



NURSING CONTRIBUTIONS TO THE PATIENT'S SAFETY IN THE INTENSIVE CARE UNIT: AN INTEGRATIVE REVIEW

CONTRIBUIÇÕES DA ENFERMAGEM NA SEGURANÇA DO PACIENTE DA UNIDADE DE TERAPIA INTENSIVA: UMA REVISÃO INTEGRATIVA

CONTRIBUCIONES DE ENFERMERÍA EN LA UNIDAD DE CUIDADOS INTENSIVOS DE SEGURIDAD DEL PACIENTE: UNA REVISIÓN INTEGRADORA

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ABSTRACT

Objective: to analyze the scientific production on nursing related to patient's safety in the intensive care unit. **Method:** an integrative review conducted in CINAHL LILACS and SCOPUS databases, using the keywords: patient safety/patient safety, intensive care unit/intensive care unit and nursing/nursing. **Results:** the study included 13 articles analyzed from six categories: << Patient's safety in the prevention of adverse events in nursing >>, << Patient's safety in the safe administration of medication >>, << Patient's Safety in effective communication >>, << patient's Safety in the standardization of procedures >>, << patient's safety in the prevention of pressure ulcers >> and << patient's safety in the practice of handwashing >>. **Conclusion:** the study showed how contributions the importance of standardization of procedures and the low evidence of publications related to nursing. **Descriptors:** Nursing; Patient's Safety; Intensive Care Unit.

RESUMO

Objetivo: analisar a produção científica de enfermagem sobre a segurança do paciente na unidade de terapia intensiva. **Método:** revisão integrativa realizada nas bases de dados CINAHL, LILACS e SCOPUS, utilizando os descritores: patient safety/segurança do paciente, intensive care unit/unidade de terapia intensiva and nursing/enfermagem. **Resultados:** foram incluídos 13 artigos, analisados a partir de seis categorias: << Segurança do paciente na prevenção de eventos adversos na enfermagem >>, << Segurança do paciente na administração segura de medicamentos >>, << Segurança do paciente na comunicação efetiva >>, << Segurança do paciente na padronização de procedimentos >>, << Segurança do paciente na prevenção de úlcera por pressão >> e << Segurança do paciente na prática da higienização das mãos >>. **Conclusão:** os estudos apontaram como contribuições a importância da padronização dos procedimentos e quanto a baixa evidência das publicações relacionadas à enfermagem. **Descritores:** Enfermagem; Segurança do Paciente; Unidade de Terapia Intensiva.

RESUMEN

Objetivo: analizar la producción científica de la enfermería en la seguridad del paciente en la unidad de cuidados intensivos. **Método:** una revisión integradora realizada en las bases de datos CINAHL, LILACS y SCOPUS, usando las palabras clave: la seguridad del paciente/la seguridad del paciente, unidad de cuidados intensivos/unidad de cuidados intensivos y de enfermería/ enfermería. **Resultados:** el estudio incluyó 13 artículos analizados a partir de seis categorías: << La seguridad del paciente en la prevención de eventos adversos en ancianos >>, << La seguridad del paciente en la administración segura de medicamentos >>, << la seguridad del paciente en la comunicación efectiva >>, << seguridad del paciente en la normalización de los procedimientos >>, << la seguridad del paciente en la prevención de úlceras por presión >> y << la seguridad del paciente en la práctica de lavado de manos >>. **Conclusión:** el estudio mostró cómo las contribuciones de la importancia de la normalización de los procedimientos y la escasa evidencia de publicaciones relacionadas con la enfermería. **Descritores:** Enfermería; La seguridad del Paciente; Unidad de Terapia Intensiva.

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INTRODUCTION

Nursing is a science that aims at promoting the well-being of the patient, who can, over the course of his/her disease, come across a stay in the intensive/ICU care unit, since he/she needs continuous intensive care with all the technological apparatus for a better monitoring, or to carry out investigations of other diagnoses. Thus, not only it is nursing, but the entire multidisciplinary team the ones who work in promoting the safety of the patient when exposed to suffer some damage.

In 2004, the World Health Organization (WHO) created the Global Alliance Project for Patient Safety, which main objective was to prevent harm to patients. One of the central elements of the WHO World Alliance is the action known as the Global Challenge, which launches a priority issue every two years for adoption by members of the WHO. The previous focus to the global challenge initiative included hospital-acquired infections and safe surgery.¹ Thus, the development and knowledge dissemination of policies based on scientific evidence is of major importance, best practices in patient's safety and the development of research in the areas that will have the greatest impact on security issues.²

Constitute the International Patient Safety Goals: identify patients properly; improve the effectiveness of communication; improve security for high-risk drugs; eliminate surgery/wrong procedures on the wrong patient and wrong part; reduce the risk of nosocomial infection and to reduce the risk of injury resulting from falls patient. It appears that the adoption of International Patient Safety Goals reflects good practice proposed by experts, and is a strategy for reducing the risk of errors and adverse events in health institutions.²

Risks of adverse events in the health care exist in different environments where such assistance is offered. Among these different environments, there is the Intensive Care Unit (ICU) which is considered a welfare scenario of high risk. This unit has the peculiarity of intensive care, which means that must be provided quickly, involves many procedures, produces a large amount of information is held by a large and varied number of professionals in the face of severity of patients, working under a severe

stress. They deal directly with situations of life and death in which decisions must be taken quickly.³

Moreover, the study aims at analyzing the scientific production of nursing on patient safety in the intensive care unit.

METHOD

Integrative review, which uses a summarization of the completed researches by inferring a proposed study of interest. Thus, allowing relevant research analysis that gives decision support and improvement of clinical practice, enabling the state knowledge synthesis of a particular subject, while pointing out gaps in knowledge that need to be filled with new studies.⁴

This study followed the methodological steps of the integrative review that consists of six steps. The first step is the theme of identifying and selecting the hypothesis or research question for the preparation of the study, is considered a guiding stage for an elaborate integrative review.⁵

Thus, the theme chosen for this review was patient's safety in clinical practice nursing in the intensive care unit, in order to see what has been published about this important issue nowadays. For this, the following question was elaborated: *What nursing has addressed the safety of the patient's intensive care unit?*

After the elaboration of guiding question, came the second stage, which aims in establishing the criteria for inclusion and exclusion of studies/sampling or literature search. Therefore, the omission of the sampling procedure may be the greatest threat in the validity of the review. This procedure of inclusion and exclusion of articles should be conducted in a rigorous and transparent way, since the representativeness of the sample is an indicator of the depth, quality and reliability of the final conclusions of the review.⁴

The study was made through a thorough research on the following bases and data indexed in the CAPES portal: Cumulative Index to Nursing and Allied Health Literature (CINAHL), Latin American Literature Health Sciences (LILACS) and Scopus (Elsevier) The Scopus was used for being the reference in publications regarding the field of intensive care, and

the other bases are always referenced for research in global health.

The proper refinement of the search originated from the definition of a sample, according to the following inclusion criteria: full articles available in full in English, Portuguese and Spanish. To perform the search we used the following descriptors controlled the registered English in MeSH (Medical Subject Headings): patient safety, intensive care unit and nursing; and descriptors of Portuguese registered in Decs (Health Sciences Descriptors): patient safety, nursing and intensive care unit.

As exclusion criteria, articles published by professionals other than nurses and papers that were not available online in its entirety were elected. The articles could be written by other professionals, since together with nurses, once the purpose of the study was intended to publications related to nursing. Thus, during the selection, some articles were excluded after reading the summaries, not fit the proposed inclusion criteria; others were selected and excluded after reading the full article, also not in accordance with the criteria previously settled down.

The search for articles in the databases occurred in January to May 2014. As defined in January 2009 to December 2013 because it is a topic that has been much discussed in recent years, although the concern not harm the patient is inserted from the insertion of early care.

The third step is to establish the information to be extracted from selected studies and their proper categorization. This step aims at organizing and summarizing the information in a concise manner, forming an easy access and management database. Generally the information should cover the study sample (subject), objectives, methodology, results and key findings of each study.^{4,5}

The search was initiated by the CINAHL database through the terms patient's safety, intensive care unit and nursing, returning the total of 191 studies. Among the 114 studies published from January 2009 to December 2013 were selected those in full text, which were filtered 57 studies. Then, they selected studies involving the category of all adults among which reached the result of 24 scientific articles. After the reading of the abstract of each study, seven

scientific articles were obtained as a sample.

Regarding LILACS, the search began with the descriptors patient's safety, intensive care units and nursing. Yielded three articles, which were available in full text.

In SCOPUS, 369 studies were detected with the descriptors "safety patient", "intensive care unit" and "nursing". Were selected 234 studies published from January 2009 to December 2013. Then, 226 studies published in Portuguese, English and Spanish were selected. Later 163 scientific articles were filtered. All articles involving neonatology, pediatrics, obstetrics and geriatrics were then excluded, resulting a total of 79 articles. 50 articles that were involved with the theme patient safety were selected. After thoroughly reading the abstracts, three articles that contemplated all the above requirements were selected.

After reading all the elected articles, was filled an instrument already validated in the research branch containing the following topics: year of publication, language, country where it was performed, the study objectives, methodology, research subjects, summary results, conclusions, level of evidence and the step involving patient safety.⁵

In the fourth stage, an assessment of the studies included in the integrative review was made. This step is equivalent to the analysis of data in a standard search, in which there is the use of appropriate tools. To ensure the validity of the review, the selected studies should be analyzed in detail. The analysis should be carried critically, seeking explanations for the different or conflicting results in studies.^{4,5}

Since it is an evidence-based research, the level of evidence of the articles evaluated was identified by applying the following rating system: Level I - Evidence from systematic reviews/ meta-analysis of randomized controlled clinical trials; Level II - evidence derived from at least one randomized controlled clinical trial clearly delineated; Level III - evidence from non-randomized clinical trials; Level IV - evidence originating from cohort studies and case-control; level V - evidence from a systematic review of descriptive and qualitative studies; Level VI - evidence derived from a single descriptive or qualitative study; level VII - evidence from

opinion of authorities and/or report of expert committees.^{4,5}

The fifth stage relates to the interpretation of the results corresponding to the discussion stage of the main results of conventional research. The reviewer based on critical evaluation of the results of the included studies makes the comparison with theoretical knowledge, identifying conclusions and implications of the integrative review.⁵

The sixth step is the preparation of the document, which should include a description of the steps taken by the reviewer and the main results evidenced analysis of the included articles. It is a work of extreme importance since it has an impact due to the accumulation of existing knowledge about the researched topic.⁴

The selected articles were analyzed and categorized into six thematic categories: << Patient’s safety in the prevention of adverse events in nursing >>, << Patient’s safety in the safe administration of medication >>, << Patient’s Safety in effective communication >> << patient’s Safety in the standardization of procedures >>, << patient’s safety in the prevention of pressure ulcers >> and << patient’s safety in the practice of handwashing >>.

RESULTS

The characterization of the articles regarding the authorship, country, year of publication, database, objectives, level of evidence, the step that involves the safety of the patient and the synthesis of the results are shown in Figure 1.

Article	Author (s) / Journal / Year / Country / Database	Objectives	Level of Evidence	Category	Summary of results
Errors in the administration of antibiotics in the intensive care unit of University Hospital	Rodrigues; Oliveira/ Rev. Eletr. Enf/ 2010/ Brasil/ CINAHL	Check for errors in the administration of antibiotics in patients in intensive care units of a teaching hospital of the Federal District, as well as to characterize them as to the types	VI	Patient’s safety in the safe administration of medication	It was observed the prevalence of antibiotic administration at the wrong time. Disinfection absence of bottles of drugs and lack of hand hygiene of professionals. ⁶
Brazilian registered nurses’ perceptions and attitudes towards adverse events in nursing care: a phenomenological study	Freitas; Hoga; Fernandes; González; Ruiz; Bonini/ Journal of Nursing Management/ 2011/ Brasil/ CINAHL	Explore the perceptions and attitudes of nurses in relation to adverse events in nursing care.	VI	Patient’s safety in the prevention of adverse events in nursing	The human factor was the element that prevailed in the four dimensions involved in this issue: the patient, professional, family and health institution. The results indicate the need to eliminate the fear of punishment for reporting adverse events. ⁷
Nursing documentation prior to emergency admissions to the intensive care unit	Jonsson; Jansdattir; Moller and Baldursdattir/ Nursing in Critical Care/ 2011/ Islândia/ CINAHL	To estimate the accuracy of nursing records in accordance with the parameters comprising MEWS in patients before emergency admission to the intensive care unit.	VI	Patient’s safety in effective communication	The survey results highlight insufficient documentation of key physiological parameters of patients, particularly respiratory function. ⁸
A qualitative exploration of nurse’s perception of Critical Outreach Service: A before and after study	Athifa; Finn; Brearley; Williams; Hay; Laurie; Leen; O’Brien; Stuart; Watt; Leslie/ Australian Critical Care/2011/	Explore the perceptions of the nursing team before and after the introduction of a SOFC in three teaching hospitals in Australia.	VI	Patient safety in effective communication	Occurred both the improve the communication process between the members of the multidisciplinary team and the transfer of in-hospital level

	Austrália/ CINAHL				patient. ⁹
Adverse drug events in intensive care units: A cross-sectional study of prevalence and risk factors	Seyenaeve; Verbrugghe; Claes; Vandenplas; Reytiens; Jorens/ American Journal of critical Care/ 2011/ Bélgica/ CINAHL	To evaluate the characteristics of adverse drug events in hospitalized patients in the intensive care unit and determine the impact of disease severity and nursing workload in the prevalence of events.	VI	Patient's safety in the safe administration of medication	Almost all adverse drug events were Class E: no serious complications were seen. Nursing workload was significantly associated with the incidence of adverse drug effects of events. ¹⁰
Development of standard practice guidelines for open and closed system suctioning	Ozden; Gorgulu/ Journal of Clinical Nursing/ 2012/ Turquia/ CINAHL	Determine the knowledge and practice of nurses before and after training and the development of guidelines for standard practice for open system and closed aspiration in patients with an endotracheal tube.	VI	Patient's safety in standardization procedures	The increased level of knowledge of nurses meant that the procedure was performed correctly. In view of these results, it can be said that it is highly beneficial to provide a theoretical and practical training for nurses and develop guidelines for standard practice. ¹¹
Pressure ulcers in the intensive care unit: the relationship between nursing workload, illness severity and pressure ulcer risk	Cremasco; Wenzel; Zanei; Whitaker/ Journal of Clinical Nursing/ 2012/ Brasil/ CINAHL	Check the association between pressure ulcer development with nursing workload and severity of the disease to see if the nursing workload and severity of disease are related to the scores of the Braden Scale.	VI	Patient's safety in the prevention of pressure ulcers	The nursing workload and severity of illness explained only 45% of the variability in Braden scores, suggesting that other factors are involved in the risk assessment for the development of UP in critically ill patients in the ICU. The precise identification of risk factors and the use of clinical judgment in the assessment of skin are prerequisites to determine appropriate strategies to prevent pressure ulcers, to improve quality of care for patient safety and decrease the ICU time and hospital stay and costs. ¹²
Allocation of the nursing team and the occurrence of adverse events / incidents in intensive care unit	Gonçalves; Andolhe; Oliveira; Barbosa; Faro; Gallotti; Padilha/ Rev Esc Enferm USP/ 2012/ Brasil/ LILACS	Check the adequacy of the allocation of the nursing staff and the hours of care required by patients and to identify the relationship between the allocation of nursing staff per patient and the occurrence of adverse events.	VI	Patient's safety in the prevention of adverse events in nursing	The greater the difference between the available hours of nursing and care required by patients in nursing allocations, the lower the frequency of adverse events and incidents. ¹³

Infrastructure and adherence to hand hygiene: challenges to patient’s safety.	Bathke; Cunico; Maziero; Cauduro; Sarquis; Cruz/ Rev Gaúcha Enferm/ 2013/ Brasil/ LILACS	Investigate material infrastructure and adherence to hand hygiene in intensive care unit.	VI	Patient’s safety in the practice of handwashing	There was greater adherence in directions that reflect the professional protection compared to those related to the Patient Protection and, although, there have been variations between professional categories, it can be said that the assistance unit investigated under the perspective of poor compliance of hand hygiene, implies risk to the safety of critically ill patients. ¹⁴
Psychometric analysis of the predisposition of scale to the occurrence of adverse events in nursing care in ICUs	Lobão; Menezes; Rev. Latino-Am. Enferm/2013/ Brasil/ LILACS	Present the results of studies of validity and reliability of the predisposition of scale to the occurrence of adverse events	VI	Patient’s safety in the prevention of adverse events in nursing	It was felt the need to apply the predisposition to scale the occurrence of adverse events in ICUs in order to establish a comparison between the results obtained and possible expansion of the understanding of the attitude of nurses in relation to aspects of the structure and process that can trigger the occurrence the adverse event during nursing care in ICUs. ¹⁵
Medication administration via enteral tubes: a survey of nurses practices	Phillips; Endacott/2011/ Australia/ SCOPUS	Investigate nursing practices in medication administration by enteral tube.	VI	Patient’s safety in the safe administration of medication	There was a large variation of the practice of nurses in relation to drug administration by enteral feeding and care in installation and maintenance of the same. ¹⁶
Impact of a preventive programme on the occurrence of incidentes during the transport of critically ill patients	Berubé; Bernard; Marion; Parent; Thibault; Williamson; Albert/ Intensive and Critical Care Nursing/ 2013/ Canadá/ SCOPUS	Determine whether a program as a preventive is beneficial in reducing incidents related to the transport of ICU patients	VI	Patient’s safety in effective communication	A prevention program implemented by all care providers involved in the transport of critically ill patients was associated with the reduction of incidents. The implementation of the program should be recognized as a standard of care, considering the risks inherent in the transport of ICU patients. ¹⁷
Patient’s safety culture in intensive care:	Mello; Barbosa/Texto Contexto	Systematize the recommendations of nursing	VI	Patient’s safety in effective	The ICU of 1 professional recommendations

nursing recommendations	Enferm/ 2013/ Brasil/ SCOPUS	professionals from the responses to this question	communication	highlight the need for improvements in mainly quantitative professionals; ICU 2 points need for interventions to improve the communication in relation to changes in routines and communication between the teams. ¹⁸
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Figure 1. Distribution of articles inserted in the second integrative review authors, journals, year of publication, country of publication, database, study objectives, level of evidence, studied prognostic indexes and summaries of study results. Fortaleza, Brazil, in 2014.

It was found that of the 13 articles analyzed, eight (61.5%) were enrolled in English and five (38.5%) in Portuguese. Regarding the temporal distribution, it was noticed that most of the studies were published in 2011 (5 = 38.4%) following the 2013 (4 = 31.8%) and then the years 2012 (3 = 23.1%) and 2010 (1 = 7.6%).

As the host country of the study, seven studies (61.6%) were performed in Brazil, two (15.4%) in Australia, one in Belgium, one in Iceland, one in Canada and one in Turkey. As for the level of evidence, it was observed that all studies were classified as level six being classified as weak evidence. About the authorship of articles, it is clear that all were written by nurses.

DISCUSSION

The selected articles were analyzed and categorized into six thematic categories.

◆ **Patient's safety in the prevention of adverse events in nursing**

The term patient's safety involves generally the prevention of errors in patient care and the elimination of damage that can be caused by such errors. The error in the care provided by the nursing staff results in unintended action caused by any failure or problem during patient care and may be made by any staff member at any time care.¹⁹

Several terms are used as synonyms of adverse events: iatrogenic event occurrences; nursing errors; occurrences reactions; iatrogenic complications; iatrogenic; iatrogenic disease and failure. However, all are defined as undesirable events, unintended, harmful or detrimental to the patient nature, compromising their safety, consequential or not on the failure of the professional involved.⁷

This study found that of the 550 adverse events in nursing care in the most frequent

ICU were related to drug administration (51.4%), followed by nursing notes (24.0%), the therapeutic and diagnostic devices (15%) and procedures not performed (9.6%), with a monthly average of 55 occurrences, the highest incidence recorded in the first 30 days of data collection.²⁰

◆ **Patient's safety in the safe administration of medication**

Adverse drug events are defined as loss or damage caused to the patient resulting from the use of drugs, not all are attributed to errors, exemplifying an allergic reaction presented by the patient to the drug, previously unknown, can be considered an adverse event. An allergic reaction presented by the patient that has been previously documented must be classified as medication error.³

Without the error notification, the awareness of all nursing staff that there will be no punishment for the error should be fostered. Nurses should take this time and identify the difficulties of professional and immediately start guidance and training. This study also points out that continuing education, updates, improvements and recycling to increase the knowledge acquired in basic training curriculum also help reduce failures. It concluded that drug administration is one of the most important activities of nursing and know the types of errors and the causal factors in the occurrence of failure in the administration of medication is essential for the development of preventive measures to reduce them. It is important that the errors are interpreted as consequences and not as causes.²¹

◆ **Patient's safety in effective communication**

Studies have pointed out the importance of communication in the act of transfer and transport of the patient. It is known that in

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Brazil there is the publication of RDC number 7, which establishes the minimum requirements for Intensive Care Units operation. And one of those requirements relates exactly to the process mentioned above related to the critically ill patient.²²

Communication is a two-way process, a dynamic force able to interfere in relations, facilitate and promote the development and maturation of people and influence behavior. There are several forms of communication, such as verbal, non-verbal, written, telephone, electronics, among others, being fundamental to occur properly allowing understanding between people. The patient receives several professional cares and in different locations, which is essential to effective communication among those involved in the process.²³

Nursing is the team that most interacts with the patient, where there are too many assignments and, thus, there is a wide concern about the quality and humanization of care. Most of the time patients, family and society have difficulties to recognize the different members of the nursing team, a fact that can be solved when each professional identifies including name, category, and the procedure to be performed, and will give more security to patient.²⁴

Patient's safety has become a global concern due to the effects of the damage derived from the assistance provided thus affecting not only the patient but their families and health professionals involved in health care. Recently this issue has become frequently discussed by health organizations. We can see with further studies one triad of relevance: security x quality x communication, since there is a great importance of communication as a determinant of quality and safety in care. So, to have an effectiveness in assisting with this trinomial, are required prepared and trained professionals to build a structured relationship through the quality of information exchanged, reducing the risks and failures to his patient, favoring better security, promoting quality health without causing damage.²⁴

Communication between the teams contributes to a common understanding, a team that is not working effectively increases the possibility of errors, and leads to insecurity. When groups work efficiently, discussing the instructions, they avoid

misunderstandings and failures, bringing greater safety, avoiding errors and improving the quality of care, making that assistance does not result in harm to the patient.²⁴

♦ Patient's safety in standardization procedures

The concerning about the quality in the provision of health services is not new, and the customer's objective when needing hospital services is to restore the health, solve problems and balance disorders. For he/she to enjoy quality service, a management system that recognizes their needs, establish standards and seek to keep them to ensure their satisfaction is needed. Quality management can be useful for nursing, contributing to the implementation of new methodologies and changes necessary to improve care and contentment of the team and the patient. The best way to start the standardization is through the mechanisms involved in the process. In this case, a systematic representation is needed: an example is the Standard Operating Procedure (SOP), which describes each critical and sequential step that should be given by the operator to ensure the desired result of the job, and relate to the technique, a Greek word that refers to the provision that do things with the aid of a true rule.²⁵

Technical acts induce repeated action, sometimes by many different hands, with some assurance same result. However, professionals of the art that are different beings with talents, feelings and knowledge regularly act the same way and produce, not always with exactly the same means because of the work contexts, similar results and also meet different people. In nursing, the SOPs are contained in manuals in order to answer questions and guide the implementation of actions and must comply with the guidelines and regulations of the institution, be updated whenever necessary, according to scientific principles to be followed by all (doctors, nurses and assistants) in a standardized way.²⁵

Considering the results, it is important that the objective of POP is really answer questions, but must be continuously, as well as continuing education and, therefore, there is the need for specific training on their use, for a better understanding of why the conducting standardized techniques for all professionals do not happen. It is not

desired automatic performing techniques, but rather to combine *know to do*, even before actions considered simple. Therefore, there is need for committed professionals with care and, for common results, are involved with the philosophy of the institution and to cooperate and engage your entire team, participating in the process to improve the care offered.²⁵

♦ Patient's safety in the prevention of pressure ulcers

The Intensive Care Units (ICUs) receive patients with single or multiple organ failure, which requires life support measures such as mechanical ventilation, continuous sedation and vasoactive drugs, as well as various types of devices such as catheters, drains, probes and immobilizers. These measures undermine one of the most important mechanisms of the skin maintaining the integrity of the mobilization in the bed of highly vulnerable patients to the development of pressure ulcers.²⁶

Pressure ulcer is an injury to the skin or underlying tissues or structures located generally over a bony prominence, resulting from pressure alone, or in combination with friction and/or shear. Periodic assessment of the risks that each patient presents to the occurrence of pressure ulcers guides professionals to develop strategies for prevention.³

Prevention of pressure ulcers (UPP) is an important issue considering the global movement context for patient safety. May cause damage of several kinds to individuals and health services. The UPP is also considered one of the negative indicators of care quality of health and nursing services.²⁶

The risk assessment for the development of the UPP and the use of appropriate preventive measures are recommended by international guidelines and cited by authors as "best practices." So, can reduce the incidence, improving the quality of nursing care and therefore greater safety for patients, especially for those in the Intensive Care Units.²⁶

One of the most used scales to help identify the UPP development risk is the Braden Scale. The total score ranges from six to 23, in which scores from 19 to 23 indicate patients without risk, from 15 to 18 low risk, 13 to 14 moderate risk, ten to 12 high-risk score $\leq$ nine indicates patients very high risk.²⁷

The purpose of the scale is to help hospital nurses in the clinical evaluation to predict whether the patient may develop pressure ulcers and point out the risk factors in evidence. From this, the purpose is to plan effective strategies and individualized prevention based on risk factors found in patients through the instrument.²⁷

For the risk assessment scale for UPP to reach the proposed objective, it is important for nurses to know how to use the instrument and that there is agreement among those who use.¹⁴ A high correlation indicates a high level of reliability among observers, a necessary condition to obtain valid scores.²⁸

In Brazil, as in other countries, the issue of compliance and reliability scores and subscores of risk assessment scale, obtained by different nurses, is important for healthcare institutions, because it allows the appropriate risk classification of UPP patients to the correct calculation of the ulcer incidence, and the improvement of nursing care through the establishment of protocols for prevention according to the level of patient risk.^{27,28}

♦ Patient's safety in the practice of handwashing

Health care associated infections (HAIs) currently represent a concern not only of the relevant health agencies, but a problem of social, ethical and legal implications in relation to the lives of users and the risk to which they are submitted.²⁹

These infections, besides affecting customers also threaten health professionals (PAS), support service workers, caregivers and other service users. The impact of HAIs implies prolonged hospital stay, increased antimicrobial resistance, overspending for the health system, patients and families and high mortality. Hand hygiene aims at removing dirt, sweat, sebum, hair and scaly cells from the skin microbiota, in order to prevent and reduce health care-related infections.¹⁴

In view of the records analyzed in 951 (72.3%) opportunities, there was no HM practice, highlighting the non-compliance, especially before performing noninvasive procedure with the patient (24%), followed by before placing gloves (17.7%) after performing non-invasive procedure with a patient (13.9%) and contact between different patients (11.4%).²⁹

These data suggest that the importance of HM in the professional point of view is his/her own protection, as after contact with organic matter, only 0.3% did not hygiene hands and, before non-invasive procedure with the patient, 24%. These are discrepant data to think that care, treatment and customer protection are requirements for health professionals.²⁹

CONCLUSION

With this study, it was observed that the theme patient's safety has been widely discussed in recent times. However, there are still many goals to be achieved in order to improve the quality of care. While all health professionals know the importance of following international goals, it is observed that many are resistant to following these steps. Steps that are considered very important in preventing damage to customers.

Therefore, nursing is a unique profession that provides its services 24 hours uninterrupted patient who is frail in his bed waiting for a safe care. But there is no point to be taken care by a multidisciplinary team that aims to promote the patient's well-being if the structure does not cooperate with the proper functioning of the provision of quality care.

In conclusion, the study showed results with a significant relevance to healthcare practice, however observed that nursing, you need to grow a lot in terms of evidence in publications so we can not only question but also endorse managers improvements that could enable a safe patient care.

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