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ORIGINAL ARTICLE

NOTIFICATIONS OF INCIDENTS RELATED TO PATIENT SAFETY IN A SENTINEL UNIVERSITY HOSPITAL

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ABSTRACT

Objective: to analyze the notifications of incidents related to patient safety in a sentinel public university hospital. **Method:** retrospective, quantitative research conducted in a university hospital located in southern Brazil. It analyzed 760 notifications of incidents that occurred in the years 2015 to 2017 forwarded to the risk management sector of the institution. Data was collected from May to August 2018. Descriptive statistical analysis was performed using the Statistical Package for the Social Sciences version 20.0. **Results:** the incidents reported were pressure ulcers (64.0%), followed by falls (25.0%), medication errors (9.7%), incorrect patient identification (1.0%) and incidents in surgical procedures (0.3%). The morning period, nursing professionals and adult intensive care unit were the ones that made the most notifications. The most reported adverse event was related to medication error (50.7%) followed by falls (26.8%). **Conclusion:** the results of this study contribute to increasing interest in the analysis of incident and adverse event data, and to defining or refining strategies to improve patient safety.

Keywords: Patient safety. Quality of health care. Health services research. Patient harm. Risk management.

INTRODUCTION

Worldwide, patient safety has become a challenge for health care organizations because it is considered a component of the quality of care provided to patients and because of its relevance in improving health care[1-3]. In this aspect, the theme has been highlighted by proposing measures to prevent risks and damage to patients' health. It is up to health professionals to identify these risks and complications during the client's stay, because they are key players in ensuring patient safety[1-3]

Incidents related to health care have occurred with unacceptable frequency and affect clients who seek healthcare facilities for treatment, prevention, diagnosis or rehabilitation. It is necessary to understand the causes and factors that contribute to the emergence of incidents, with or without damage, and also to analyze their consequences and repercussions for the development of solution and mitigation strategies, in order to prevent their occurrence[3].

Safety incidents are defined as events or circumstances that may or may not trigger unnecessary harm to the patient. Those arising from health care can have negative impacts on their quality of life and major implications for inpatient mortality and morbidity[2-3]. Incidents that cause harm are called adverse events (AE), which can worsen the condition or lead to disability[3-4]. Adverse events, in particular, can lead to immeasurable harm to the patient and consequences for healthcare institutions[5].

In Brazil, the advancement in the area occurred with the institution of the National Program for Patient Safety (NPPS), through the publication of Ordinance No. 529/2013 and the

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Collegiate Board Resolution (CBR) No. 36/2013, in order to qualify health care and determine the mandatory implementation of Patient Safety Centers (PSCs) in all health facilities in the country[4]. One of the PSC's main competencies is to notify technical complaints and incidents linked to healthcare[4,6].

In this sense, incident notification systems (INS) are created, which help identify risks, contribute to data collection and analysis, and promote safety culture. In Brazil, the INS is the (NOTIVISA), which receives the mandatory notifications since 2014 from sentinel hospitals[5].

Thus, hospitals have developed strategies for monitoring incidents and AEs through notifications and analysis of the indicators generated[5]. These data allow a detailed evaluation of the conducts and of the need or not of the implementation of new actions that make it possible to reduce the risks to patients, considering the particular practice of each institution[2].

It is understood that by analyzing the notifications of incidents and AEs, these results may favor the evaluation of the causes and effects, which contributes to reducing the occurrence of undesirable events, qualifying health care, through the development and strengthening of the culture of institutional safety[7,8].

Despite the mandatory reporting of incidents and the implementation and creation of the PSCs, of which there are about 4,000 in Brazil, the number of notifications is low, since, among the institutions that have the PSC implemented, only 1,664 have made at least one notification, making it evident that the implementation may have happened more to comply with the legislation than for the incorporation of the tool that has the potential to change health care and sediment a culture of safety[8].

Therefore, knowing the incidents related to patient safety can contribute to the intervention in health care, in order to make it safer and of quality. Thus, the following question arose: What are the characteristics of the notifications of patient safety incidents in a sentinel hospital?

The objective of this investigation was to analyze the notifications of incidents related to patient safety in a sentinel public university hospital.

METHOD

A retrospective and descriptive study, with a quantitative approach, carried out in a public university hospital in the interior of the state of Paraná. The institution has 291 beds and has been part of ANVISA's Brazilian Network of Sentinel Hospitals since 2001, and should mandatorily carry out notifications of technical complaints and incidents, contributing to risk management in health services, in partnership with the PSC and the Hospital Risk Management sector.

The study population comprised all incident and adverse event notification forms managed by the Patient Safety Center of the institution under study. All printed forms of incident and adverse event notifications performed in the period from 2015 to 2017 were included. Hand hygiene practice and communication notification forms were excluded, as they were in the process of structuring and implementation at the hospital.

Data collection took place between May and August 2018, through an electronic instrument developed by the researchers in Google forms, divided into two sections. The first section collected data regarding patient identification, such as: initials of the patient's name, care record, age (in years), gender (male/female), admission diagnosis, and present morbidities. In this session, information regarding the reason for the incident (pressure ulcer, fall, medication error, failures in patient identification and errors related to surgical procedures), presence of a companion (yes/no), date and period of the occurrence (morning, afternoon and evening), moment of the occurrence (admission, care, during care and not informed), unit of the incident and notifying professional were also filled in.

In the second session, data related to the incident were collected. Thus, this section was subdivided into five subsections, as follows: incidents related to pressure ulcers (PU), falls, medication, patient identification, and surgical procedures. In the presence of PU, the data collected were: ulcer stage (1, 2, 3, 4, non-stageable), site, external risk factors (shear, friction and humidity), risk factors inherent to the patient, Braden scale assessment, time of PU detection, prevention measures adopted (change

of decubitus every two hours, active mobilization in bed, dressing for ulcer prevention and treatment, viscoelastic mattress, nutritional support, skin hydration, limb elevation, frequent sanitization and others). To list the risk factors and the evaluation of the prevention measures adopted, the notification form allowed the choice of more than one item.

When reporting falls, the following variables were collected: type of incident (incident without damage or adverse event), place of the fall, main consequences (no consequences, abrasions and bruises, fracture, bleeding/bleeding, small cuts, pain, and/or others), Morse scale assessment, prevention measures, companion at the time of the fall (yes, no) and disclosure (yes, no). For the collection of the variables main consequences and evaluation of the preventive measures adopted, the notification form gave the possibility of describing more than one item.

In the presence of a medication-related incident, the following variables were collected: type of incident (incident without harm or adverse event), classification of adverse event (mild temporary harm, severe harm, and moderate harm), drug category, route of administration (intravenous, oral, subcutaneous) and disclosure (yes, no). Information was also collected regarding the factors that contributed to the incident and the prevention measures, and these variables gave the possibility of describing more than one item.

When the notification dealt with an incident related to failures in patient identification, the factors that contributed to the incident were collected. Due to the specificity of the notifications referring to the operating room, the following variables were collected: type of surgery and problem occurred.

It is noteworthy that the instrument developed by the authors was built based on the notification forms of the institution under study and the data requested in the NOTIVISA. Thus, since this is a retrospective research, the variables of this study followed those found in the notification forms. It is also noteworthy that these notification forms were developed based on the experience of NSP professionals of the institution under study.

The database was built and organized in Microsoft Office Excel version 2014. The descriptive statistical analysis was performed using the Statistical Package for the Social Sciences (SPSS) version 20.0, with the presentation of relative and absolute frequencies and standard deviation.

The research was approved by the Research Ethics Committee of a public university, under Opinion no. 765.995 and CAAE: 34938614.9.0000.5231.

RESULTS

From 2015 to 2017, there were 760 incident notifications. The year 2017 had the highest number of notifications, totaling 609 (80.1%). Regarding the profile of the patients who suffered the incidents, the predominance is male with 62.0%. The average age was 57 years (SD: 19 years), ranging from zero day to 97 years. The sectors that most reported incidents are shown in Table 1.

Table 1. Hospital unit of occurrence of the incidents reported in the period 2015 to 2017 (n=760). Paraná, Brazil, 2018

Units	n (%)
Adult Intensive Care Unit	183 (24.1)
Female Medical-Surgical Unit	157 (20.7)
Male Medical-Surgical Unit	145 (19.1)
Emergency Room	145 (19.1)
Infectious Diseases	39 (5.1)
Burn Care Center	32 (42.)
Maternity Ward	8 (1.0)
Pediatrics	3 (0.4)
Neonatal and Pediatric Intensive Care Unit	3 (0.4)
Surgical Center	3 (0.4)
Not informed	42 (5.5)
Total	**760 (100)**

Source: Research data (2018).

Regarding the period of notification and occurrence of the incident, there was a predominance of the morning, with 45.1%. The professional who most made the notifications was the nurse, with 37.7%, and in 46.3% of the forms the professionals were not identified, because this information was optional in the forms.

There was a predominance of: pressure ulcers (493; 64.0%), falls (183; 25.0%), medication errors (73; 9.7%); inadequate identification of the patient presented eight (1.0%) and incidents in surgical procedures, only three (0.3%) notifications.

Table 2 characterizes the PU notifications as to stage, location, and external risk factors.

Table 2. Stage, site of the PU and external risk factors for PU development (n=493), in the period 2015 to 2017. Paraná, Brazil, 2018

Variables	n (%)
Stage of the PU	
Stage 2	231 (46.9)
Stage 1	130 (26.4)
Stage 3	84 (17.0)
Non-stageable	22 (4.5)
Stage 4	9 (1.8)
Not informed	17 (3.4)
Total	**493 (100)**
Location of the Pressure Ulcer	
Sacral	253 (51.3)
Calcaneus	61 (12.4)
Gluteus	37 (7.5)
Trochanter	22 (4.5)
Intergluteal	20 (4.1)
Ischium	13 (2.6)
Occipital	12 (2.4)
Auricular	10 (2.0)
Other places	57 (11.6)
Not informed	8 (1.6)
Total	**493 (100)**
External Risk Factors	
Shear, Friction and Moisture	214 (43.4)
Shear and Friction	88 (17.8)
Friction	51 (10.3)
Friction and Moisture	27 (5.5)
Shear and Moisture	17 (3.6)
Moisture	15 (3.0)
Shear	15 (3.0)
Not Informed	66 (13.4)
Total	**493 (100)**

Source: Research data (2018).

For the collection of external risk factors, one or more factors could be considered. Besides the external risk factors, the form also contained an item for the description of risk factors inherent to the patient for the occurrence of PU. Among them, 87.0% of the forms were related to immobility and impaired or reduced mobility; 53.5% were related to nutritional conditions; 47.7%, to age; 38.9%, to tissue perfusion; 34.0%, to systemic conditions; 33.9%, to comorbidities; 23.5%, related to the use of specific medications that can contribute to the development of LP; 15.6%, to body temperature; and in 3.4% forms this information was not described.

Regarding the moment of PU detection by the professional, it occurred: in 57.2% during care delivery, 27.4% upon admission of the patient to the unit, 0.8% in transfers, 0.8% during the consultation, 0.4% at discharge, 11.0% at other times, and 2.4% did not report this data.

Regarding notifications of pressure ulcers (PU), the institution adopts the Braden scale as a form of risk classification and monitoring of PUs. Thus, 43.0% of the forms were related to patients who were classified as high risk, according to this scale, followed by 28.7% as

moderate and 8.0% as low risk. This data was not filled out in 20.3% of the forms analyzed.

The main measures adopted to prevent PU were: change of decubitus every two hours and active mobilization in bed in 80.3% of the reports, dressing for prevention and treatment of the lesion in 82.9%, use of viscoelastic mattress in 20.5%, improvement in nutritional support in 17.0%, skin hydration in 5.0%, elevation of the limbs with PU in 4.5%, and frequent washing of the patient in 2.4%. These behaviors could be adopted concomitantly by the team.

The notifications regarding falls were also described in this study. These notifications accounted for 54.6% of the notification forms classified as incidents without ulcers, 26.8% as adverse events, and in 18.6% the consequences were not informed. Table 3 below characterizes the notifications of falls.

Table 3. Place of occurrence of falls, their main causes and their consequences (n=183), in the period 2015 to 2017. Paraná, Brazil, 2018

Variables	n (%)
Location of the fall	
Infirmary	96 (52.5)
Bathroom	37 (20.2)
Ward corridor	11 (6.0)
Procedure room	3 (2.3)
Ambulatory	1 (0.5)
Hospital entrance hall	1 (0.5)
Access ramp to the units	2 (0.5)
Not informed	32 (17.5)
Total	**183 (100)**
Main consequences of falls	
No consequences	100 (54.6)
Excoriations and hematoma	16 (8.7)
Fracture	6 (3.3)
Bleeding/bleeding	6 (3.3)
Minor cuts	6 (3.3)
Pain	4 (2.2)
Other	11 (6.0)
Not Informed	34 (18.6)
Total	**183 (100)**

Source: Research data (2018).

At the study institution, the Morse scale is used to assess patients' risk of falling. Thus, fall notifications comprised the following scores: 15.2% moderate risk, 8.8% low risk, 8.1% high risk, and in 67.9% of the forms this information was not filled in. Regarding disclosure involving falls, 27.3% were communicated to their families/ companions.

Among the measures performed by health professionals for the prevention of falls, the following stood out in 72.7% of the forms, the information to keep the safety rails elevated; in 66.6% the delivery of a folder and patient orientation; in 54.0% the identification in a bracelet with the use of a red clasp, with the purpose of signaling the risk of a fall, and the plaque of fall risk; in 53.5% the orientation to keep the bed in the low position and with the wheels locked; in 53.0% of the forms, the care to keep the most used belongings and objects within the reach of the patients; and in 14.7% to keep the doorbell within the reach of the patient. These measures were indicated, and the association of one or more preventive measures was possible. Another aspect evaluated was that 64.5% of the patients had no companions and/or family members during the fall.

Regarding incidents involving the use of medicines, 50.7% of the notifications were classified as adverse events, 39.7% as incidents without harm, and in 9.6% of the forms this information was not filled out. Among the adverse events, 20.5% were classified as mild temporary harm; 11.0% as severe harm; and 6.8% as moderate harm. In these data, 12.4% of the adverse events were not filled in regarding severity. Table 4 details the notifications of incidents with medications found in this study.

Table 4. Medication category, route of administration and factors that contributed to medication incidents (n=73), in the period 2015 to 2017. Paraná, Brazil, 2018

Variables	n(%)
Medication Category	
Antibiotic	22 (30.1)
Insulin	4 (5.5)
Antibiotic and other drug combination	4 (5.5)
Sedatives	2 (2.7)
Analgesics	1 (1.4)
Other	34 (46.6)
Not Informed	6 (8.2)
Total	**73 (100)**
Route of administration	
Endovenous	25 (34.2)
Oral	6 (8.2)
Subcutaneous	4 (5.5)
Intravenous and subcutaneous	1 (1.4)
Not informed	37 (50.7)
Total	**73 (100)**
Factors that contributed to the incident	
Prescribing errors	12 (16.4)
Dosage	8 (11.0)
Administration of non-prescribed drug	7 (9.6)
Incorrect time of day	4 (5.5)
Incorrect route of administration	3 (4.1)
Transcription of the drug	3 (4.1)
Delivery system	3 (4.1)
Other causes	33 (45.2)
Total	**73 (100)**

Source: Research data (2018).

As for preventive practices for incidents with medications, the following stood out: training 23.3%, double-checking of high surveillance medications 19.2%, improving professional attention during medication preparation and administration 12.3%, improving communication between the multidisciplinary team 9.6%, updating prescriptions daily with attention 8.2%, verification of all prescriptions by nurses in the different shifts 5.5%, medications with better packaging 1.4%, and 20.5% of the forms did not present this information.

Another point addressed in this study refers to the notifications regarding patient identification. In this aspect, the main factor that contributed to the occurrence of the incident was related to the change of the patient's name (75.0%), followed by the lack of identification wristband (12.5%), and in 12.5% the information was not presented on the forms.

Regarding surgical procedures, only three notifications were made during the period that comprised the data collection of this study, and they were related to electric scalpel burns (the type of surgery was not informed), associated organ damage (bilateral mastectomy) and surgical procedure in the wrong place (diabetic foot amputation).

DISCUSSION

The need for notification is justified in the real evaluation of the factors that may have led to the incident, thus enabling its prevention or minimizing the consequences of adverse events[9].

It is noted in this study the increase in incident notifications in the year 2017. It is assumed that this is due to the fact that in that year the institution intensified the awareness of professionals with guidance and training, as an example, the formulation of the "Patient Safety Olympics" held at the institution. According to the literature, from the moment the professional is stimulated and trained, he starts to understand the importance of safety in the quality of care. He feels encouraged to make the notifications in

order to improve the care offered[9].

The nurse's professional basis is to provide quality care to the patient. In this aspect, it is noteworthy that this professional category was the one that presented the most notifications. This result is associated with the culture of this professional in performing procedures and inserting tools in their work dynamics for monitoring and follow-up of these incidents[10].

Other points that justify the greater engagement of nurses in notification are the fact that they spend more time with the patient and manage the unit and nursing care, besides being a reference to the multidisciplinary team[10].

It is noteworthy that several health professionals do not identify themselves when making the notifications. Although the literature addresses that adverse events occur due to failed systems and not to negligence or lack of technical training of the professional, it is noted that among health professionals still permeate feelings of fear and guilt to be involved in an incident, reinforcing the mystification of the punitive culture present in health institutions, contributing to the omission of information[11]. Thus, the entire healthcare team must be aware of its important role in the reporting of adverse events.

Thus, it is necessary to identify the flaws in this process, seeking preventive alternatives instead of punitive ones. Thus, communication between care professionals and managers is necessary, sharing responsibilities, information, and seeking measures to prevent future errors and ulcers[11].

Another aspect evaluated in this study is disclosure, which is considered an extremely important process, because it is at this moment that communication occurs between the professional, the patient, and their families. The healthcare professional must provide information about what happened, what behaviors and measures were adopted to prevent future incidents. This communication process should occur with the professional of assistance, manager and legal professional, demonstrating the concern of the institution and the commitment to patient safety[12].

Patient identification is another key aspect to ensure safety in healthcare institutions. The use of the identification wristband and the identification of the bed are daily and necessary practices. It is the responsibility of the multidisciplinary team to check, in order to prevent possible incidents[10].

In a study conducted by the Department of Biomedical Engineering, aiming to analyze the applicability of infusion devices, it was found that 30% of incidents in health care institutions were related to medication errors. The main medication administration errors were related to dosage, administration of non-prescribed drugs, and incorrect timing, and 80% of the recorded incidents were related to intravenous drugs[13-14], therefore, incidents involving medication can compromise your clinical picture and increase your length of stay.

It is observed that many times omission of this information occurs, due to fear of punishment and lack of knowledge about the characterization of what a medication-related incident is[11]. This demonstrates the need for professionals involved in patient safety to deepen their knowledge of the subject and implement teaching strategies that can be adopted in the institution where they work.

As presented in the literature, the main adverse events in health care institutions are those related to medication[11,13], unlike the data from this study, in which falls and PUs have the highest rates.

In a survey conducted in a general hospital in the countryside of São Paulo, Brazil, the occurrence of PU was the second most reported adverse event in the institution, showing its high rate of occurrence[11]. In another study, in the United States, it is pointed out that about 60,000 patients die each year due to the development of PU, making it a worldwide public health problem[15].

The literature shows some risk factors for the development of PU, highlighting impaired or limited physical mobility, sensory loss, tissue perfusion, urinary and fecal incontinence, nutritional deficiency, age, polypharmacy, and changes in the level of consciousness[16]. This result is in line with the findings of this study, with emphasis on the patient's impaired mobility. Therefore, preventive practices such as changing the decubitus every two hours, active mobilization in bed, improving nutritional support, use of protective barriers and

viscoelastic mattress become fundamental in care.

It is important that the nursing team pays attention to risk factors and preventive measures, minimizing the occurrence of these events. The development of PU can generate negative consequences for the patient and his quality of life, including increased hospitalization time, emotional damage, worsening of clinical status, and increased health care costs[16].

The identification of the risks of PU is performed mainly by the nurse, through the use of tools such as the Braden scale[17]. This action reveals the zeal of the health professional in managing care[11].

Falling was another incident addressed in this study and is considered a common but impactful problem in healthcare institutions[18]. Among the main factors found are those related to age, balance and strength problems, reduced mobility, polypharmacy, psychic problems such as mental confusion, and the patient's own clinical condition. Falls can have a bad impact, since most incidents generate negative consequences, including fractures, increased hospitalization time, and can worsen the patient's clinical condition[5].

Thus, fall notifications are an important tool in care management, because they provide indicators that help in the understanding of how and why these incidents occur in health institutions, in order to assist in prevention measures[5,11].

In the analysis of the notification forms it was possible to observe the failure to fill in some data, erasures, lack of content, and omission of information. It is noted in the literature that problems with registration of information are present in health institutions[19]. Therefore, it is essential that the notification forms are simple, objective and easy to understand.

Another important aspect is the need for continuing education of all health professionals, in which they are instructed on the importance of filling out this data for better analysis of the cause and effect of the incident[8-9].

The limitation of this study was the fact that, because it was a retrospective study with data collected from notification forms, not completing these topics made deeper analyses of the theme unfeasible.

CONCLUSION

This study highlights the importance of encouraging health professionals to make the notifications, modifying and improving the safety culture for the entire multidisciplinary team, not only focusing on the nurse professional.

The results of this study can contribute to stimulate health services in the training of professionals, in the creation of objective and clear notification forms, so that all relevant information is contemplated, because it is a low cost tool and high impact in promoting Patient Safety.

Furthermore, the importance of preventive practices for the occurrence of adverse events is emphasized, so that health professionals reflect positively on the quality of care provided to patients.

NOTIFICAÇÕES DE INCIDENTES RELACIONADOS À SEGURANÇA DO PACIENTE EM HOSPITAL UNIVERSITÁRIO SENTINELA

RESUMO

Objetivo: analisar as notificações de incidentes relacionados à segurança do paciente em hospital universitário público sentinela. **Método:** pesquisa retrospectiva, quantitativa, realizada em hospital universitário localizado no Sul do Brasil. Foram analisadas 760 notificações de incidentes ocorridos nos anos de 2015 a 2017 encaminhadas ao setor de gerência de risco da instituição. Os dados foram coletados de maio a agosto de 2018. A análise estatística descritiva se realizou com o auxílio do Statistical Package for the Social Sciences versão 20.0. **Resultados:** os incidentes notificados foram lesão por pressão (64,0%), seguida de quedas (25,0%), erro de medicação (9,7%), identificação incorreta do paciente (1,0%) e incidentes nos procedimentos cirúrgicos (0,3%). O período matutino, profissional enfermeiro e a unidade de terapia intensiva adulto foram os que mais realizaram as notificações. O evento adverso mais notificado estava relacionado ao erro de medicação (50,7%) seguido de quedas (26,8%). **Conclusão:** os resultados deste estudo contribuem para aumentar o interesse na análise dos dados de incidentes e eventos adversos, bem como para definir ou refinar as estratégias de melhoria da segurança do paciente.

Palavras-chave: Segurança do paciente. Qualidade da assistência à saúde. Pesquisa sobre serviços de saúde. Dano ao paciente. Gestão de riscos.

NOTIFICACIONES DE INCIDENTES RELACIONADOS CON LA SEGURIDAD DEL PACIENTE EN UN HOSPITAL UNIVERSITARIO CENTINELA

RESUMEN

Objetivo: analizar las notificaciones de incidentes relacionados con la seguridad del paciente en hospital universitario público centinela. **Método**: investigación retrospectiva, cuantitativa, realizada en hospital universitario ubicado en el Sur de Brasil. Se analizaron 760 notificaciones de incidentes ocurridos en los años 2015 a 2017 dirigidas al sector de gestión de riesgos de la institución. Los datos se recopilaron de mayo a agosto de 2018. El análisis estadístico descriptivo se realizó con la ayuda del *Statistical Package for the Social Sciences* versión 20.0. **Resultados**: los incidentes notificados fueron lesión por presión (64,0%), seguida de caídas (25,0%), error de medicación (9,7%), identificación incorrecta del paciente (1,0%) e incidentes en los procedimientos quirúrgicos (0,3%). Los que más realizaron las notificaciones fueron el profesional enfermero, período matutino y la unidad de cuidados intensivos adulto. El evento adverso más notificado estaba relacionado con el error de medicación (50,7%) seguido de caídas (26,8%). **Conclusión**: los resultados de este estudio contribuyen a aumentar el interés en el análisis de los datos de incidentes y eventos adversos, así como para definir o refinar las estrategias de mejora de la seguridad del paciente.

Palabras clave: Seguridad del paciente. Calidad de la atención a la salud. Investigación sobre servicios de salud. Daño al paciente. Gestión de riesgos.

REFERENCES

1. Schiff G, Shojania KG. Looking back on the history of patient safety: an opportunity to reflect and ponder future challenges. BMJ Qual Saf. 2022 Feb;31(2):148-152. Doi: http://dx.doi.org/10.1136/bmjqs-2021-014163.

2. Andrade LEL, Lopes JM, Souza FMCM, Vieira JRF, Farias LPC, Santos CCM et al. Cultura de segurança do paciente em três hospitais brasileiros com diferentes tipos de gestão. Ciênc. Saúde Colet. 2018; 23(1):161-72. Doi: https://doi.org/10.1590/1413-81232018231.24392015.

3. Adamy EK, Metelski FK, Argenta C, Silva OM, Zocche DAA. Reflection on the interface between patient safety and the nursing process Rev Enferm Health Care. 2018; 7(1):272-8. Doi: http://dx.doi.org/10.18554/reas.v7i1.2219.

4. Brasil. Ministério da Saúde. Portaria n. 529, de 1º de abril de 2013. Instituição do Programa Nacional de Segurança do Paciente (PNSP) [on-line]. Brasília: Ministério da Saúde, 2013. Diário Oficial da União, Brasília, 1 de abril de 2013. Disponível em: https://bvsms.saude.gov.br/bvs/saudelegis/gm/2013/prt0529_01_04_2013.html.

5. Luzia MF, Cassola TP, Suzuki LM, Dias VLM, Pinho LB, Lucena AF. Incidence of falls and preventive actions in a University Hospital. Rev. Esc. Enferm. USP. 2018; 52:e03308. Doi: https://doi.org/10.1590/S1980-220X2017024203308.

6. Prates CG, Magalhães AM, Balen MA, Moura GM. Patient safety nucleus: the pathway in a general hospital. Rev. Gaúch. Enferm. 2019; 40 (spe):e20180150. Doi: https://doi.org/10.1590/1983-1447.2019.20180150.

7. Maia CS, Freitas DRC, Gallo LG, Araújo WN. Registry of adverse events related to health care that results in deaths in Brazil, 2014-2016. Epidemiol. Serv Saúde. 2018; 27(2):e2017320. Doi: https://doi.org/10.5123/S1679-49742018000200004.

8. Harada MJCS, Silva AEBC, Feldman LB, Tavares SS, Gerhardt LM, Lima Jr AJ et al. Reflections on patient safety incident reporting systems. Rev. Bras. Enferm. 2021;74(Suppl 1):e20200307. Doi: https://doi.org/10.1590/0034-7167-2020-0307.

9. Wanderlei PN, Montagna E. Formulation, implementation and evaluation of a distance course for accreditation in patient safety. Einstein (São Paulo). 2018; 16(2):eGS4316. Doi: https://doi.org/10.1590/S1679-45082018GS4316.

10. Silva AT, Terra FS, Dázio EMR, Sanches RS, Resck ZMR. Nurses and patient safety in hospital practice. Cogitare Enferm. 2016;21(5):1-8. Doi: http://dx.doi.org/10.5380/ce.v21i5.45550.

11. Figueiredo ML, D'Innocenzo M. Adverse events related to pratical assistence: an integrative review. Enferm. glob. 2017;16(47):605-50. Doi: http://dx.doi.org/10.6018/eglobal.16.3.256091.

12. Choi EY, Pyo J, Lee W, Jang SG, Park YK, Ock M et al. Perception Gaps of Disclosure of Patient Safety Incidents Between Nurses and the General Public in Korea. J. Patient Saf. 2021; 17(8):e971-e975. Doi: https://doi.org/10.1097/pts.0000000000000781.

13. Garzin ACA, Melleiro MM. Safety in the training of health professionals. Ciênc., Cuid. Saúde. 2019;18(4): e45780. Doi: https://doi.org/10.4025/ciencuidsaude.v18i4.45780.

14. Brasil. Ministério da Saúde. Secretaria de Gestão de Investimentos em Saúde. Projeto REFORSUS Equipamentos Médico-Hospitalares e o Gerenciamento da Manutenção: capacitação à distância [on-line]. Brasília: Ministério da Saúde, 2002. Disponível em: http://bvsms.saude.gov.br/bvs/publicacoes/equipamentos_gerenciamento1.pdf.

15. Ganz DA, Huang C, Saliba D, Shier V, Berlowitz D, Lukas CV et al. Preventing Falls in Hospitals [on-line]. Rockville, MD: Agency for Healthcare Research and Quality; 2021. Available from: https://www.ahrq.gov/patient-safety/settings/hospital/fall-prevention/toolkit/index.html.

16. Rodrigues TS, Almeida CAPL, Goiano PDDOL, Nepomuceno VMS, Sousa CDCM, Carvalho MLD. Eficácia do curativo hidrocolóide em relação ao filme transparente na prevenção de lesões por pressão. Enferm. Foco. 2018; 9(1):3-6. Doi: https://doi.org/10.21675/2357-707X.2018.v9.n1.1301.

17. Chen Hl, Cao YJ, Wang J, Huai BS. Calibration power of the Braden scale in predicting pressure ulcer development. J Wound Care. 2016;25(11):102-13. Doi: https://doi.org/10.12968/jowc.2016.25.11.655.

18. Urbanetto JS, Creutzberg M, Franz F, Ojeda BS, Gustavo AS, Bittencourt HR et al. Morse fall scale: translation and transcultural adaptation for the portuguese language. Rev. Esc. Enferm. USP. 2013;47(3):568-74. Doi:

https://doi.org/10.1590/S0080-623420130000300007.

19.Faustino TN, Batalha EMSDS, Vieira SL, Nicole AG, Morais AS, Tronchin DMR et al. National Patient Safety Program in Brazil: Incidents Reported Between 2014 and 2017. J Patient Saf. 2021;17(8):e1202-e1208. Doi: https://doi.org/10.1097/pts.0000000000000496.

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