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REFLECTIVE ANALYSIS ARTICLE

SAFETY CULTURE OF THE PATIENT IN HEALTHCARE: REFLEXIVE ANALYSIS

CULTURA DE SEGURANÇA DO PACIENTE NO CUIDADO EM SAÚDE: ANÁLISE REFLEXIVA

CULTURA DE SEGURIDAD DEL PACIENTE EN EL CUIDADO DE LA SALUD: ANÁLISIS REFLEXIVA

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ABSTRACT

Objective: to promote reflection about the performance of the managers/professional/family/patient in developing a safety culture of the patient in healthcare. **Method:** this is a study of reflexive analysis, based on a bibliographic survey. **Results:** the care provided to patients is complex and requires to be performed with quality and without causing unnecessary damages to the individual. The existence of a vicious circle is noticeable, and that needs to be broken to review processes and implemented strategies aimed at the quality and guarantee of safe care. **Conclusion:** the challenges in the development of safety culture of the patient are enormous and include the need for strategies for the participation of the involved subjects. Achieving a culture of safety requires an understanding of values, beliefs and norms about what is important in an organization and which attitudes and behaviors related to patient's safety are expected. **Descriptors:** Patient Safety; Organizational Culture; Patient Care Team; Family.

RESUMO

Objetivo: promover reflexão sobre a atuação dos gestores/profissional/familiar/paciente no desenvolvimento de uma cultura de segurança do paciente no cuidado em saúde. **Método:** estudo de análise reflexiva, fundamentado em um levantamento bibliográfico. **Resultados:** o cuidado prestado aos pacientes é complexo e requer que seja executado com qualidade e sem gerar danos desnecessários ao indivíduo. É perceptível a existência de um círculo vicioso que necessita ser rompido para que processos sejam revistos e estratégias implementadas visando à qualidade e à garantia de cuidados seguros. **Conclusão:** os desafios no desenvolvimento da cultura de segurança do paciente são enormes e englobam a necessidade de estratégias para a participação dos sujeitos envolvidos. Alcançar uma cultura de segurança requer um entendimento de valores, crenças e normas sobre o que é importante em uma organização e quais atitudes e comportamentos relacionados à segurança do paciente são esperados. **Descritores:** Segurança do Paciente; Cultura Organizacional; Equipe de Assistência ao Paciente; Família.

RESUMEN

Objetivo: promover reflexión sobre la actuación de los gestores/profesional/familiar/paciente en el desarrollo de una cultura de seguridad del paciente en el cuidado de salud. **Método:** estudio de análisis reflexivo, fundamentado en un levantamiento bibliográfico. **Resultados:** el cuidado prestado a los pacientes es complejo y requiere que sea ejecutado con calidad y sin generar daños desnecesarios al individuo. Es perceptible la existencia de un círculo vicioso que necesita ser roto para que procesos sean revisados y estrategias implementadas, visando la calidad y la garantía de cuidados seguros. **Conclusión:** los desafíos en el desarrollo de la cultura de seguridad del paciente son enormes y engloban la necesidad de estrategias para la participación de los sujetos involucrados. Alcanzar una cultura de seguridad requiere un entendimiento de valores, creencias y normas sobre lo que es importante en una organización, y cuales actitudes y comportamientos relacionados a la seguridad del paciente son esperados. **Descriptores:** Seguridad del Paciente; Cultura Organizativa; Equipo de Asistencia al Paciente; Familia.

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INTRODUCTION

Security is the first step to being taken for quality in healthcare. There is no offer of a good healthcare if it is not primarily grounded in security. The actions and efforts for humanization become obsolete at any health service if they do not include patient’s safety as a fundamental component in the quality of healthcare. As health care organizations continually strive to improve its services, there is a growing recognition of the importance of a safety culture of the patient. Achieving a safety culture requires an understanding of values, beliefs and norms about what is important in an organization and which attitudes and behaviors related to patient’s safety are supported, rewarded and expected.¹

Culture is an abstract and complex term that covers everything from the aspects about the learning of a population to the epistemological aspects and development of the intelligentsia of the human being. It is observed as a phenomenon that occurs in daily life and has features that even though trivial, often are unnoticed by the subjects.

In this perspective, culture can be defined as the sum of values, experiences, attitudes and practices that guide the behavior of a group. The characteristics of a strong safety culture include some assumptions, such as the commitment to discuss and learn from the mistakes, the recognition of the inevitability of error, proactive identification of latent threats and incorporation of a non-punitive system for reporting and analysis of adverse events.¹

Patient’s safety is the reduction to an acceptable minimum, the risk of unnecessary harm associated with healthcare. In this definition, it can be observed that there is a damage need.² For the safety of care, it is necessary to build a safety culture defined by the National Patient’s Safety Program as culture in which all employees, including professionals involved in the care and management, take responsibility for their own safety, the safety of their colleagues, patients and families; culture that prioritizes safety above financial and operational goals; culture that encourages and rewards the identification, notification and resolution of security issues; culture that from the occurrence of incidents, promotes organizational learning; and culture that provides resources, structure and accountability for the effective maintenance of security.³

The concept of safety culture was boosted after the Chernobyl nuclear disaster in 1986. Observing the economic, social and moral impact of such a disaster, the organizations, and systems that were performing dangerous operations, such as civil aviation and chemical industry, started to invest in ways to develop strategies focused on safety aspects. These organizations were able to effectively reduce the incidence of Adverse Events (AEs) despite operating complex systems. Highly reliable organizations maintain the commitment to safety at all levels, from the operational to the leaders and to the top management.^{1,4}

Safety culture is present in highly credible organizations, which are characterized by complex risk processes, but with low error rates. Such organizations achieve high credibility because are concerned about the damage, and are sensitive to how each team member affects a process; they rely on those who are more knowledgeable of the process for decision-making and they resist the temptation to blame individuals errors within complex processes.⁵

Observing the specific aspects of the general organizational culture, safety culture is defined as the product of values, attitudes, skills and individual and group behavior patterns, which determine the commitment, style and management proficiency of a healthy and safe organization. Organizations with a positive safety culture are characterized by communication founded on mutual trust by shared perceptions of the importance of security and confidence in the effectiveness of preventive actions.⁶

The quality of care is defined as the degree to which health services increase the probability of obtaining the desired results with the level of current scientific knowledge, i.e., based on scientific evidence. Effective/necessary care is the one that has reasonably robust scientific evidence indicating that it responds better than any alternative and that the benefits for patients exceed the risk of possible damage. Variations insensitive care to patients’ preferences point to the importance in knowledge advance on the effectiveness of the procedures, but in particular to the need to change the prevailing medical culture.⁷⁻⁸

OBJECTIVE

- To promote reflection about the performance of the managers/professional/family/patient in developing a safety culture of the patient in healthcare.

METHOD

The idea of working the issue in question arose from the concern about the questions listed during the discipline “Patient’s Safety” in the Post-Graduate Program - Master’s Degree in Nursing from the University of Brasília - UNB. The questions such as: “Who are responsible for the development of safety culture and which is the nursing role?” subsidized discussions of the students in the discipline and allowed to base this study.

It is a reflection of the safety culture development, in conjunction with the relevant national and international legislation. Thus, this methodological approach allowed to perform a survey of the subject, with considerations about the interaction and performance of the actors involved in the development of a safety culture of the patient in healthcare, namely: health service managers, professional and health, family/caregiver and patient, observing what it says both the legislation and also published articles.

RESULTS AND DISCUSSION

The challenges for the development of safety culture of the patient are immense but

not insurmountable and include the need to establish effective strategies involving the participation not only of professionals and health services but also the family/caregivers and patients.

At all healthcare levels, it is necessary to develop an expanded view beyond the professional practice and therefore, to the multiple factors that jeopardize the patient’s safety in the care process. When the actions become complex, they begin to require intense and coordinated effort for the health care processes, from planning, to be feasible, i.e., that the rules, procedures, routines, strategy maps, *checklists*, among others, could be implemented, contributing to the safety and reflecting the quality of care.⁹ Thus, complexity is seen as an indivisible whole and requires a multidisciplinary and multi-referenced approach for the construction of knowledge. The role of the actors involved in the organizational culture of patient’s safety is grouped in the text in separate categorizations, only for teaching purposes. It is noteworthy that there is a co-participatory dependence, implying that each involved actor has not an exclusive role but, whether resulting from the interaction, i.e., from a joint operation, as seen in Figure 1.

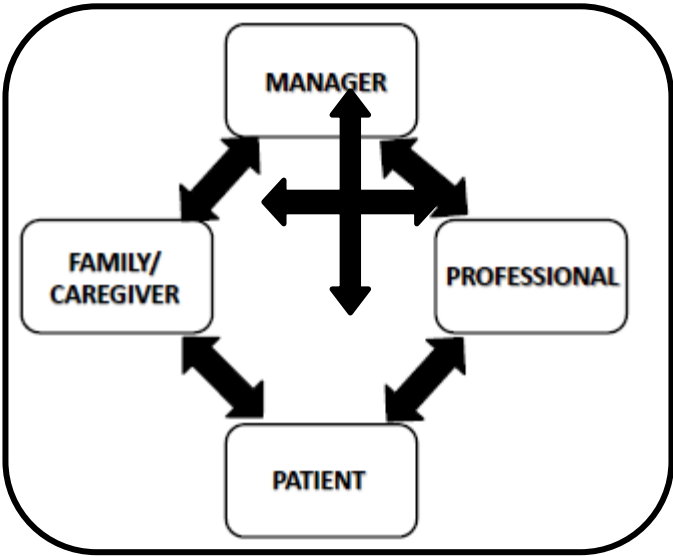


Figure 1. Illustration of the interaction of the subjects involved in the development of safety culture of the patient.

♦ The role of the managers in the health services

The contemporary development of the patient’s safety area allowed a new view about healthcare while was influenced by disciplines from other fields of knowledge that have turned to study human error, accidents and its prevention. The understanding of the factors associated with incidents guides the development of actions to reduce risk,

increasing patient’s safety. The response of the organization to the incident includes measures to the specific situation with consequent learning that leads to changes in the system in a movement of continuous quality improvement.⁸

The safety culture has been the focus of attention in the field of health organizations since health care is increasingly complex, raising the potential for accidents, errors or

failures. Injuries or damages resulting from provided care are serious problems related to the performance of health services; insecure healthcare cause significant morbidity and mortality worldwide.⁶

The quality of patient care results from a secure service, and, therefore, the establishment of a safety culture is required. This culture involves the commitment of the institution and its managers in identifying the need for safety culture as a guiding of its organization, and get involved with everyday situations and seeking to know the difficulties and challenges that direct care provider faces daily to thus, create an effective communication channel with the hierarchical levels and allow the building of trust among all involved.¹

For an organization to get patient's safety results, it is important to establish in advance a safety culture among its employees. The cultural aspect due to its subjectivity is the greatest challenge for the implementation of a health insurance system. The predominance of a blame culture is observed, where mistakes are seen as personal failures, and should be replaced by a culture where mistakes are seen as an opportunity to improve the system.¹

There are a variety of studies focused on safety culture of the patient where they are listed as the most important facts and exploitation of the organization's deficit, communication, and personal skills. An informed culture depends on how managers use and disseminate the information. Failures in communication are also seen as primary points to be noted since it is necessary the interaction between all those involved in the construction process of the patient's safety culture.

♦ The Nursing Role

The nursing professionals, by the specificity of the profession, are those that come closest to the patient, being the most likely to commit adverse events due to the completion of several invasive interventions. It is noticed that even planning their actions within routines, standards, protocols, and they are often faced with the unexpected, i.e., an adverse event. Facing this kind of problem is difficult to know how to act or even notice. Therefore, in health services, these events are often veiled, attenuated or even hidden, preventing users to realize they are injured in their care rights, strengthening a culture based on fear and unethical behavior.¹⁰

An extremely important aspect is the change in the culture of punishment that

punishes the professional and does not evaluate the context in which the security incident occurred. This model, already outdated, is still present in the design of many managers and institutions and leads to recurrence of security incidents and not to its prevention.⁹ Many professionals say that culture in their workplace is not conducive to learn from the mistakes of others and their suggestions about patient's safety would not be put into practice due to the fact by not being heard by the administration of the health service.¹¹

Several surveys portray that, in most cases, nursing shown professionally dissatisfied regarding the accumulation of activities and little prospect of obtaining new knowledge, damaging the quality of their performance with the patient.¹¹ The process of continuously create new knowledge and disseminating them widely is one of the main tools that health professionals have to ensure safe care and quality to patients.

The fact of being actively inserted in care practice is implicitly imposed to the professional to the need for technical improvement concerning technical skills. From this premise then emerges the conflict, as a halt between the need to search for knowledge being rendered impossible by excessive working hours and activities.

The patient's safety movement has been adding some initiatives to improve health care processes. In this sense, an adequate dimensioning of nursing staff according to the severity and the need for patients is necessary because it influences the care and the occurrence of adverse events.¹²

♦ Family/caregivers role

Noting the doctrinal principles of the SUS and its applicability as users right, we can conclude that all those who need and are under the Brazilian legal mantle can be assisted by the system. Thus, the healthcare also reaches the socially vulnerable users who mostly are under the judicial custody or unfamiliar legal representative. Therefore, it is necessary to elucidate the differences between family and caregiver, excluding the image and performance of the professional caregiver who is hired to provide a monitoring service.

To promote safe health care has been a central theme in many discussions on health in almost all parts of the world. The family/caregiver are also part of this scenario, and most of the time, given the complexity of the situation, the caregiver develops a keen eye, being inquisitive, curious and insecure,

which can often be interpreted as an uncompromising family, invasive and unwanted by the health team for being inquiring about what is happening with the patient.¹³

The active communication process in health services can be one of quality monitoring factors in care before the care offered to patients. It is essential to ensure the right attention and care to the patient and the family, especially for the many factors involved that can cause the production of Adverse Events (AEs), directly impairing the development and recovery of the health of those involved. The family must be accompanied at all times of the assistance, since it will fit, often, the process of decision making.¹³

It is known that, in health care settings, information is important in ensuring patient safety. When communication is not effectively, and actively established among professionals, patients, and family/caregiver, it may result in damages. The literature shows that, in most cases, there is a dissatisfaction of the family/caregiver about the received information, considered limited and identified as lack of transparency in the care process. In care situations of mentally patient unable to answer for their actions, patients who present lowering of consciousness, even if momentary, and also in the patient that is at the extremes of age (children and elderly), family/caregiver have the right to follow full-time and may choose not to leave if asked.

♦ The patient's role

Patients expect and believe they will receive from health professionals, appropriate and safe care according to their needs. To provide and receive health care, is fundamental to develop an act of partnership and trust between patients and health professionals. Thus, the involvement of the patient and their companion is a measure to strengthen the safety care. Users of health care services are provided by law, their rights to maintain their autonomy in defense of their physical and moral integrity and information about their health. In addition to the recognition of their right to participation, it is important that patients understand that also share with health professionals the responsibility for proper and safe care.¹⁴

The World Health Organization developed the Patient's Safety Program and among the 13 actions defined by the program, it recommends that one of the initiatives to ensure patient's safety is the development of autonomy and the patient's responsibility in the process of treatment, recovery and

healing. In line with this recommendation, the National Health Surveillance Agency (ANVISA), which coordinates national action for patient's safety and quality in health services, launched in 2012 the Patients Project for Patient's Safety in Healthcare.¹⁵

For health professionals, to involve patients creating a partnership enables offering individualized care, adjusted to their needs and particular conditions. As for the patient, the performance of an active role allows to combat impotence and hopelessness, enables them to realize that it is not simply a victim of errors and failures in security and can affect changes.¹⁶

The patient can and should contribute to the quality of care to their health, providing important information about themselves and interacting with health professionals. They should be encouraged to participate in the assistance and encouraged to make inquiries since they are who have knowledge of their health history, the progression of their disease and symptoms and experiences with treatments that have been already submitted. Also, to develop an environment that provides patient's centered-care, making it, as well and their families, making them active agents in search of safety, promotes interest, motivation and satisfaction with the provided care, aspects that make it possible to have a good result in health conditions.¹⁷

Through a partnership with the patient, the healthcare team fosters their autonomy, recognizes their right to participation in decision-making and restores its leading role in the healthcare, and prepares them for self-care.¹⁷

It is essential to appreciate the close relationship between cultural beliefs and values and how the patient perceives the disease, understand and accept the care and the recommended treatment. In the face of ethnic, gender, sexual orientation, socioeconomic status, age, religious and political beliefs diversities, among others, the health professional should recognize the individuality of each patient and demonstrate acceptance and respect.

The participation of the patient, which must pervade all areas of security and healthcare, including inquiring about their preferences, promote their relationship with the health team, preparing materials for patient's safety, create advisory committees for families, formulate policies and demand changes through partnerships with regulatory and accreditation agencies.

FINAL CONSIDERATIONS

The care provided to patients is complex, abstract and requires to be executed with quality and without causing unnecessary harm to the individual. In practice, it is perceived the existence of a vicious circle that needs to be broken so that processes should be reviewed and implement strategies to improve quality and guarantee safe care.

Patients are increasingly active and committed to the care provided by health institutions. To promote an open and honest relationship between the professional and the patient will create space for dialogue and effective mechanisms to build a safer healthcare system. Still, the government level, managers, trainer agencies and health institutions should support and encourage the participation of the patient in the process of their care aiming a greater safety in care.

It is important to understand that the way to achieve health safety practices is long and challenging, especially for conceiving the differences and difficulties in access to healthcare and the care, teaching and research structures. However, it is known, also, that this is a path without return and thus, can glimpse positive changes ahead.

To assess safety culture enables to identify and manage prospectively, relevant issues of safety routines and working conditions. This approach allows accessing information from employees about their perceptions and security-related behaviors, identifying strengths and weaknesses of their safety culture and the most problematic areas so that we can plan and implement interventions.

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