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HOW TO IMPROVE PATIENT SAFETY IN HEALTH INSTITUTIONS THROUGH SCIENTIFIC RESEARCH

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Abstract: The promotion of patient safety must be a systemic organizational concern, especially in the hospital environment, where the advancement of technological density in care is accelerated; therapeutic diagnostic procedures are more complex; work dynamics tend to be more troubled and, as a result, the risk of harm to the client/patient is more palpable, becoming a continuous challenge for institutions. The hospital environment must provide comfort, well-being and interaction between users, family and staff; provide reception, favor the establishment of a bond between those involved, in addition to enabling the rescue of values of solidarity, respect and co-responsibility with the other. However, few actions can bring as much effectiveness avoiding suffering, loss of money and lives, than the use of evidence with scientific basis, for decision making both in human health and in the right to health. The methodology used in this work was based on the study of the bibliographic reference available in the discipline's Webquest and on the consultation carried out in the Virtual Health Library. This research resulted in the collection and analysis of scientific articles from 2016 to 2019. In this article, therefore, we will present a general analysis of how to improve patient safety in a health institution, observing the possibilities and strategies through scientific research, where it will help in good results.
Keywords: Hospital Environment, Patient safety, Scientific Evidence.

INTRODUCTION

The practical application of evidence-based medicine (EBM) is based on the identification of the best scientific evidence regarding the efficacy, effectiveness, efficiency and safety of each intervention, whether diagnostic, therapeutic or preventive. In turn, security requires due evidence, in order to ensure that every decision will bring more benefits to individuals and society than harm. (Atallah et al., 2018).

The dissemination of individual or collective knowledge is favorable for the implementation of quality improvement, a determining factor for the provision of good services, as it links the increase in productive efficiency to greater customer retention, improvements in the quality of service and greater safety in the services, both for those who offer and for those who receive them. This way, the actions adopted by scientifically based processes in health institutions impact good quality practices in health care services and patient safety. (Terra et al., 2017).

The present work has as methodology the bibliographic review through the Virtual Health Library, use of DeCS to choose the descriptors and a qualitative approach, to answer on how to improve patient safety in a hospital environment, through scientific evidence.

DEVELOPMENT

According to Atallah (2018), evidence-based medicine (EBM) originated from the new science resulting from the association of epidemiology methods with clinical research. Archibald Cochrane integrated knowledge from both areas and created what came to be called clinical epidemiology and, with the help of other collaborators, including Professor Kherr L. White, equated his appeal for efficacy, effectiveness and efficiency in teaching, in practice. and in clinical research. The MBE came to elect the fundamental concepts of Medicine and Health. The MBE concept was introduced in the early 1990s, followed by the founding of the Cochrane Collaboration in 1992 in Oxford by Professor Iain Chalmers. Cochrane Brazil, on the other hand, was founded in 1996 with the support of the Associação Paulista de Medicina (APM)

and the Coordination for the Improvement of Higher Education Personnel (CAPES), where everything has been available to all Brazilians since 1995.

Among the emerging safety strategies in the modern hospital scenario, patient identification has been highlighted; safe surgical care; prevention of falls and pressure ulcers; emphasis on hand hygiene to prevent infections; prescription; fall prevention; safe use and administration of medicines and improvement in communication processes between health professionals. (Oliveira et al., 2017).

However, there are often problems configuring or implementing these protocols in hospitals. Knowledge of workers and their adoption of clinical protocols and guidelines are crucial for effective patient safety strategies, as well as the availability of resources and equipment to carry them out. (Serra et al., 2016).

The high costs of adverse events, the diversity and complexity of procedures, patient and family monitoring and legal requirements, lead managers to increasingly adopt the systematic evaluation of practices in services, using tools capable of identifying and locating factors that interfere in the generating expected results. (Serra et al., 2016).

Assessment is based on learning from real experiences. It involves understanding the causes that led to successes or errors and thus clarifying what measures need to be taken to avoid difficulties and achieve the expected results. From these assessments, it is possible to correct errors, improve performance and reduce the occurrence of adverse events. (Serra et al., 2016).

Safety strategies and health education positively affect the effectiveness of self-management and must be carried out according to the state of the needs, knowledge and competence of patients and their companions. Furthermore, patient empowerment is defined as a process in which patients/family caregivers understand their role and receive knowledge and skills from health professionals in an environment that encourages this participation. (Neri et al., 2019).

It is considered that the process of implementing safety strategies is an asset that deserves to be systematically managed in the organizational routine and that some aspects inherent to teaching hospitals can facilitate the process of implementing these measures. However, the top management (present in all hospitals) needs to encourage actions aimed at safe care. It is worth noting that the studies have limitations, such as the participation of a very homogeneous population and the use of individual and unique interviews. Despite this, their findings can contribute to the contribution of knowledge related to the topic of patient safety, especially by addressing aspects that facilitate the implementation of their strategies. (Oliveira et al., 2017).

A national study carried out with managers identified that the best practices in risk management are shaped by a critical analysis of reality, multiple dimensions of management and permanent education as axes that guide improvements in care processes. Therefore, the importance of permanent human capital education as a means of facilitating the implementation of patient safety strategies, which, notoriously, is one of the main goals of any health organization. (Oliveira et al., 2017).

Continuing Education in Health (EPS) determines a learning process that uses the problematization of the local reality with a view to building knowledge and training professionals in order to transpose the concepts of in-service education and continuing education, enabling the reorganization of professional practices to improve the work process. The issue of teaching at work and

even research in university/teaching hospitals (present in the excerpts) corresponds to the literature, which points out that these organizations tend to facilitate the processes of learning, investigation and, as seen in the excerpts, implementation of security strategies. (Oliveira et al., 2017).

In recent years, the development of global policies and strategies for patient safety has been observed in countries with different levels of development, driven by the World Health Organization (WHO), and thus, the theme has been spreading among health institutions. health. It is understood that health care strives for the institution's commitment to the services provided and to the safety of the client, promoting quality care free of risks or failures. (Sartor et al., 2016).

According to the W.H.O, many patients suffer injuries due to health care failures, and it is estimated that, in every ten patients, one suffers an adverse event during care in hospitals. Thus, it is necessary to develop and incorporate strategies that aim at changing the institutional culture, detecting failures and preventing errors, with the implementation of measures to improve the quality of the processes carried out. (Sartor et al., 2016).

The principle of the existence of defined guidelines and recommendations in health policies alone does not guarantee the expected results; it is also necessary to use monitoring and systematic evaluation tools to establish safety practices in daily care. (Serra et al., 2016).

In recent years, there has been a complete development of global policies and strategies in countries with different levels of development, implemented by the World Health Organization. Thus, the strategic option of security was included in the agendas of institutions, organizations and health systems as a priority. However, in studies, assessment of improvement is achieved by collecting data from medical records through a retrospective cohort design. It is necessary to seek a way to meet the aspirations of professionals regarding adequate methods of conduction and improve the quality of care provided through the control and prevention of adverse events, aiming to achieve a better assessment of the quality of care. (Silva et al., 2016).

Thus, showing that safety in health care requires decision-making and training, in addition to the commitment and dedication of all, that is, managers, professionals and patients. Managers, with the responsibility of providing dimensioning and development of professionals, with the appropriate adequacy of material resources, equipment and the use of evidence based on scientific, for decision making. Health professionals need to adopt and maintain an attitude of responsibility for the safety of patients and families, for their own safety and that of colleagues. And as for patients and family members, it is necessary to encourage greater involvement in decision-making about the actions developed for their care, since they have a privileged position of observation of almost all stages of their care and need to be involved in their care. Above all, if we look at patients as a top priority, involving attentive and committed professionals with care, we will enter a virtuous circle, where everyone will only gain. Errors, failures, adverse events can occur at any time, but if we are attentive, these can be avoided. Patient safety is a commitment of everyone involved in their care. (Ronnau, 2018).

CONCLUSION

With the review presented, we understand that analyzing the patient safety situation is a fundamental step for health institutions that seek excellence and this way, impact on the quality of care offered. Thus, it stands out as an area of global relevance that, among other

objectives, seeks to develop a culture of safety in hospitals and safe care practices.

However, simple and effective strategies can prevent and reduce risks and damages in health services, such as the development of specific protocols, actions that serve as a safety barrier and permanent education in hospitals. Understanding the risks, the characteristics of care and the hospital structure can provide important elements for improving care.

Finally, it is expected that new studies will be encouraged so that the topic Patient Safety is continuously researched and disseminated in the academic and social environment. In view of this, investigations with different methodological approaches are suggested, such as analytical studies, focusing on the impact of managerial action in favor of the establishment of safety measures and, also, related to safety indicators, inherent to the work of the team.

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