

Patient safety in primary health care: elaboration of form and notification flowchart

RESUMO | Objetivo: descrever a elaboração de um instrumento de notificação de evento adverso/incidente na atenção primária à saúde. Método: pesquisa descritiva, exploratória, de abordagem qualitativa, realizada em um município da região metropolitana de Curitiba-PR, em julho de 2017 a setembro de 2018, com 23 enfermeiros da estratégia de saúde da família. Resultados: a ação estratégica apontada pelos enfermeiros no grupo focal para segurança do paciente na atenção primária a saúde foi a elaboração da ficha de notificação como forma de conhecer e monitorar os eventos. Conclusão: a ficha de notificação foi elaborada como uma ferramenta que promoverá o levantamento dos danos/incidentes decorrentes da assistência para gerar informação que subsidie ações de prevenção.

Descritores: Segurança do paciente; Notificação; Atenção primária à saúde.

ABSTRACT | Objective: to describe the development of an adverse event/incident notification instrument in primary health care. Method: descriptive, exploratory research, with a qualitative approach, carried out in a city in the metropolitan region of Curitiba-PR from July 2017 to September 2018, with 23 nurses from the family health strategy. Results: the strategic action pointed out by the nurses in the focus group for patient safety in primary health care was the elaboration of the notification form as a way of knowing and monitoring the events. Conclusion: the notification form was developed as a tool that will promote the survey of damages/incidents resulting from the assistance to generate information that subsidizes prevention actions.

Keywords: Patient Safety; Notification; Primary health care.

RESUMEN | Objetivo: describir el desarrollo de un instrumento de notificación de eventos adversos/incidentes en la atención primaria de salud. Método: investigación descriptiva, exploratoria, con enfoque cualitativo, realizada en una ciudad de la región metropolitana de Curitiba-PR, de julio de 2017 a septiembre de 2018, con 23 enfermeros de la estrategia de salud de la familia. Resultados: la acción estratégica señalada por los enfermeros del grupo focal de seguridad del paciente en la atención primaria de salud fue la elaboración del formulario de notificación como forma de conocimiento y acompañamiento de los eventos. Conclusión: el formulario de notificación fue desarrollado como una herramienta que promoverá el levantamiento de daños/incidentes resultantes de la asistencia para generar información que subsidie las acciones de prevención.

Palabras claves: Seguridad del Paciente; Notificación; Atención Primaria de Salud.

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INTRODUCTION

The definition of patient safety is known as the reduction to an acceptable minimum of the risk of harm from health care, arising from circumstances or agents that have the potential to cause harm to patients. ⁽¹⁾

Studies reaffirm the premise that Primary Health Care (PHC) is a relatively safe context when compared to others, due to the profile of the technology used, however, it is important to reaffirm that errors can be present at any point in the provision of care. ⁽²⁾

In this sector, it is necessary to establish actions in accordance with current legislation and local management, and

therefore, the literature emphasizes the importance of jointly discussing, between teams and managers, strategies for raising awareness, training and planning for local patient safety. ⁽³⁾

The concern with seeking actions that make PHC safer is based on ensuring the sustainability and universality of providing safe care. The qualification of these services is essential for the fulfillment of the United Nations Sustainable Development goals, ensuring the promotion of health and well-being for all. ⁽⁴⁾

In this context, there is evidence that the notification of adverse events has not been valued in the way it should, despite the existence of an already consolidated sentinel network, which implies managing risks, making adverse events communicable. ⁽⁵⁾

With a view to improving and qua-

lifying the care provided in the Family Health Strategy (FHS) units in a city in the metropolitan region of Curitiba-PR, the objective was to discuss and develop strategies to strengthen patient safety.

METHOD

This is a descriptive, exploratory research with a qualitative approach, carried out from July 2017 to September 2018. The study included 23 nurses who work in Units with a Family Health Strategy (ESF) in a city in the Metropolitan Region of Curitiba/PR. The invitation was made after a meeting was held that explained the topic of patient safety.

As inclusion criteria, nurses who worked in Primary Health Care for more than six months were chosen. Exclusion criteria were nurses on leave due to health reasons, vacations or unavailability to participate in the research.

The research was divided into three stages: diagnostic, analytical and operational. In the first stage, diagnosis, the Medical Office Survey on Patient Safety Culture (MOSPSC) questionnaire was used in order to characterize the profile of the participants. The MOSPSC proved to be a useful tool to obtain a patient safety culture in Primary Care.⁽⁶⁾ 23 questionnaires were distributed, all of which returned completed.

The analytical stage was developed in two phases: 1) analysis of patient safety culture data and 2) understanding and describing a problem that could be intervened. The first phase included the descriptive analysis of the data obtained in the application of the MOSPSC. Data were tabulated using an Excel® spreadsheet and, subsequently, analyzed using descriptive statistics.

In the second phase of this stage, a focus group was held to present the results of the first phase and seek to collectively understand the problem situation and intervention priorities. The focus group was chosen as a technique

for data collection and analysis, since its use is shown to be adequate for inserting individuals into discussions that

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result in rethinking personal and professional attitudes and their practice in PHC.⁽⁷⁾

The purpose of applying this technique was to facilitate the discussion to outline strategies to promote patient safety from the evaluation of the safety culture in PHC. The number of meetings, frequency and duration were proposed by the participants and agreed with the Municipal Health Care Division. The focus group was carried out with all nurses who completed the instrument, identified as (E1 to E23).

In the presentation of the results, intervention actions were proposed by the group, they were: action plan; patient safety protocols for PHC and the elaboration of an adverse event/incident notification form, which was described by the group as a priority action.

After defining the problem situation and identifying the intervention priority, the third and final stage, operational, consisted of planning and execution. The group defined the elaboration of the adverse event notification form, for the quantification and characterization of errors resulting from the assistance in PHC. The notification form was prepared in accordance with the technical note GVIMS/GGTES/ANVISA nº 01/2015, which provides general guidelines for reporting adverse events related to health care.

Ethical aspects were respected, following the norms for research with human beings provided for in Resolution No. 466/2012 of the National Health Council (CNS). Approval was obtained in the opinion number 2,043,970 of the Research Ethics Committee (CEP) of the Health Sciences Sector of UFPR and CAAE: 66939717.3.0000.0102, which is registered with the National Research Ethics Commission of the MS (CONEP/MS).

RESULTS

Twenty-three nurses participated in the study, of which 82.6% (n=19) declared themselves to be nurses, while 17.4% (n=4) were nurses/managers,

aged between 30 and 40 years, 52.2% (n=12). Most of them had training for more than 10 years, 47.8% (n=11), and 56.5% (n=13) had postgraduate degrees. All professionals working 40 hours per week.

The descriptive analysis of the variables obtained through the MOSPCS compared the averages of each item between the sections. Due to the extension of the instrument and for a better understanding of the need to prioritize the elaboration of a notification form, the results that were most highlighted will be presented.

Section A of the MOSPCS seeks to assess aspects of the culture of safety and quality of patient care. The items of access to care (A1) as well as patient identification (A2) obtained the best ratings in this section, both factors with 56.5% (n=13), did not occur in the 12 months prior to the survey. The frequent unavailability of equipment due to lack of maintenance stood out with 30.4% (n=7), failure to perform laboratory or imaging tests necessary for treatment 39.1% (n=9) and frequent inaccessibility to test results when necessary 47.8% (n=11).

Regarding communication between institutions (section B), the results showed a higher frequency of failures in this process in the imaging services/laboratories of the health care network 47.8% (n=11). Section C, which investigates the theme "Working in this health service", revealed that most 52.2% (n=12) of nurses do not feel rushed when caring for the patient and 43.5% (n=10) report receiving training as new processes are implemented. However, the disorganization of the work environment 60.9% (n=14) is greater than acceptable.

Regarding the evaluation of communication and monitoring (section D), 43.5% (n=10) of the respondents stated that there was always an incentive to express other points of view and 26.1% (n=6) almost always. Despite this, there

is a fear for 56.5% (n=13) of the participants to question when something does not seem right, as well as the difficulty of expressing a contrary opinion 47.8% (n=11).

The next three sections concern the support of leaders/managers/administrators (E), service assessment (F) and finally, global assessment of the quality of the respective service (G). The data reveal that for 42.1% (n=8) of the participants, managers do not invest enough to improve the quality of care, while 47.4% (n=9) agreed that they ignore errors that happen frequently.

Regarding the evaluation of the service, 69.6% (n=16) of the nurses revealed the occurrence of errors with a higher frequency than acceptable and the majority, 47.8% (n=11) agreed, and 13% (n=3) fully agreed that 'In this service, the amount of activities performed is more important than the quality of care provided'. However, 95.7% corresponded to the sum of nurses who agreed (n=14) and totally agreed (n=8) with the proposition 'When there is a problem in our service, we assess whether it is necessary to change the way we do things'.

Regarding the general assessment of patient safety, 56.5% (n=13) rated as "good" the clinical processes that health services use to prevent problems with the potential to cause harm. Likewise, care was seen as sensitive to the individual needs of patients by 56% (n=13) and impartial, rated as "very good" by 47.8% (n=11) of the participants.

Still in the diagnostic stage, in the section that allows discursive responses, five nurses made comments. The processing of the speeches resulted in a cloud of words, in which the terms service stood out, present in all speeches 100% (n=5), followed by the term quality 60% (n=3).

After presenting the respective data, the main problems and critical points were listed and then possible strategic actions aimed at improving the quality

of services were discussed, such as:

develop a patient safety protocol for primary care, action plan and event notification form. Of these, when establishing priorities, it was decided to prepare the notification form and flowchart. The following reports from section I of the MOSPCS exemplify:

"We could make a protocol and include in it the issue of the notification form for these events." (E2)

"[...] and it would be possible to quantify the data". (E6)

"[...] and according to this information, the service can be improved because it will be possible to quantify and be documented." (E8)

The prepared form (Appendix 1) follows a flowchart (Appendix 2) that serves as a guide for proper completion, and contains the definition of adverse events/incidents related to health care, having as relevant items the patient's age, the type of event/accident, that is, whether the failure is in administrative activities, procedures, during care, in laboratory failure or fall.

The damage is classified as "mild", "moderate", "severe" or "death". It also classifies the care phase of the event: "reception", "sorting", "consultation", "post-consultation", "nursing procedure" or "transfer". The date of the event and the factors contributing to the damage. Reserve space for improvement actions. Finally, it identifies the name of the Health Unit and the person responsible for filling it out.

DISCUSSION

From the application of the instrument to nurses working in FHS units, it was possible to obtain aspects of the patient safety culture in the PHC health

services of the respective municipality, providing support for the formulation of strategic actions to strengthen the patient safety culture.

It was verified the difficulty that the services present to provide clinical exams when the user needs it, as well as to access their results in a timely manner to the treatment. Failures in the physical and technological structure have been identified in PHC services.⁽²⁾ Such aspects may imply damage to its role as a gateway to other health services.

Failures and lack of maintenance in equipment are another factor associated with the disqualification of care provided in PHC services, which compromises patient safety.⁽⁸⁾ Other studies in this same context found a higher frequency of these problems in FHS services when compared to primary care units.⁽²⁾

The results showed the professionals' dissatisfaction with the management, the data corroborate a similar study that made use of the aforementioned instrument with PHC nurses.⁽⁹⁾ This professional perception implies the commitment of the teams to patient safety, since managers and local administration form a subculture within the organizational culture, being essential for the political construction of the institution, directly influencing the care provided to the user.⁽¹⁰⁾

In the context of the FHS units, it is noted that the quantity is sometimes superimposed on the quality of the activities that are carried out⁽⁹⁾, corroborating the results found in this study. However, despite the existing problems, nurses identified positive points in their services, classifying them in general as good. This professional perception is linked to an adequate risk assessment and the strengthening of the patient safety culture.⁽¹⁰⁾

Among the problems identified, communication failures stood out. It was possible to verify that a portion of the professionals do not feel comfortable to express opinions and are afraid

to give an opinion contrary to what is being proposed. Similar data can be found.⁽¹¹⁾

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the role that communication plays in sharing information on the network, Macedo and collaborators (2019) point

out weak communication links between PHC services and other health services.⁽⁹⁾ The recommendation is that the services involved in the exchange of information improve communication in order to enable assertive actions for patient safety.⁽¹²⁾

This difficulty in establishing strong communication links may be linked to the understanding that the error presupposes some form of punishment, since the error is easily linked to guilt, leading the professional not to take the necessary measures such as reporting and notifying, making it difficult or even impossible to analyze the problems, causing them to remain or worsen. The literature shows strong results related to the punitive culture.⁽¹³⁻¹⁵⁾

Finally, it appears that even after a few years of its publication, many PHC professionals are still formally unaware of the National Patient Safety Program (PNSP - Programa Nacional de Segurança do Paciente).⁽³⁾ It is therefore necessary to include the theme, both in theory and in practice, aiming at the development of competences.⁽¹⁶⁾

It is understood that risk management implies the necessary training of these professionals, mitigating underreporting. Such an outcome depends on joint efforts so that risks are identified in time to implement improvements that avoid the negative outcome. Furthermore, this process must be continuous.⁽¹⁷⁾

CONCLUSION

It is understood that the development of tools to notify adverse events, built and validated together with care professionals and service managers, can be useful as a risk management mechanism, as they make it possible to help prevent new incidents.

It is worth emphasizing that the notification form is not enough to solve problems related to patient safety, however, it is an important step towards promoting a culture of patient safety in

PHC services.

Constructs of this nature can be adapted to the digital format, integrating the units that have computerized systems, being thus applicable in municipalities with or without registration of assistance, expanding the ballast of

actions in favor of patient safety, in primary health care services.

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