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Patient safety in primary care: conceptions of family health strategy nurses

Segurança do paciente na atenção primária: concepções de enfermeiras da estratégia de saúde da família

Seguridad del paciente en la atención primaria: concepciones de enfermeras de la estrategia de salud de la familia

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ABSTRACT

Objectives: To understand the conceptions of nurses working in the Family Health Strategy about patient safety in primary health care and how they affect the daily actions of these professionals.
Methods: A descriptive-exploratory study of a qualitative approach, carried out with nurses working in Family Health Strategies, in a municipality in the central region of RS. Data collection techniques were semi-structured interview and non-participant systematic observation, carried out from April to November 2017. The data were submitted to the Thematic Content Analysis.
Results: Data analysis resulted in three thematic categories addressing the meanings, difficulties and strategies related to safe care.
Conclusions: The research shows the need for new studies on the subject. The reflections can contribute to nursing care with a view to patient safety, qualifying both nurses' work and health care in an expanded way.
Keywords: Patient safety. Primary health care. Nursing.

RESUMO

Objetivos: Compreender as concepções de enfermeiras atuantes na Estratégia de Saúde da Família acerca da segurança do paciente na atenção primária em saúde e de que forma estas repercutem nas ações cotidianas dessas profissionais.
Métodos: Estudo descritivo-exploratório de abordagem qualitativa, realizado com enfermeiras da Estratégia de Saúde da Família, em município da região central do RS. As técnicas de coleta de dados foram a entrevista semiestruturada e a observação não participante, realizadas no período de abril a novembro de 2017. Os dados foram submetidos à Análise de Conteúdo Temática.
Resultados: A análise resultou em três categorias temáticas abordando os significados, as dificuldades e as estratégias relacionadas ao cuidado seguro.
Conclusões: A pesquisa mostra a necessidade de novos estudos sobre o tema. As reflexões podem contribuir para a assistência de enfermagem com vistas à segurança do paciente, qualificando tanto o trabalho das enfermeiras, como o cuidado em saúde de modo ampliado.
Palavras-chave: Segurança do paciente. Atenção primária à saúde. Enfermagem.

RESUMEN

Objetivos: Comprender las concepciones de enfermeras actuantes en la Estrategia de Salud de la Familia acerca de la seguridad del paciente en la atención primaria en salud y de qué forma éstas repercuten en las acciones cotidianas de estas profesionales.
Métodos: Estudio descriptivo-exploratorio de abordaje cualitativo, realizado con enfermeras que trabajan en Estrategias de Salud de la Familia, en un municipio de la región central del Rio Grande do Sul. Las técnicas de recolección de datos fueron la entrevista semiestructurada y la observación sistemática no participante, realizadas en el período de abril a noviembre de 2017. Los datos fueron sometidos al Análisis de Contenido Temático.
Resultados: El análisis de los datos resultó en tres categorías temáticas abordando el significado de seguridad del paciente, las dificultades y estrategias para el cuidado seguro.
Conclusiones: La investigación muestra la necesidad de nuevos estudios sobre el tema. Las reflexiones pueden contribuir a la asistencia de enfermería con miras a la seguridad del paciente, calificando el trabajo de las enfermeras como del cuidado en salud de modo ampliado.
Palabras clave: Seguridad del paciente. Atención primaria de salud. Enfermería.

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INTRODUCTION

The topic of patient safety (SP), today, is a subject much discussed worldwide. From this perspective, in 2004, the World Alliance for Patient Safety was created by the World Health Organization (WHO), with the purpose of establishing concepts and guidelines related to this field of knowledge and practices, as well as recommending actions with the objective of reduce risks and adverse events[1-2].

According to this Alliance, the patient's safety is the reduction, to a lesser risk of harm that is appropriate, added to health care. In this context, the definition of damage can be understood as the occurrence of an injury when there is the involvement of a structure or its performance in the body, coming from some action taken in the care. The damage ranges from pathologies to the extinction of life, being physical, psychic or social[2].

The first global challenges posed by the Global Alliance to mitigate risks and mitigate adverse events were actions aimed at reducing cases of infection related to health care. Initially, through campaigns for hand washing, considered an essential practice to avoid infections[2-3].

Following this global trend, in Brazil, in 2008, the Brazilian Network of Nursing and Patient Safety (REBRAENSP) was created to disseminate knowledge in the field of Nursing and SP, establishing connection and collaboration between individuals, establishments and companies for the expansion and consolidation of its practices of care, research, teaching and technical cooperation, among others.

In 2013, the National Patient Safety Program (PNSP) was established, which represents a milestone for the quality of care in the different health spaces, whether public or private. This program aims to promote actions aimed at patient safety and to disseminate information about this topic in health training centers[2,4].

These guidelines were initially related to care in hospitals. However, from the point of view of health care networks (RAS), primary care is understood as the care coordinator and the preferred gateway of the user to the different points of attention of the SAN, making it relevant to research SP practices in this scenario[5]. This concern was confirmed by the WHO in the year 2012, when it established a working group of specialists to discuss the safety of care in primary care[1].

In the Brazilian context, the terms 'primary care' and 'primary care' are understood as synonyms. However, during the process of implementation of the Unified Health System (SUS), basic attention has been designated as a differentiation of selective primary care, which in the international context refers to programs focused on dealing with a limited number of problems of health directed to the mother-child group as oral rehydration, immunizations and family planning[5].

In the international literature, it is argued that health care networks can improve clinical quality, health outcomes, and reduce health care costs, thus impacting on the safety of care. Moreover, there is evidence that health care systems aimed at strengthening primary health care can organize themselves based on the health needs of the population and, therefore, be decisive in confronting the hegemony of chronic conditions, having an impact health levels of the population. In Brazil, networking is relatively recent and its coordination by a qualified APS, based on resoluteness and accountability by its population is a challenge[6].

Currently, the reorganization and strengthening of primary care occurs through the Family Health Strategy (ESF). It proposes the expansion, qualification and consolidation of primary care, by favoring the reorientation of the work process with greater potential to increase the resolution and impact on the health situation of individuals and communities. In this perspective, the focus is on the family and not just the individual, which has repercussions on practices focused on the integrality of health care and promotion[5].

This strategic model must act as a computer for the flow of people in different health care networks, supported by diagnostic, logistical and governance support services[6]. In addition, the ESF intends to restructure primary care in accordance with the principles of the SUS, and actions are organized to be dynamized through the performance of health teams made up minimally by a physician, a nurse, an auxiliary and/or technician. nursing and four community health agents (ACS). Dentistry workers and the agent for the control of endemics (ACE)[5,7].

The nurse practitioner is an integral and indispensable part of the multiprofessional team and, even considering the complexity of the nurses' performance in this scenario, there are still little known and exploited risks in the literature[5,8]. There are certain procedures such as dressing, collection of cytopathological exams, capillary glycemia, medication administration, among others, which are invasive in character, are likely to result in an adverse event[9].

It is therefore considered that there is a greater concern about SP in recent years, but most studies remain focused on care performed in the hospital context and primary care research is still restricted[2,3,10]. What is found in greater volume are studies developed in institutions of higher education and technical productions of the Ministry of Health[2,11].

Faced with this reality, **we question**: what is the understanding of the nurses of the Family Health Strategy about patient safety in Primary Health Care? In order to answer the

question referred, the **objective** of the study was to understand the conceptions of nurses working in the Family Health Strategy about patient safety in primary health care and how they impact on the daily actions of these professionals.

METHODOLOGY

Descriptive-exploratory study with qualitative approach[12], carried out in a municipality of the central region of Rio Grande do Sul. The research was developed in seven Family Health Strategies (ESF) located in the western region. The choice of these Health Units is justified because they represent fields of practical activities and curricular stages of the Undergraduate and Residency Courses of the University whose research is linked. The study is part of the research process of an Academic Master's Dissertation in Health and Life Sciences[13].

The study participants were all nurses working in these places, making an intentional sample of 10 (ten) professionals. It was decided to present the participants in the feminine gender, since they are all women. As inclusion criterion, it was considered: to be a nurse working in the ESF of the western region of the municipality during the period of data collection; and as exclusion criteria: to be away from their professional practices due to vacation, award or license. Data collection was performed between April and November 2017.

As data collection techniques, systematic non-participant observation was chosen and the semi-structured interview. The questions related to the techniques were elaborated based on a questionnaire adapted and validated in Brazil to evaluate the culture of patient safety in primary care[14].

Observations were made at the nurses' workplaces in two separate shifts, i.e. one morning and one afternoon with an average observation period per shift of 3 hours. The scheduled meetings took place on the same day or every other day, and the criteria for the scheduling were the participants' availability. These observations are justified by the possibility of observing how the conceptions of the nurses expressed in the interviews have repercussions on their daily actions.

The observations were made based on a pre-established script that included the following aspects to be observed: communication with users; risks related to nursing care in the institution; incorporation of safe and evidence-based practices; barriers and opportunities for safe care. Also, dimensions related to the organization of the nurses' work process were observed, with a focus on the humanization of care: to call the users by name; present themselves to users; and organization of the spontaneous and programmed demand of the Unit. All observations were recorded in the form of a field diary.

The interviews were also scheduled previously with the participants, after the systematic observation. After consent, the interviews were recorded on a digital recorder and then transcribed in their entirety and listed at random. In order to guarantee the anonymity of the participants, in the analysis of the data, these were mentioned as ENF, followed by the interview number, from 1 to 10. As regards the observations, these are mentioned from the OBSENF codes, also followed by corresponding numbers.

The data were analyzed according to the Thematic Content Analysis, which is divided into three stages: 1) pre-analysis: corresponds to the phase of transcription and data organization, where the initial objectives of the research were resumed in order to operationalize and systematize the initial ideas; 2) exploration of the material: the thematic categories that were initiated in the previous phase were defined and organized; and 3) treatment of the results and interpretation, where the data of the study were articulated to the literature of the area and new information was constructed from the object of study[12].

Participating nurses signed the Informed Consent Term (ICF) in two copies and the other ethical aspects of Resolution 466, dated December 12, 2012, of the National Research Council. The study was approved by the Research Ethics Committee according to the opinion 1.876.855.

RESULTS AND DISCUSSION

The process of data analysis resulted in the organization of three thematic categories: Patient safety meanings for the nurses of the Family Health Strategy; Difficulties related to safe care in the practice of nurses and Strategies for safe care in the work of the nurses of the Family Health Strategy.

Patient safety meanings for nurses in the Family Health Strategy

This first category presents the meanings attributed by the nurses participating in the research on the actions of patient safety in primary health care. In this sense, the participants, for the most part, expressed SP meanings related to a care that avoids damages and risks. Thus, both the statements and the observations made reinforce this understanding:

> *It means you take all precautions to avoid infection. I think it starts with the basic principle of hand washing, all care so that the patient who seeks care here does not acquire something more, a disease, more for contamination (ENF 8).*

Nurse explains why they serve the tests, washes their hands, puts on the gloves and spreads paper towel on the table to put the materials. Clarify how the result will be, record the performance of the tests in a standard book. It shows the result to the user, collects everything, removes the gloves and washes the hands again (OBS ENF 3).

This understanding of some nurses is in line with what has been described in the literature. Although SP has several definitions, according to the WHO, this is defined as reducing the risk of unnecessary damages aggregated to health care up to a minimum allowable value, meaning that this acceptable small harm is related to available human, scientific and structural resources, as well as to the conjuncture in which assistance was given[2-3].

In addition, the concern with the prevention of infections was one of the criteria to avoid risk and harm. Recent studies have shown that the most notable risks related to primary care are allusions to immunization. However, there are several invasive procedures performed in this scenario that could lead to an adverse event, such as capillary glycemia, dressings, nebulization, collection of cytopathological exams, medication administration, among others[8].

In the interviews, participants also cited hand hygiene as one of the factors related to care that avoids harm and risk. Hand hygiene is one of the strategic actions proposed by the WHO as the first global challenge for the reduction of infections[3]. This theme was emphasized in a protocol defined by WHO and, in Brazil, constituted the text of Ordinance MS/GM No. 529/2013, as one of the priority actions of REBRAENSP[4].

However, although some statements have indicated this concern, some nurses showed that this understanding, in some cases, does not affect professional practice:

In a prenatal consultation nurse does not wash hands, takes physical, uses sonar. Enter the information on the computer and write in the pregnant woman's wallet, look at the exams that the pregnant woman brought, finishes and does not wash her hands. (OBS ENF 10).

After the observations made, the practice of hand hygiene in the daily routine of nurses presented some weaknesses, because in many cases, the technique was more focused on the safety of the professional, since, in general, hand washing was performed after the procedures. This fact is in line with another study[15] when describing that the hygiene of the hands occurs, predominantly, after the contact with the users.

Still in relation to the practice of hand hygiene, it was observed that in many rooms there were no sinks, or they were not functioning. In the same direction of the present study, another study revealed that even though there were satisfactory hand washing sinks and dispensers, they often did not have good conditions of use and managers did not know these difficulties[16].

A broader conception of patient safety also emerged in the testimonials, related not only to care related to technical procedures, but also to the welcoming and resolute stance of the family health team:

It goes beyond the concern with the transmission of diseases, because in collective health we must think about his house, how he can do to achieve the planning that we did with him. Regarding comorbidity, it would be you to protect it from some infection, but also to guide the possible infections that may exist (ENF 6).

Another pregnant woman arrives, without previous appointment, with laboratory tests performed, nurse receives for nursing consultation, introduces me and the residents to the user, asks if we can stay in the room. Nurse performs anamnesis, does asepsis on the hands with alcohol gel before performing the breast exam, schedules a new consultation with the gynecologist for the next month, directs that you do not have to stand in line to mark the appointment (OBS ENF 2).

In the same direction, some statements denote conceptions related to multidimensional care, related to the conditions of the users to adhere to the orientations derived from the educational activities in health, as well as the means that they must follow the planning agreed with the health team in relation to your care process. Still, teamwork is mentioned as an inherent factor in the ESF care process:

I think it's us to perform a care, giving the patient one, a security of care, not having any, not taking risks, not only physical security, but the security of being well oriented of everything that we are going making, having a care that does not generate risk to the patient (ENF 5).

Puerperium consultation, nurse checks vaccines portfolio, advises not to medicate without a prescription. The ACS is present, the child is safely weighed to avoid falling, the nurse advises on the danger of taking home, cooking pots on the fire, the child is almost walking and sends her to a doctor, because the child has a fever at home. (OBS ENF 3).

These conceptions are in line with the National Policy on Basic Health Care - PNAB[3], when it states that the essence of teamwork is centered in interdisciplinary actions, adding diverse technical fields and workers of different knowledges. Also, for safe care to be established in this context, strategies that are in line with individual and collective health needs are needed. For this to happen, it is indispensable that a distribution of knowledges, intersectoral learning and a management of care in networks should occur, envisaging a multidimensional care.

Difficulties related to safe nursing practice

The second thematic category addressed elements that make SP difficult in the context of ESF. Besides the meanings attributed by the nurses, who seem to guide their care processes, some difficulties were also signaled both in the testimonies and in the professional performance, through the observations. These were divided into structural, organizational/management difficulties and professional overload.

In relation to the structural difficulties, these were predominantly related to the conditions of the buildings of the Health Units and to the lack of inputs from these units:

You do not have correct access here, not for a wheelchair person. Very uneven, there is a hole in the doorway, so there are several things that can pose a risk to the patient. Today there was a lady who fell in the front and was injured, the whole face. So it does not have a proper physical structure, it rains inside (ENF3).

There is no air conditioning in the vaccine room (OBS ENF 1).

The nebulization and dressing room is the same, there is no purge in the health unit (OBS ENF 7).

According to the above, the greatest difficulties reported by the participants were in relation to the structure of the Units. It is noteworthy that only in the Health Unit that was built according to the criteria established by the Ministry of Health, did not emerge any report related to structural difficulties as one of the barriers to SP. It should be noted that the other Units are allocated in spaces adapted to allow their functionality.

The user's access difficulties to the Unit were also mentioned, mentioning the bumpy streets, many without pavement, the lack of access ramps or poorly constructed for disabled people or people with difficulty of locomotion. Inside the Units there are many uneven floors, unfinished walls and lack of maintenance. Confirming with the findings of this study, one of the main challenges for the qualification of primary care is related to the adequacy of the physical structure of the Health Units, since there is a significant number of UBS inappropriate, which directly affects SP[17].

Regarding the difficulties related to the management and/or organization of the BHU, the nurses reported mainly the lack of human resources, especially of professionals responsible for hygiene and the shortage of Community Health Agents:

For example, the day that we have collection of preventives in the afternoon the garbage will stay there until the other day in the morning. I'll do it on Friday and the trash will stay there until Monday, contaminated trash. Biological garbage will stay there. Today I did a lot of collections, I did a lot of rapid testing, so the contaminated biological material is all there (ENF4).

We cannot get pregnant early without the community agent, we cannot get these children with delayed vaccine, we search through the telephone, but that fundamental role of the agent is impaired (ENF10).

In the organization of ESF, the ACS has a strategic role in the assigned territory, since its attribution is to work in defined geographical areas, register all the individuals in its micro area, follow the families and carry out the home visit. These visits are considered instruments of care that allow an extended evaluation of the living/health conditions, being planned in a team, based on the dimensioning of the need for vulnerability and risk in the area covered by the service[17].

Another problem raised by the participants was in relation to the excessive work done by them. Often this work too, according to their reports, are tied to the demand of users pertinent to a Health Unit:

I see risk because it has a lot of demand to attend and in this way, you can end up being careless between one patient and another, doing the washing of hands and taking some basic care due to the demand. When we end up getting tired, exhausted, faults begin to happen at any service (ENF8).

The nurse performs many shots on the shift. I have sometimes noticed that the speed, in order to deal with the demand, hampers the guidelines and even the appropriate techniques, such as hand washing (OBS ENF 1).

As difficulties related to the professional overload reported by the participants, the literature affirms that it is imperative that there is an appropriate number of professionals for safe care, and that it is an institutional responsibility to provide adequate conditions in units[18]. The National Program for Improving Access and Quality of Primary Care (PMAQ) instructs that excessive numbers of people residing in a catchment area may affect the work of the team. The quality of their actions can be affected as the teams work with overload[17].

In this context, a study showed that there is an expressive association between SP and the workload of professionals. This research points out that in places where there were fewer users were the places that exhibited better numbers in the quality of care and management of SP. Likewise, it suggests that improper staffing increases the percentage of turnover and absences at work, hindering safe care due to elements such as fatigue, illness and turnover of the professional staff[19].

In summary, multiple factors may be potential indicators of patients' uncertainty, such as the reduced workforce, the workload of health professionals, and scarce or improper material for the development of the care process[18]. Although this possibility does not apply to ESF teams, the new PNAB allows for the AB teams, i.e. the traditional Health Units, the composition of the minimum workload per professional category of 10 (ten) hours, with no maximum of three (3) professionals per category, with a minimum of 40 hours/week. The work process, the combination of the work days of the team professionals need to be organized with a view to ensuring access and the link between people and professionals, as well as the continuity, coordination and longitudinality of care[7].

Although many difficulties have been mentioned and observed in nurses' work, it is important to highlight that they have been developing some strategies to promote safe care, even in adverse working conditions. Among these strategies, we can mention those related to nursing care, ethics of care and reception processes.

Strategies for safe care in the work of the nurses of the Family Health Strategy

Regarding the strategies adopted by nurses for the development of safe care, the following aspects were highlighted: in relation to technical procedures, professional ethics and care.

As factors that collaborate for the SP, emerged in the speeches the concern with technical procedures, such as hand washing, non-contamination and the use of personal protective equipment. In a broader perspective, it was also mentioned the concern with the reception of the user in UBS:

Because we know that it is a care that must be with the patient, the disposal of the material, the washing of hands to avoid cross-contamination, this is automatic, but it is a conscious automatic. We do it because you know you need to do it (ENF 1).

She cleans the litter with alcohol, changes the sheet, cleans the hands with alcohol, locks the door, puts on gloves, performs the breast exam, puts on touch gloves and performs the cytopathological examination on the wearer (OBS ENF 4).

Another strategy for safe care, mentioned by a nurse, alludes to professional ethics as part of the SP field:

It's a thing of mine, everyone must be very ethical. They are welcomed, I try to gain their trust, it is good to treat, that this is something that should be inherent in all professionals. We have these offices here, which we do not hear. Although this structure is open, we do not hear what in a doctor's office we are talking about. We have already done this by worrying about this question, about that security, about that autonomy (ENF 2).

The development of safe care related to professional ethics was also mentioned by the participants. The empathy and disposition of the worker, as well as his ethics about the situation, are ways of establishing links in order to promote continuity of care. The posture, the way of listening and facing the unexpected constitute the affirmation of relations between employee and user, especially when people seek assistance in the absence of scheduling or without consultation[3].

The host was also mentioned as a strategy for the improvement of care, evidencing the nurses' concern with the user, in being available to listen and to attend to all in the best possible way.

We left a suggestion box for a couple of months there, and they chose to schedule the appointments at 10 o'clock, there is the case that the patient needs something complete, we ask for a reception, no patient who comes to look for us leaves without service (ENF 4).

One more host, calls the user by name, user with doubts about the use of contraceptive, is well oriented about the

use and its exchange and nurse agenda consultation with the doctor (OBS ENF 6).

A strategy proposed by nurses for safe care is based on the form of reception, the user feels safe and welcomed at the place of the health service. It is observed that for the security of access it is indispensable to get and to identify the main problems, using, for that, qualified listening and some care devices that can be effective, such as home care, interdisciplinary consultation, unique therapeutic projects, genograms, among other strategies with potential for qualification of care. Studies also point out that the implementation of the ESF extended the access of the users to the services offered by the primary health care, having as focus the attention to the chronic conditions. In addition, by adopting interprofessional work processes, it has the potential to promote the promotion of more integrated and humanized actions that reflect in greater security of care[9,20].

The acceptance of the spontaneous demand signifies for modifications in the way of working of the teams, in the models of care and in the relationship between the professionals. Sheltering spontaneous demand with equality and responsibility, thus reverting to safe care, is not restricted to offering limited passwords or leading them to the doctor, since the organization of care through the reception is related to integral care of the health team[5,17].

According to the data found, in order to offer a safe and quality care, it is necessary to articulate responsibilities related to the management and the professionals with the guidelines and evidences already available in relation to the norms, techniques and studies realized about the safe care. Examples of some health care such as hand washing, equipment conferencing, routine identification of user identification are health care practices that need to be prioritized for a secure organization[19].

Based on the foregoing, it is necessary that the existing basic protocols set forth in Ordinance 529/2013 be implemented and used, such as: patient identification; hand hygiene practice in health facilities; safe surgery; communication in the environment of health facilities; prevention of falls; pressure ulcers; safety in prescription, use and administration of medications; transfer of patients between points of care and safe use of equipment and materials. It should be noted that these protocols are those recommended by the WHO[2].

It was noticed in the observations and in the speeches of the participants the absence of the insertion of all the team for a safe care, since the care to the patient is not only of a professional class it goes through all the professional categories. Thus, the interdisciplinary team in collective health must work together, with responsibility and competence for the service to happen effectively[7]. Teamwork with effective communication among professionals is essential if there is to be quality assistance[10].

FINAL CONSIDERATIONS

In this study it was possible to identify that, in a general way, the nurses relate SP to attitudes that do not cause greater damages to the user, specifying the technical procedures practiced with appropriate techniques as a way of performing the safe care. The difficulties encountered related to safe care in primary care were many, among the most present were the inadequate physical structure and the lack or lack of consumption material. Also, those relating to management and or organization and work overload. Likewise, it was observed that nurses seek to develop strategies for the development of safe care. Special mention should be made of aspects related to technical procedures and safe care relevant to professional ethics and care.

Furthermore, the data from this research can support actions in the nursing training processes, giving visibility to patient safety in the Family Health Strategy. In the context of research processes, it strengthens the field of studies on patient safety in primary health care, bringing data to the debate on the subject and launching perspectives for the development of new studies.

It should be emphasized that this research presents limitations, especially since it was carried out with the involvement of nurses working in a region of the municipality. However, it contributes to more subsidies on the subject, mainly due to the observation that investigations on the subject are incipient in Brazil.

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