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ORIGINAL ARTICLE

Perception of professionals about patient safety in psychosocial care

Percepção dos profissionais sobre segurança dos pacientes na atenção psicossocial

Percepción de los profesionales en torno a la seguridad de pacientes en la atención psicosocial

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ABSTRACT

Objective: To understand the professionals' perception of risks and factors related to patient safety incidents in psychosocial care. **Methods**: Descriptive-exploratory study, with a qualitative approach, carried out with 31 professionals in type III Psychosocial Health Care Centers, between October 2016 and April 2017. Data collection was mediated by the Experiential Learning Cycle. Content analysis was performed. **Results:** The professionals revealed risks and factors related to safety incidents in their daily practices, associated with the institution's physical and organizational structure, with the configuration of the clinical process, with clinical administration and organizational management. **Final considerations:** Continuous efforts are needed on the part of senior managers and professionals to improve the work process and organizational structure in psychosocial care, contributing to the development of the patient's autonomy and social rehabilitation, avoiding institutionalization and, especially, ensuring the safety of this type of care.
Descriptors: Mental Health Services; Patient Harm; Patient-Centered Care; Quality of Health Care; Patient Safety.

RESUMO

Objetivo: Conhecer pela percepção dos profissionais os riscos e os fatores relacionados aos incidentes de segurança do paciente em atenção psicossocial. **Método**: Estudo descritivo-exploratório, de abordagem qualitativa, realizado com 31 profissionais em Centros de Atenção Psicossocial tipo III, entre outubro de 2016 e abril de 2017. Coleta de dados mediada pelo Ciclo de Aprendizagem Vivencial. Realizada análise de conteúdo. **Resultados**: Os profissionais revelaram riscos e fatores relacionados aos incidentes de segurança em suas práticas diárias, associados à estrutura física e organizacional, condução do processo clínico, administração clínica e gestão organizacional. **Considerações finais**: São necessários esforços contínuos por parte da alta direção e dos profissionais para melhorar o processo de trabalho e estrutura organizacional na atenção psicossocial, a fim de contribuir com o desenvolvimento da autonomia e reinserção social do paciente, evitar a institucionalização e, especialmente, garantir uma atenção psicossocial segura.
Descritores: Serviços de Saúde Mental; Dano ao Paciente; Assistência Centrada no Paciente; Qualidade da Assistência à Saúde; Segurança do Paciente.

RESUMEN

Objetivo: Conocer la percepción de los profesionales en torno a los riesgos y los factores relacionados con los incidentes de seguridad del paciente en la atención psicosocial. **Método**: Estudio descriptivo-exploratorio, de abordaje cualitativo, en el cual participaron 31 profesionales de Centros de Atención Psicosocial tipo III, realizado en el período entre octubre de 2016 y abril de 2017. En la recopilación de datos se utilizó el Ciclo de Aprendizaje Vivencial. Se hizo el análisis de contenido. **Resultados**: Los profesionales revelaron riesgos y factores relacionados con los incidentes de seguridad en sus prácticas diarias, que están asociados a la estructura física y organizacional, al manejo del proceso clínico, a la administración clínica y a la gestión organizacional. **Consideraciones finales**: Se necesitan esfuerzos continuos por parte de la administración superior y de los profesionales para que mejore el proceso de trabajo y la estructura organizacional en la atención psicosocial, a fin de contribuir al desarrollo de la autonomía del paciente y su reinserción social, de evitar la institucionalización y, especialmente, de garantizar una atención psicosocial segura.
Descriptores: Servicios de Salud Mental; Daño del Paciente; Atención Dirigida al Paciente; Calidad de la Atención de Salud; Seguridad del Paciente.

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INTRODUCTION

The Brazilian Psychosocial Health Care Centers (Caps) are community mental health services, originated in the Brazilian psychiatric reform and considered important components of the Psychosocial Health Care Network, with recognized effectiveness in the care of people with severe psychic suffering[1].

Despite the advances of the psychiatric reform, mental health safety is a neglected field, since patients may be less likely to be heard when it comes to their care and safety[2].

Patient safety is defined as the reduction of risks and unnecessary damage associated with health care down to an acceptable minimum[3]. It is estimated that security incidents – events or circumstances – which may result or have resulted in unnecessary damage to patients affect thousands of people every year in different countries of the world, most being preventable[4]. These events may cause physical, psychological and social problems for patients and their families. In addition, they produce an economic impact, overload the health systems and interfere with the health institutions' reliability[5].

Although the focus of the research on patient safety is still centered on hospitals, much of the care has been offered in primary health care, where the majority of incidents are related to the patients' diagnosis and drug prescriptions[6].

In the context of community psychiatric services, the literature on patient safety is still scarce, both nationally and internationally[2,6-7]. The expansion of the study of incidents in psychosocial care is thus necessary, to subsidize more assertive decisions, based on scientific evidence.

Many safety incidents that take place in the context of psychosocial care are similar to those reported in other contexts, for example, medication errors, diagnostic errors and accidents with patients, such as falls[8]. Experts indicate the patients' perspective about mental health care as a priority area for research in psychosocial care, including their perspective about the planning of the safety of health care actions, self-harm and the medication process[9].

To start a process of engagement of patients in this movement, professionals in psychosocial care need to be prepared to recognize and understand the factors that interfere with the patient's outcome. However, it is still necessary to develop tools for guiding the professional's performance in this context, especially in relation to the prevention of incidents, risk management and the strengthening of the safety culture in psychosocial care[6-7].

Understanding the risks and factors related to patient safety incidents, from the experiences of professionals immersed in psychosocial care, is the first step to support the development of specific policies and protocols for the safe care of this population, as well as the strengthening of the existing safety policies.

OBJECTIVE

To understand the risks and factors related to patient safety incidents in Psychosocial Care Centers, according to the professionals' perspective.

METHOD

Ethical aspects

The study was approved by the Committee of Ethics in Medical, Human and Animal Research of the Federal University of Goiás' Teaching Hospital (CEP/HC/UFG), according to the ethical requirements proposed by Resolution 466/12 of the National Health Council. All participants received information about the research and signed the Informed Consent Form.

Theoretical-methodological framework

Study setting and design

This was a descriptive-exploratory study, with a qualitative approach, based on the realization of group meetings according to the methodology of the Experiential Learning Cycle (CAV), developed in two type III Caps located in the municipality of Aparecida de Goiânia, Goiás, Brazil. One Caps offers its services to adults with mental disorders, and the other, to adult users of alcohol and drugs.

CAV's approach was the most appropriate for supporting the study as it allows the achievement of positive changes in the initially problematized reality, promoted by the group experience. The methodology of this cycle is developed in four stages. In the first, a situation proposed by the coordinator of the group that requires the participants' commitment for the resolution of problems is experienced; the analysis begins in the second, with extensive discussions about the situation experienced, critical evaluation of the results and sharing of feelings between the participants; in the third, the theoretical foundations that promote the awareness of aspects that hindered the activity are identified; and finally, in the fourth stage, a connection is made by comparing the aspects of the experience and theory with the practical situations of work and life[10].

The Caps III setting is characterized by a more challenging, inquisitive and creative posture. It stood out due to its good interactivity, power of contextualization and more defensive attitudes. This research approach in different scenarios favors a constructivist collection of ideas supported by subjectivity, understanding, dialogue, interactivity, contextualization, multiple realities and relativism of the contents. The researchers highlighted experience, symbolism and intersubjectivity as elements of human individuality and social reality[11], as well as the awareness of the role of each individual in society and in the construction of knowledge[12].

Expanding this study to other fields of knowledge does not ensure the same results, because it was developed alongside a multidisciplinary team with participants from different backgrounds, with different organizational cultures, and it is known that each group is unique in its constitution, history, working methods, among other peculiarities. Nevertheless, the research process revealed important reflections that highlighted relevant facts compromising the safety and quality of care, with generalizable applicability.

Population

The population consisted of twelve professionals of the type III Alcohol and Drugs Caps and nineteen of the type III Adult Caps, totaling 31 professionals. Coordinators and technical staff of each service who were working at the period of data collection and who were willing to participate were included in the study.

The study included several occupational categories, involving the fields of health, human and social sciences, with the sum of the professional identities unveiling the richness of psychosocial care, which requires an integrated and multidisciplinary approach. The priority of the study was the participants' opinion, their convictions, doubts and reflections in relation to those of the others. The focus was on what was thought, felt and said by the group[11].

Data collection

Data collection took place between October 2016 and April 2017, in group meetings conducted according to CAV's methodology.

Eighteen meetings were held, nine in each Caps. They were conducted based on group techniques that were consistent with the theme of the meeting and with the group's movement and characteristics, having lasted from three to four hours each. They occurred in the participants' respective work units, in the time intended for the teams' meeting, which enabled the participation of a greater number of professionals. The meetings were mediated by a professional trained in the use of the Experiential Learning Cycle's methodology, and the following structure was adopted to conduct the meetings: coexistence agreement, analysis of prior knowledge about patient safety (meeting 1); reflection about the professionals' performance when carrying out health care actions (meeting 2); analysis of the professionals' theoretical understanding of the patient safety terminology (meeting 3); presentation of the theoretical framework for patient safety (meeting 4); reflection about the social processes developed at the Caps (meeting 5); theoretical training in aspects of patient safety to identify risk situations and incidents in the services (meetings 6 and 7); description of the factors related to the incidents discussed in previous meetings by the professionals (meetings 8 and 9). The problematization techniques used in the Experiential Learning Cycle revealed the professionals' reality and significant contents associated with the risks and factors related to patient safety incidents in the context of the Caps.

As limitation of the CAV's application, it should be noted that only a portion of the institution's staff participated in the study, which may reduce the impact of the changes. However, it is essential for mobilizing the group's driving and restrictive forces, in addition to working on the emotional and cognitive level, making the learning process meaningful and substantial[13].

Data analysis

The data were subjected to content analysis, based on Bardin[14], having been organized into three chronological poles: pre-analysis, moment of organization and recognition of the data by reading them; analysis of the material, where the encoding of the data and identification of the nuclei of meaning that were in line with the study's objectives were conducted; and processing and interpretation of the results obtained. The Atlas.ti 6.2 software was used in the processes of analysis and pre-analysis for organization of the large volume of the material.

Four thematic categories emerged from the analysis of the contents: influence of physical structure and medical devices on the patient's safety and behavior; clinical process and non-individualized care; interference of clinical administration in the patient's therapy; and influence of resources/organizational management on the effectiveness of care.

Each category was exemplified with the professionals' reports, identified as Caps III or Caps AD III, considering the institution of origin of the report. For each thematic category, subcategories that reflected the risk situations and factors related to incidents derived from the care provided in the services were devised, based on the professionals' experience.

RESULTS

A total of 31 professionals participated in the study, 21 (67.75%) of them being female and the other ten, (32.25%) male. Ages ranged between 23 and 65 years old, the range from 23 to 30 years old having predominated (41.2%). Higher education was mentioned by 28 (90.3%) professionals, including psychologists, social workers, nurses, educators, occupational therapists, pharmacists, music therapists, physical educators, physiotherapists and economists. The latter is a Nursing Technician. Three (9.8%) had a degree from a technical course in Nursing.

Chart 1 – Thematic category – Influence of physical structure and medical devices on the patient's safety and behavior, Aparecida de Goiânia, Goiás, Brazil, 2017

<table>
<tr><td colspan="2">Reports:
"In addition to physical structure, the wet floor is slippery, absence of lamps, grab bars, huge risk of falls, steps" (Caps III); "Inadequacy of the physical structure, stairs, handrail in the bathroom, absence of beds with protection, the mobility of people who are under the influence of medication is impaired. Absence of ramps and presence of many steps" (Caps AD III); "There are leaks everywhere, it rains inside as much as outside, everything becomes wet, the chart, the professionals, the patients" (Caps III); "Lack of physical resources, such as, for example, house calls which we cannot perform, because there's no car. Sometimes we want to do more activities with the groups, but there are no rooms available" (Caps AD III); "The door to this room nor the cabinet has a key, there are sharp materials in there. The nurses station has no lock, nor does the storeroom with flammable products" (Caps III); "Another example is that it leaves materials at the disposal of users, one of them tied a cloth around his neck and tried to hang himself in the bathroom" (Caps III); "There are scissors within the reach of users in the workshops, you have to be careful, they can hide them" Caps AD III); "There was an user who punched the glass door, but it was kept there, until a boy cut his hand, then they removed all the glass" (Caps III).</td></tr>
<tr><td>Risk situations: risk of falling; risk of drowning; risk of self-harm and of harm induced by others; crisis; suicide attempts; relapse to drug use.</td><td>Factors related to incidents: holes on the floor; bathroom without grab bars; stairs; slippery floors; low-level pool with free access; unlocked offices and storerooms; glass structures; small physical space for the number of users; broken down car.</td></tr>
</table>

Chart 2 – Thematic category – Clinical process and non-individualized care, Aparecida de Goiânia, Goiás, Brazil, 2017

Reports: "Our difficulty is only because the food comes from the network ready to eat, it's not adapted to the user. When they arrive here we perform the nursing consultation, recognize their comorbidities, but after that there are no mechanisms to recognize this user when he's here at meal times" (Caps III); "We'd need a nutritionist here at the Caps 24 hours a day" (Caps III); "There are no different foods for those who need it, this possibility doesn't exist, not even for the professionals" (Caps AD III); "There are users who need more psychotherapy sections, there's only short-term psychotherapy available here, we don't have psychologists for the long term" (Caps AD III); "There have already been cases of an user saying 'oh, I want to kill myself, set my house on fire', and the professional really didn't give it much thought, didn't inform the team of it, and the user went back home and did it" (Caps III).	
Risk situations: hyperglycemia; hypertension; manifestations of food intolerance; risk of suicide.	**Factors related to incidents:** food is the same for all, it is not tailored to users with multimorbidity; lack of nutritionists; failure in the patient's assessment; care not centered on the patient.

Chart 3 – Thematic category – Interference of clinical administration in the patient's treatment, Aparecida de Goiânia, Goiás, Brazil, 2017

Reports: "Sometimes consultations are scheduled for the wrong date or scheduled with the user but not written down in the appointment book. Then the user shows the document with the date and it's not in the book" (Caps III); "We forget to write something down, we pick up the notebook to do it, then someone comes and interrupts us. That's the end of it, we don't write it down and forget all about it" (Caps AD III); "Sometimes we cancel an appointment and don't inform the user of it, we cannot reach the person, then the user shows up on the set date" (Caps III); "There are things we can't handle, they pile up due to problems of articulation with the network, so there may be damages if there's nothing we can do" (AD Caps III); "The network doesn't go beyond the walls of the Caps, there's no continuity of care" (Caps III); "Lack of knowledge on the part of users, they come here believing we offer emergency services, they want to be seen by a psychiatrist, they are mistakenly referred to the Caps" (Caps III); "A user got nervous in the lobby once, he was erroneously referred to the Caps, we tried to help him but he got angry, 'This sucks, I've been all over the network and it's not here either'" (Caps III); "Sometimes a user comes in here seeking admission, let's assume this user needs nightly admission, he will have to wait a little, get in the queue" (Caps AD III); "There are times when users get here and are promptly treated. Some other days it takes more time, they have to wait to be admitted" (Caps III).	
Risk situations: unnecessary commute to the unit; anxiety; crisis; delay in the start of proper treatment; the offer of care not meeting the demand; mental distress; death; demotivation and/or withdrawal from treatment; worsening of the user's clinical and psychosocial situation.	**Factors related to incidents:** work overload; wrong scheduling (no notes in the doctor's appointment book); cancelling appointments and not warning the user; lack of services in the network; lack of knowledge about the network; wrong referrals; users unnecessarily going to the Caps; waiting queue for nightly admission; disarticulation between the health care network's services.

Chart 4 – Thematic category – Influence of resources/organizational management on the effectiveness of care, Aparecida de Goiânia, Goiás, Brazil, 2017

Reports: "The service's demand hinders the safety measures in the environment" (Caps III); "We have no CGM right now, the blood pressure device is very deregulated, but I see a lot of people using it, it's a risk" (AD Caps III); "The pharmacy dispenses medication, the user comes here screaming and nervous, only the pharmacist can give it to him, and there's only one, so it's a risk situation" (Caps III); "There are ways to reduce these errors, but unfortunately we can't here because we don't have a computerized system. When you have a computerized system, you can minimize errors" (Caps III); "Our dispensing system is manual, but the medicines are organized in the cabinet" (Caps AD III); "Medication is always lacking, we never have everything they need" (Caps AD III); "We have bed bug infestation again. If we could have more nursing technicians, more teams to take care of the beds, but we lack the manpower" (Caps AD III); "We've had tick infestation before (...) and we put medicine on the dog" (Caps AD III); "With the demand here it's impossible for me to know everyone, talk to everyone and understand each individual need" (Caps III); "There are days when this room is crowded with more than 30 people, we can't even call it a round-table discussion, rather a round-table chitchat, the psychotherapist can't even listen to the person speaking sometimes" (Caps III); "If you're cleaning a toilet you'll be faced with a dilemma, you have one liter of alcohol here and an alcoholic user there" (Caps AD III).	
Risk situations: false result of blood pressure and blood sugar; lack of medication; manual dispensing system; storage of medications in a single cabinet; bed bug infestation; appearance of ticks; non-performance of individualized care in the medium or long term; groups without therapeutic purposes; discontinuity of care; frustration of users; risk of relapse to drug use.	**Factors related to incidents:** lack of maintenance of the blood pressure device; lack of CGM; anxiety of users; crisis; dispensing of wrong medicines; lack of material for realization of the environment's and the user's hygiene; lack of nursing professionals to take care of the unit's hygiene and clean the beds; lack of periodic pest control in the unit; low number of professionals for the number of users; negligence on the part of the professionals.

Working time at the Caps was less than one year for ten (32.3%) professionals, eighteen (58%) reported having worked there from two to four years, and three (9.7%) from five to seven years.

The professionals' reports allowed identifying risk situations and factors related to incidents derived from the care offered to patients in psychosocial care services. Charts 1, 2, 3 and 4 present a summary of the reports, according to the thematic categories defined.

DISCUSSION

In the context of the National Mental Health Policy, discussing patient safety is necessary, since it is an attribute of the quality of care[2,15]. It consists of preventative and educational conducts associated with the health care processes, which have the purpose of identifying incidents before they cause harm to patients. It is important to know the most critical processes and those with greater likelihood of incidents to develop effective actions for prevention and mitigation of risks in health care[15].

The data analysis revealed that one of the risks relates to the lack of articulation of the Health Care Network, which influences the care offered to users by the Caps. Thus, the supply of the service by itself will not result in the deinstitutionalization of the practices involved in the asylum culture, but rather the character of the actions developed[16]. Institutionalization is related to lack of knowledge about the services available in the network and to

the insufficient number of professionals to follow-up the patient in the process of social reintegration, making it difficult for the Caps to achieve favorable outcomes. This reality was revealed in the professionals' reports, especially in the categories that relate to the influence of clinical administration and organizational resources in the treatment of patients.

The lack of services or of knowledge about the Health Care Network leads the patient to become dependent on the Caps' structures, hindering social reintegration and the development of autonomy. This impairs the fulfilment of the preconditions of the Brazilian Unified Health System (SUS) and of the initiatives of reintegration and rehabilitation for work and leisure, from the perspective of the National Mental Health Policy, and may result in incidents related to the clinical process, since proper treatment is not being developed.

The Caps should promote articulation between the health and other services, as well as the social mechanisms intended for leisure, becoming a space that induces new practices and attitudes and promotes the recovery of autonomy[17]. The existence of flaws in this articulation results in wrong referrals to the service, delay of the beginning of treatment, increase in mental suffering and even death.

The institutionalization in the Caps is justified by the lack professionals in relation to the large number of patients, which makes it impossible for them to follow patients in the integration process, resulting in difficulties to achieve favorable outcomes. A study conducted in the Caps of the municipalities in the state of Goiás found insufficient investment in human resources, with 68% of the services lacking the minimum recommended team, showing the need for strengthening the employment relationships, for remuneration that is consistent with the professionals' performance, for improvements in working conditions, in addition to the training of the professionals[18].

Offering only guidance and referrals may be insufficient in the deinstitutionalization process. The deinstitutionalization of mental health services is directly related to the quality of care and to greater autonomy on the part of patients[19].

The professionals acknowledged the risks to the safety of patients in various aspects of the units' physical structure. The Caps operate in rented houses, not suited for the functioning of a health service, and that have some physical specificities which are incompatible with mental health aspects. These specificities include: low-level swimming pool with free access, representing the risk of drowning; holes on the ground; bathrooms without grab bars; stairs without handrails; slippery floors that are conducive to falls; and glass on windows and doors, which may be broken and injure patients and/or professionals.

Among the risks related to physical structure, falls stand out as they may result in morbidity, mortality and fear of suffering a new fall[20]. The reduction in falls in these environments can be achieved with the abolition of the use of wax on the floors or by replacing it with non-slip wax; with the placement of grab bars in the bathrooms next to the toilet and shower and of double steps to prevent the patients from slipping down the beds; and with the request for the purchase of beds with guardrails that allow the adjustment of height in relation to the ground[21].

The use of some medications can impair a person's ability to get up and move independently. Thus, it is necessary to adapt the physical structure and the furnishings to the characteristics of the population served, as effective measure in the control of extrinsic risk factors[20].

The small physical space for the high number of users that circulate in the Caps, in association with the low number of professionals, make it impossible to properly care for and follow-up these patients. Inadequate care leads to the risk of triggering depressive, anxious or psychotic crises, suicide attempts, suicide and relapses to drug use.

Despite serving the whole municipality, Caps III has capacity for fourteen nightly admissions (seven beds for each sex) and Caps AD III has capacity for fifteen nightly admissions (ten male beds and four female beds). The number of beds is insufficient for a population of more than half a million people, which often results in waiting queues for nightly admissions. This wait can discourage drug users or depressed patients to start treatment and even lead them to give it up, which may trigger the clinical and psychosocial deterioration of the situation of the users of both Caps.

In addition, there is uncertainty regarding the maintenance of structural aspects such as lack of periodic fumigation to control insects and pests. The stings of arthropods cause injuries, skin conditions and various infectious or parasitic diseases, which should be investigated regarding clinical, epidemiological and laboratory evidence[22].

Good personal hygiene habits and clean environments decrease the chances of infestations, characterized by the uncontrolled proliferation of insects[22], which may represent a difficulty in the Caps due to the lack of cleaning supplies.

Both Caps have devices for checking the blood pressure and blood glucose of patients, but they are not given proper maintenance, offering the risk of false results. The non-detection of hypertensive and hyperglycemic peaks can generate clinical consequences for patients or even lead them to death[23].

The insufficiency of human resources in relation to the needs of the service generates work overload, which consequently leads to the turnover of professionals, disorderliness of the medical charts, lack of professional motivation, professional negligence, non-continuity of the agreements signed in meetings with the team, miscommunication, disorganization of work, dissatisfaction and decreased productivity. These factors expose patients to incidents, disrupting the therapeutic development and hindering the adherence to the necessary treatment for rehabilitation[24-25].

In relation to drug dispensing, the professionals reported incidents, such a lack of medication, dispensing of the wrong medicine due to the adoption of a manual dispensing system (the professional dispenses the medicines him/herself) and the storage of medications in a single cabinet. The low availability of medicines is one of SUS's difficulties, showing that the health system is not universal, fair and effective in its offer of services to the population[26].

In the public sector, the availability of drugs is essential, because their lack in health units puts at risk the health and lives of patients whose income is not enough for purchasing the necessary medication[27]. This raises costs for the State, because the disease worsens, requiring hospital care.

How the medicines are kept in the Caps was also identified as a risk factor for the occurrence of incidents. They are stored

in a single cabinet, with the danger of similarities between the labelling and names of the medicines, which may lead to drug dispensing errors[28]. The similarity of the packaging and labels may induce the professionals involved in the dispensing and administration of these drugs to make unintended swaps.

Drug dispensing in the Caps is manually performed by the pharmacist in an environment that, though private, is not soundproof, which may affect the professional's concentration. The professional needs agility to deal with the pressure exerted by patients who need to receive the medication quickly.

Dispensing errors lead to the disruption of drug use safety, such as higher doses than necessary, causing risk of toxicity, or doses below the minimum effective concentration, as well as dispensing of wrong medicines or dispensing of the right ones, but in a pharmaceutical form other than that prescribed. These errors indicate that the deployment of safe, organized and effective systems, such as the use of barcodes, is a fundamental measure to minimize the occurrence of incidents involving drugs. Thus, there is need for the introduction of a calm environment, training of the staff and deployment of a support system for pharmaceutical professionals involved in this process[29].

In relation to records and information, these are not kept in safe and private locations. In Caps III, the medical charts are stored in a room with no lock and a leaking ceiling, representing a definite risk of data loss. The records must be protected against loss, destruction and adulteration, kept in areas which may only be accessed by authorized professionals, and where there is no possibility of damage by heat, water or fire[30].

In a context where the concern with the quality and safety of health care has been gaining world repercussion, knowing the risks and factors related to incidents in psychosocial care services can support the creation of more effective management and evaluation policies, focused on specialized care to ensure patient safety.

Considering the complexity of the health care system and the variety of the services offered, the incidents are related to issues in these services' structure and organization, in association with the human condition[5]. The importance of prioritizing studies in the field of psychosocial care with the aim of extending concepts is however emphasized. The big challenge is considering the presence of factors associated with the patient, especially those related to individual behavior, such as running away, violence, self-harm and suicide[8,31]. These factors constitute bad results in relation to the control of the outcomes that are specific to mental health. The professional should be qualified to understand and predict these behaviors, to avoid the omission of care and ensure a timely intervention.

The factors that can aggravate a situation of crisis must also be managed. In mental health, professionals recognize that the term "risk" evokes the discussion of the individual conduct of patients and the difficulty in providing clinical care when dealing with unpredictable behaviors[31]. These can arise from factors related to the patients' context and to the physical environment, resulting in an increase in risks also for third parties. Training professionals in psychosocial care services to carry out this systemic analysis of the environment is an indispensable component of safety culture, resulting in a more individualized care plan.

Due to these specificities, three of the six areas considered to be priorities for the safety of psychosocial care involve patient-centered care, highlighting the need to encourage studies on the contributions of patients to their own safety, their perspective about safety in the use of medicines and the aspects of safety culture in relation to self-harming. The other priority areas relate to the effective and individualized planning of safety, plans for improvements in safety and factors to reduce restrictive practices, including restraint and seclusion[9]. The cross-sectional study of the participants' reports confirms the need of a collective effort to elucidate the safe practices to be adopted in psychosocial care, and the need to train professionals for the effectiveness of the actions developed.

This study was based on the proposal of evaluation of a specific context, having been guided by the Experiential Learning Cycle, which allowed it to go beyond the traditional research approaches regarding the data collection technique, expanding the methodological-theoretical framework in the scope of qualitative research. The method allowed the group to reflect on their actions, encouraging dialogue and the exchange of knowledge, which culminated in the learning process.

Study limitations

Considering the importance of the results obtained, the study has limitations for having been conducted in a restricted setting, including only two type III adult Caps, the only ones certified in the state of Goiás at the time of data collection (2015).

It is known that the number of type III Caps in the state of Goiás, and also in Brazil, has been considerably increasing. Therefore, it is necessary to expand the studies in various territories, including different age groups and considering their peculiarities, to allow the generalization of the data.

Contributions to the field of nursing, health or public policy

This study brings as main contribution the diagnosis of risk situations for the occurrence of incidents and their related factors, based on the experience of professionals who are directly involved in psychosocial care. Recognizing the existence of these factors in the environment of practice is the first step to trigger corrective actions for improvements in the work process.

The results reinforce the need to prioritize the management of the professionals' knowledge, focusing on the National Mental Health and Patient Safety Policy.

The contribution of the data collection method used should also be noted, as it allowed to base the group discussions on the reflections of professional practice and on dialogue, which were converted into care practices, enabling the fulfillment of the social role of research in a short period of time. It is therefore considered that the Experiential Learning Cycle is a fertile exchange between research and practice, with emphasis also on the theoretical contribution provided by this relationship to those involved.

FINAL CONSIDERATIONS

The situations experienced by the professionals during patient care in psychosocial services offer risks to their own safety, in relation to the institution's physical structure, the availability of

medical equipment and devices, the configuration of the clinical process, clinical administration and organizational management.

This study reflects the need for continuous efforts on the part of senior management and direct care professionals, with the aim of promoting a physical, human and organizational structure that is suited to the needs of patients in psychosocial care services, combined with a culture of safety of the services provided. The ability to anticipate problematic situations and incidents, considering the intrinsic factors related to the patient's unpredictable behavior, was revealed as critical for promoting safe health care, and should be further exploited by research and better analyzed by the professionals.

The risks revealed support the adoption of corrective and preventive actions, resulting in improvements in health care processes. Enhancing the capacity of response to patients in psychosocial care favors the reduction of institutionalization and, consequently, the development of the patient's autonomy and social rehabilitation, increasing the effectiveness of care.

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