EVALUATION OF THE IMPLANTATION OF A PATIENT SAFETY NUCLEUS

AVALIAÇÃO DA IMPLANTAÇÃO DE UM NÚCLEO DE SEGURANÇA DO PACIENTE

EVALUACIÓN DE LA IMPLANTACIÓN DE UN NÚCLEO DE SEGURIDAD DEL PACIENTE

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ABSTRACT

Objective: to share the experience with the evaluation of the implantation of a nucleus of patient safety. **Method:** this is a qualitative, descriptive study, a type of experience report, developed with nurses who conducted an evaluation process of the implantation of a patient safety nucleus in a university hospital. A semi-structured script was used for data collection. **Results:** it is revealed that the process covered the antecedent, characterization and development phases, and of the eight national protocols, the nucleus developed actions in four (hand hygiene, patient identification, safe surgery and prevention of pressure ulcers) and has set goals for two (prevention of patient falls and effective communication). Actions related to other two were developed (safety in the prescription, use and administration of drugs and blood and blood products) without the effective participation of the nucleus. **Conclusion:** it was possible to recognize, through the evaluation, the contribution of the nucleus to the implementation of patient safety practices in the hospital. **Descriptors:** Patient Safety; Program Evaluation; Health Evaluation; Quality of Health Care; Safety Management; Nursing.

RESUMO

Objetivo: compartilhar a experiência com a avaliação da implantação de um núcleo de segurança do paciente. **Método:** trata-se de estudo qualitativo, descritivo, tipo relato de experiência, desenvolvido com os enfermeiros que conduziram um processo avaliativo da implantação de um núcleo de segurança do paciente em um hospital universitário. Utilizou-se, para a coleta de dados, um roteiro semiestruturado. **Resultados:** revela-se que o processo contemplou as fases de antecedentes, caracterização e desenvolvimento, e, dos oito protocolos nacionais, o núcleo desenvolveu ações em quatro (higienização das mãos, identificação do paciente, cirurgia segura e prevenção de úlceras por pressão) e traçou metas para dois (prevenção de quedas dos pacientes e comunicação efetiva). Desenvolveram-se ações ligadas a outros dois (segurança na prescrição, uso e administração de medicamentos e de sangue e hemoderivados) sem a participação efetiva do núcleo. **Conclusão:** permitiu-se reconhecer, pela avaliação, a contribuição do núcleo para a efetivação de práticas de segurança do paciente no hospital. **Descritores:** Segurança do Paciente; Avaliação de Programas e Projetos de Saúde; Avaliação em Saúde; Qualidade da Assistência à Saúde; Gerenciamento de Segurança; Enfermagem.

RESUMEN

Objetivo: compartir la experiencia con la evaluación de la implantación de un núcleo de seguridad del paciente. **Método:** se trata de un estudio cualitativo, descriptivo, tipo relato de experiencia, desarrollado con los enfermeros que condujeron un proceso de evaluación de la implantación de un núcleo de seguridad del paciente en un hospital universitario. Se utilizó, para la recolección de datos, un guion semiestructurado. **Resultados:** se revela que el proceso contempló las fases de antecedentes, caracterización y desarrollo, y de los ocho protocolos nacionales, el núcleo desarrolló acciones en cuatro (higienización de las manos, identificación del paciente, cirugía segura y prevención de úlceras por presión) y trazó metas para dos (prevención de caídas de los pacientes y comunicación efectiva). Se desarrollaron acciones relacionadas a otros dos (seguridad en la prescripción, uso y administración de medicamentos y de sangre y hemoderivados) sin la participación efectiva del núcleo. **Conclusión:** se permitió reconocer, por la evaluación, la contribución del núcleo para la efectucción de prácticas de seguridad del paciente en el hospital. **Descriptores:** Seguridad del Paciente; Evaluación de Programas y Proyectos de Salud; Evaluación en Salud; Calidad de la Atención de Salud; Administración de la Seguridad; Enfermería.

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INTRODUCTION

The main focus of the evaluation should be within health institutions to identify possible structural failures and/or processes that favor quality deviations, compromising the results of the assistance (direct or indirect) and, therefore, safety of the patient.¹ The National Patient Safety Program (NPSP)² was established with the aim of contributing to the qualification of care by the Ministry of Health, and among the regulations created, the Resolution of the Collegiate Board of Directors (CBD) no. 36, which describes the actions for the effectiveness of the NPSP, as well as making the implementation of the Patient Safety Nucleus (PSN) compulsory in health services.³

There is the PSN as the local body that should promote and support practical actions to develop the organizational culture of patient safety. Among its competencies are the implementation of the PNSP protocols, which address the following topics: 1) hand hygiene; 2) identification of the patient; 3) Safe Surgery; 4) pressure ulcer prevention; 5) prevention of falls in patients; 6) safety in the prescription, use and administration of medicines; 7) safety in the prescription, use and administration of blood and blood components; 8) effective communication.²

It is understood that, considering that the NPSP is a relatively recent program and that one of the forms of its practical implementation in health institutions should occur through the PSN, it is of the utmost importance that such an institution undergo periodic evaluations.

OBJECTIVE

- Share the experience by evaluating the deployment of a patient safety core.

METHOD

This is a qualitative, descriptive study, a type of experience report, developed with nurses who conducted an evaluation process of the implantation of a patient safety nucleus in a university hospital located in Paraná, Brazil, during the second semester of 2016. It used for the data collection, a semi-structured script, which allowed to evaluate the implantation of the nucleus from the point of view of its effectiveness, identifying which of the national protocols of patient safety were already effective in the institution, after three years of core deployment. The results

are presented descriptively, evidencing which and how the protocols were implemented.

The study was developed as an academic activity, developed during the Health Policy and Health-Disease Process classes of the Postgraduate Program in Biosciences and Health, State University of the West of Paraná (PPG-BCS/UNIOESTE). It was considered, therefore, given its nature, it is not necessary to present it to the Research Ethics Committee of the institution.

RESULTS

The processes of antecedents, characterization and development were considered by the process, which are detailed below.

It is reported that during the second semester of 2016 the subjects of "Health Policies and Health-Disease Process" were compulsory subjects of a Master's Program, which was the initial organization for the process. A challenge was launched at the beginning of the class, along with the general presentation on the subject and its objectives, by the teacher responsible for the same, that, from the theoretical knowledge transmitted in the subsequent meetings, the graduate students would have to develop, in practice, all the stages of the evaluative process of a health program.

The process was characterized as an evaluation of effectiveness, ie, it was sought to establish a relationship between the patient safety practices developed by the PSN and the eight protocols in the NPSP initially described. It is reported that the evaluation was of the ex-post type, carried out after the implementation of a service and/or program. It is considered that the evaluation process occurred in response to the challenge proposed in the discipline, whose purpose (function) of the evaluation was academic, of the strategic/relevance type.

It was developed by the authors, based on a specific theoretical framework,⁴ the evaluation process of PSN implementation through six phases. The following phases are presented in Figure 1, as well as the activities carried out in each one of them.

Phases	Performed activities
1. Engagement of interested persons	Organization of the working group responsible for the evaluation process and determination of the object of evaluation (program); Nominal identification of those responsible for the program to be evaluated; Orientations and guidance, by the teacher, for the next phases.
2. Presentation of the evaluated program	Comprehension about the program, through a theoretical study, with the identification of their needs (scope / involvement), expectations (goals / outcomes), activities (patient safety practices), resources (tools / protocols) and other information , with the preparation of a report.
3. Objective and methodology	Determination of the specific evaluation object (PSN implementation); Strategic planning for conducting the evaluation process (methods, tools, sources of information collection, resources needed and deadlines).
4. Collection, meeting and evaluation of information	Interview with a member of the PSN, with the application of a semistructured questionnaire, composed of questions that would enable information on patient safety practices, according to the eight NPSP protocols; Systematization and analysis of data and information collected.
5. Evaluation report	Theoretical-scientific support to the results of the critical analysis made to the pooled evidence, based on the premises of the NPSP and its protocols.
6. Sharing of lessons learned	Classroom discursive presentation of the stages of the evaluation process and its results, with further discussion about their practical implications and usefulness in order to promote improvements in the actions developed by the PSN ;Sharing lessons learned with members of the hospital PSN; Elaboration of a scientific article, in the experience reporting modality, to share the lessons with the academic-scientific community.

Figure 1. Phases for the development of the evaluation process. Cascavel, PR, Brazil, 2016.

According to the information collected, the PSN was evaluated in 2013, in the form of a commission, and in the same year it was designated as the nucleus itself. At the end of 2014, the Patient Safety Plan 2015-2016 was

prepared. The following table shows the patient safety practices developed in the institution after the PSN implementation, analyzed according to the eight NPSP protocols (Figure 2).

Protocol	†Actions
1. Hand hygiene	In partnership with several sectors of the institution (such as Hospital Infection Control Service, Permanent Education Service, Building Maintenance Service and Hospital Hygiene and Support Service, among others): a) improvements in the physical structure of the hospital, facilitating access solutions and repair of dispensers; b) designation of a support service official to identify defective dispensers, as well as maintenance and daily replacement of solutions used for hand hygiene; c) implementation, analysis and continuous monitoring of indicators of hand hygiene (quantitative dispensing and use of alcoholic preparations); d) educational actions with the institution's professionals; e) distribution and installation of information material for the professional awareness of patients, caregivers and family members.
2. Patient identification	In partnership with the Hospital Internment Service and Permanent Education Service: a) Initialization of the use of wristbands to identify the patient, adhesive seal, inviolable and with printed data obtained in the institution's electronic medical record system; b) trainings with the teams on the national protocol and the institutional project to identify the patient through the bracelets; c) identification of the rate of use of the bracelets by the patient (use rate in 2014 - general, 45.5% / in accordance with the national protocol of approximately 31%, use rate in the first half of 2016 - 80% in accordance with the national protocol); e) team meetings to know the potentialities/fragilities of the institutional patient identification project.
3. Safe Surgery	Actions initiated in 2014 and led by a group of nursing professionals from the surgical ward, with the support and assistance of the PSN: a) revision and adaptation to the institutional reality of the NPSP safe surgery check protocol; b) insertion of illustrative tables containing the checklist in all operating rooms; c) permanent education about the checklist and qualification of the team for its application; d) meetings and discussions with obstetric center staff; e) in July 2016,

	official implantation of the protocol of safe surgery, in the institutional scope, with forecast for reassessment in November 2016.
4. Prevention of pressure ulcer	In partnership with the team of the Commission on Dressings: a) in July 2016, studies began for the elaboration of the institutional protocol for the prevention of pressure ulcers (PPU), with the implantation of the same, in the first instance, in the Unit intensive care unit (ICU) for adults, due to the high incidence and prevalence of PPU.
5. Prevention of patient falls	No practical activity, effective or in progress, with the participation of the PSN at the moment of the evaluation, but with actions in the planning phase.
6. Safety in the prescription, use and administration of medicines	According to information collected, at the time of the evaluation, some actions were being carried out by the pharmacovigilance team, however, without effective participation of the PSN.
7. Safety in the prescription, use and administration of blood and blood products	According to information collected, at the time of the evaluation, some actions were being performed by the haemovigilance team, however, without effective participation of the PSN.
8. Effective Communication	No practical activity, effective or in progress, however, with actions in the planning phase.

Figure 2. Practical patient safety actions developed by the PSN assessed. Cascavel, PR, Brazil, 2016.

† Instituted from the implementation of the PSN and, carried out or in progress at the time of the evaluation.

DISCUSSION

It was verified, with the evaluative process, that, after three years of its implantation, the PSN of the hospital had already collaborated effectively to develop actions related to four (50%) of the eight national protocols, being still in strategic planning of the activities that would be developed for the implementation of two other protocols, as presented in table 2.

It should be noted that the protocols are part of the NPSP, whose implementation in Brazil followed a worldwide trend of promoting patient safety and, at the national level, there was an improvement in the quality of the Health Care Network and, therefore, improvement of the Unified Health System, especially the use of proposed flows, procedures and indicators for each process.⁵

It is revealed that the implementation of the PSN, with the consequent elaboration of a PSP in the scope of the health services, is something to be celebrated, since it denotes a relevant advance for the incentive of the culture of patient safety and the quality of care to the health, explaining the concern of the local managers in supporting actions of improvements in the structure and in the processes, with final focus in the improvement of the results of the assistance provided by the institution.

It is understood, however, that establishing and periodically applying evaluative processes strongly corroborates the effectiveness analysis of the actions.⁶ In turn, the analysis of effectiveness is based on the re-discussion

of work methodologies, the renewal of priorities and, therefore, is based on the reorganization of the strategic situation planning.¹

The report "Self-Assessment of Patient Safety Practices - 2017"⁷ was recently published by the National Agency of Sanitary Surveillance (ANVISA)⁷, which presents the results of self-assessment carried out by 984 hospitals throughout Brazil. It is observed that the most frequently implanted protocol refers to hand hygiene (94.7%), followed by patient identification protocols (87.2%).

From the evaluative process performed, it was found that PSN also emphasized the actions associated with these protocols, as well as the activities for the implantation of the protocol of safe surgery. On the other hand, the PSN had not developed effective practical actions for the implementation of protocols for fall prevention and effective communication (Table 2).

It was identified, in 2014, through research on errors and adverse events - performed in the same hospital - a culture unfavorable to effective communication among professionals.⁸ A number of associated factors are represented by the lack of effective communication, representing one of the main obstacles to the identification of incidents and adverse events. It is necessary, therefore, to implement alternative strategies for the knowledge of such occurrences.⁹

It is emphasized, therefore, that the evaluation process was conducted by post-graduate students, as a practical exercise carried out during the participation in

compulsory discipline of an interdisciplinary masters program. It is important to highlight the discussion of patient safety issues in the academic context, by scholars, who "often during their training, professionals are not presented to the topic of patient safety, generating crisis situations, both in universities and in health care settings".^{10:22}

It was verified, in an investigation carried out by researchers of the Paulista School of Nursing, on the inclusion of the subject in the graduations in health, that patient safety is approached in a fragmented and superficial way in the courses, portraying the need to broaden the discussions in the university context.¹¹ The experience was then shared by post-graduate students who also had little contact with the subject during graduation, being that students graduated in Nursing had better mastery of knowledge than colleagues with training in other subareas of health. It is recalled by scholars from the Federal University of Rio Grande do Sul that, in Brazil, Nursing has been standing out in relation to the debate on the subject.¹²

It is recorded, in this direction, that the university should be a space destined to teaching-learning, with diffusion of knowledge, acquisition of skills and, therefore, training of health professionals with capacity to act based on effective and safe care, as well as as well as knowing about aspects related to the evaluation of the effectiveness of the actions developed within the scope of care practice.

CONCLUSION

It was concluded that the evaluation process made it possible to recognize the contribution of the PSN to the institution of patient safety practices in the hospital environment, as well as to identify the points that deserve greater commitment on the part of the professionals that make up the nucleus, so that the actions necessary for the implementation of all national protocols. It was also contributed by the practical exercise of analyzing the component of a national health program, in an unique way, for the interdisciplinary training of students as post-graduate students, providing them with the necessary knowledge for professional performance with a broader vision, especially , for the comprehensive analysis of Brazilian public policies.

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Submission: 2018/09/12

Accepted: 2018/01/10

Publishing: 2019/02/01

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