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Patient safety in a general hospital's psychiatric hospitalization unit: a phenomenological study*

Segurança do paciente em uma unidade de internação psiquiátrica em hospital geral: estudo fenomenológico

Seguridad del paciente en una unidad de internación psiquiátrica de un hospital general: estudio fenomenológico

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ABSTRACT

Objective: To understand the meaning of patient safety for a multiprofessional team in a psychiatric unit of a general hospital. **Method:** Qualitative study adopting the social phenomenological framework, employing open-ended interviews whose content was analyzed and discussed based on the literature through the elaboration of categories of analysis. **Results:** Eleven open-ended interviews were conducted. The meaning of psychiatric patient safety was understood to encompass team management experiences that emphasize physical coercion and control of symptomatology while indicating the expectation of elaborating new procedures that account for humanization. It also includes issues regarding organizational composition and experienced difficulties concerning physical structure, its interference in the process of providing safe care and expectations of improvement. **Conclusion:** This study analyzed the conception of patient safety in the multiprofessional team viewpoint, considering socio-historical and cultural contexts and the mutual relations that are part of meaning construction in the study setting.

DESCRIPTORS

Patient Safety; Mental Disorders; Psychiatric Nursing; Hospitals, Psychiatric; Mental Health.

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INTRODUCTION

Considering the late start of Psychiatric Reform in Brazil, it was known that the complexity of a new assistance model aimed at overcoming the asylum model would encounter hindrances such as low investment in public policies and the slow changes for the complete substitution of the mental asylum model[1-2]. With the creation of the Psychosocial Care Network (RAPS – *Rede de Atenção Psicossocial*), assistance devices were reassessed and, within hospital care, beds in general hospitals emerged as an alternative to hospitalization in psychiatric hospitals[2-3].

Although not constituting a basis for assistance, the General Hospital Psychiatric Hospitalization Units (UIPHG – *Unidades de Internação Psiquiátricas em Hospitais Gerais*) play an important role in the acute phase of psychiatric conditions, when out-of-hospital services are insufficient[3]. Due to their providing integral care in moments of crisis to return subjects to daily life, assessing how patient safety is operationalized in such places becomes opportune, since they are not concerned with hospitalizations which are permanent or may cause loss of identity and harm to the patients' relations[3-5]. A possible definition of patient safety is the reduction in risk of unnecessary damage during health assistance to the minimum acceptable level. Movements in favor of this theme emerged after the Institute of Medicine's publication of a document in the United States in 1999, titled *To Err is Human*, in which 44 to 98 thousand deaths were then estimated to be due to events related to health assistance[6-7].

In Brazil, remarkable events which promoted this theme include the creation of the Worldwide Alliance for Patient Safety (*Aliança Mundial para a Segurança do Paciente*), in 2004, by the World Health Organization, aimed at inducing commitment by its member countries to the development of patient safety practices, along with the creation of the National Program for Patient Safety (PNSP – *Programa Nacional de Segurança do Paciente*) in 2013, whose objective is contributing to the qualification of care in all health institutions nationwide[8].

The effort towards including reorganization of the care process in hospitals' agendas, focusing on patient safety, is noticeable, as is the increase of publications on this theme; however, when it comes to psychiatric patients, the setting is different and this issue remains little explored[5-8]. In 2011, a study on the emerging issues and challenges for patient safety improvement in the mental health already comprised a discussion on the need for research in this area, considering the particularities of psychiatric patient care[5,9-10]. Psychiatric hospitalization is usually long-lasting, leading to iatrogenesis. Although some of its characteristics are shared with other areas, such as events related to medication, procedures and communication, there are also singularities which require the theme to be studied separately[9-12]. Themes relevant to psychiatric patient safety include cases of violence and aggression, self and hetero-aggression, destructive behavior, suicide attempt and self-mutilation, as well as a psychiatric diagnosis which, due to similarities, may induce mistakes, leading to an incorrect treatment, which is followed by worsening conditions. There are also errors involving coercive measures, escape attempt, overmedication and falls due to medication use[9-12].

However, studies focus on specific risks, such as medication-related adverse events; psychiatric patient safety is not discussed in an integrated perspective. Also, such studies are, in short, conducted outside Brazil[9-12]. The lack of conceptions on psychiatric patient safety – which are often left unclear – and what it encompasses is also a challenge, especially in a setting where such issues are current and require better comprehension[5].

This study departs from a phenomenological perspective to analyze comprehension of patient safety by the multiprofessional team, seeking to provide an effective outlook on their experiences. Consequently, it enables consideration of psychiatric patient safety as including other variables which, beyond classifying, are related to experiences and life[13-14].

This study is thus justified by the need for understanding the reality of this setting as perceived by the multiprofessional team, accounting for the fact that patient safety must be a shared responsibility[8]. Hence, this study aimed at understanding the meaning of patient safety for a multiprofessional team at a UIPHG.

METHOD

Study type

Qualitative study using a social phenomenological approach and employing Alfred Schütz's theoretical-methodological framework[15-16]. In Nursing and mental health contexts, it supports conceiving the subject as a being in the world who has knowledge, subjectivity, singularity, a determined biography and motivations[13-16].

Scenario

The study was conducted at a university hospital's UIPHG in São Paulo's countryside in 2017. The hospital had sixteen mixed gender beds and a team comprising six nurses, one nursing supervisor, eight nursing technicians, four psychiatrists and a volunteer occupational therapist (who provided weekly care). There were no hired psychologists at that moment and psychological support was provided by four psychology residents, who had been working in the ward for a year. The team included also two multiprofessional residents – a nurse and a phonoaudiologist – and medicine residents. The studied population comprised eleven multiprofessional team members, including three nurses, a psychiatrist, two occupational therapists, two psychologists and three nursing technicians. To approach participants, a network sampling known as "snowball" was employed, in which one participant indicates the next one[17]; the first was selected by the researcher through a random draw to start sampling.

Selection criteria

Multiprofessional team members working in different shifts and not on leave or off work during collection. Dentists and physiotherapists were excluded from this research, since

they provided care via referral only, and were not in direct contact with the patients of the unit.

Data collection

A phenomenological interview, based on intersubjective researcher-participant relation, was conducted[13-14,18]. This type of interview enables subjects living the phenomenon to externalize the meaning of their actions, developed in their world of relations, ensuring that, when concentrating on meaning, they do not bother with facts, but with meaningful events[18]. Semi-structured, individual interviews with no directive questions were conducted, providing conditions for the participants to express themselves freely in a private room while being recorded for a minimum 30 and maximum 55 minutes. Such interview comprised the following leading questions: "tell me a situation you have lived involving psychiatric patient safety" and "how do you think psychiatric patient safety should be like in this UIPHG?".

Data collection, conducted from May to July 2017, was terminated due to theoretical saturation, i.e., the researcher's questions were answered and the study's objectives were accomplished[19].

Data treatment and analysis

The methodological framework proposed by researchers of social phenomenology in mental health was used to analyze the interviews[13-16]. Firstly, interviews were thoroughly read for identifying the overall meaning of psychiatric patient safety for the multiprofessional team[14,18]. They were then reread to establish units of meaning and identifying the "reasons for" and the "reasons why" of the action[14,18]. The meanings of actions were then described in two categories[14,18]: a) psychiatric patient safety: management experiences and the path to a new outlook; b) daily challenges and expectations of improvement.

Some social phenomenology concepts proposed by Alfred Schütz were used as a theoretical framework for data discussion[13-16].

Interviews were identified by letters from A to J to maintain anonymity. One of the interviews was excluded, since it was used to perform adjustments to the study question.

Ethical aspects

This study complies with all the ethical aspects of research involving human beings, as proposed in the National Health Council's Resolution n. 466/12, and it was approved by Universidade Estadual de Campinas' Ethics Committee in opinion n. 2.025.552 in 2017.

RESULTS

Category A – Psychiatric patient safety: management experiences and the path to a new outlook

The team's understanding of psychiatric patient safety regarding lived experiences - i.e., the "reasons why" - is shown to be related to conditions of aggression and agitation, as well as to the supremacy of discourses marked by negative experiences they have lived at the UIPHG:

I think of aggression, of their own and others' safety, of their agitation, aggression. That's what I think of when you talk about safety (A).

He broke the jar against the table and cut himself. So, this was something that really shocked the patients, and everyone got very agitated (G).

The peculiarities of psychiatric patient care, which differ from those of other specialties, were also an aspect that emerged from the interviews.

Yes, it's very different. Psychiatric patients are a lot more demanding. Sometimes on things you can't even imagine (B).

Another important finding is their understanding of patient safety as physical coercion, which was mentioned as the first action they think of to promote safety for professionals, patients, and society. It was also seen as the most practical and more manageable conduct, being a recurrent solution during actions performed by the multiprofessional team:

I imagine more like this sense of coercion and the risk they represent for themselves and society; every time someone talks about safety in mental health this is what comes to mind (H).

The first thing that comes to my mind is coercion, right? Coercion as a safety strategy, both for the professional and the patient (I).

The most recurrent solutions on patient safety always actually involved the issue of coercion (C).

Even though they mention coercion, the participants perceive that this practice has positive and negative aspects. Among negative aspects, they mentioned excess use of force and the limit between care and iatrogenesis, which involves risks such as loss of ethics and injuring the patient, as well as the conduction of this procedure with an insufficient number of professionals:

During coercion not everyone really uses only the force necessary for containing the patient. I think some people overdo it a little (G).

There's often no time to find five people to hold them, is there? I think this is also harmful, it ends up hurting the employee and hurting the patient as well, doesn't it? (G).

A patient who broke his arm during coercion because he was beating an employee. There was also a fall, they both fell down to the floor (G).

We're very close to losing our ethics when it comes to coercion, because you're subject to suffering an aggression when coercing a patient, and that has happened before, so you're torn between not being attacked and not hurting the patient (D).

The positive aspects mentioned by the multiprofessional team include care and technical management aimed at preventing that patients suffer major damage:

I have witnessed, for example, cases involving physical coercion, and I think there was a certain caution, at least in terms of technique and patient management (C).

Meaning is also built from action based on doctor-centered characteristics, which is demonstrated by the use of terms such as "medicating and tying" and by a sequence of subordinate actions during work which are conducted by authorization from medical professionals.

If patients are a little agitated, you medicate them, tie them, as long as you have authorization from professors: residents, physicians (E).

Everything is done in a logic of prescription (C).

The meaning of patient safety is also composed by discourses that address daily care risks, such as lesions due to pressure, fall, ingestion of objects, suicide, aggression by other patients and escapes.

Along with all the common risks of a hospital, bedsore risks, due to being restrained to their beds, they risk falling when taken out of bed to go to the shower (B).

Also, they put everything they find in their mouths, isn't it? They swallow it. Suicide risk, for some depressive patients. Of suffering aggression by other patients as well (B).

It's different because in other wards you don't need to account for the risk of being attacked by a patient, of patients running away. Here, what I see in terms of safety is that we are always watchful; there are grids in the windows, stools, you have to be constantly observing (E).

Another important finding is the description of actions that would lead to psychiatric patient safety, but are not implemented, such as identification wristbands. Their non-implementation is justified by employees being able to identify patients throughout hospitalization and by perception of the risk for the patient removing, disposing of, or eating the wristband. They also mention a lack of control on items brought from home and people circulation at the unit's entrance.

No, they don't keep the identification. Since hospitalization is not subject to high turnover here, (...) *we start recognizing patients as time goes by. We reinforce this every day; I think this is a positive aspect* (F).

We don't have a safety wristband for patients here, do we? This is really due to the patients themselves; some of them will often remove the wristband, throw it away, eat it (G).

This is a criticism I make; there should be more control over companions coming in, over visits, because we can't make sure that this is really about a visit, whether those people are really who they claim to be, what are their intentions; this should be done during patient admission (J).

This patient returned and we even had the family go in there, open their bag, take a look inside, because as a professional I can't frisk patients' bags, because having bags is their right. But we can talk to the family (D).

Other than their experiences, the multiprofessional team express their future expectations, i.e., how patient safety should be, which constitutes the "reasons for" of the action. They mention that there is a need for listening to patients more than just when conducting procedures and for an outlook which is not stigmatized or stereotyped, accounting for the nurse-patient relation and involving humanization of care and empathy.

Being more attentive when talking to patients, not talking only when providing medication or measuring their pressure. Not looking at them with such a stigmatized, stereotyped outlook, I'm not sure if these are the right words, but allowing yourself to have a new outlook (A).

Something aimed more at listening than simply technical management. And after the coercion situation, I guess we should back constant listening, especially from nursing, which I think is rare (...) a care that leans more towards humanization (...) not centered on something as immediate as a situation when someone is verging on aggression. The empathic thinking issue. We should do some reflection here in the unit, singularizing our outlooks toward the individual (C).

The part of how to approach the patient, the way you should talk, trying to reduce anxiety and confrontation through conversation. I think it would reduce aggression during coercion (G).

Category B – Daily challenges and expectations of improvement

The meaning of psychiatric patient safety is also related to challenges imposed during the work processes of the unit's daily life, such as elements of physical structure, of organization of care, of team formation and service offering.

According to participants, UIPGH has a striking setting: its grids seem to mark the workers' experiences. The discourses point situations when patients hurt themselves with sharp and cutting objects placed over equipment and furniture. Also, physical structure is reported as dreadful:

I think the grid comes to mind, right? I remember that when I started three years ago that was a little frightening. Because all the other wards are open, and the grid is exactly in the psychiatric ward only (J).

Patient safety? Equipment, I guess, right? Starting with beds, windows; the treatment is good, but the structure is terrible (B).

I think our patients are still exposed to glass from the windows, maybe the availability of equipment may also represent a certain risk. We don't have much space to rearrange this equipment. I worry a lot about the glass issue (D).

Team members diverge also on the conception of what a UIPHG is and where it should be located. Even though some thought it should not be part of a hospital environment, there was also understanding that such space could be more open, deviating slightly from a hospital-centered logic:

Well, first of all I think we're inside a hospital area, maybe it's not such an appropriate area for a psychiatric ward (D).

Structurally, I think this is a very closed space, isn't it? If we could really have an open space, just so that they could go out a little, breath, right? This would be my suggestion (F).

Concerning the work processes developed at the UIPHG, findings provide evidence of the lack of professionals and how this problem interferes in care provided to psychiatric patients in the daily life of the multiprofessional team. This implies a reduced offering of activities, which leads to a hospitalization characterized by idleness and confinement, with no workshops or activities.

I won't say: "let's all have many workshops and so on", because we also need an occupational therapist and a psychologist here (A).

Sometimes they arrive thinking "gosh, there's nothing to do here", "I'm tired of being here". And there's nothing indeed. They are very much confined in here, aren't they? There's a girl who's just started and she comes generally in the afternoon. So, they just look at each other. And so, they just get a little lost with no activities to do, right? (E).

Among the "reasons for" mentioned in the discourses, there was a clear expectation of changes toward the reorganization of UIPHG, with controlled access and a structural reform:

I think that if the rooms had a different disposition, maybe this aggression wouldn't have occurred. And also, that mirror, right? With the other patient (A).

It would be necessary to break and rebuild it. Sometimes I think the rooms are too much in the back; this is not so good, they even let riskier patients in the front, whatever risk it is, either health--related or of doing something, like a hetero or self-aggression, at the front, but the others stay in these more isolated rooms here (A).

It needs a real standard psychiatric structure. These beds: they bring here all the broken ones, there is not one good bed here (B).

The nurses station can't be as open as it is, it should be a closed station which only nurses and physicians could access (B).

DISCUSSION

The world of daily life is previously structured, preceding human birth. People act naturally according to what is presented to them as a social reality[14].

Humans live in the world guided by their definition of the scenario for their action, which they interpret from their existential motives. "Reasons why" refer to previous experiences, which determine how a subject acted or acts, and are understood only when an action is performed, i.e., when it becomes an act[16]. "Reasons for", by their turn, are related to existing projects and expectations[16].

By entering the life-world of the multiprofessional team, it is possible to notice that they develop care from previous experiences built throughout their lives. UIPHG is analyzed as becoming integrated to the team's daily life, since in that space, along with living and acquiring knowledge, members develop their work[14-16].

The investigation of the nature of action not only departs from a previously structured world, but is also carried where humans are located with their feelings, worries and experiences, that is, in an intersubjective relation with other social actors[14]. Sets of knowledge provide a basis for action and are constituted and structured primarily by parental teaching, educators' knowledge and concrete experiences lived and expressed individually, which represent the totality of their construction by subjects throughout their existence[14-16].

The team's set of knowledge, which is available, accessible, and allied to subjective experience, was partially built in the UIPHG by means of negative signification, as shown in discourses involving conditions of agitation, lesions and remarkable situations involving patients and their safety.

Although experiences have a component of intersubjectivity, accounting for particular biographical situations of the multiprofessional team, they encompass a considerable part of the historical construction of madness and the prevailing social stigma, mainly in mental health services, providing evidence for the persistence of the mental asylum model[1]. Such a fact is validated by the team members' recognition that psychiatric patient safety includes peculiarities, which demonstrates acquired knowledge. Nevertheless, they still relate this knowledge to reductionist concepts, such as locking doors and restricting patients' movements as a manner of providing care. Naturalization of such actions in daily life and their dissemination in the work process were noticed. Also, the influence of this model in making meaning of psychiatric patient safety is present when the team refers primarily to actions such as medication and coercion, with a dynamics of care based on the elimination of aggressive behavior and conditions of agitation[1,5].

Self and hetero-aggression, as well as conditions of agitation and violence, are part of the course of mental disorders, and should be evaluated even in a comprehensive differential investigation, as through diagnostic and mental state tests[9,20]. However, not only isolated aggression should be recognized, but also its cause and sources for the patient's aggressiveness. Understanding this would provide the team with a set of possibilities and procedures to be employed before medication and coercion, since the latter, in moments of crisis, should be well-grounded so as not to constitute repression or threat, but a form of leading patients to understand that they need help at that moment[20-21].

The reported lack of training and professionals during coercion is harmful either to the patient and the staff. Further evaluation, as verbalized by one of the interviewees, is not always possible, which shows care is of a prescriptive kind, whose major concern is fulfilling medical orders.

In this study, coercion emerges for the team in a very singular way. In the phenomenological perspective, even in a common environment, every subject has a specific biographical situation. This denotes that the same object can mean different things to a subject in relation to what it means to others, which is due to the diverse positions occupied by actors and differences in individual perspectives[15-16].

Although this study's focus is the multiprofessional team, discourses show that medical knowledge is overvalued in relation to other types. The team also makes it clear that it needs medical approval to perform actions for the patient. The affirmation of social division of labor is thus validated, leading to hierarchical relations, with other team members taking subordinate positions and becoming secondary in the care process[22].

Even though physical coercion is a process that depends on evaluation and medical prescription, many others do not. Prescription should be interdisciplinary and decided by the multiprofessional team. For this reason, it is necessary to think of field and nucleus actions and how the non-valuing of the set of acquired knowledges and imposition of medical knowledge are present in this study.

However, for nucleus and field to relate and for a support network to become viable, communication between subjects needs to take place in the daily life-world[15-16]. Only by means of face-to-face relations, i.e., in a direct relationship with others, mutual conscience of existence emerges[14-16]. Hence, relations established by the diverse multiprofessional team members lead to the comprehension of existing power hierarchies, promoting the discussion of field and nucleus while making other team members protagonists in the process of providing safe care. Also, communication problems and lack of knowledge are factors which lead to errors during assistance; efficient communication between team members may reduce such factors and even prevent them[23].

The "reasons why" comprise what was already lived, i.e., action is only elaborated through concrete situations. Thus the risks mentioned in the interviews also seem to be those the team had more contact with at the time or identified as a risk[15-16]. Called "running away" by this study's participants, hospital escape is highly widespread as a safety measure when it comes to psychiatric nursing care and mental health[9]. Caution for this risk ranges from patient transference to enclosed hospitalization units and closer observation to calling the police when escape occurs[9].

While real risks for such actions are assessed – regarding escape, patient suffering a lesion or being run over, for example – there are also conceptions that seem understand the mentally ill as uncapable of being responsible for their actions, requiring family or hospital supervision. The care provided to these patients is often inferred to be guided more by expectations from families and institutions than by real care demands and patient needs[22].

Suicide risk was also mentioned sometimes by this study's team. Suicide is a multicausal and complex phenomenon due to interaction among diverse factors, including biological and psychological dimensions, philosophical, anthropological and social issues[23].

In this study, locking doors are mentioned as a safety measure for such situations; however, even if protecting patients momentarily, such measure may interfere with their psychic condition, causing depression, anxiety and frustration, as well as reinforcing stigma around mental disorders[10,23]. As a possibility for rethinking care, there are strategies that take into account the team's intersubjectivity and its current space, such as qualified listening, risk evaluation, supervision, medication, psychotherapy and orientation to patients and their caregivers[23]. In other words, it is possible to rethink care through the biographical situation of the patient, team and family[15-16].

Concerning the "reasons for", which are associated to expectations regarding psychiatric patient safety, it was shown that certain actions regarding patient control are more likely to be taken. According to the interviews, control of access to the unit and items brought from home should be more judicious. Construction of meaning in this study is perceived once again to be based on stigma and control practices. On the other hand, an outlook seeking to care in a subjective manner and account for subject identification is also perceived; this is noticeable when the wristband is mentioned as unnecessary, since it is possible to recognize everyone at the UIPHG.

According to the interviews, the identification wristband is not employed due to patients staying long in the UIPHG, which makes their identification possible, as well as due to risks of psychiatric patients removing, disposing of, or even eating it. However, wristbands are known to be advocated by PNSP and are widely discussed worldwide for reducing mistakes and improving safety practices, since identification plays the double role of safely determining the legitimacy of those receiving the treatment or procedure and certifying that the process to be executed is the necessary one[24].

Even though the beds are few, patients are assisted by diverse teams and different professionals, often having no direct contact with and not recognizing them. Also, considering UIPHG's characteristics, it can be accessed by workers from other sectors. Therefore, carrying an identification is necessary and indispensable[24].

Their attribution of meaning to patient safety also includes projections of change in their team's social reality, i.e., what members expect to be different regarding psychiatric patient safety in terms of relational issues. In this sense, they verbalize the need for a different outlook toward the patient, accounting for issues which precede coercion, closer to the biopsychosocial paradigm and trying to turn the focus from disease to integral care. In this new outlook, health is considered a continuous process, a consequence of interaction between genetic, biological, psychological and cultural factors[4].

The sets of knowledge and the way subjects organize their lives constitute processes disseminated socially, received from their predecessors and previous experiences; however, they are also constantly developed in a sedimentation process which is consonant to intersubjectivity[15-16]. Thus, although the outlook toward safety concentrates on biomedical and historically determined issues, care should not be considered a stagnant process. It is quite the opposite: there is a growing need for the adoption of theories supporting care as a way of finding support in knowledge standards which imply changes of attitude[25].

The team's outlook is focused on what is expected from others, and not on what is expected regarding changes among its members. This may be better elucidated by analyzing the second category, in which care involving control of symptomatology and coercion is described and, simultaneously, organizational changes are expected as a result. That is, structural changes emerge as a solution for issues of a different nature.

In this study, physical structure, described as unsatisfactory, brings issues related to stigmatization of hospitalization units, precarious investments in health and reproduction of the psychiatric hospital in new care devices. This includes an

outlook which transposes the psychiatric hospital to RAPS services, setting aside issues that are pertinent to the psychosocial model, such as ambience, and the adjustment of new spaces for mental health, which would favor an integrated outlook toward patients and their safety[20]. However, team members should be held responsible collectively in this process, since the resolution of many issues involving mental health and psychiatry demand primarily paradigm shifts to take place[20,25].

The limited number of participants and institutional singularities may be considered study limitations; however, given the complexity of the meaning of patient safety for the studied UIPHG's multiprofessional team, it might be inferred that such a conception includes a reminiscence of mental asylums, since their practices are still under construction and moving towards stabilization of the psychosocial model.

CONCLUSION

Through this study, it was possible to understand the meaning of patient safety to a UIPGH's multiprofessional team. Approaching the multiprofessional team's life-world, the meaning of psychiatric patient safety was learned to account for the participants' set of knowledge, which are still under a paradigm shift process, but show doctor-centered features. It is also evident that the discourses indicate the expectation of building a new outlook, with more listening and humanization, related to the biopsychosocial model.

Organizational transformations are noticed to be central, with no joint team responsibility for a safe care process and, consequently, for the paradigm shift involving mental health and psychiatry.

Finally, the multiprofessional team's conception of patient safety was analyzed, considering its socio-historical and cultural context and the mutual relations that are part of the construction of such meaning in the care scenario. This study is considered an initial discussion, considering its proposed theme. For those who work in this area, the need for psychiatric patient safety to be seen in a more judicious manner is emphasized. Everyone plays a crucial role in the construction of elements that favor the safety of this kind of patient.

The conduction of actions in the unit, with a permanent education focused on producing reflections to build meaning on themes related directly or not to patient safety is one of this study's intended outcomes for nursing practice. The challenge is hence contributing to transformations while placing the professionals as actors in the production of strategies for changing the current scenario.

RESUMO

Objetivo: Compreender o significado da segurança do paciente para a equipe multiprofissional de uma unidade de internação psiquiátrica de um hospital geral. **Método:** Estudo qualitativo orientado pela vertente fenomenológica social, com entrevistas abertas cujo conteúdo foi analisado e discutido baseando-se na literatura, por meio da composição de categorias de análise. **Resultados:** Realizaram-se 11 entrevistas abertas. Foi possível compreender que o significado da segurança do paciente psiquiátrico envolve as experiências no manejo da equipe, com ênfase na contenção física e no controle de sintomatologia, mas também aponta para a expectativa de construção de um novo fazer que leve em conta a humanização. Inclui ainda questões referentes à composição organizacional e dificuldades vivenciadas quanto à estrutura física, sua interferência no processo de cuidar de forma segura e as expectativas de melhoria. **Conclusão:** Com esta pesquisa, pôde-se analisar a concepção de segurança do paciente pela ótica da equipe multiprofissional, considerando o contexto sócio-histórico e cultural e as relações mútuas que fazem parte da construção desse significado no cenário de estudo.

DESCRITORES

Segurança do Paciente; Transtornos Mentais; Enfermagem Psiquiátrica; Hospitais Psiquiátricos; Saúde Mental.

RESUMEN

Objetivo: Comprender el significado de la seguridad del paciente para un equipo multiprofesional de una unidad de internación psiquiátrica de un hospital general. **Método:** Estudio cualitativo guiado por la vertiente fenomenológica social, con entrevistas abiertas cuyo contenido fue analizado y discutido en base a la literatura, a través de la composición de categorías de análisis. **Resultados:** Se realizaron 11 entrevistas abiertas. Se pudo entender que el significado de la seguridad del paciente psiquiátrico implica las experiencias en la gestión del equipo, con énfasis en la contención física y el control de los síntomas, pero también se apuntó a la expectativa de construir un nuevo procedimiento que tenga en cuenta la humanización. También incluye cuestiones relativas a la composición de la organización y las dificultades experimentadas en relación con la estructura física, su interferencia en el proceso de cuidado seguro y las expectativas de mejora. **Conclusión:** Con esta investigación se pudo analizar el concepto de seguridad del paciente desde la perspectiva del equipo multiprofesional, considerando el contexto sociohistórico y cultural y las relaciones mutuas que forman parte de la construcción de este significado en el escenario de estudio.

DESCRIPTORES

Seguridad del Paciente; Trastornos Mentales; Enfermería Psiquiátrica; Hospitales Psiquiátricos; Salud Mental.

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