PATIENT SAFETY: APPROACHING AN OLD ISSUE

“First, do not harm” was the objective of the patient safety proposed in the first meeting between representatives that constituted the World Alliance for Patient Safety, launched in Washington, D. C., in 2004. Brazil, as a country that signed the joint compromise to plan and implement actions toward reducing the occurrence of adverse events and make healthcare actions safer, instituted, in 2013, the National Program for Patient Safety\(^1\) and actions for patient safety in health services\(^2\), with the publishing of six Basic Protocols directed to priority areas.

However, the creation of regulating norms and mechanisms is not enough if there are no changes of institutional and actually structuring character. After all, the guarantee of safe care is related to a multilayered context that involves several assistance processes, which vary in degree of complexity and demand of different resources.

Many of the problems evidenced in the health area, such as the limitation or scarcity of resources, overwork due to insufficient number of professionals and their lack of qualification, influence patient safety negatively. Within the Nursing sphere, this issue becomes more evident because professionals develop activities of direct contact with the patient in a frequent or uninterrupted manner, and because of the unsatisfactory compensation that leads them to multiple militancy, boosting the tiredness and stress that may result in errors during assistance.

Especially in hospitals, whether public or private, the nursing team faces constant conflict situations, in which a dichotomous relationship between theory and practice persists. In this scenario, the nurse, as the leader of the team, needs to develop or enhance his or her skills for the management of the service and supervision of the nursing assistance, aiming at the acquisition, maintenance and/or improvement of physical, technological, human and information resources that contribute to a greater safety for patients, their families and all people involved in the care process. By doing so, the nurse can act as an agent of social transformation, so that there is collective effort and commitment in the deconstruction of the current punitive culture and development of a culture of safety.

This is hard work, because, despite the big discussion, the importance of notifying adverse events and the need to adopt strategies for their prevention, nursing and health praxis is also combined with the fear of retaliation and punishment, resulting in omission of errors. Consequently, there is no opportunity for the recognition of the situations that generated adverse events and for the establishment of strategies to protect the patient’s health and safety.

When considering that patient safety is defined as the reduction of the risk of unnecessary damages to an acceptable minimum level, and that this parameter is determined by the notion of conducts that are viable in face of the current knowledge, of available resources and of the context in which the assistance has been performed\(^3\), it is necessary, then, to deepen our understanding through an efficient integration and communication between assistance, teaching and research.

The day we are really prepared to admit that patient safety is an indelible condition to healthcare, and support our actions on a practice based on evidences, with legitimatization of policies and guidelines about this theme, the context and the
conditions of the nursing work will be certainly better. By then, the large amount of lives harmed or even lost due to assistance mistakes will continue to be acceptable.

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