health policies formulated for patient safety. We conclude that the challenge to cope with the reduction of risks and harm in health care will depend on the strengthening of the safety culture by the professionals in the coming years, together with the patient's safety policies, instituted nationally.

**DESCRIPTORS:** Public Health Policy; Patient Safety; Quality of Health Care.

## RESUMEN

La preocupación por la calidad del servicio de salud ofrecido es una preocupación ya descrita por Hipócrates en los primeros días de la medicina y surgió con el paso de los años después de la realización de estudios que apuntaban al número de daños a la salud y muertes relacionadas con errores durante el cuidado. Las políticas públicas se instituyeron internacionalmente, con la preocupación de garantizar la seguridad del paciente atendido en los servicios de salud. El objetivo de este estudio fue reflexionar sobre la aplicación de las políticas de salud pública formuladas para la seguridad del paciente. Concluimos que el desafío de hacer frente a la reducción de riesgos y daños en la atención sanitaria dependerá del fortalecimiento de la cultura de seguridad por los profesionales en los próximos años, juntamente con las políticas de seguridad del paciente, instituidas nacionalmente.

**DESCRIPTORES:** Política Sanitaria Pública; Seguridad del Paciente; Calidad de la Atención Sanitaria.

## RESUMO

A preocupação com a qualidade do serviço de saúde já descrita por Hipócrates desde os primórdios da medicina emergiu com o passar dos anos após a realização de estudos que apontaram para o número de danos à saúde e mortes relacionados a erros durante o cuidado. Políticas públicas foram instituídas internacionalmente, com a preocupação de garantir a segurança do paciente atendidos nos serviços de saúde. Refletir sobre a implementação das políticas públicas de saúde formuladas para a segurança do paciente foi o objetivo deste estudo. Concluímos que o desafio para o enfrentamento da redução dos riscos e dos danos na assistência à saúde dependerá do fortalecimento da cultura de segurança por parte dos profissionais nos próximos anos, aliada às políticas de segurança do paciente, instituídas nacionalmente.

**DESCRITORES:** Política Pública de Saúde; Segurança do Paciente; Qualidade dos Cuidados de Saúde.

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### Leonor Coelho da Silva

Nurse. Master. Doctoral student of the Nursing Graduate Program at UERJ. Captain-Lieutenant (S) of the Brazilian Navy Health Team. <https://orcid.org/0000-0001-5633-549X>

### Célia Pereira Caldas

Nurse. Post-Doctor. Full professor at the State University of Rio de Janeiro. Rio de Janeiro Brazil. <https://orcid.org/0000-0001-6903-1778>

### Iraci dos Santos

Nurse. Post-Doctor. Full Professor of the Postgraduate Program in Nursing at the State University of Rio de Janeiro, Brazil. <https://orcid.org/0000-0002-1734-5561>

## INTRODUCTION

Health care has historically been influenced by economic and social constraints, and these can determine the quality of service provided to the population. Since health is a fundamental right, the formulation and implementation of public policies that ensure that it is delivered in a safe and effective manner can minimize the impact of socioeconomic issues. "Health is defined in the historical context of a given society and at a given moment in its development, which must be won by the population in their daily struggles"<sup>(1)</sup>.

Rethinking health care, in addition to the question of being a legal right, but that citizens can enjoy it with the guarantee that when necessary they will receive it with the concern that it is oriented to their needs and free of damages, boosted the formulation of public policies aimed at patient safety. In this sense, patient safety has emerged as an international concern and commitment, based on public policies aimed at guaranteeing the quality of the service offered.

Negative health outcomes are known primarily as adverse events or any type of incident with the potential to cause harm to patients and which can provide important information for building a safer health system<sup>(2)</sup>. Patient safety can be defined as decreasing the risk of unnecessary harm associated with healthcare, to the minimum acceptable<sup>(3)</sup>.

Since the early days of medicine, Hippocrates (400-377 b.C.) pointed out that the provision of care should not cause harm to the patient, so that "Primum non nocere" is recognized as one of the first quotes related to patient safety<sup>(4)</sup>.

In the 20th century, the doctor and professor Avedis Donabedian, through his quality study, proved that changes in the structure of processes become indirect measures of quality of care<sup>(5)</sup>.

In the context of seeking to improve quality by standardizing processes, in 1951, the non-governmental and non-profit company Joint Commission Accreditation of Hospitals (JCAH)

was founded in the United States, a name changed a posteriori to Joint Commission Accreditation of Healthcare Organizations (JCAHO), whose mission is: "to continuously improve health care for the public, (...) evaluating health organizations and inspiring them to excel in providing safe and effective care"<sup>(6)</sup>.

In 1999, with the publication of the report "Err is human", there was a signal for the strengthening of a safety culture at the organizational level, as a fundamental measure to the process of improving patient safety in the hospital context. The magnitude of the patient safety problem was strongly evidenced, as results revealed that 44 to 98 thousand Americans died annually due to errors associated with health care<sup>(7)</sup>.

From this perspective, when considering patient safety as a quality criterion, guided by policies implemented to ensure its achievement, the question was used to guide this study: How did patient safety develop as a public health policy? In order to reflect on the implementation of public health policies aimed at patient safety.

## METHODOLOGY

It is a theoretical study, of critical analysis, inspired by the arguments and understandings that emerged during the discipline Trends in care/ care: a family-centered approach, from the Graduate Program in Nursing at the State University of Rio de Janeiro, taught to academic master's and doctoral students in the second semester of 2018.

The authors used the 1988 Federal Constitution to discuss the evolution and consolidation of Patient Safety as a health policy.

## DISCUSSION

### Patient safety as a public policy

The Federal Constitution of 1988 established health in Brazil as a universal right, becoming a constitutional duty of all spheres of government and extended to all citizens, not only to the insured worker. The concept of health was expanded and linked to policies<sup>(8)</sup>.

In 2004, the World Health Organization (WHO) published a World Alliance

Program for Patient Safety and proposed actions aimed at improving health care practices and reducing the risks of harm to patients. To this end, it established three global challenges: "Clean care is safer care" (2005), "Safe surgeries save lives" (2008) and "Safe use of medicines" (2017). As a WHO Member State, Brazil has adhered to the challenges and has been developing work to improve health care<sup>(9)</sup>.

In 2011, the National Health Surveillance Agency (ANVISA) approved technical regulation RDC No. 63, which advocates the adoption of good practices by public or private, civil, or military health services, including those that implement teaching and training actions. The Resolution defines minimum standards for the functioning of these services with regard to the provision and management of health care<sup>(10)</sup>.

In 2013, the Ministry of Health instituted the National Patient Safety Program (PNSP) instituted by Ordinance No. 529, of April 1, standardizing the "Patient Safety" dimension in legal terms, with a view to contributing to the qualification health care in this aspect, in all health establishments in the national territory<sup>(11)</sup>.

The Resolution of the Collegiate Board (RDC) No. 36 regulated actions to promote patient safety and improve the quality of health services. The mandatory creation of Patient Safety Centers in all Brazilian hospitals and the development of Patient Safety Plans are highlighted, where risk management strategies and actions are established in care in order to avoid the occurrence of incidents that lead to damage to patients seen<sup>(12)</sup>.

The formulation of public policies geared towards patient safety has emerged as an important factor in the search for quality and guarantee of harm-free care. However, only its formulation, without the commitment of managers and professionals in its correct implementation, seems insufficient for safe assistance to be achieved.

### Patient Safety in Brazil

Brazil, guided by the same objectives of WHO and at the initiative of the Pan

American Health Organization, established the Brazilian Network of Nursing and Patient Safety (REBRAENSP), whose fundamental role is to disseminate and sediment the safety culture<sup>(13)</sup>.

In Brazil, in 2018, 103,275 cases of incidents related to health care were reported, of which 96,113 (93%) occurred in a hospital environment. Of which 49,600 (51%) occurred in inpatient units, 27,147 (28%) in adult, pediatric and neonatal intensive care units, 7,158 (7.5%) in the emergency room and 4912 (7%) in the operating room<sup>(14)</sup>. This number possibly does not reflect the reality, since, under-reporting is a reality, often caused by the concern with job maintenance, fear of punishment and legal consequences.

A little more than five years after the institution of the PNSP, we realized that there was an advance in strengthening the culture of patient safety, in the formulation and implementation of strategies and

actions aimed at guaranteeing the provision of safe care, but that stimulating notification, discontinuing the punitive nature associated with it can be an important factor to support training and actions geared to the real needs of professionals.

Public and private institutions have been engaged in the standardization of processes, with a view to minimizing possible errors occurred during the provision of health care, there is still a way to go, but having come out of inertia makes this objective feasible.

Raising awareness of the problem has made patient safety a priority dimension of quality of care and a critical component of the management of health systems and services<sup>(7)</sup>.

## CONCLUSION

The challenge to face the reduction of risks and damages in health care will depend on the necessary change in the culture of professionals for safety in the

coming years, coupled with the patient safety policy, instituted nationally. Thus, investing in changing the system, improving the health team, using good practices, improving technologies, and improving work environments are essential actions to achieve the best results for users of health services, family, and community, as well as for professionals.

Possibly there has already been an important increase in the culture of patient safety among professionals and managers, but this must be an institutional concern, and its strengthening must permeate the objectives of the institutions that provide health care.

Disseminating and strengthening the safety culture in health services, in order to broaden the view and the confrontation of professionals and managers in the face of errors, can contribute decisively to the reduction of risks and incidents in the context of health care, by providing implementation improvement actions in search of safe care. ■

## REFERENCES

1. Ministério da saúde (BR) Conferência Nacional de Saúde, 8º Relatório Final. Brasília (DF): MS; 1986.
2. Victora CG, et al. Condições de saúde e inovações nas políticas de saúde no Brasil: o caminho a percorrer. *Lancet*. 2011; 90-102.
3. Ministério da Saúde (BR). Portaria n.º 529 de 1o de abril de 2013: institui o Programa Nacional de Segurança do Paciente (PNSP). Brasília (DF): MS; 2013.
4. Sousa P. Segurança do paciente: conhecendo os riscos nas organizações de saúde. Rio de Janeiro: ENSP; 2014.
5. Donabedian A. Explorations in quality assessment and monitoring. Ann Arbor: Health Administration Press. 1980; 1.
6. Joint Commission International [Internet]. Oak Brook: Joint Commission International. 2015 [acesso em 30 out 2018]. Disponível em: <http://www.jointcommissioninternational.org>.
7. Reis CT, Martins M, Languardia J. A segurança do paciente como dimensão da qualidade do cuidado em saúde: um olhar sobre a literatura. *Cienc. saúde coletiva* (Online). 2013; 8(7):2029-36.
8. Brasil. Constituição da República Federativa do Brasil de 1988 [Internet]. Brasília (DF). Presidência da República, 2016 [acesso em 30 out 2018]. Disponível em: [http://www.planalto.gov.br/ccivil\\_03/Constituicao/Constituicao.htm](http://www.planalto.gov.br/ccivil_03/Constituicao/Constituicao.htm).
9. World Health Organization. Medication without harm: WHO's Third Global Patient Safety Challenge [Internet]. Geneva: World Health Organization, 2017 [acesso em 30 out 2018]. Disponível em: <http://who.int/patientsafety/medication-safety/en/>.
10. Agência Nacional de Vigilância Sanitária (BR). RDC n.º 63, de 25 de novembro de 2011. Dispõe sobre os Requisitos de Boas Práticas de Funcionamento para os Serviços de Saúde. Brasília (DF): ANVISA; 2011.
11. Ministério da Saúde (BR). Programa Nacional de Segurança do Paciente/Ministério da Saúde; Fundação Oswaldo Cruz; Agência Nacional de Vigilância Sanitária [Internet]. – Brasília (DF): MS; 2014 [acesso em 02 dez 2017]. Disponível em: [http://bvsms.saude.gov.br/bvs/publicacoes/documento\\_referencia\\_programa\\_nacional\\_seguranca.pdf](http://bvsms.saude.gov.br/bvs/publicacoes/documento_referencia_programa_nacional_seguranca.pdf).
12. Agência Nacional de Vigilância Sanitária (BR). Resolução da Diretoria Colegiada da ANVISA - RDC n.º 36, de 25 de julho de 2013. Institui ações para a segurança do paciente em serviços de saúde e dá outras providências. *Diário Oficial da União* 2013; 25 Jul. Brasília (DF): ANVISA; 2013.
13. Caldana G, Guirardello EB, Urbanetto JS, Peterline MAS, Gabriel CS. Rede brasileira de enfermagem e segurança do paciente: desafios e perspectivas. *Texto & contexto enferm*. 2015; 24(3).
14. Agência Nacional de Vigilância Sanitária (BR). Boletim Segurança do Paciente e Qualidade em Serviços de Saúde no 20: Incidentes Relacionados à Assistência à Saúde – 2018. nov. Brasília (DF): ANVISA; 2019.