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ORIGINAL ARTICLE

OCCURRENCE OF ADVERSE EVENTS IN INTENSIVE CARE UNIT IN SOUTH BAHIA, BRAZIL[1]

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ABSTRACT

Objective: to analyze the correlations between adverse events (AE) and variables related to the profile of patients from general and COVID-19 intensive care units (ICU). **Method:** descriptive epidemiological survey that included patients admitted to the ICU of a service in southern Bahia, Brazil. The analysis involved 399 medical records, from March to October 2020. **Results:** the largest occurrences identified were pressure injuries (54.2% general ICU, 46.1% COVID-19 ICU) and device loss (40.7% general ICU; 46.3% COVID-19 ICU). In both units, the occurrence of AE was positively correlated with the length of stay (general ICU: $r = 0.314$, $p < 0.001$; COVID-19 ICU: $r = 0.230$, $p < 0.001$) and negatively with the mean score of the Braden scale (General ICU: $r = 0.197$, $p = 0.03$; COVID-19 ICU: $r = -223$, $p = 0.03$). **Conclusion:** the analysis showed PI and device loss as the most frequent AE, related to the time of hospitalization and the average Braden. In the general ICU, age and higher risk of PI at admission were relevant; in the COVID-19 ICU, the rapid evolution to severity was highlighted. The study reinforces the need to strengthen patient safety culture in order to improve care.

Keywords: Patient Safety. Intensive Care Units. COVID-19

INTRODUCTION

Patient safety (PS) was highlighted worldwide after the release of the report "To Err is Human", published in 1999 by the Institute of Medicine, pointing out that, in that time, more than one hundred thousand people were victims of adverse events (AE). The World Health Organization defines AE as undesirable incidents in healthcare that may or may not cause harm to the patient, and are important quality indicators whose data collection can promote continuous improvements in the care provided[1].

For a long time, errors were neglected, either because they were understood as occurrences inherent to the service or because of fear that audits could tarnish the reputation of institutions. Over the years, there has been a paradigm shift, accompanied by the perception that mistakes can happen in any company and do not usually have a single culprit, so it is necessary to identify the causes for healing them[2]. In this context, health institutions should direct care towards safer practices, understanding that safety and quality of care are inseparable characteristics. Worldwide, the incidence of AE in intensive care units (ICUs) varies from 0.87 to 34.7/100 admitted users, with 64% of these events considered preventable, leading to complications, prolonged hospitalizations and death[3].

From this perspective, it is important to focus a vigilant look at ICUs, hospital sectors that receive highly complex patients with imminent risk of death and that are subjected to complex procedures[4]. Patients with severe hemodynamic instability and submitted to multiple diagnostic-therapeutic interventions face a greater risk of AE[4].

Large inequalities in health care were aggravated by the exponential increase in

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demand during the pandemic5. In March 2020, the low number of mechanical fans available in Brazil highlighted the scarcity of resources, highlighting regional differences. Such event directly affected the quality of care and survival rates of patients with COVID-19[5].

A cohort study with 650 people hospitalized for COVID-19 in a university hospital in Brazil showed that 39.7% had AE. In addition, it was found that these patients underwent invasive procedures and ran risks of AE associated with care, such as renal failure, nosocomial infection and thromboembolic/vascular events[7].

The research of Yackel and collaborators showed that delays in care, exposure to COVID-19, laboratory errors, misprocedures and failures in patient identification were the most common events in units such as emergency departments and ICUs, what serves as a warning to managers and government organs[7].

The COVID-19 pandemic has increased the occupancy of ICU beds worldwide, causing health damage due to the intensity of respiratory impairment. Conducting studies on the prevalence of AE, especially comparing data between general ICUs and COVID-19, can promote measures to improve care, including theoretical, practical and operational advances for the construction of public policies regarding PS.

Considering the importance of the topic and the lack of studies on PS-related incidents, especially those that cause damage[8], it is important to analyze the occurrence of AE and its correlated variables in the ICU to fill the knowledge gaps. In addition, it is important to know the prevalence of AE in ICUs and whether there was an impact of the COVID-19 pandemic on the occurrence of these events.

This study corroborates the mapping of AE occurrence, providing greater engagement of the institution in the goals of PS. Within the context of health, understanding these events and their causes is fundamental to improve care practices. The importance of understanding AE is not limited to the correction of punctual failures, but covers a systemic vision that contributes to the prevention of future incidents, the improvement of professional skills and the strengthening of safety culture.

Once these considerations are made, questions arise: were patients admitted to the COVID-19 ICU more vulnerable to AE? What factors may be associated with the occurrence of these events? This study aims to analyze the correlations between AE and variables related to the patient profile among general ICUs and COVID-19 in a city of Bahia, Brazil.

MATERIALS AND METHODS

Descriptive epidemiological research based on records of patients hospitalized in general ICU and COVID-19 from a health institution located in a medium-sized municipality in the South of Bahia, Brazil. At the time of the study, the institution had 20 beds for general ICU and ten for COVID-19 ICU. Data from the interns in the period from March to October 2020 were considered.

For the calculation of sample size, the software GPower v. 3.1 was used. The sample calculation was based on the occurrence of AE, with effect size of 15% between the COVID-19 ICU and the general ICU, considering annual data. Thus, considering an effect size of 0.159, power of 80% and error of 5%, the total number suggested was 485 patients. With a view to possible sample losses, an additional 15% was added, totaling 558 patients. After the calculation, exclusion criteria were used, totaling 399 patients, 169 from the COVID-19 ICU and 230 from the general ICU. The decrease in sample size was caused by the exclusion of medical records with missing data (in one or more fields).

Medical records of patients over 18 years old hospitalized for more than 24 hours were included. Medical records with incorrect data were excluded, namely: Braden[10] scale on admission, age and readmissions. Data collection occurred in the period from May to July 2021. The AE were measured from the analysis of records in the medical records, following criteria established by the World Health Organization[11] and management protocols for AE[12]. Aspects such as identification and classification of the event, type of AE, severity and conditions of occurrence were considered. Data collection was performed using an Excel® spreadsheet,

developed to ensure the accuracy and reliability of records.

The variables were AE, age, gender, main diagnosis, origin, score of the Braden scale and period of hospitalization. The AEs were classified according to the types of occurrence, according to the technical standard 05/2019 of the National Health Surveillance Agency. The value of the Braden scale, updated every 24 hours, refers to the risk rating of the patient to develop pressure injury (PPL): very high (6 to 9 points), high (10 to 12), moderate (13 to 14), low (15 to 18), no risk (19 to 23)[12].

Three collection instruments were used. The instrument A for characterizing individuals includes the following variables: age, gender, main diagnosis, origin, date of admission, discharge and death. Instrument B records the notifications of AEs and considers: date, problem occurred, type of event and damage. Instrument C includes the daily recording of the score of the Braden scale until the outcome of discharge or death.

The data collection was carried out by only one researcher, because at this stage, even during the COVID-19 pandemic, only one person from the team was allowed to enter the institution. Subsequently, the data was transcribed to Excel®. Double typing was performed with equality verification using the validation resources of the program, considering true the data typed equally and false the divergent.

Data were analyzed by descriptive statistics and expressed as mean, standard deviation and median for continuous variables, as well as frequencies and percentages for categorical variables. The Shapiro-Wilk test was used to verify the distribution of continuous data. The Mann-Whitney U test was used to compare continuous variables between independent samples (general ICU and COVID-19). For comparisons between the proportions of categories of a same variable, the chi-square test of adherence was used. For the association between the occurrence of AE (yes and no) of general ICU and COVID-19 ICU, the chi-square test of independence was used. The mortality indicator was calculated by dividing the number of deaths by the total number of hospitalizations in the period, then multiplying the result by 100 to obtain the percentage.

In each ICU, the Spearman correlation test was used to correlate the occurrence or not of AE with the continuous variables "age", "length of stay", "Braden A" (Braden value at admission), "Average Braden" (mean Braden value over the period of hospitalization) and occurrence or not of AE with category "Braden Classification A" (no risk/low risk, moderate risk and high/very high risk). The significance level adopted was 5% for all analyses, and the statistical package used was IBM SPSS Statistics for Windows version 25.0.

The data were collected after approval by the Research Ethics Committee of the State University of Santa Cruz, opinion number 4,707,682 of May 12, 2021. Having submitted a plan for anonymizing the data, the researcher requested waiver of the Informed Consent Form. Participants were given identification numbers from 0 to 399 to protect their privacy in accordance with the General Data Protection Act.

RESULTS

There were 399 participants in the study, mostly men, with an average of 66.2 years old and 11.6 days hospitalization. The most recurrent outcome for general ICU was discharge (71.3%), and for COVID-19 ICU death (52.1%), as shown in Table 1. The main diagnoses present at admission to general ICU were immediate postoperative of various surgeries (21.7%) and cardiac surgeries (17.4%). Regarding the origin, most patients from COVID-19 ICU were admitted from the ward (36.6%) and from the general ICU of the emergency department (28.7%).

Table 1. Characterization of ICU patients. Brazil. 2020

Characteristics	**All (n = 399)**	**COVID-19 ICU (n = 169)**	**General ICU (n = 230)**	**Test value**	**p-value**
Admission n (%)	399 (100)	169 (42,4)	230 (57,6)	X^2: 9,32	**0,002**
Age (years)*	66,2 ± 17,2 (68)	62,2 ± 16,3 (64)	69,2 ± 17,1 (72,5)	U: 14437	< **0,001**
Time of hospitalization	11,6 ± 15,7 (5)	11 ± 9,9 (8)	12,2 ± 18,9 (5,5)	U: 16611	**0,013**

(days)*					
Sexo					
Male n (%)	222 (55,6)	109 (64,5)	113 (49,12)	X²: 0,07	0,788
Female n (%)	177 (44,5)	60 (35,5)	117 (50,9)	X²: 18,3	< **0,001**
Desfecho					
Discharge	245 (61,4)	81 (47,9)	164 (71,3)	X²: 28,1	< **0,001**
Death	154 (38,6)	88 (52,1)	66 (28,7)	X²: 3,14	**0,076**
38 52	28	X²: 7,20	**0,007**		
Diagnóstico					
Sepsis	3 (0,75)	-	3 (1,3)	-	
Respiratory diseases	30 (7,5)	-	30 (13)	-	-
Kidney diseases	11 (2,75)	-	11 (4,8)	-	-
Heart diseases	41 (10,3)	1 (0,6)	40 (17,4)	X²: 37,09	< **0,001**
Neurological diseases	30 (7,5)	-	30 (13)	-	-
IPO cardiac surgeries	19 (4,8)	-	19 (8,3)	-	
IPO various surgeries	50 (12,5)	-	50 (21,7)	-	
Neoplasms	5 (1,25)	-	5 (2,2)	-	
Obstetric complications	3 (0,75)	-	3 (1,3)	-	
Gastrointestinal diseases	14 (3,55)	-	14 (6,1)	-	
Metabolic disorders	5 (1,25)	-	5 (2,2)	-	
COVID-19	170 (42,6)	168 (98)	2 (0,9)	X²: 162,0	< **0,001**
Other diagnoses	11 (2,75)	-	11 (4,8)	-	
Not informed	7 (1,75)	-	7 (3)	-	-
Procedência					
Infirmary	120 (31,0)	62 (36,6)	58 (25,2)	X²: 0133	0,715
Emergency room	120 (31,0)	54 (32)	66 (28,7)	X²: 1,200	0,273
Surgical center	60 (15,5)	1 (0,6)	59 (25,7)	X²: 56,06	< **0,001**
Hemodynamics	12 (3,2)	-	12 (5,2)	-	-
ECU	22 (5,7)	22 (13)	-	-	-
ICC	2 (0,6)	2 (1,2)	-	-	-
CIU	1 (0,3)	-	1 (0,4)	-	-
Other	49 (12,7)	28 (16,6)	21 (9,1)	X²: 1,000	0,317

*variables expressed as mean, standard deviation and median, X² = chi-square goodness-of-fit test; U = Mann-Whitney U test; IPO = immediate postoperative period; ECU = emergency care unit; ICC = intensive care center; CIU = cardiointensive care unit.
Source: Created by the authors. Brazil, 2020

In relation to the average value of the Braden scale at admission, general ICU presented a higher risk for developing PPL compared with COVID-19 ICU, showing significant difference between units ($p < 0.001$), as shown in Table 2.

Table 2. Patients admitted to ICUs according to characteristics obtained from the Braden scale. Brazil. 2020

Characteristics	**All (n = 399)**	**COVID-19 ICU (n = 169)**	**General ICU (n = 230)**	**Test value**	**p-value**
Braden na admissão*	13,2 ± 3,39 (13)	14 ± 3,79 (14)	12,6 ± 2,94 (12)	U: 14668	< 0,001
Braden at admission*					
Braden Category	62	31 (18,3)	31 (13,5)	-	-
Very high	119	27 (16)	92 (40)	X²: 35,50	< 0,001
High	86	28 (16,6)	58 (25,2)	X²: 10,46	0,001
Moderate	99	62 (36,7)	37 (16,1)	X²: 6,313	0,012
Low	33 (8,2)	21 (12,4)	12 (5,2)	X²: 2,455	0,117
No risk					

* variables expressed as mean, standard deviation and median, X² = chi-square goodness-of-fit test, U = Mann-Whitney U test.
Source: Created by the authors. Brazil, 2020

Occurrences such as PI, phlebitis and device loss were identified. When associating the units to the occurrence of AE, an association with the COVID-19 ICU was found (p = 0.001). In the comparison between PI and device losses, there was no significant difference in the occurrence of these AEs (Table 3).

Table 3. Occurrence of AE in ICUs. Brazil, 2020

Type of adverse event n (%)	All (n = 399)	COVID-19 ICU (n = 169)	General ICU (n = 230)	Test value	p-value
Failure to provide care					
Failure to identify the patient	1 (1,6)	1 (2,6)	-	-	-
Pressure injury	3 (4,8)	3 (7,7)	-	-	-
Phlebitis	31 (49,2)	18 (46,1)	13 (54,2)	X^2: 0,806*	0,369
Lost devices	2 (3,2)	-	2 (8,3)	-	-
Others	25 (39,7)	16 (41)	9 (37,5)	X^2: 1,960*	0,162
Adverse events n (%)	1 (1,6)	1 (2,6)	-	-	-
No					
Yes	336 (100)	202 (89,4)	134 (77,5)	X^2: 10,478#	**0,001**
Type of adverse event n (%)	63 (100)	24 (10,6)	39 (22,5)		

* = chi-square goodness-of-fit test; # = chi-square test of independence.
Source: Created by the authors. Brazil, 2020.

When all units were considered, it was observed that the length of stay is positively correlated with AE (r = 0.279; p < 0.001). Age was only correlated with AE in the general ICU (r = 0.149; p = 0.024). The Braden mean had a negative correlation when all units were considered (r = -0.253; p < 0.001), when only COVID-19 ICU was considered (r = -223; p = 0.03) and only general ICU (r = -0.197; p = 0.03). Braden on admission and Braden's classification on admission had no correlation with EA (Table 4).

Table 4. Correlation between AE and clinical variables in ICUs. Brazil, 2020

Clinical variables	All units		COVID-19 ICU		General ICU	
	Correlation coefficient	p-value	Correlation coefficient	p-value	Correlation coefficient	p-value
Time of hospitalization	0,279**	0,000	0,314**	0,000	0,230**	< **0,001**
Age	0,019	0,708	- 0,057	0,457	0,149*	**0,024**
Braden A	- 0,093	0,062	- 0,136	0,073	- 0,105	0,110
Braden A Classification	- 0,087	0,082	- 0,126	0,098	- 0,092	0,163
Braden Mean	- 0,253**	0,000	- 0,223**	0,003	- 0,197**	**0,003**

Braden A: Braden value at admission.
Source: Created by the authors. Brazil, 2020

DISCUSSION

The present study agrees with national and international publications in several aspects. Regarding age, the mean was equivalent to other studies, but COVID-19 patients were younger than patients admitted to the general ICU[13]. This data converges with studies conducted in Belgium and Italy, which had close averages. In Brazil, a survey conducted in Paraná found no statistical difference for age in the two units[14].

A relevant feature is that the population admitted to the ICU, can be majorly considered elderly. It is important to consider that aging, with a higher prevalence of comorbidities such as diabetes mellitus and heart problems, is associated with a greater likelihood of developing the severe form of COVID-19, which makes these individuals more vulnerable[15].

When thinking about PS in critical environments such as the ICU, the age of the patient is a relevant factor to draw the profile of the unit, since it strengthens the choices in the sizing of nursing personnel. This is because older people require more attention, especially in relation to skin, hydration, hygiene and other

comorbidities that increase the risk of PP[14].

This research had a larger male audience in the ICU COVID-19, as also found in other research[14,16]. Regarding the time in days of hospitalization, that of COVID-19 ICU patients was similar to that found in a national research[17]. Epidemiological reports of hospitalizations in ICU due to severe acute respiratory syndrome due to COVID 19, published by the Ministry of Health, identified that, in Brazil, patients remained on average for 10.1 days internated[16]. However, in Brasilia the average time was higher, 14.72 days[18].

When establishing a relationship with hospitalization and mortality indicator, in this study, the COVID-19 ICU presented shorter duration of hospitalization and higher percentage of mortality, which may indicate a higher frequency of evolution to death among patients with COVID-19 than among patients in the general ICU. This is possibly due to the public health emergency brought about by a new infectious agent, on which there were few studies and guidelines at the beginning of the pandemic.

A survey conducted in four units of a private general hospital of high complexity in Brazil, from May to October 2020, showed that the mortality evaluated in COVID-19 ICU was 18.1% to 22.7%, while in general ICU it was 10.4%[19]. However, authors believe that the clinical outcome and the year of hospitalization may be related to the time of hospitalization; during the pandemic, especially in 2021, patients' chances of dying were higher[17].

Regarding the risk of developing PI, from the Braden scale, the profile found showed that patients in the general ICU had a higher risk of developing PI at admission, when compared to patients in the COVID-19 ICU, whose majority presented low risk at admission. A national survey, conducted in COVID-19 ICU, found divergent data, with average Braden score of 12 in the first 24 hours of hospitalization, pointing to high risk of developing PI, equivalent to the general ICU of this research, and also associated the occurrence of the lesion with prona position[20].

It is worth emphasizing the importance of using scales to measure the predisposition of patients to develop PI. In the institution of the study, the widely used Braden scale is recommended, whose performance should be part of the daily routine of nurses as a tool to assess the risks of patients with reduced mobility and/ or bedridden. This favors the direction of nursing care, facilitating that they are carried out in a preventive way. In the literature there are also references to the scales of Waterlow, Cubbin & Jackson and Sunderland that conceptualize them as more accurate and with high sensitivity for critical patients[21].

Regarding the occurrence of AE, in this study, statistical analysis indicated an association with the COVID-19 ICU, although it presented a lower percentage compared to national and international surveys. A multicenter study conducted in ICUs in France showed that 85.9% of the sample analyzed presented at least one AE, and 41.5% of these occurred during a nursing procedure[22].

A study in an academic hospital in Japan showed that 51% of patients had one or more AEs, 20% of which could be averted[23]. In Brazil, a low incidence of AE was also found, 8%, but the same study highlighted that the low quantity may have occurred because they directed the research to only six specific AEs[24].

In agreement with this research, in São Paulo, a study showed a higher incidence of PI and loss of devices, and the units may have a similar profile[24]. Most studies show that PI is prominent in the occurrence of AE, which implies the need for strengthening actions to prevent it, especially considering the increased risk of patients in ICU due to the use of vasoactive drugs and sedation[24,25].

It is necessary to highlight the difference between these lesions, considered preventable, and acute skin failure, a new term associated with lesions resulting from terminal phase, tissue loss and patient severity. The latter are considered inevitable, especially in COVID-19 patients, and may occur due to prolonged invasive mechanical ventilation, respiratory, renal and cardiac insufficiency, sepsis of respiratory focus, use of vasoactive drug, Hemodynamic instability with intolerance to minimal repositioning, prolonged fasting and intravascular coagulopathy[26].

Research conducted in Brazil and Japan showed that the most common AEs are due to errors in patient care and PI[23,27]. In this research, no failure was reported during assistance, which is an important point to be analyzed. This information is important to identify failures in the care provided, which may have personal, multiprofessional or institutional causes, and its absence can highlight the fear of performing the notification.

In the present study, the Braden mean was correlated with the occurrence of AE when all units were considered. It can be inferred that when the degree of dependence of the patient increases, the chances of developing PI increase, at the same time that increases the chance of an AE occurring. The Braden variables at admission and the Braden classification at admission were not predictors of AE.

The length of stay was positively correlated with AE when all units were considered, given convergence with literature[24]. Age was correlated with AE only in the general ICU. The authors also found this association and explained that the chance of AE in elderly patients is major[24].

From all the above, it is understood that care for critical patients since the act of hospitalization plays an important role in addressing disparities in health care, as they help to track vulnerable and high-risk groups. User safety is emphasized as the responsibility of all health professionals, who have the responsibility to adopt strategies for damage prevention and reduction of risk[28].

The *Manual para Profissionais de Saúde*, created by the São Paulo Regional Nursing Council, in accordance with the Brazilian Network of Nursing and Patient Safety, is composed of 12 strategies that meet this needs[29]. Basically, the proposed strategies are: hand hygiene; patient identification; effective communication; fall prevention; pressure ulcer prevention; safe administration of drugs; safe use of intravenous devices; safe surgical procedures; safe administration of blood and blood components; safe use of equipment; patients partners in their own safety; training of health professionals focused on safe care.

The main advantage of this study is that it is based on primary data from a significant population of patients from both COVID-19 ICU and general ICU. In addition, the present study depicts the health situation of a municipality with few data. Regarding the limitations, another point to be raised is that there may have been classification of events at the time of notifications, but in the sample studied, the damage was not reported, which makes it difficult to assess the impact of AEs for patients.

It is important to highlight the limitations of the study, such as the gap left by the underreporting inherent in health services, which already signals the great challenge of patient safety culture to professionals and managers. For example, the occurrence types could not be analyzed statistically in their entirety due to the non-occurrence of some of these. This scenario was found and reinforced in a study conducted in an institution in the south of Bahia, whose analyzed notifications identified that the time elapsed between occurrence and notification was associated with the type of AE and the patient's evolution, demonstrating the need for strategies to strengthen the safety culture[22].

Another limitation of the study was the non-use of the Trigger Tool[30] tool, which could have increased the detection of EA not evident in medical records. Also, the results of this study showed a reduction in the size of the final sample compared to the estimated in the sample calculation due to the number of readmissions and lack of information, given that data were collected from the first phase of opening the COVID-19 ICU in the institution. Despite this limitation, the main objective was achieved, because the analysis of the records allowed to identify relevant AE, taking into account the proposal.

Considering the above, the implementation of multiprofessional care, combined with prevention and promotion of public policies, will contribute to the improvement of future care, enabling the reduction of AE in the hospital context.

CONCLUSION

This study showed that the highest occurrence AEs were PI, followed by device loss, and are related to the length of stay and average Braden for both units. In the general ICU, age also correlated with the occurrence of AE. In addition, an association was found between the occurrence of AE and the COVID-19 ICU.

Regarding the risk of developing PI, patients from general ICU had a higher risk at admission, which is justified by the fact that COVID-19 ICU patients are older and have other comorbidities. COVID-19 patients had a rapid evolution to severity, but lower mobility limitations at admission.

There were more AE registrations in the COVID-19 ICU, which may indicate either higher occurrence or that it was the sector with the highest number of notifications. The number of AE notifications in this study was small, making it difficult to analyze statistics. It is necessary to strengthen the patient safety culture and decrease the punitive culture, making clear to professionals the importance of not being afraid to make notifications, which allow strategies to improve the quality of care provided.

Intensive care teams need to know the profile of the unit in order to draw up specific and more effective strategies for the sector. It is important to understand that, in the same institution, the characteristics of the hospitalized patients vary, being necessary to adjust strategies to reduce AE caused by nursing practices, thinking that PI and loss of devices, although they are discussed among nursing teams, they are still the main causes of harm to patients.

OCORRÊNCIA DE EVENTOS ADVERSOS EM UNIDADE DE TERAPIA INTENSIVA NO SUL DA BAHIA, BRASIL

RESUMO

Objetivo: analisar as correlações entre os eventos adversos (EA) e as variáveis relacionadas ao perfil dos pacientes de unidades de terapia intensiva (UTI) geral e COVID-19. **Método**: pesquisa epidemiológica descritiva que incluiu os pacientes internados em UTI de um serviço do sul da Bahia, no Brasil. Foram analisados 399 prontuários, de março a outubro de 2020. **Resultados**: as maiores ocorrências identificadas foram lesões por pressão (54,2% UTI geral, 46,1% UTI COVID-19) e perda de dispositivos (40,7% UTI geral; 46,3% UTI COVID-19). Nas duas unidades, a ocorrência de EA foi positivamente correlacionada com o tempo de internamento (UTI geral: $r = 0,314$, $p < 0,001$; UTI COVID-19: $r = 0,230$, $p < 0,001$) e negativamente com a média de pontuação da escala de Braden (UTI geral: $r = 0,197$, $p = 0,03$; UTI COVID-19: $r = -223$, $p = 0,03$). **Conclusão**: a análise apontou LPP e perda de dispositivos como EA mais frequentes, relacionados ao tempo de internação e à média Braden. Na UTI geral, idade e maior risco de LPP na admissão foram relevantes; na UTI COVID-19, destacou-se a rápida evolução para gravidade. O estudo reforça a necessidade de fortalecer a cultura de segurança do paciente para melhorar a assistência prestada.

Palavras-chave: Segurança do paciente. Unidades de Terapia Intensiva. COVID-19.

INCIDENCIA DE EVENTOS ADVERSOS EN UNIDAD DE CUIDADOS INTENSIVOS EN EL SUR DE BAHIA, BRASIL

RESUMEN

Objetivo: analizar las correlaciones entre los eventos adversos (EA) y las variables relacionadas con el perfil de pacientes de unidades de cuidados intensivos (UCI) general y COVID-19. **Método**: estudio epidemiológico descriptivo que incluyó a pacientes ingresados en UCI de un servicio del sur de Bahia, en Brasil. Se analizaron 399 registros médicos, de marzo a octubre de 2020. **Resultados**: las mayores incidencias identificadas fueron lesiones por presión (54,2% UCI general, 46,1% UCI COVID-19) y pérdida de dispositivos (40,7% UCI general; 46,3% UCI COVID-19). En dos unidades, la incidencia de EA se correlacionó positivamente con el tiempo de internación (UCI general: $r = 0,314$, $p < 0,001$; UCI COVID-19: $r = 0,230$, $p < 0,001$) y negativamente con el promedio de puntuación de la escala de Braden (UCI general: $r = 0,197$, $p = 0,03$; UCI COVID-19: $r = -223$, $p = 0,03$). **Conclusión**: el análisis señaló LPP y pérdida de dispositivos como EA más frecuentes, relacionados con el tiempo de internación y el promedio Braden. En la UCI general, edad y mayor riesgo de LPP en la admisión fueron relevantes; en la UCI COVID-19, se destacó la rápida evolución a gravedad. El estudio refuerza la necesidad de fortalecer la cultura de seguridad del paciente para mejorar la atención ofrecida.

Palabras clave: Seguridad del paciente. Unidades de Cuidados Intensivos. COVID-19.

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