

Nursing and the Research on Patient Safety

In recent decades, concern about safety in patient care has become one of the priority issues in health, reflecting the search and development of scientific evidence.

The subject had a great impact in the United States of America in the late 1990s, then reached countries like Canada, Spain, UK, Australia and Latin America: Brazil, Peru, Argentina and Colombia, from the publication of the report "To err is human" by the Institute of Medicine of the United States⁽¹⁾.

In 2002, in the wake of international impact, the World Health Organization (WHO) established a working group to evaluate, systematically, the patient safety in health care and defined in 2005, the program called World Alliance for Patient Safety, that proposed rules and strategies to encourage and promote, in different countries, practices that would ensure the patient safety and set the development research based on scientific evidence with best practice focused on patient safety. Today the term used by WHO is Patient Safety Program.

In Brazil, the end of the 1990s and the early years of the 2000s found a favorable environment for the incorporation of actions about patient safety in health care and hence the development of scientific investigations.

One of these actions was the creation by the Ministry of Health in 1999, of the National Health Surveillance Agency (ANVISA) with the mission to protect and promote health, ensuring the health safety of products and services. Within the ANVISA need to obtain information regarding the performance of health products used in Brazil, it established the Brazilian Network of Sentinel Hospitals. This network service is intended to notify adverse events and technical defects of health products, blood and blood products, materials and medical and hospital equipment. Among the actions that Network Sentinel hospitals should implement was the figure of the risk manager, appointed by the board of the hospital to act as a liaison with ANVISA and that had an important role in national initiatives on patient safety in institutions, although this was not the original purpose.

Another interesting initiative for the development of actions aimed at patient safety was the creation of multidisciplinary committees in the health institutions to articulate and coordinate programs and prevention activities of adverse events, called the Quality Committees or Committee of Pharmacy and Therapeutics or Patient Safety Committee⁽²⁾. Some private hospitals led this initiative and influenced, with their successful experiences, public hospitals. These committees were created for the purpose of promoting a culture hospital focused on patient safety through planning, development, control and evaluation of care processes. These committees when established are generally linked to higher management institution and many are led by nurses.

In 2005, the Office of Human Resources for Health of the Pan American Health Organization created the International Network for Nursing and Patient Safety in Concepcion, Chile, in order to track trends and priorities in nursing development in the area of Patient Safety, to discuss cooperation and information exchange between countries and needs strengthening nursing care from scientific evidence.

The Brazilian Network for Nursing and Patient Safety-REBRAENSP, created in May 2008 was the strategy adopted by groups of nurses to develop coordination and cooperation between health institutions and education with the goal to strengthen nursing care safely and with quality. It is a successful and exemplary social movement in Brazilian nursing that recognizes their role in health care, in searching for cooperation, partnership and change.

The work of this Network was broadcasted through its poles, state and local whose role is to promote the concepts of patient safety from WHO and other institutions, encourage the creation

and participation of nurses on patient safety committees and establish, in the workplace, attitudes and initiatives with scientific basis, to reduce risks and ensure patient safety, recognizing that risks are inherent in any work process.

Currently, the Pan American Health Organization works to the quality guideline of care and patient safety with the following lines of action: place the theme as a priority sector grounded on scientific evidence and economic analysis; promote community participation by facilitating information and knowledge for patients and families, generate information and evidence through evaluation studies and research and develop, adapt and support quality solutions developing them, compiling and disseminating in models and quality tools.

And what is the future of research on patient safety?

The most current studies on the issue and international research funds has early on the need for researchers to develop projects that propose, test and evaluate the various approaches to simulation. The simulation, in health care, is a training technique that places individuals and teams in realistic clinical challenges through the use of mannequins, virtual reality and other forms of training that would allow participants to experience, in real time, the consequences of their actions and decisions.

I consider that this topic, not only from the perspective of human resources education in health, but allied to the purposes of improving the quality of care, as a recent and important action and direction that research in patient safety should take in the coming years.

REFERENCES

1. Kohn L, Corrigan J, Donaldson M, editors. *To Err Is Human: Building a Safer Health System*. Washington (DC): National Academies Press; 2001.
2. Cassiani SHB, editor. *Hospitais e Medicamentos: impacto na segurança do paciente*. Sao Paulo (SP): Yendis Editora; 2010.

Silvia Helena De Bortoli Cassiani

PhD, Full Professor at the Nursing School in Ribeirão Preto, Universidade de São Paulo - EERP-USP, Ribeirão Preto (SP), Brasil