Federal University of Rio de Janeiro State

Journal of Research Fundamental Care Online

ISSN 2175-5361
DOI: 10.9789/2175-5361

REVIEW INTEGRATIVE

Segurança do paciente: como a enfermagem vem contribuindo para a questão?

Patient safety: how nursing is contributing to the issue?

¿Seguridad del paciente: cómo la enfermería viene contribuiendo a la cuestión?

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ABSTRACT

Objectives: Characterizing the scientific production in nursing journals on patient safety and identifying the contributions of these productions for the same. **Method:** Integrative review in the databases of the Virtual Library of Nursing using the following health descriptors: nursing, patient safety, iatrogenic disease and adverse events. **Results:** We identified 6 categories: Culture of patient safety, adverse events, nursing care, education, reporting and ethical aspects. **Conclusion:** therefore, we checked the focal point of the researches, their contributions and advancements needed. **Descriptors:** Nursing, Patient safety, Iatrogenic disease, Medical errors.

RESUMO

Objetivos: Caracterizar as produções científicas em periódicos de enfermagem sobre segurança do paciente e identificar as contribuições dessas produções para a mesma. **Método:** Revisão integrativa nas bases de dados da Biblioteca Virtual de Enfermagem utilizando os descritores em saúde: enfermagem, segurança do paciente, doença iatrogênica e eventos adversos. **Resultados:** Identificamos 6 categorias: Cultura de segurança do paciente, eventos adversos, Assistência de Enfermagem, educação, notificação e aspectos éticos. **Conclusão:** Verificamos, assim, os focos das pesquisas, suas contribuições e os avanços necessários. **Descritores:** Enfermagem, Segurança do paciente, Doença iatrogênica, Erros médicos.

RESUMEN

Objetivos: Caracterizar la producción científica en revistas de enfermería a cerca de la seguridad del paciente e identificar las contribuciones de estas producciones para el mismo. **Método:** revisión Integral en las bases de datos de la Biblioteca Virtual de Enfermería utilizando los descriptores en la salud: enfermería, seguridad del paciente, las enfermedades iatrogénicas y los eventos adversos. **Resultados:** identificamos 6 categorías: Cultura de la seguridad del paciente, los efectos adversos, la atención de enfermería, la educación, la información y los aspectos éticos. **Conclusión:** Tomamos nota, también, de los focos de la investigación, sus aportaciones y avances necesitados. **Descriptores:** Enfermería, Seguridad del paciente, Las enfermedades iatrogénicas, Los errores médicos.

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INTRODUCTION

Patient's safety sets "to reduce the risk of unnecessary harm associated with healthcare to an acceptable minimum".[1:22] These damages, currently called adverse events (AEs) are unintended injuries or complications arising from care provided to patient, which can cause injury or disability, temporary or permanent, prolongation of hospitalization and even death, having no correlation with disease that determined admission.[2-3]

It is a matter of concern remote, but who rose to prominence in 1999 with the publication of the report To Err is Human: building a safer health system by the Institute of Medicine of the United States. At that time, it was found that about 44.000 to 98.000 people died each year in that country, due to AEs, mostly preventable.[4] From this publication originated the movement in favor of patient safety, among them stands the World Alliance for Patient Safety linked to WHO.

The worldwide incidence of AEs is high. Studies in the United States, Australia, UK, New Zealand, Canada, the Netherlands and Sweden found that 2,9 to 16,6% of hospitalized patients were victims of AEs, 50% preventable. We also observed that most caused mild disability but emphasize by 4,9 to 13,6% of these events led to patient death. In Brazil, a study conducted in the emergency department of a university hospital showed that 50% of patients at hospital discharge and 70% of who died experienced at least one AE. Already on research conducted in three teaching hospitals in Rio de Janeiro in 2009, the incidence of patients suffering from these AEs was 7.6%, 66,7% were preventable.[3,5-6]

The surveys confirm the magnitude of the issue. Consequences arising from the breach of patient safety increase spending on health and hospitalization time, causing complications and deaths, which results in the reduction of user trust in the healthcare system and results in psychological damage.

Among health professionals, nursing staff is the most likely to commit AEs since performs several invasive interventions and stays for a long time with the patient.

Given the premise, we question: What is the scientific production of nursing on patient safety, and how this has contributed to the quality of care?

Thus, the study aimed to characterize the scientific production published in nursing journals about patient safety, and to identify the contributions of these to the quality of care.

METHOD

This is an integrative review conducted in the databases of the Virtual Library of Nursing using the descriptor Health (DESCs) "nursing" associated with descriptors: patient

safety, iatrogenic disease and AEs in Portuguese, English and Spanish. The AEs descriptor is not cataloged in DESCs, but is the International Classification for Patient Safety of the WHO.

Publications with full articles, published in nursing journals since 2004, year of establishment of the World Alliance for Patient Safety/WHO have been selected.

In the initial screening of title and abstract readings were performed. Accordingly, we considered the contemplated articles to established goals. Year of publication, journal name, authors of the study, the research site, approach the study sample, objectives, results and conclusions: Following the full text of the articles and book report of the data was performed. The articles were grouped by subject and presented in graphs and tables.

RESULTS AND DISCUSSION

There were identified in the survey 57 publications, as noted in Table 1. Of these, 36 (63%) were performed in Brazil, with 27 (47%) published in national journals. The searches were performed on documents (22; 39%), as well as professionals, nursing students (18; 32%) and patients (07; 12%). As shown in Figure 1, in 2004 we did not identify any publications.

Table 1 – Characterization of nursing production on patient safety for the period from 2004 to 2012 according to periodical, place of performance and sample.

Results	N	%
National Journals		
Brazilian Journal of Nursing – REBEn	06	10
Journal of school of nursing of UERJ	03	5
Journal of the nursing school of the University of São Paulo	06	11
Electronic journal of Nursing	03	5
Other national journals	09	16
Total national journals	**27**	**47**
International Journals		
Cuban Journal of nursing	05	9
Latin American Journal of nursing	10	18
Resource Nursing Health	02	3
Other international journals	13	23
Total of international journals	**30**	**53**
Total of periodicals	**57**	**100**
Place of performance		
Belgium	01	2
Brazil	36	63
Brazil and USA	01	2
Canada	01	2
Colombia	01	2
Cuba	05	8
Spain	01	2
USA	11	19
Total	**57**	**100**
Sample		
Documents	22	39
Patients	07	12
Professionals and students of nursing	18	32
Other	10	17
Total	**57**	**100**

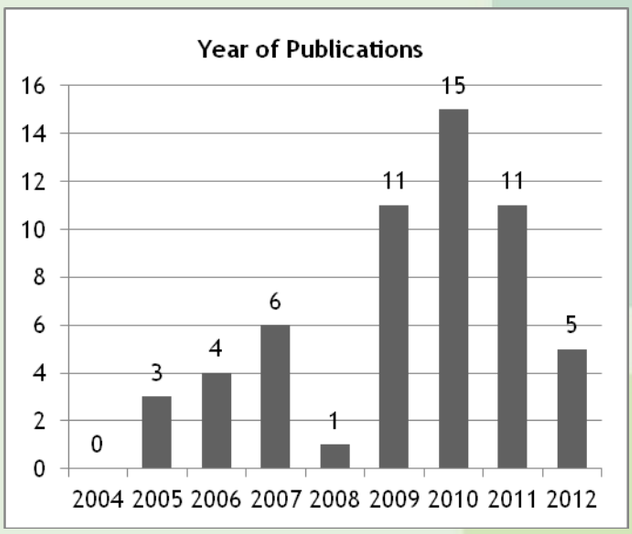

Figure 1 - Distribution of the production of nursing on patient safety, according to the year of publication.

Six themes have been identified, as described in Figure 2:

THEMES	SUBTHEMES
Patient safety culture	Implementation facilitators – training, continuing education, professional – patient communication and research; Difficulties of implementation – corporatism, institutional philosophy, infrastructure, demand, administrative structure, lack of evaluation, noise assessment, insecurity, lack of training and continuing education, lack of partnership with managers, lack of patient safety commissions, lack of incorporation of Patient Safety Network; Differences in perceptions – length of service; Need for scientific basis – practical activities and assistance administration.
Adverse events	Identification of AEs – errors during: the administration of medications, installation of catheters and probes. Falls and pressure ulcers.
Nursing care	Ineffective nursing care – related to occurrence of AEs; Time of nursing care – related to medication administration errors; Time of professional experience – related to the incidence of urinary tract infections; Number of professionals – related to reduction of mortality in the immediate postoperative period.
Education	Vocational training – with caregiver profile, focused on patient safety; Use of technology – development of virtual specific environment.
Notification	Notification of AEs – performed by nurses, higher incidence in medication administration; Underreporting of AEs – related to embarrassment and fear of punishment; Penalties for the pros – verbal warning; Instruments for notification – need for elaboration.
Ethical aspects	Actions of professionals in occurrence of AEs – were based on values and beliefs, in appreciation of the work and the experiences that they experienced.

Figure 2 – Themes identified in the productions of nursing on patient safety, for the period from 2004 to 2012.

The scientific literature on patient safety has grown every year since the creation of the World Alliance for Patient Safety by WHO. We emphasize that in 2008 was identified only one publication, unknown reason for the decrease in production in that year.

We emphasize that Brazil was the leading of scientific production in this area, although inconsistently, because only a small percentage was performed with patients who, in turn, are the subjects that could damage resulting from failures in health care.

The theme of "adverse events" was the most published corroborating the priority of the political agenda of the WHO member states with patient safety. AEs are unintended harm, and their most preventable, resulting from care provided by health professionals. Such damage can be temporary or permanent physical, psychological or social.[7-8] They have, however, a major impact on health and global spending and its rate has been used as an indicator of the quality of health services, which explains the large number of publications on this topic.

The main events were related to medications, probes, drains and catheters, falls and pressure ulcers. Activities in which nursing is directly connected, which demands a lot of attention these professionals not only in the prevention, harm reduction to the patient as well as the notification of these events, that "[...] are important sources of alerts and information, promoting safety in the hospital environment and contributing to the management of nursing care".[9:288] But in the world of nursing scientific production, this topic has not highlighted.

We emphasize that there is still a high incidence of underreporting, as well as incomplete reports. In a study conducted in São Paulo in 2007 with intensive care nurses, about 50 to 71,4% of them showed underreporting of AEs in their work units and indicated as main reasons overwork, forgetfulness, no recovery of such events, fear and shame, and the feeling of fear related to the culture of punishment, still lingering in health facilities.[10]

AEs may result from reversible damage to death. When AEs are related to drug administration is not uncommon to be featured in the media and that these are related to the work of the nursing team.

AEs in medications are preventable events related to drugs under control of professionals or patients, causing damage. A study of nursing technicians found that 62,69% of medication errors were related to the preparation and, of these, the rate with the potential to alter the microbiological safety was above 70%. 53,68% of the errors corresponded to the anticipated preparation that may have altered the chemistry of some drugs, thereby modifying the therapeutic outcome. In 6,29% of cases there were dosing errors.[11]

The above figures indicate the severity of the problem and are indirectly related to various factors such as technical causes, limited human resources, illegible prescriptions, work overload due to high demands and multiple employments.

The falls were also mentioned, but despite the small percentage are events that require care, especially with seniors. In the United States these events were the main cause of accidental death in the elderly.[12]

Regarding the safety culture of the patient is necessary to develop strategies to eliminate or reduce barriers to implementation. Among these provide working conditions for nursing staff, considering the impact the care provided by these professionals in patient safety. It was found that a deficient team of nurses is associated with poor medication errors, falls, and spread of infections, increased mortality and deficit in resuscitation of patients.[13]

We added to appropriate working conditions, the importance of training and update as having one of the goals for patient safety, said member in only 11% of the articles

surveyed. Since the quality of students' education is essential to produce professionals capable of working in the development of systems for patient safety.[14]

We consider as essential the approach of patient's safety focused on ethical aspects. According to this research, are still incipient the scientific productions turned to the theme. The ethical occurrences, ie, the faults committed by professionals and that result in harm to patients may be due to negligence - Divergent action of right, arising from passivity or inaction professional - malpractice - lack of knowledge or ability to perform a particular function or recklessness - exposing the patient to unnecessary risks, precipitous action.[15]

CONCLUSION

Patient's safety is an old question, but specific professional approaches, as well as conducting research are still recent. However, there is a growing profile, which is positive for diagnosis as well as proposing strategies those can positively impact factors related to safety.

The Brazilian Nursing emerged in research on patient safety, contributing to improving the quality of health care services. But few studies have been carried out directly with the patient.

Other topics discussed in regard to patient safety were the AEs, staff training, notifications of events and ethical issues.

The contributions of the studies were diverse, since the evaluation of health services through research of AEs, reflections on nursing performance to propose strategies to promote patient safety.

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Received on: 16/04/2013
Required for review: No
Approved on: 10/01/2014
Published on: 01/04/2014

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