

NURSING PERFORMANCE IN STRENGTHENING PATIENT SAFETY IN NEONATOLOGY

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Patient safety is understood as a strategy to reduce, to the bare minimum, the risk of unnecessary damage related to health care. The discussion on initiatives to promote safety and quality in health care worldwide has been fostered after the publication of the American report *To the human being: building the health care system*, in the year 2000, pointing out that, worldwide, millions of people suffer injuries and deaths from health practices⁽¹⁻²⁾.

Regarding patient safety in neonatology units, this discussion becomes essential, since children are more susceptible to incidents due to their particularities and vulnerabilities⁽³⁾. In this setting, where newborns are often exposed to long periods of hospitalization, numerous interventions by different professionals, excessive manipulation, invasive procedures, complex technologies and equipment are all factors that can contribute to the safety breakdown. Adverse events may be understood as an event or circumstance that could have resulted in, or resulted in, unnecessary harm to the patient⁽⁴⁾. A study carried out in a neonatal unit of a Brazilian hospital showed that of the 218 infants admitted in a five-month period, 183 (84%) suffered adverse events, corresponding to a rate of 2.6 adverse events for each patient during an average hospitalization period of 13.5 days⁽⁵⁾.

The main adverse events in neonatology refer to errors with medications and patient identification, lack of communication among health staff, infections from health services and use of devices in health care. A study found that the predominant adverse events found, in addition to those mentioned above, were cutaneous lesions, problems with the use of mechanical ventilation and vascular catheters, and the ones that cause the most damage are associated with health care-related infections (IRAS)⁽⁶⁾.

In this context, as a mediator between the nursing staff, health professionals and the family, the nurse has an important role in understanding the problems and needs of the newborn and his/her family, as well as in the articulation with the health team to carry out a plan care for the newborn and their families⁽⁷⁾.

Because nursing is involved in many work processes in neonatology and because it is in close proximity to the neonate and its family, becomes a key element for patient safety. Among the various nursing activities, in this context, the emphasis is on encouraging the involvement of parents or caregivers in the neonate care, becoming critical and active partners throughout the care process; systematization and promotion of secure communication between professionals and also with the family; implementation of

interventions and decision-making based on protocols, derived from scientific evidence, use of Bundles to prevent injuries; the use of validated instruments as a checklist to guide nursing care, as well as strengthening the safety culture among professionals, can lead to important contributions to safety and to the prevention of adverse events.

Finally, it is emphasized that nursing performance, unrelated to the multiprofessional staff, does not guarantee patient safety in neonatology. It is necessary that all the professionals and managers of the service are engaged in the discussion and planning of the work processes in search of the neonatal patient safety. In addition, it is necessary to monitor and evaluate indicators of processes and results in order to guide other actions and strategies that lead to safety.

REFERENCES

1. Runciman W, Hibbert P, Thomson R, Van Der Schaaf T, Sherman H, Lewalle P. Towards an international classification for patient safety: key concepts and terms. *Int J Qual Health Care*. 2009; 21(1):18-26.
2. Kohn LY, Corrigan JM, Donaldson MS, Committee on quality of health care in America. *To err is human: building a safer health system*. Washington DC (US): National Academy Press; 2000.
3. American Academy of Pediatrics. Policy statement: principles of pediatric patient safety-reducing harm due to medical care. *Pediatrics*. 2011 Jun;127(6):1199- 210. Available in: <http://pediatrics.aappublications.org/content/127/6/1199>
4. Martins M. Qualidade do cuidado em saúde. In: Bridi AC, Grilo AM, Uva AS, Alves A, Teles A, Tavares A, et al. *Segurança do paciente: conhecendo os riscos nas organizações de saúde*. Rio de Janeiro (RJ): Editora Fiocruz e EAD/ENSP; 2014. p. 25-38.
5. Ventura CMU, Alves JGB, Meneses JDA. Eventos adversos em unidade de terapia intensiva neonatal. *Rev Bras Enferm*. 2012; 65(1):49-55. Available in: <http://www.scielo.br/pdf/reben/v65n1/07.pdf>
6. Lanzillotti LS, Seta MH, Andrade CLT, Junior WVM. Eventos adversos e outros incidentes na unidade de terapia intensiva neonatal. *Ciênc. Saúde Coletiva*. 2015; 20(3):937-946. Available in: http://www.scielo.br/pdf/csc/v20n3/pt_1413-8123-csc-20-03-00937.pdf
7. Sousa Fernanda Coura Pena de, Montenegro Livia Cozer, Goveia Vania Regina, Corrêa Allana dos Reis, Rocha Patrícia Kuerten, Manzo Bruna Figueiredo. A Participação da família na segurança do paciente em Unidades neonatais na perspectiva do enfermeiro. *Texto contexto - enferm*. [Internet]. 2017 [cited 2018 Sep 21]; 26(3): e1180016. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0104-07072017000300314&lng=en. Epub Aug 17, 2017. <http://dx.doi.org/10.1590/0104-07072017001180016>

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