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# The application of measures against avoidable harm in Brazilian Health Services: A strategy focusing on patient safety

# A aplicação das medidas contra danos evitáveis nos Serviços de Saúde do Brasil: Uma estratégia com enfoque na segurança do paciente

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## ABSTRACT

The study is the development of a qualitative integrative review, which addresses issues about patient safety with emphasis on the nuances that permeate the proposals of the praxis of the professional who works in health care and the correlation with everyday practices and the possibility of reducing possibly avoidable harm. The main objective of this study is to understand the tools used to eliminate avoidable harm to patients in Brazilian Health Services. The methodology used consisted of an integrative review with a qualitative approach that analyzed studies on the subject published in the 5-year time frame (2018-2023). The results found were the protagonism of nursing in the development of actions to prevent the appearance of damage compared to other team members and the need for permanent education strategies to share knowledge and continuity in the integral care of the user. Thus, it is necessary to strengthen notification instruments to understand the general picture and create strategies to reduce the potential for harm to arise, in addition to proposals for health education strategies at all hierarchical levels for professionals who work directly or indirectly in patient care.

**Keywords:** Patient safety, Organizational culture, Health care.

## INTRODUCTION

Several discussions are raised regarding patient safety. Alves et. AL (2015) in discussions of his study contemplates us with the reflection of the concept of patient safety, as a proposal shaped by several negative influences, such as medical errors, and positive ones, such as the search for and improvements in the quality of care. Thus, Patient Safety is related to the prevention of errors in medical and hospital care, as well as its quality.

The Ministry of Health, not unlike this discussion, defines Patient Safety as: "Reducing to an acceptable minimum the risk of unnecessary harm associated with health care" (BRASIL, 2014). From this perspective, it reinforces the concept already established by the World Health

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Organization. Focusing on the reduction of avoidable harm, which is perhaps a central theme of this study, we identified proposals that have been discussed by the World Health Organization (WHO) with a focus on reducing these errors.

Therefore, in order to mitigate adverse events and possible damages, the WHO prioritized two proposals that were classified as central objectives, namely: The reduction of infections associated with health care, through the hand hygiene campaign, and the promotion of safer surgery and the second with the application of a check-list before, during and after surgery. Such proposals were understood as global challenges by the WHO.

The agencies and services responsible for blood transfusions, for the control and prevention of healthcare-associated infection, and for anesthesia services in Brazil can be considered pioneers in terms of measures that promote patient safety. For years, they have adopted measures to ensure the safety of care processes, with good results (UMintimo da Saúde, 2014).

Considering these conditions, this theme aroused the interest of the authors, taking into account the scenario experienced during the residency course, where it was possible to observe the preservation of the proposals and conditions discussed on the theme more present in some sectors of the hospital than in others. This idea brings to light great possibilities for applying concepts to achieve the goal of reducing avoidable harm to patients, if applied in a systematic way in all sectors. In addition, the theme represents us as professionals because it is extremely relevant in the integral care of the patient, directly or indirectly.

Due to the great potential to explore new nuances within the theme, the Ministry of Health, through the Research Priorities Agenda of the Ministry of Health (APPMS, 2018) defined the theme as a priority through Axis 9 - Health Programs and Policies and their Sub-Agendas: 9.1- Evaluation of adverse events in Primary Health Care, related to Patient Safety, and its impacts on public health; 9.2- Evaluation of the National Patient Safety Program (PNPS) in the SUS; 9.3- Economic and patient safety evaluation, considering waste in health services; 9.4- Analysis of the relationship between the performance of local hospital management (states and municipalities) and patient safety.

The World Health Organization (WHO) has key concepts of the international classification of the patient. The WHO's perspective with standardization of definitions on patient safety was to propose measures to reduce risks and mitigate the emergence of adverse events. Thus, the definitions were systematized within the health sectors, with a focus on providing guidance on certain terms. In order to reduce risks and mitigate Adverse Events, the

WHO prioritized two, which were called global challenges: reducing healthcare-associated infection, through the hand hygiene campaign, and promoting safer surgery, through the adoption of a checklist before, during, and after surgery. (WHO, 2004).

## METHODS

This study takes place through an integrative review, a specific method that summarizes the past of the empirical or theoretical literature, in which we aim to provide a more comprehensive understanding of a particular phenomenon (BROOME, 2006). For Souza et al., (2010, p. 103), the integrative review "... It is the broadest methodological approach to reviews, allowing the inclusion of experimental and non-experimental studies for a complete understanding of the phenomenon analyzed." It also combines data from the theoretical and empirical literature, and incorporates a wide range of purposes: definition of concepts, review of theories and evidence, and analysis of methodological problems of a particular topic. (OLIVEIRA, et al, 2023)

Thus, the integrative review was used as a method for the development of theoretical-analytical studies. This procedure was chosen because it enables the synthesis and analysis of the scientific knowledge already produced on the investigated theme.

As for nature, it is a qualitative research, which, in the interpretative perspective of Minayo (1994), "works with a universe of meanings, motives, aspirations, beliefs, values and attitudes, which corresponds to a deeper space in relationships, processes and phenomena that cannot be reduced to the operationalization of variables". The qualitative approach, in this way, "delves into the world of the meanings of human actions and relationships, a side that is not perceptible and cannot be grasped in equations, averages and statistics" (MINAYO, 1994, p. 22).

For this investigation, we used the integrative review criteria as an instrument, which are divided into 6 phases. The steps consist of: 1. Identification of the theme and selection of the research problem, 2. Establishment of inclusion and exclusion criteria; 3. Identification of pre-selected and selected studies; 4. Categorization of selected studies, 5. Analysis and interpretation of the results. 6. Presentation of the review/synthesis of knowledge. (SOUZA, 2010).

Thus, a theoretical survey was necessary, because, with regard to methodological aspects, according to Gil (2017, p. 17), we can define research as "[the] rational and systematic procedure that aims to provide answers to the problems that are proposed". Research, therefore,

is required when "there is not enough information to answer the problem, or when the available information is in such a state of disorder that it cannot be adequately related to the problem" (GIL, 2017, p. 17).

As for the part of recurrent research on books and other written materials, it is classified as bibliographic to the extent that it "uses secondary sources, covers all bibliography already made public in relation to the subject of study, from individual publications, bulletins, newspapers, magazines, books, research, monographs, theses, cartographic material (MARCONI; LAKATOS, 2003, p.183). In the perception of Minayo (2003, p.224), "The purpose of scientific research is not only a report or description of empirically raised facts, but the development of an interpretative character, with regard to the data obtained". To this end, "it is essential to correlate the research with the theoretical universe, opting for a theoretical model that serves as a basis for the interpretation of the meaning of the data and facts collected or collected" (MINAYO, 2003, p.224).

In these circumstances, "The integrative review determines the current knowledge on a specific theme, since it is conducted in such a way as to identify, analyze and synthesize the results of independent studies on the same subject" (SOUZA et al., 2010, p. 103), in these tracks, for the composition of the theoretical and analytical topics, it was necessary to make an exhaustive search for the authors of the areas that give theoretical support to this research. For the inclusion criteria, only full-text articles, available for evaluation and free download, studies that are in the Brazilian Portuguese language, within the time frame of 5 years (2018 to 2023), will be evaluated. The exclusion criteria will eliminate studies that are not presented in full text, theses, dissertations, TCC's and other studies that make up the gray literature, studies in a language other than Portuguese Brazilian, and outside the previously established time frame.

To select the studies that served as a sample for this integrative review, searches were conducted through the Virtual Health Library (VHL) with the combination of the following Health descriptors (DeCS and MeSH): "patient safety" "harm" "Organizational Culture", thus, 18 available studies were found. In time, the following filters were applied: "Full text", "Only in the Portuguese language"; time frame in the last 5 years, leaving 7 studies for detailed evaluation. Search strategy details: "patient safety" "harms" "organizational culture" AND (fulltext:("1") AND la:("pt")) AND (year_cluster:[2018 TO 2023]). After a thorough reading of the abstracts, 4 articles remained for the composition of the integrative review, of these, 3 were excluded because they did not fit the inclusion/exclusion criteria.

There was no need to go to the Research Ethics Committee (CEP), according to Resolution No. 506/2016 of the CEP/CONEP System. Thus, we present below an illustrative table with the main characteristics of the studies that will serve as a sample. The following is information such as title, journal of publication, and year of the articles analyzed: Patient safety culture and incidents recorded during nursing shift shifts in intensive care units. REV BRAS TER INTENSIVA (2022); Incidents in the care of parturients and newborns: perspectives of nurses and physicians. ANNA NERY SCHOOL (2021); Patient safety climate in critical hospital units: scoping review of strengths and weaknesses assessed by the safety attitudes questionnaire (SAQ). ANNA NERY SCHOOL (2019); Patient safety culture and cultural nursing care. REV ENFERM UFPE ON LINE (2018).

## DISCUSSION

Errors and adverse events are one of the biggest challenges in health systems globally (RODRIGUES *et al*. 2020). In time, the study estimates that one in ten patients suffer some adverse effect during hospital care, most of which are preventable. These damages sustained prolong the length of hospital stay and can cause the death of patients. In addition, the study conducted by Campelo *et al*. (2018), for example, points out that organizations that have a positive safety culture are characterized by communication based on mutual trust, shared perceptions of the importance of safety, and trust in the effectiveness of preventive actions.

In summary, it is notorious in all the studies that were used as a sample the peculiarity of the statement that safety is related to the organizational culture by promoting team engagement, favoring relevant changes and recognizing care as a complex adaptive system resulting from the different processes and actors involved. Therefore, the positive safety culture values the successes or successful results obtained, learning from mistakes, participation in the resolution of failures in care processes and active collaboration in improvement actions. (RODRIGUES *et al*. 2020)

It is already known that patient safety is a shared responsibility among all workers who work directly or indirectly in care, family members, patients themselves and the institution and, once adopted in the service, it facilitates the understanding by professionals of the need for sharing, enabling the understanding of the protagonism of the patient and his family as a fundamental part for the success of achieving satisfactory levels of health and well-being (CAMPEL *et. al*, 2018). However, through this research, we can identify the role of nursing in terms of ensuring and guaranteeing the safety of users. Nursing has, among its attributions, the

prevention of complications caused by adverse events during care practice.

Thus, the importance of investing in a culture of patient safety is founded, taking into account strategies such as communication among the team and a non-punitive discussion at the time of the error. (CAMPEL *et al.* 2018) Studies in the literature reinforce these findings, identifying that investment in nursing processes and in the participation of nurses promote communication, a feeling of security in decision-making, and the empowerment of professionals to report incidents, which directly favors patient safety, especially to treat and prevent new incidents (OLIVEIRA *et al*. 2022).

It is important to emphasize that health institutions need to invest their resources in proposals that better train their employees. Such investment corroborates the training of the team in factors that make up the patient safety culture, especially those with higher proportions of positive responses. Correct patient identification, for example, is a priority in preventing incidents and improving patient safety. That is, the study pointed out that 10% of the hospitalized patients were exposed to the potential risk of care errors because the first and last names were identical. (RODRIGUES *et al*. 2020).

However, organizational culture is seen as a critical factor in the advancement of the intended improvements, in view of the tendency to observe attitudes of acceptance of the cultural standard established in health care and work. Culture is expressed "in how it is done" and "in what one chooses to tolerate" in organizations and, in this way, correlates with the level of achievement of the expected results. (RODRIGUES *et al*. 2020). With this, we reinforce that it is extremely important to strengthen the notification and monitoring forms of incidents; security protocols; human and material resources, and limitations in professional knowledge. (RODRIGUES *et al*. 2020).

The dimensions of communication openness, feedback, and communication about error show the weaknesses of communication in the units of this study. Regarding the dimensions related to communication, the literature also shows proportions of positive responses below 50%, suggesting a fragility of the safety culture in the communication aspects and justifying the result of the patient safety culture only acceptable or weak for nurses and nursing assistants (CAMPELO, et. al, 2018)

Therefore, we emphasize that, in order to ensure that care is focused on safeguarding the patient, health institutions should, at first, evaluate and understand the existing safety culture so that, subsequently, measures and actions can be planned to reduce failures in work processes and the occurrence of adverse events. However, in addition to evaluating the safety culture, it is

the responsibility of the service to inform the results of these evaluations to professionals and managers, as well as to implement the necessary measures so that safe care can be offered to patients.

Finally, we hope that the results described here will contribute to the debate about the challenges in incident prevention and the necessary advances in care and research on the subject, including the use of more comprehensive and participatory methods that contemplate other contexts, scenarios and perspectives of the multidisciplinary team.

## CONCLUSION

The study showed that it is necessary to invest in the culture of patient safety and in the tangent aspects, mainly, the investment in the training of the team in general. In addition, we understand that nursing is a protagonist in actions involving the safety culture and takes the lead in safeguarding patients in health institutions.

It is concluded that, in this context, health professionals need to understand that both individual and organizational cultural conceptions directly interfere in the quality and safety of the care offered to patients. Thus, the Theory of Diversity and Universality of Cultural Care is perfectly appropriate in the context of patient safety culture, as the concepts of culturally competent care and communication. It is worth mentioning that it is necessary to strengthen the support network and understand the notifications of damages, with a focus on understanding the general state of the health institution and developing strategic proposals to reduce the emergence of avoidable damage.

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