PSICOLOGIA EM ESTUDO

ARTICLE 10.4025/psicolestud.v29i1.55560

KNOWLEDGE OF PROFESSIONALS FROM PSYCHOSOCIAL CARE CENTERS ON PATIENT SAFETY

Adrielle Cristina Silva Souza[1 2], Orcid: https://orcid.org/0000-0002-9169-7143
Cristiane Chagas Teixeira[1 3], Orcid: https://orcid.org/0000-0002-4752-0439
Johnatan Martins Sousa[1 4], Orcid: https://orcid.org/0000-0002-1152-0795
Eurides Santos Pinho[1 5], Orcid: https://orcid.org/0000-0002-1158-8247
Tathianny Tanferri de Brito Paranaguá[6 7], Orcid: https://orcid.org/0000-0003-0562-8975
Ana Lúcia Queiroz Bezerra[1 8], Orcid: https://orcid.org/0000-0002-6439-9829

ABSTRACT. The objective of this study was to understand the meanings attributed by the professionals of the Psychosocial Care Centers about the terminologies of the International Classification for Patient Safety (ICPS). A qualitative study was conducted with 31 PSCC III professionals from a city in the Midwest region of Brazil. Data collection was performed by group technique, guided by the Experiential Learning Cycle. The data were submitted to content analysis using the Atlas.ti software. The results made it possible to go beyond situational diagnosis of prior knowledge of ICPS by professionals; promoted awareness of incident recognition in units; and constituted an initial strategy for developing awareness of the need for safe care planning in psychosocial care. It was highlighted the need to develop training for patient safety in PSCC, in order to promote safer care, in line with the objectives of international and national health organizations and needs to build safety culture in mental health services.

Keywords: Psychosocial care center; knowledge; security.

CONHECIMENTO DE PROFISSIONAIS DE CENTROS DE ATENÇÃO PSICOSSOCIAL SOBRE SEGURANÇA DO PACIENTE

RESUMO. O objetivo deste estudo foi compreender os significados atribuídos pelos profissionais dos Centros de Atenção Psicossocial acerca das terminologias da Classificação Internacional para Segurança do Paciente (CISP). Estudo de abordagem qualitativa, conduzido com 31 profissionais de CAPS III de um município da região Centro-Oeste do Brasil. A coleta de dados foi realizada por técnica de grupo, guiada pelo Ciclo de Aprendizagem Vivencial. Os dados foram submetidos à análise de conteúdo, com auxílio do software Atlas.ti. Os resultados possibilitaram ir além do diagnóstico situacional sobre o conhecimento prévio da CISP pelos profissionais; promoveram a sensibilização para o reconhecimento de incidentes nas unidades; e constituíram estratégia inicial de desenvolvimento de consciência quanto à necessidade do planejamento do cuidado seguro

[1] Universidade Federal de Goiás. Goiânia-GO, Brasil.
[2] E-mail: enfeadrielle@gmail.com
[3] E-mail: cc-teixeira@hotmail.com
[4] E-mail: johnatanfen.ufg@gmail.com
[5] E-mail: euridesenf@gmail.com
[6] Universidade de Brasília (UnB). Brasília-DF, Brasil.
[7] E-mail: ttb.paranagua@gmail.com
[8] E-mail: analuciaqueiroz@uol.com.br

na atenção psicossocial. Destacou-se a necessidade de desenvolver formação para segurança do paciente nos CAPS, a fim de promover uma assistência mais segura, em consonância com os objetivos das organizações internacionais e nacionais de saúde e necessidades de construção da cultura de segurança nos serviços de saúde mental.

Palavras-chave: Centro de Atenção Psicossocial; conhecimento; segurança.

CONOCIMIENTO DE PROFESIONALES DE CENTROS DE ATENCIÓN PSICOSOCIAL SOBRE SEGURIDAD DEL PACIENTE

RESUMEN. El objetivo de este estudio fue comprender los significados atribuidos por los profesionales de los Centros de Atención Psicosocial sobre las terminologías de la Clasificación Internacional para la Seguridad del Paciente (CISP). Estudio de abordaje cualitativo, realizado con 31 profesionales CAPS III de un municipio de la región central de Brasil. La recolección de datos se realizó mediante una técnica grupal, guiada por el ciclo de aprendizaje experiencial. Los datos se sometieron a análisis de contenido con la ayuda del software Atlas.ti. Los resultados permitieron ir más allá del diagnóstico situacional sobre el conocimiento previo de CISP por parte de los profesionales; promovió la conciencia para el reconocimiento de incidencias en las unidades; y constituyó la una estrategia inicial para desarrollar la conciencia de la necesidad de una planificación de la atención segura en la atención psicosocial. Se destacó la necesidad de desarrollar la formación en seguridad del paciente en CAPS, con el fin de promover una atención más segura, en consonancia a los objetivos de los organismos de salud internacionales y nacionales y la necesidad de construir una cultura de seguridad en los servicios de salud mental.

Palabras clave: Centro de atención psicosocial; conocimiento; seguridad.

Introduction

The Psychosocial Care Centers (PSCC) are mental health care services, a proposal resulting from the Psychiatric Reform movement that advocates safe practices in addressing people in psychological distress, focused on the subject, their suffering and life projects, for the development of skill for co-management of care. These services work through the teamwork of health professionals, from various areas of knowledge, with free access to users, family members and society, embracing everyone, whether spontaneously or referenced (Silva, Amboni, Silva, Kern, & Ferraz, 2019).

Currently, the themes of patient safety and quality in health services have been highlighted and mobilized partnerships between health services, professionals and users to build technologies that promote safe and quality health care, considering the reality of each service (Sousa Neto, Lima Júnior, & Souza, 2018). This concern extends to mental health scenarios that have sought to promote patient safety in mental distress (Vantil et al., 2020; Souza et al., 2018).

The risks of occurrence of failures is a reality in the context of various mental health services and the knowledge of professionals about this reality becomes a competitive advantage for improvements in the care processes of the professionals themselves and that involve the population (Oliveira et al., 2016). In this perspective, safe psychosocial care is dependent on a health team instrumentalized to provide safe care.

The Ministry of Health, through Ordinance n. 529/2013, launched the National Patient Safety Program (NPSP), which aims to support the implementation of initiatives aimed at patient safety; to produce, systematize and disseminate knowledge about patient safety; to promote the inclusion of the theme in the educational processes in the health area; and thus to contribute to the qualification of health care in all health facilities in the national territory (Portaria nº 529, 2013).

Evaluation of knowledge related to patient safety therefore becomes timely. Understanding the basics of the International Classification for Patient Safety (ICPS) - patient safety, incident, adverse event, harm, near miss and notifiable circumstance-, in the practice of services and care guides the analysis of the context of patient safety and enables comparisons between institutions, regions and the various specialties of health care services (World Health Organization [WHO], 2009).

A health institution can offer a fully safe care when the professionals that compose it are aware and reflect on the failures that permeate the care processes (Oliveira et al., 2016).

Considering that the literature on patient safety in the context of PSCC is scarce (Souza, Bezerra, Pinho, Nunes, & Caixeta , 2017) and in order to contribute to the strengthening of qualified and safe care in this care environment, the following question arises: what is the knowledge of professionals about the safety of patients assisted in Psychosocial Care Centers?

To answer the question presented, the objective of this study was to understand the meanings attributed by the professionals of the Psychosocial Care Centers in relation to the terminologies of the International Classification for Patient Safety (ICPS).

Methodology

Descriptive-exploratory study with a qualitative approach to allow the knowledge of the perceptions and reflections of the participants, concerning a certain theme, ideal to understand the meaning and intentionality of the speeches, values, needs and attitudes, reality in a contextualized way (Minayo, 2014).

The research was carried out in two PSCC type III, adult, one for attention to people with mental disorders and another aimed at assisting individuals with needs arising from the use of crack, alcohol and other drugs. Both managed by the Municipal Health Department of a city belonging to the metropolitan region of Goiânia, Goiás, Brazil.

The study included 31 professionals, including coordinators and technical team of the services formed by nurses, nursing technicians, psychologists and social workers, among others, divided into two groups, one group in each PSCC. Inclusion criteria were: to compose the multiprofessional team of the PSCC, to have at least three months of experience and to be in professional practice at the time of data collection. Those who were on official leave from the service and professionals who were not willing to participate in the meetings did not participate.

Data collection took place in April 2017, using a group technique guided by the Cycle of Experiential Learning (CEL), characterized by a positive operationalization. This technique brings a methodological core that aims to change from learning based on direct experiences. It is developed through the participation of professionals in activities related to daily life and the commitment to solving problems and exercises arising from learning. This process enables the development of reflection, dialogue and the consolidation of information that can be converted into practices (Moscovici, 2008).

Sixteen group meetings were held with the professionals, eight in each PSCC. The groups were closed, that is, always with the same participants, mediated by two researchers with qualification and experience in group technology. The qualification took place through the course of Coordination and Group Dynamics, at the Brazilian Institute of Psychoanalysis, Group Dynamics and Psychodrama. In addition, they had more than five years of experience in conducting groups (therapeutic and health education groups with users of the service and Permanent Health Education with the team) in PSCC.

At the first moment, the Municipal Coordination of Mental Health was requested to authorize the beginning of the study and the insertion of the researchers in the scenarios, through a visit to the PSCC. After authorization, team meetings were scheduled in each unit, when the verbal invitation was made to all professionals, in addition to presenting and clarifying the study proposal, highlighting the character of voluntary participation, the guarantee of confidentiality and anonymity, also respecting the right of non-participation. Then, the doubts were answered and the Informed Consent Form was given to the professionals of the units, which was returned spontaneously at the end of the meeting.

The professionals, in this meeting, defined that the groups would occur in the respective PSCC, place of work of the professionals, in time of meeting of the team, where the largest number of professionals were, besides not interfering in the routine of assistance.

Initially, the collective coexistence contract was carried out and a semi-structured instrument containing data regarding the personal characteristics of the participants was delivered. Health team professionals were then asked about the meaning of each ICPS terminology, namely: patient safety, incidents and their types, degrees of damage, near miss, adverse event and notifiable circumstance. A description of situations occurring in the working environment of the PSCC, representing each type of incident, was also requested to contextualize the assigned meaning; and, finally, an analysis of previous knowledge about patient safety was performed in parallel to that described in the World Health Organization's ICPS (WHO, 2009).

The data were recorded by voice recorders, making audio-transcription and field diaries. The characterization of the participants was analyzed descriptively. The reports were coded, categorized using the Atlas.ti 6.2 software and submitted to content analysis. The statements were identified according to the type of PSCC.

The study was approved by the Research Ethics Committee of the Clinics Hospital of the Federal University of Goiás (CEP/HC/UFG), through Plataforma Brasil, and followed the rules of resolution CNS 466/2012, favorable opinion protocol n. 1,413,964, CAAE n. 52437315.6.0000.5078. All participants, duly informed, signed the Informed Consent Form (ICF).

Results and Discussion

Of the 31 participants, 21 (67.75%) were female, aged between 23 and 65 years, with a predominance between 23 and 30 years (41.2%). As for education, 29 (93.55%) had completed higher education, two (6.45%) had a nursing technical course, and both were graduate students, one in nursing and the other in hospital management; six (20.69%) were psychologists, six (20.69%) social workers, four (13.80%) nurses, three (10.35%) pedagogues, two (6.90) occupational therapists, two (6.90) pharmacists, two (6.90) music therapists, two (6.90) physical educators, one (3.45%) physiotherapist and one graduated in economic sciences (3.45%). As for the duration of work in mental health, three (9.7%) professionals had less than two years; 19 (61.3%) two to four years; seven (22.6%) five to

nine years; and two (6.4%) 10 to 15 years. The weekly workload was 30 to 40 hours, and 20 (64.52%) professionals reported working 30 hours per week and 11 (35.48%) reported working 40 hours per week. The majority 75% (n=21) of the professionals had more than one employment relationship.

The analysis allowed the emergence of meaning cores that revealed thematic categories: Conceptions about patient safety in psychosocial care; Understanding and recognition of safety incidents in psychosocial care; and Reflections on knowledge of professionals in patient safety in psychosocial care.

Conceptions about patient safety in psychosocial care

This thematic category was constituted in order to reveal that the conception of patient safety for PSCC professionals is comprehensive.

In the subcategory, Humanization of environment and care, reports have shown that patient safety is understood as promoting a welcoming environment, which assists the patient in their needs, which makes them especially safe among those in street situations: “Be assisted by the team in the unit. Especially that user in street situation, the gate is security for them not to be assaulted” (PSCC AD III).

In the perception of professionals, all this process converges to the humanization of care and adherence to therapy, bringing greater relevance to the care safety.

> Patient safety is a look at the patient and being closer, the more welcoming, the environment will become safer for that person. Sometimes their home is not a safe environment, but when they come here, they feel safe, supported (PSCC III).

An important indicator of safe care in psychosocial care is to be supported and guided by the Singular Therapeutic Project (STP), as it is an ordering tool for care actions in PSCC. The STP is described by Rodrigues and Deschamps (2016) as the plan of therapeutic conducts articulated in the interdisciplinary and intersectoral logic, through a collective construction among those involved.

Adequate adherence to STP is achieved as the patient care in the unit or outside it is individualized and that during their daily stay in the service is oriented according to their needs and motivations, considering the extra PSCC experiences. Non-adherence can be given by the illusory idea that only medicines cause rehabilitation; the socioeconomic conditions that influence the social environment; the lack of training of professionals for the embracement and promotion of bonding; in addition to the family influence, related to the support and participation of family members in the treatment and change of lifestyle (Ferreira, Borba, Capistrano, Czarnobay, & Maftum, 2015). To achieve complete and safe care, one must consider multidimensional points such as housing, leisure, family, exchange of popular and social experiences.

In the subcategory, Health Risk Assessment, the relationship between safety and risk assessment and perception in services was raised, which allows the adoption of preventive measures: “Prophylactic measures in the routine of the service. When it is possible to assess and understand the possible risks in the service” (PSCC AD III).

It is worth mentioning that PSCC emerged to break with harmful assistance, focused on drugs and invasive measures. The professionals attribute patient safety to the user’s embracement and bond with the unit. These conceptions are in line with the National Mental Health Policy (NMHP), which establishes assistance in PSCC in addition to the biomedical

mode, focused on disease, medications, complications and treatments (Lei federal nº 10.216, 2001).

The subcategory Family participation showed that the concept of patient safety by professionals went beyond direct patient care, with emphasis on family involvement in the care process and continuity of care: “The family must be seen so that the patient does not leave alone, many families cannot pick them up” (PSCC AD III).

Low family participation in treatment is a risk factor for patient safety, since the family environment is fundamental in treatment. The principle of patient safety proposes to rethink care processes in order to identify the occurrence of failures before they cause harm to patients (WHO, 2009). “We have the difficulty of bonding with the family, then the user can abandon the treatment” (PSCC AD III).

Rescuing the elaboration of the STP, the insertion of the family is a priority at all times and not only in psychic suffering. The health professional, when planning care, should include the family in the production of care, giving visibility and guiding the different positions that it can take in the course of care processes, and through healthy relationships, build a system in more solid and participatory networks (Ferreira, Sampaio, Oliveira, & Gomes, 2019).

The units that provide assistance in areas characterized by the use of illicit substances and violence have more health risks related to family abandonment, social deprivation, lack of conventional housing and more cases of violence (Brickell et al., 2009). In this context, there is a need to articulate with intersectoral services that respond to the psychosocial needs of the patient to ensure safe treatment.

The Ministry of Health foresees the existence of an Adult Care Unit (ACU), designed to provide residential environment and continuous health care for people with needs arising from the use of crack, alcohol and other drugs, of both sexes who have marked social and/or family vulnerability and require therapeutic and protective follow-up of a transitory nature, with a length of stay of up to six months (Portaria nº 121, 2012), period to invest in family reintegration or undertake possibilities of autonomy and/or permanent shelter. In the city, field of this study, there are no embracement units for homeless people, which makes safe and quality care impossible for users and professionals.

The last subcategory, Safety of health professionals, revealed that patient safety was also related to the safety of health professionals, which influences the care process: “To be safer here [...] ‘feel’ supported, and fear is related to this security. Patient safety is opposite to this situation” (PSCC AD III).

The promotion of patient safety was associated with the safety of professionals due to the vulnerability to the occurrence of accidents. By living with illicit drug users and alcoholism, it was noticed constant fear of PSCC AD professionals, since some users of the service have episodes of aggression and/or have judicial issues in their history. In these situations, it is expected that professionals prioritize psychosocial care, not undertaking value judgments to judicial issues.

Although most users of mental health services do not present risk of harm to people and professionals, there is an association between mental illness and the risk of violence. The Psychiatric Reform (law 10.216/01), by ensuring the social reintegration of the person with mental disorder, aims to overcome the presumption of danger (Lei federal nº 10.216, 2001).

In an environment whose embracement is permeated by clear communication between users and professionals, trust and empathy can promoted to achieve patient safety

and worker safety. It is argued that patient safety is a set of strategies that ensures the reduction of the risks of incidents to the patient and ensures the well-being of users and the multiprofessional team (Costa, Ramos, Gabriel, & Bernardes, 2018).

The classic concept of patient safety brings the need to reduce the risk of unnecessary harm associated with health care to an acceptable minimum (WHO, 2009; Portaria nº 529, 2013). Given this definition, it is undeniable the relationship that the content raised by the reports of health professionals brings harm reduction, considering all the systematics involved in mental health care, generating greater benefits for health care results and, still, satisfaction to the patient. A similar study conducted in Primary Health Care revealed that professionals understand the term patient safety as attitudes and actions that minimize risks of harm, favoring user satisfaction (Silva et al., 2019).

Understanding and recognition of safety incidents in psychosocial care

The subcategory, Understanding the safety incident, revealed that the meaning of incidents in psychosocial care for health professionals is associated with something negative, unexpected and that may or may not interfere with the results: “Unexpected situation, unpredictable, has negative potential, but does not really need to materialize this negativity. An unexpected event” (PSCC III).

They also explained the meaning of incident with example of situations associated with damage to the physical structure of the unit: “Something that happens in the unit that escapes routine, where safety in the service is put at risk. The user enters the unit in crisis and damages public assets” (PSCC III).

Incidents are unexpected circumstances or events, arising from the care provided and not associated with the underlying disease, which can result or result in unnecessary harm to the patient. Incidents are multifactorial and have a negative influence on health care (WHO, 2009; Portaria nº 529, 2013). The professionals who exemplify situations occurred in PSCC relate the causal factors to users, removing professional responsibility. They attribute psychosocial crises as incidents, but, in the case of specialized services in mental health, moments of crises are expected. Establishing preventive measures to avoid triggering crises is the competence of these professionals. When perceiving the manifestation of signs of crisis by the user, they must act, preventing their evolution in order to reduce personal injury as much as possible (Martins, 2017).

It is important to train the PSCC teams to meet crisis situations, through care based on psychosocial care, light technologies, care in freedom, producing services and networks that effectively respond to the needs of people in their real life contexts, which guarantee freedom, rights and provide new possibilities for life, overcoming the action of silencing symptoms and isolation of the subject, away from the myth of danger in psychic suffering (Zeferino, Cartana, Fialho, Huber, & Bertoncello, 2016), which for decades generated an evil and harmful treatment through the institutionalization of patients.

It is worth mentioning that the risk of incidents can arise from the inadequate management of a crisis or absence of preventive measures that can exacerbate the clinical picture of the patient with aggressive reactions, damage to the professional, to the own patient and even to the public patrimony.

Another important aspect associated with the incident was the discontinuity of patient care, corresponding to an inadequate attitude: “A user who leaves home, to get here sober, smokes a marijuana cigarette, for example, they know that it is wrong, that they should not have done, but they do anyway” (PSCC AD III). The professional embracement is important

for this user, offering a safe, comfortable place and stimulating water intake to re-establish. Later, there is an individual consultation to understand the phenomenon of use and thus try to slow down the situation and prevent repetitions. It is important not to adopt rigid and punitive practices (such as treatment suspension), with standardized responses to the risk behavior of users, because what is expected from the psychosocial model is to focus care on the person and embrace them in their demands.

It is known that the notification of this fact with the multidisciplinary team and family members/companions subsidize the situational and causal diagnosis of incidents, which strengthens the patient-centered care model. Incidents need to be socialized ethically also with the management of the health unit so that collective care actions are implemented (Capucho, Arnas, & Cassiani, 2013).

Safe practices depend on culture change that leads to behavioral transformation, with a view to the accountability of professionals, since their actions directly influence the form of organization and management in the work environment (Tobias, Bezerra, Moreira, Paranaguá, & Silva, 2016).

Re-meaning the understanding that the occurrence of incidents is related to failures in the health system and admitting that people are susceptible to errors encourage professionals to think that actions to make care safe and should focus on changes in the work system and that may result in fewer adverse events (AE) (Vantil et al., 2020).

The subcategory Occurrence of incidents in PSCC revealed the understanding of types of incidents by health professionals and found the occurrence of adverse events, near misses and notifiable circumstances. Despite not describing the types of incidents conceptually, the category reveals that health professionals can identify the occurrence of incidents in a psychosocial care environment.

The professionals surveyed refer to adverse event as a: “Situation that occurs in the service that can compromise the stability of the user and the team. Example: crisis without doctor presence, suicide attempt, aggression, sexual abuse in the unit, user’s death” (PSCC III).

> Certain instrument that will lead to a withdrawal crisis instantly, as has already happened. Knowing that, I will not take that instrument, or that song, I will work with another possibility. I am able to work preventively here (PSCC AD III).

The adverse event necessarily occurs when it results in harm to the patient, and may be mild, moderate, severe or death (WHO, 2009). A study that investigated nurses' knowledge and perception of adverse events showed that participants had little clarity of their meaning, which led to low notification (Araújo et al., 2016). Continuing education processes of multiprofessional teams of PSCC can help change this reality.

Patient safety needs to be treated in the various types of health institutions, as a priority, in order to prevent the occurrence of adverse events, especially in view of the finding of its preventable characteristic. The reports showed that health professionals recognize adverse events and their consequences, drawing attention to the possibility of prevention.

A Mexican study conducted in a teaching hospital identified 34 serious adverse events, 82.35% classified as preventable (Gutiérrez-Mendoza, Torres-Montes, Soria-Orozco, Padrón-Salas, & Ramírez-Hernández, 2015). The prevention of adverse events can be reinforced in the face of a management work focused on the use of instruments for monitoring and evaluating the causes of these events, with perspectives to develop, institutionally, the culture of patient safety (Tobias et al., 2016).

Although clear to some, the association of adverse event to adverse drug effect is still present: “The adverse event is something believed to happen. It has an adverse effect of a drug, it is what you expect to happen, it is not always applicable, but you know it can happen” (PSCC III).

The adverse effect is unintentional occurrence by reaction to a pharmaceutical product, which can occur in doses normally used by a patient, related to its pharmacological properties. The adverse event is any unfavorable medical occurrence, which may occur during treatment with a drug, but which does not necessarily have a causal relationship with this treatment (WHO, 2009).

Recognizing AE favors the mitigation of harm to patients and this coherence still needs to be addressed among PSCC health professionals. On the subject, it was revealed that professionals understand harm as something inevitable that involves the user, the professional or the system that assists the patient: “Damage is when there is physical loss, in relationships, in assets or in treatment” (PSCC III).

When the user stops attending the PSCC, the team must perform active search, investigating the reason. If it is worsening of the situation, promote reintegration to treatment; if for improvement, guide to attend units in the territory that offer continuity of care, reducing risks of damage to health.

Damage refers to aggravations resulting from the structure or function of the body, and may be physical, social or psychological or also plans/actions performed during care (WHO, 2009). By knowing the work process, the professionals relate the distance of the user to the unit as a potential situation for damage, being a frequent situation in the routine of the PSCC.

In this regard, the inclusion of primary care in the active and home search becomes important, since the professionals of the BHUs must have knowledge of the users linked to the PSCC to provide comprehensive care, according to their family reality and community.

However, the active search is weakened by the presence of insufficient personnel, lack of transportation and overload of demand in the service itself (Lima, Gussi, & Furegato, 2018), impairing local care and diagnosis, reintegration of the user in treatment and for family inclusion, by better understanding the context of abandonment.

Study that addressed the factors that lead users to the abandonment of treatment of drug dependence identified several issues such as the lack of adaptation to the rules of the institution, understanding that the treatment is unnecessary, looking for a job, divorce, change of city and relapse (Fernandes, Marcos, Kaszubowski, & Goulart, 2017).

The non-adherence to treatment is responsible for several damages in the life of the individual and their families, which are related to the worsening of the disorder, family wear, preventable hospitalizations and increase in the cost of health care. Services and professionals should broaden the understanding of the complexity involved in the attitude of abandoning treatment, which should be present in the health education processes of patients and families (Ferreira et al., 2015).

The nature of occurrence of incidents presents the characteristic of avoidability. By knowing the structure and work processes, the professionals who make up the health team can recognize risk situations, characterized as the first step to subsidize decision making to promote the resolution of problems for the execution of patient safety (Oliveira et al., 2016).

In this perspective, performing systemic and careful evaluation of the STP can help in the survey of factors that lead to the user’s distancing, allowing a preventive action of this situation. The National Mental Health Policy guides a model of psychosocial care of PSCCs

configured as an open door and defines that the user has the right to leave the unit voluntarily at any time (Lei federal nº 10.216, 2001). However, abrupt distancing, breaking with the STP should be systematically investigated and worked with the user, protagonist of the care.

Reports that portray the occurrence of near miss were revealed and showed the importance of professional attention to be able to intercept a possible incident, including in situations that the own patient may be a generator of injury/damage: “It is a situation of imminent error that can be corrected in a timely manner, that is, the error is there triggered, only before it happened, there was an intervention and this error was annulled” (PSCC AD III).

The near miss consists of an incident that, for some reason, was intercepted before reaching the patient and could or could not cause damage (WHO, 2009). Tracking this type of incident favors the recognition of critical nodes of the work process that must be reviewed. In general, health professionals can identify a near miss. However, misconceptions on the subject were still revealed: “Do something, even being insecure, taking the risk of making a mistake” (PSCC AD III).

It is a fact that doing something, being insecure, is characterized as imprudence. The professional knows the degree of risk involved in the activity, and believes that it is possible to perform without prejudice to anyone, extrapolating the limits of intelligence and common sense. If insecurity is due to lack of ability, it is configured as malpractice (Gomes, 2017).

In this context, it is important to discuss the concept of fair culture, which encourages the analysis of the work process, allowing differentiating the behavior of health professionals who act competently from those who take a risky stance, without justification. In addition to analyzing the professional profile, the just culture assumes that incidents are associated with systemic and not only individual failures (Costa et al., 2018).

Professionals report flaws that can cause incidents: “Some things imply damage [...], if we do not pay attention to this, something worse can happen. For example, the car of the unit broken or unavailable prevents from making home visit” (PSCC III).

The reports show incidents of the notifiable circumstance type, a situation in which there is significant potential for damage, but the incident does not happen (Portaria nº 529, 2013). Such situations refer to the safety of the patient and worker. The absence of protocols, notification system or systematized routine that includes incident reporting, associated with lack of knowledge about patient safety by professionals, hinders the implementation of institutional changes and/or adoption of preventive actions of incidents of any nature (Tobias et al., 2016).

Thus, there is need to program and improve care strategies that prioritize the safety of the health worker and the safety of the patient, since several situations put the health and safety of these authors at risk (Souza et al., 2021).

Reflections on knowledge of professionals in patient safety in psychosocial care

This category was formed by the subcategory Limitations of the training process, which revealed that, in addition to not having a specific training in patient safety, health professionals also did not have access to the subject during their technical and/or academic training process.

Given the records made on the knowledge and/or understanding of the ICPS of the World Health Organization (WHO, 2009) and mediated by the CEL, the professionals perceived and affirmed conceptual limitation regarding the terms and principles of patient

safety. Therefore, the concepts were described from the semantics of the word: “We based on the logic of the word, but we did not know the theory itself about the ordinance” (PSCC III).

They also reported not knowing the current legislation in Brazil, highlighting knowledge gaps associated with the training process.

> We study much things of medicine, psychology, but we do not study the care itself, what we can do to prevent harm. Training nowadays in Brazil does not teach to have contact with the human (PSCC III).

It was possible to show that the participants have limited knowledge, from the conceptual point of view, about the ICPS, although after eight years of the implementation of the NPSP. This plan, established by Ordinance n. 529/2013, aims to disseminate knowledge about patient safety in all health facilities in the national territory, and thus contribute to the qualification of health care.

The reflections in the course of the study were more present in the psychological scope, which can be justified by the picture of participants being composed of a multidisciplinary team, mostly with a degree in social, human and pedagogical sciences.

It is worth noting that the fear and insecurity of professionals facing some users of psychosocial care services was referenced at various times, which may be a barrier to the implementation of a safety culture, which will only be achieved when the patient is incorporated into the service in an integral way, embraced with their life history, having space to re-mean their health situation, without preexisting fears. A successful safety culture must involve the patient in their own safety, since they are the main actors of their own processes of recovery in health and citizenship; fear can lead to misconception of the professional by considering them as problems to be addressed by other services (Eiroa-Orosa & Rowe, 2017).

In psychosocial care, it is urgent to develop educational processes to undertake safe practices, considering the characteristics of the care units, ensuring that the theory is apprehended and possible to be applied in this specific and highly relevant context (Cuadros, Padilha, Toffoletto, Henriquez-Roldán, & Canales, 2017).

The professional and the state are responsible for ensuring qualification for the work they have been assigned. Nevertheless, PSCC professionals, when seeking qualification, mostly opt for specific teaching programs in mental health, which do not yet include the subject Patient Safety. The NPSP also plans to promote the inclusion of the subject of patient safety in technical, graduate and postgraduate education in health (Portaria nº 529, 2013).

In a safe, non-punitive work environment, the professional will assume a position of social responsibility and notify the institution, encouraging the repair of damage and adopting measures that prevent new occurrences (Romero, González, Calvo, & Fachado, 2018).

In services that still predominate a punitive and coercive culture, which blame professionals for mistakes, it is not uncommon and is understandable that it derives in secrecy, shame, concealment and defensive practices (Costa et al., 2018; Romero et al., 2018).

Guilt-free safety culture does not mean no responsibility. Denying individual responsibility and attributing it solely to the institution or the patient supposes admitting a false moral immunity of professionals. Individual attitude of accountability is an ethical requirement of the professional and a means to modify the insecure systems themselves. The legitimate and effective exercise of this capacity depends on a predictable, fair and

effective institutional infrastructure, with proportional consequences and alignment of values and accountability processes (Romero et al., 2018).

Final considerations

The development of this study made it possible to identify that, despite the conceptual limitations, the PSCC teams presented a comprehensive perception of patient safety, recognized risk situations and described the occurrence of patient safety incidents, as well as identified gaps related to the training process.

Thus, the professionals participating in the study stated the need to be trained on the subject, considering the daily work to rethink the current practices in the services, adapting them to promote safer care.

In the context of mental health, carrying out educational processes that encompass the recognition of professional accountability in the occurrences of the various types of incidents was perceived as a latent need for the behavioral change in the patient safety promotion, overcoming the act of justifying the occurrence of incidents in the conducts or in the user's profile, reaching, then, the ability to perform systemic analyses of the service and its work processes.

We hope that the results of this work help organizations recognize the importance of training mental health professionals for the development of safe care. In this regard, we envision that the management of services encourages and proposes permanent education processes in mental health units, aiming at quality care results to a population that for years has been excluded and needs problem-solving health care, safe and humanized.

The results reinforce the need for continuous evaluation in the various care services for safe care, strengthening the knowledge management of professionals, focusing on the National Policy of Mental Health and Patient Safety, knowledge gaps, as well as (re)formulation of preventive strategies, subsidized by educational policies that strengthen the culture of safety and quality in mental health services.

References

Araújo, J. S., Nascimento, H. M., Farre, A. G. M. C., Brito, R. O., Santos, J. P. A., &Vasconcelos, T. T. S. (2016). Conhecimento dos enfermeiros sobre evento adverso e os desafios para a sua notificação. *Cogitare Enfermagem, 21*(4), 01-08. doi: 10.5380/ce.v21i4.45404

Brickell, T. A., Nicholls, T. L., Procyshyn, R. M., McLean, C., Dempster, R. J., Lavoie, J. A. A., ... Wang, E. (2009). *Patient safety in mental health.* Edmonton, Alberta, CA: Canadian Patient Safety Instituteand Ontario Hospital Association. Recuperado de: https://www.patientsafetyinstitute.ca/en/toolsResources/Research/commissionedResearch/mentalHealthAndPatientSafety/Documents/Mental%20Health%20Paper.pdf

Capucho, H. C., Arnas, E. R., & Cassiani, S. H. B. (2013). Segurança do paciente: comparação entre notificações voluntárias manuscritas e informatizadas sobre incidentes em saúde. *Revista Gaúcha de Enfermagem, 34*(1), 164-172. doi: 10.1590/S198314472013000100 021

Costa, D. B., Ramos, D., Gabriel, C. S., & Bernardes, A. (2018). Cultura de segurança do paciente: avaliação pelos profissionais de enfermagem. *Texto & Contexto Enfermagem, 27*(3), e2670016. doi: 10.1590/0104-070720180002670016

Cuadros, K. C., Padilha, K. G., Toffoletto, M. C., Henriquez-Roldán, C., & Canales, M. A. J. (2017). Ocorrência de incidentes de segurança do paciente e carga de trabalho em enfermagem. *Revista Latino-Americana de Enfermagem, 25*(e2841), 1-8.doi: 10.1590/ 1518-8345.1280.2841

Eiroa-Orosa, F. J., & Rowe, M. (2017). Taking the concept of citizenship in mental health across countries: Reflections on transferring principles and practice to different sociocultural contexts. *Frontiers in Psychology, 8*(1020), 1-11. doi: 10.3389/fpsyg. 2017.01020

Fernandes, S. S., Marcos, C. B., Kaszubowsk, E., & Goulart, L. S. (2017). Evasão do tratamento da dependência de drogas: prevalência e fatores associados identificados a partir de um trabalho de busca ativa. *Cadernos de Saúde Coletiva, 25*(2), 131-137.doi: 10.1590/1414462 x201700020268.

Ferreira, A. C. Z., Borba, L. O., Capistrano, F. C., Czarnobay. J., & Maftum, M. A. (2015). Fatores que interferem na adesão ao tratamento de dependência química: percepção de profissionais de saúde. *Revista Mineira de Enfermagem, 19*(2), 150-56.doi: 10.5935/1415-2762.20150032

Ferreira, T. P. S., Sampaio, J., Oliveira, I. L., & Gomes, L. B. (2019). A família no cuidado em saúde mental: desafios para a produção de vidas. *Saúde Debate, 43*(121), 441-449.doi: 10.1590/0103-1104201912112

Gomes, T. R. (2017). Análise Idiossincrática dos discursos proferidos nas decisões judiciais sobre erro médico no TJDFT: um estudo qualitativo. *Cadernos Ibero-Americanos de Direito Sanitário, 6*(4), 55-69.doi: 10.17566/ciads.v6i4.416

Gutiérrez-Mendoza, L. M., Torres-Montes, A., Soria-Orozco, M., Padrón-Salas, A., & Ramírez-Hernández, M. E. (2015). Costs of Serious Adverse Events in a Community Teaching Hospital, in Mexico. *Cirugía y Cirujanos, 83*(3), 211-216. doi:10.1016/ j.circen.2015.09.021

Lei federal nº 10.216, de 06 de abril de 2001. (2001). Dispõe sobre a proteção e os direitos das pessoas portadoras de transtornos mentais e redireciona o modelo assistencial em saúde mental. Brasília, DF: Ministério da Saúde. Recuperado de: https://hpm.org.br/wp-content/uploads/2014/09/lei-no-10.216-de-6-de-abril-de2001. pdf

Lima, M. G., Gussi, M. A., Furegato, A. R. F. (2018). Centro de atenção psicossocial, o cuidado em saúde mental no Distrito Federal. *Tempus - Actas De Saúde Coletiva*, *11*(4), 197-220. doi: 10.18569/tempus.v11i4.2487

Martins, A. G. (2017). A noção de crise no campo da saúde mental: saberes e práticas em um centro de atenção psicossocial. *Mental, 11*(20), 226-242. Recuperado de: http://pepsic.bvsalud.org/pdf/mental/v11n20/v11n20a12.pdf

Minayo, M. C. (2014). Apresentação. In R. Gomes. *Pesquisa qualitativa em saúde* (p. 5-7). São Paulo, SP: Instituto Sírio Libanês.

Moscovici, F. (2008). *Desenvolvimento Interpessoal: treinamento em grupo*. Rio de Janeiro, RJ: José Olympio.

Oliveira, R. M., Bandeira, E. S., Silva, C. R., Soares, A. M. L., Fonteles, D. B., & Barboza, F. B. M. (2016). Tomada de decisão de enfermeiros frente a incidentes relacionados à segurança do paciente. *Cogitare Enfermagem, 21*(3), 01-10. doi: 10.5380/ce.v21i3.45683

Portaria nº 121, de 25 de janeiro de 2012. (2012). Institui a Unidade de Acolhimento para pessoas com necessidades decorrentes do uso de crack, álcool e outras drogas (Unidade de Acolhimento), no componente de atenção residencial de caráter transitório da Rede de Atenção Psicossocial. *Diário Oficial da República Federativa do Brasil*. Recuperado de: http://bvsms.saude.gov.br/bvs/saudelegis/gm/2012/prt0121_25_01_2012.html

Portaria nº 529, de 1º de abril de 2013. (2013). *Institui o Programa Nacional de Segurança do Paciente (PNSP).* Diário Oficial da República Federativa do Brasil. Brasília, DF: Ministério da Saúde. Recuperado de: http://bvsms.saude.gov.br/bvs/saudelegis/gm/2013/prt0529_01_04_2013.html

Rodrigues, J., & Deschamps, A. L. P. (2016). Política de saúde mental e projeto terapêutico singular. *Cadernos Brasileiros de Saúde Mental, 8*(17), 78-92. Recuperado de: https://periodicos.ufsc.br/index.php/cbsm/article/view/68966

Romero, M. P., González, R. B., Calvo, M. S. R., & Fachado, A. A. (2018). A segurança do paciente, qualidade do atendimento e ética dos sistemas de saúde. *Revista Bioética, 26*(3), 333-342. doi: 10.1590/1983-80422018263252

Silva, M. L., Amboni, G., Silva, D. M., Kern, C. A. R., & Ferraz, F. (2019). Escuta psicanalítica no acolhimento em um Centro de Atenção Psicossocial. *Cadernos Brasileiros de Saúde* Mental, 11(29), 63-83. Recuperado de: https://periodicos.ufsc.br/index.php/cbsm/article/view/69781/42017

Sousa Neto, A. L., Lima Júnior, A. J., & Souza, R. C. (2018). A segurança do paciente no ensino profissionalizante: relato de uma campanha. *Revista ELO - Diálogos em Extensão, 07*(02), 44-48. doi: 10.21284/elo.v7i2.1268

Souza, A. C. S., Bezerra, A. Q., Caixeta, C. C., Pinho, E. S., Paranaguá, T. T. B., & Teixeira, C. C. (2018). Percepção dos profissionais sobre segurança dos pacientes na atenção psicossocial. *Revista Brasileira de Enfermagem, 73* (Suppl 1), e20180831. doi: 10.1590/0034-7167-2018-0831

Souza, A. C. S., Bezerra, A. L. Q., Pinho, E. S., Nunes, F. C., & Caixeta, C. C. (2017). Segurança do paciente nos serviços comunitários de saúde mental: estudo bibliométrico. *Revista de Enfermagem UFPE on line, 11*(Supl. 11), 4671-7. doi: 10.5205/reuol.11138-99362-1-SM.1111sup201717

Souza, A. C. S., Pinho, E. S., Limongi, A. M. S., Teixeira, C. C., Bezerra, A. Q., & Paranaguá, T. T. B. (2021). Medidas de segurança durante a pandemia de infecções por coronavírus. *Revista de Enfermagem UFPE on line, 15*, e246701. doi: 10.5205/1981-8963.2021.246701

Tobias, G. C., Bezerra, A. L. Q., Moreira, I. A., Paranaguá, T. T. B., & Silva, A. E. B. C. (2016). Conhecimento dos enfermeiros sobre a cultura de segurança do paciente em hospital universitário. *Revista de Enfermagem UFPE on line, 10*(3), 1071-1079. doi: 10.5205/ reuol.8702-76273-4-SM.1003201617

Vantil, F. C. S., Lima, E. F. A., Figueiredo, K. C., Massaroni, L., Sousa, A. I., & Primo, C. C. (2020). Segurança do paciente com transtorno mental: construção coletiva de estratégias. *Revista Brasileira de Enfermagem, 73*(1), e20170905. doi: 10.1590/0034-7167-2017-0905

World Health Organization [WHO]. (2009). *World Alliance For Patient Safety Taxonomy. The conceptual framework for the international classification for patient safety: Final technical report*. Genève, CHE. Recuperado de: https://www.who.int/patientsafety/taxonomy/icps_full_ report.pdf?ua=1

Zeferino, M. T., Cartana, M. H. F., Fialho, M. B., Huber, M. Z., & Bertoncello, K. C. G. (2016). Percepção dos trabalhadores da saúde sobre o cuidado às crises na Rede de Atenção Psicossocial. *Escola Anna Nery Revista de Enfermagem, 20*(3), e20160059. doi: 10.5935/ 1414-8145.20160059

Recebido em 31/08/2020
Aceito em 07/02/2022

Contribuição dos autores

Adrielle Cristina Silva Souza, conception, design, analysis and interpretation of data; writing of the manuscript, critical review of the content and approval of the final version to be published.

Cristiane Chagas Teixeira, conception, design, analysis and interpretation of data; writing of the manuscript, critical review of the content and approval of the final version to be published.

Johnatan Martins Sousa, conception, design, analysis and interpretation of data; writing of the manuscript, critical review of the content and approval of the final version to be published.

Eurides Santos Pinho, conception, design, analysis and interpretation of data; writing of the manuscript, critical review of the content and approval of the final version to be published.

Tathianny Tanferri de Brito Paranaguá, conception, design, analysis and interpretation of data; writing of the manuscript, critical review of the content and approval of the final version to be published.

Ana Lúcia Queiroz Bezerra, conception, design, analysis and interpretation of data; writing of the manuscript, critical review of the content and approval of the final version to be published.