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SAFETY IN NURSING CARE

SEGURANÇA NO CUIDADO DE ENFERMAGEM LA SEGURIDAD EN LOS CUIDADOS DE ENFERMERÍA

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ABSTRACT

Objective: To describe the scientific production on safety in nursing care regarding failures with potential for the occurrence of adverse events. *Method*: It is a bibliometric study in articles published between 2012 and 2016, with data collection in LILACS, IBECS, MEDLINE, and BDENF. We used the program Statistical Package for Social Science for Windows (SPSS) 22.0, calculated simple and relative frequencies, and the results are presented in tables. *Results*: The sample consisted of 98 publications. It was found that 43.9% were articles from the United States of America; 85.7% publications in English; 70.4% original articles with the thematic more often on medication and scientific production, being greater and continuous in the first 4 years. *Conclusion*: We found that the authorship of the studies was predominantly international, indicating the need for the development of researches about the theme with the intention of showing evidence for the implementation of improvements for the prevention of adverse events and contribute to safety in nursing care at national level. *Descriptors*: Patient Safety; Medical Mistakes; Nursing Care; Patient Care; Quality of Health Care; Nursing.

RESUMO

Objetivo: descrever a produção científica sobre segurança no cuidado de enfermagem quanto às falhas com potencial para a ocorrência de eventos adversos. *Método*: trata-se de um estudo bibliométrico em artigos publicados entre 2012 e 2016, com coleta de dados na LILACS, IBECS, MEDLINE e BDENF. Utilizou-se o programa *Statistical Package for Social Science for Windows* (SPSS) 22.0, calculadas as frequências simples e relativa, e os resultados se apresentam em tabelas. *Resultados*: constituiu-se a amostra de 98 publicações. Verificou-se que 43,9% eram artigos provenientes dos Estados Unidos da América; 85,7% publicações na língua inglesa; 70,4% artigos originais com a temática mais frequente sobre medicação e produção científica, sendo maior e contínua nos primeiros 4 anos. *Conclusão*: constatou-se que a autoria dos estudos foi predominantemente internacional, indicando a necessidade do desenvolvimento de pesquisas sobre o tema com o intuito de mostrar evidências para a implantação de melhorias para a prevenção de eventos adversos e contribuir para a segurança na assistência de Enfermagem em nível nacional. *Descritores*: Segurança do Paciente; Erros Médicos; Cuidados de Enfermagem; Assistência ao Paciente; Qualidade da Assistência à Saúde; Enfermagem.

RESUMEN

Objetivo: describir la producción científica acerca de la seguridad en los cuidados de enfermería ante fallas con potencial para la ocurrencia de eventos adversos. Método: este es un estudio bibliométrico en artículos publicados entre 2012 y 2016, con la recopilación de datos en LILACS, IBECS, MEDLINE y BDENF. Hemos utilizado el programa Paquete Estadístico para Ciencias Sociales para Windows (SPSS) 22.0; calculan frecuencias simples y relativas, y los resultados se presentan en tablas. Resultados: la muestra estuvo constituida por 98 publicaciones. Se encontró que el 43,9% eran artículos procedentes de los Estados Unidos de América; el 85,7% de las publicaciones en inglés; 70,4% artículos originales con la temática más frecuentemente acerca de la medicación y la producción científica, siendo mayor y contínua en los primeros 4 años. Conclusión: hemos encontrado que la autoría de los estudios era predominantemente internacional, indicando la necesidad para el desarrollo de investigaciones acerca del tema con la intención de mostrar evidencia para la implementación de mejoras para la prevención de eventos adversos y contribuir a la seguridad de los cuidados de enfermería a nivel nacional. Descriptores: Seguridad del Paciente; Errores Médicos; Atención de Enfermería; Atención al Paciente; Calidad de la Atención de Salud; Enfermería.

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INTRODUCTION

It should be noted that, over the course of the evolution of society and the advances in the health sector, safety in health care has become a challenge for professionals, since it is directly related with the work process and the quality of care provided to the patient.¹

Nursing constitutes an important part of nursing and active in the context of health and; therefore, it should provide assistance in a safe manner and demonstrate their results by means of evidence.² It is important, in this way, the research on quality care as a form of assessment of work processes of nursing practice.³

It facilitates the evaluation of the quality of nursing care in the context of safety in patient care when there is notification, and acceptance perception professionals regarding the learning resulting from failures, as well as the adoption of preventive measures to mitigate occurrence of adverse events.3 Describe the adverse events as failures arising from the care that reaches the patient, but those could be avoided.3

It should be emphasized that, when it comes to an environment in which the goal is to restore the health of the patient, gaps in assistance should not exist. It is evident; however, by means of studies, the occurrence of adverse events involving nursing care present in every moment in care.³⁻⁵

Propagate quickly, the errors arising from health care in various means of communication, even if the patient safety and quality of health care are the center of the discussions. Relate, generally, these errors to adverse events which lead to permanent sequelae or, in more serious cases, the death of the patient. Generates, with these errors, a negative impact in relation to the system, health professionals, and especially to those who receive the care.⁵

It is perceived, in literature, worldwide, the occurrence of adverse events in health institutions, demonstrating concern with the completion of actions that promote the safety of the patient,⁶ as well as publications concerning the epidemiology of medical error by focusing mainly on the prevalence, the consequences of these errors and the profile of the professionals involved therein.⁷

Become relevant, for scientific research, studies on the occurrence of adverse events in health care institutions and their relationship with the safety in nursing care; such research is, therefore, essential for the evaluation and

the projection of scenarios in the context of nursing care practice, pointing out the trends and opportunities for discussions on this topic.⁸

Proved, in a study of integrative review of literature, with a qualitative approach, about the adverse events in nursing care involving hospitalized adult patients in the period from 2010 to 2014, events related to medication administration, patient monitoring, maintenance of skin integrity and material resources.⁸

Requires caution when you announce the adverse events resulting from the nursing professionals who have a wide repercussion in the media, because these events, committed in a complex and multidisciplinary context that involves care, can hardly be attributed solely to the assistance provided by the nursing staff.⁸

It becomes relevant, in addition, meet and reflect on patient safety related to nursing care, by directly affecting the professional practice. It is known that the analysis and diagnosis provided by research are means to recognize what is being researched in this area and to understand the evolution of results and solutions that emphasize the safe care aiming at the quality of nursing care.

OBJECTIVE

• To describe the scientific production on safety in nursing care regarding failures with potential for the occurrence of adverse events.

METHOD

It is a bibliometric study, which consists in a method of quantitative analysis of scientific production about a particular subject. ⁹ It allows the researcher follow what is produced in his area of study, subsidizing the qualitative assessment of scientific activity. ^{9,10}

The data were collected in January 2017, by means of consultation in the databases of Latin American and Caribbean Literature in Health Sciences (LILACS), Spanish Bibliographic Index of Health Sciences (IBECS), Medical Literature Analysis and Retrieval System Online (MEDLINE) and the Nursing Database (BDENF). It was used for the search terms in English, from the Health Sciences Descriptors (DeCS) and the Medical Subject Heading Terms (MeSH): "Patient Safety", "Medical Errors" and "Nursing Care".

We found 150 indications, after the exclusion of repetitions and the analysis of the records (title, abstract, subject or just title

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and descriptors), in English, Portuguese and Spanish, referring to the years 2012 to 2016.

Considered to be relevant to the theme of the study, after the reading, 98 publications. It was used, then, the program Microsoft Office Excel for the construction of an instrument for data record, subsequently launched in Statistical Package for Social Science for Windows (SPSS) 22.0, in which the variables were distributed, and then calculated the simple relative and frequencies.

RESULTS

There were analyzed 98 publications corresponding to 5 years, between 2012 and 2016, according to table 1.

Table 1. Publications on safety in Nursing care, 2012 to 2016. Goiânia (GO), Brazil,

2017.		
Year	N	%
2012	19	19,2
2013	23	23,5
2014	26	26,5
2015	26	26,3
2016	04	4,1
Total	98	100,0

found indications by means of descriptors for the thematic patient safety in all databases, 84(85.7%) in MEDLINE database,

6(6.1%) in LILACS, 5(5.1%) in the IBECS and 3(3.1%) in BDENF.

Table 2. Types of publications on safety in Nursing care, 2012 to 2016. Goiânia (GO), Brazil, 2017.

Type of Publications	N	%
Original article	69	70,4
Review article	11	11,2
Editorial	05	5,1
Case report	04	4,1
Thesis	03	3,1
News	03	3,1
Case study	02	2,0
Comment	01	1,0
Total	98	100,0

It was found that the majority of the scientific production consisted in original articles, indicating the importance scientific evidence in the area studied.

Pointed out, as the vehicle of publication, 93 titles (93.9%) in scientific journals, five (5.1%)in the of **Journal Nursing** Administration, four (4.1%) in the AORN - Association of periOperative Registered Nurses, four (4.1%) in the Journal of Nursing Care Quality, four (4.1%) in the BMJ Quality & Safety, and, in the other magazines, including three (3.1%) and one (1.1%) articles published on the topic researched, respectively.

Table 3. Language of the publications on the safety in Nursing care, 2012 to 2016. Goiânia (GO), Brazil, 2017.

Language	n	%
English	84	85,7%
Portuguese	08	8,2%
Spanish	06	6,1%
Total	98	100,0%

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Table 4. Countries of the publications on the safety in Nursing care, 2012 to 2016. Goiânia (GO), Brazil, 2017.

Country	n	%
USA	43	43,9%
Brazil	10	10,2%
Canada	06	6,1%
Australia	05	5,1%
Taiwan	04	4,1%
Swiss	03	3,1%
Belgium	02	2,0%
Spain	02	2,0%
Sweden	02	2,0%
Denmark	02	2,0%
Mexico	02	2,0%
Iran	02	2,0%
England	02	2,0%
Czech Republic	02	2,0%
Netherlands	02	2,0%
New Zealand	01	1,0%
Sweden	02	2,0%
Estonia	01	1,0%
India	01	1,0%
Saudi Arabia	01	1,0%
Jordan	01	1,0%
Colombia	01	1,0%
Scotland	01	1,0%
Turkey	01	1,0%
Norway	01	1,0%
Total	98	100,0%

Considered that the publications presented, as well as the themes, the richness in the variety of approaches.

Table 5. Thematic about the safety in Nursing care, 2012 to 2016. Goiânia (GO), Brazil, 2017.

Thematic	N	%
Safety/Medication Errors	10	10,2%
Safety culture	09	9,2%
Medical Malpractice	09	9,2%
Secure care approach in higher education	80	8,2%
Improvisations, interruptions, lost and unfinished care	80	8,2%
Quality and safety management	06	6,1%
Disclosure	05	5,1%
Use of technological devices for patient safety	05	5,1%
Patient identification	05	5,1%
Quality in Assistance	05	5,1%
Communication	04	4,1%
Strategies for improvements and Error Prevention	04	4,1%
Safe Surgery	04	4,1%
Service training	03	3,1%
Workload	02	2,0%
Safety climate	02	2,0%
Consequences of Malpractice for the professional	02	2,0%
Concepts and Terminology	02	2,0%
Quality indicators	01	1,0%
Work-related stressors	01	1,0%
Total	98	100,0%

DISCUSSION

Located to 98 publications in the databases between 2012 and 2016. It was observed, in accordance with the articles raised, a larger quantity of publications from 2014 (26.5%), which may be related to the implementation of International Goals of Patient Safety, by Joint Commission International, in 2010, with emphasis on the maintenance of secure

environments in health, by means of risk management, in order to avoid errors arising out of health care.¹¹

Defines whether the Joint Commission International as an important non-governmental organization (NGO), headquartered in the United States of America (USA), which evaluates and certifies the quality of Brazilian and American hospital service and who recommends the use of

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assessment tools that can measure and monitor the performance of health institutions, the example of instruments of notification, an analysis of the causes of adverse events and the deployment of quality measures.¹¹

It has been found, in 2016, a decline of publications that can be related to the late insertion of articles in the database. The United States with the largest number of publications in the area (43.9%). It is noted that, from the dissemination of the report of the Institute of Medicine (IOM), entitled "To Err is Human", published in 2000 by the Committee on Quality of Health Care in America, the theme "Patient Safety" won global importance, by demonstrating, through surveys carried out in hospitals in New York, the occurrence of 100 thousand deaths caused by adverse events in that country. 12 It was created, in this context, in 2004, the World Alliance for Patient Safety, the World Health Organization (WHO), with the purpose of developing policies to practice improvement, aimed, in particular, for the safety and quality of care. 13

Brazil has been highlighting by the increasing research in the area, totaling 10.2% of publications, particularly involving patient safety and Nursing. It was established that, with the launch of the National Program for Patient Safety (PNSP), by the National Sanitary Surveillance Agency (Anvisa) of the Ministry of Health, the first measure adopted consists in the obligation of creation, by all health institutions, the Nuclei of Patient Safety (NSP).¹⁴

Established through Resolution N 36, 25th July 2013, actions for the safety of the patient, with ramifications in the notification of adverse events related to products and to failures in the processes of care and the development of a safety culture in health services. We started to include, therefore, Brazil in the global scenario of monitoring of adverse events, in addition to countries such as the United Kingdom, Australia, Canada, Colombia which and Mexico. feature engagement and growth in research with the thematic patient safety. 14

Describe, by WHO, the six priority areas of research: counterfeit medicines and low standard, competencies and inadequate skills, maternal care and neonatal infections associated to health care, unsafe practices of injection, unsafe practices of transfusion of blood and blood products. Indicates, in addition, that developing countries such as Brazil, focus on applied research and

evaluation, which provide the development of locally feasible solutions. 15

It is the greater involvement of different countries in research when it involves the patient safety and stands out, in these cases, the partnership of OMS. 16-18 It is noted that, in countries like Iran, the focus is the strengthening of health security; 16 Estonia already started to review its national process of development of clinical guidelines as part of a program to improve the quality of health care, with the WHO and the Faculty of Medicine of the University of Tartu. 17 It was defined, in Saudi Arabia, the National Program of Transformation with goals until 2020, aiming to improve the planning, production and management of the labor force of health.¹⁸ It is known that Scotland is not a member of the WHO country; however, the country has a long tradition in improving the quality and safety of health, since 1994, mainly, through the Scottish Patient Safety Program, which became the first health care system in the world to adopt a national approach to improve patient safety.¹⁹

It has, since 2012, that the objective of the construction process of patient safety by who is to improve health outcomes, strengthen the role of the organization leadership in the field of global health and move to the institutional excellence, having as a component of the program to improve the health of people. ¹⁸ It is recommended that, in the component of governance, increase the coherence in the area of global health and should be in the management component, trying to achieve the institutional excellence. ¹⁸

It was recorded, as well as the themes of publications, that 10.2% were related to the process of medication. Point is, in studies on this topic, the impact on the implementation of electronic prescribing system and the crucial role that the nurse develops in safe practices for the preparation and administration of medications, as well as complex processes of management, which involves other professional categories as the doctor and pharmacist. It agrees; however, that the medication error continues to be a great challenge at global level.²⁰

It is, in one study,²⁰ that the principle of "certain" during the administration of the medication is not enough for safety in this process, due to the need to strengthen the work in a multidisciplinary team and the insufficient knowledge of nurses related to pharmacology and safety in medication, which results in errors.²⁰

Consider medication errors those occurring in stages of the process of medication that

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may cause risks or damage to the patient.²¹ Approaches, in one study, the incidence of error with medications, related to factors such as the preparation and administration, distribution, the prescription form unreadable and similar packaging, as well as the reduction of errors related to medications, with the implementation of Safety Committees, on the initiative to review and analyze all errors of medicines to improve processes in the administration medication.21

Launched by WHO, in 2017, the Global Challenge of Patient Safety, with the theme "Safe Use of medicines", in order to educate and engage the members and professionals in the world to the issues related to security in the use of medications. Published if, in this sense, the specific protocol for the prevention medication errors related prescription, use and administration of medicines. lt is emphasized that the medication errors correspond to 30% of adverse events in hospitals and in primary care, children and the elderly, those most affected by these events.²²

We observed the presence, in 8.5% of the articles, the topic of safety culture, which points to the processes of change and innovation in institutions, with different organizational cultures and underlying factors that facilitate or hinder this process. Include these factors, people, ideas, patterns of relationship and time. It is suggested that, in environments, there certain organizational culture that favors the change and innovation, but not in others. It is required for the creation of a secure environment for patients and professionals, a strategic plan, leadership and team work.²³

Pointed to a culture of security involving the activities of nursing as a subject present in 9.2% of the publications. Involve in health services and the development of an organizational culture focused on patient safety, the processes of change in the management of risks and learning with errors, which in turn covers people, ideas, patterns of relationship and work processes. Should it be guided, so that the safety culture develops in an effective manner, the communication broad and systemic approach of risk.²¹

Defines the safety culture as the set of values, attitudes, skills and behaviors that determine the commitment with the management of health and safety, replacing the guilt and punishment by the opportunity to learn from the failures and improve health care.²⁴ Constitute themselves as opportunities the construction and application of research

instruments for managers of health care organizations, to understand the perceptions of professionals and the organizational practices, in order to generate actions for improvements to the patient and employees.²³

Consider the nurses, because they are professionals in the front line of direct care and continuous access to the patient, as strong influencers in the development of a safety culture. It stands out as the main attribute, the responsibility to coordinate communication among the team, which may contribute to the management and the use of standardized tools for transfer of learning, based on systems of improvement in communication. ^{25,26}

It is difficult to learn from the mistakes, since the processes and systems designed to improve this communication still remain scarce, although it is known that the teamwork and good communication between the members of the team are fundamental to the provision of high-quality care.²⁶

Approached the medical error in 9.2% of the publications, being understood as the lack of use of safety measures to prevent adverse events; furthermore, the consequence of the misconduct of the health care professional capable of producing an injury to life or health of the patient, characterized by incompetence, recklessness or negligence.²⁷

Uses, in English literature, the term medical error to refer to adverse events related to events of systemic nature and individual. Met, by means of a study related to adverse events attributed to nursing care, that the major events were related to injuries caused by pressure drops, errors in medication administration, pneumonia, urinary tract infections and the inappropriate use of containment of patients. Joins, in another study, the medical error to the organization of the service or the care provided. Stand out as the highest indices, medication errors and failures in the annotations and/or payroll records in the evolution of the patient.

It is recommended that the medical errors be recorded, that training activities be offered and that determine the patterns on the nursing care and patient safety.

CONCLUSION

Allowed for this study, show that still has a lot to advance in relation to research on the safety in Nursing care, especially those related to the number of Brazilian publications. Notes safety culture as a theme of extreme relevance and that needs to be

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explored further, which may be a new trend for future studies.

Reveal some points that may contribute to of quality failure the of compromising the safety of the patient, such as the lack of communication and risk management. Highlights the need to report the initiatives related to the management of resources, information technology human associated with patient safety, the management of physical resources and materials, as well as in health costs.

It is argued that results can subsidize new researches in order to clarify what happens in professional practice and, therefore, propose actions against the recurrence of avoidable errors, improving the safety culture and contributing to the prevention of adverse events and for the quality of care provided to the patient.

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