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Patient Safety Culture in a maternity

Cultura de segurança do paciente em uma maternidade

Cultura de seguridad del paciente en una maternidad

Roselaine dos Santos Félix[I], Nadiesca Taisa Filippin[II]

Abstract: Objective: assess the culture of patient safety from the perspective of a multiprofessional maternity team. **Method:** transversal, quantitative study, through the questionnaire *Hospital Survey on Patient Safety Culture*. 62 professionals from a hospital in Rio Grande do Sul participated. The data was analyzed by descriptive statistics. **Results:** the team did not identify areas of positive force; two dimensions were neutral, organizational learning and continuous improvement (59,5%); expectation and supervisor action (51,1%). The ten remaining showed potential to improve, being that non-punitive responses to errors (15,5%) and support from management (29,6%) obtained the lowest scores. The majority of professionals did not relate events in twelve months (80,6%) and assessed the degree of patient safety as regular (59,7%). **Conclusion:** the maternity has a culture of patient safety that is vulnerable, punitive, with weak adherence to notifications, requiring greater initiatives and support from management for essential changes to reach better results.

Descriptors: Organizational culture; Safety management; Maternity; Health organizations; Patient safety

Resumo: Objetivo: avaliar a cultura de segurança do paciente na perspectiva da equipe multiprofissional da maternidade. **Método:** estudo transversal, quantitativo, através do questionário *Hospital Survey on Patient Safety Culture*. Participaram 62 profissionais de um hospital do Rio Grande do Sul. Os dados foram analisados mediante estatística descritiva. **Resultados:** a equipe não identificou área de força positiva; duas dimensões foram neutras, aprendizado organizacional e melhoria contínua (59,5%); expectativa e ações dos supervisores (51,1%). As dez restantes apresentaram potencial para melhorar, sendo que respostas não punitivas aos erros (15,5%) e apoio da gestão (29,6%) obtiveram as menores pontuações. A maioria dos profissionais não relataram eventos em 12 meses (80,6%) e avaliaram o grau de segurança do paciente como regular (59,7%). **Conclusão:** a maternidade possui uma cultura de segurança do paciente vulnerável, punitiva, com fraca adesão as notificações, requerendo maiores iniciativas e apoio da gestão as mudanças imprescindíveis ao alcance de melhores resultados.

Descritores: Cultura organizacional; Gestão da segurança; Maternidades; Organizações em saúde; Segurança do paciente

[I] Nurse. Master in Maternal-Infantile Health. Universidade Franciscana. Santa Maria, RS, Brasil. E-mail: rsstfx@ yahoo.com.br ORCID: https://orcid.org/0000-0003-3130-6929

[II] Physiotherapist. Doctor in physiotherapy. Professor of the Physiotherapy Undergraduate Course and the Masters Professional Course in Maternal-Infantile Health. Universidade Franciscana. Santa Maria, RS, Brasil. E-mail: nadifilippin@yahoo.com.br ORCID: https://orcid.org/0000-0003-3140-2486

Resumen: **Objetivo:** evaluar la cultura de seguridad del paciente en la perspectiva del equipo multiprofesional de la maternidad. **Método:** estudio transversal, cuantitativo, por medio del cuestionario Hospital Survey on Patient Safety Culture. Participaron 62 profesionales de uno hospital del Rio Grande del Sur. Los datos fueron analizados mediante estadística descriptiva. **Resultados:** el equipo no identifico área de fuerza positiva; dos dimensiones fueron neutras, aprendizaje organizacional y mejoramiento contínuo (59,5%), expectativa y acciones de los supervisores (51,1%). Las diez restantes presentan potencial para mejorar, siendo que respuestas no punitivas de los errores (15,5%) y apoyo de la gestión (29,6%) obtuvieron las mejores puntuaciones. La mayoría de los profesionales no relataron eventos em 12 meses (80,6%) y evaluaron el grado de seguridad del paciente como regular (59,7%). **Conclusión:** la maternidad posee una cultura de seguridad del paciente vulnerable, punitiva, con débil adhesión a las notificaciones, requiriendo mayores iniciativas y apoyo de gestión a los cambios imprescindibles a el alcance de mejores resultados.
Descriptores: Cultura organizacional; Administración de la Seguridad; Maternidades; Organizaciones en salud; Seguridad del paciente

Introduction

The concern with patient safety (PS) consolidates itself each year as essential to offering safe health services and inextricable from a organizational culture which aims at the strengthening of propositions developed in the institution in favor of better results. Theses objectives will be reached incentivizing best practices, promoting organizational learning, implementing the necessary changes, commiting management and teams to the intended actions, targeting quality of assistance.[1] The topics mobilize many collaborators in virtue of their magnitude, greater complexity of care, research results, success in forming networks, all engaged in the reduction of assistance risks, and dissemination and sedimentation of the patient safety culture (PSC).[1-2]

In this sense, the national strategies consulted met the global ones to promote, guarantee and reach the acceptable minimum of incidents that expose patients in health organizations.[3] The promotion of PSC stands out, agreeing with the attitudes, values, competences, individual and group behavior patterns which identify the commitment to safety from management.[1] The refered PSC, after being understood and it's essence incorporated by all, encourages the notification and the solution of problems based on system flaws, by means of a non-punitive model that promotes organizational learning via the analysis and correction of processes,

centered on the patient and, in an interprofessional assistance, collaborative and interdependent.[1,3]

In the perspective of the maternal-infantile area, direct or indirectly, good influences took place such as the reduction of flaws in the access, cover, quality and continuity of assistance, availability of materials, human resources needed, trained team, among others. As example, there were the goals of the millenium that instigated countries to (re) formulate their policies and programs to reach targets, among them, assistance improvements to women's health, influencing the reduction of casualties, many in consequence of said flaws. The implemented practices possibilitated advancements in attention to health with consequent reduction of maternal death rates, which can be observed in the tendencies report from the World Health Organization (WHO) that showed numbers in decline between the years of 2000 and 2017, respectively from 451 thousand maternal deaths to 295 thousand, with the Latin-American region and Caribean having gone from 11 thousand to 7.700 casualties.[4]

It is known that actions were taken to improve this landscape, but others will need to take effect since these deaths may represent only the tip of the iceberg, being indispensable for knowing the real magnitude of the problem. Among the possibilities there is the decrease in assistance inequality, whether by general and/or specific interventions such as not depreciating health; the existence of different acting models for maternities; the effectuation of practices based in evidence; the organization, implementation and revision of manuals and protocols, the continuous team training with up-to-date methodologies, the reduction of assistance vacuums that contribute to the overcrowding of services, shared decision-making, the instrumentalization of managers, the analysis of work processes, risk management, knowledge and dissemination of PSC,[1] among others. Alas, the implementation and maintenance of quality standards of services need to promote safe maternity as one of the priorities of health in the world.[5]

Besides that, opportune identification of unfavorable factors, for example, preexisting clinical conditions and/or obstetric diseases of current pregnancy are fundamental to distinguish a pregnancy of standard risk from one of high risk, alerting and subsidizing the team for the decision-making. In view of the uniqueness of this moment when expectations and experiences may diverge, a lack of attention may have repercussion in quality of life for women, children and relatives. Beyond still, there may also occur sudden shifts to the pregnancy-postnatal period with the necessity of access to an ample network of well structured professionals and services; which often ends up exposing fragilities of the institutions.[3,5]

To minimize these exposures and reach better results, adequations will be needed starting from the transformation of the work environment, process analysis, adequate and up-to-date interventions, changes in behavior, training of teams, overcoming barriers and frustrations.[3,5-6] Furthermore, economical, environmental and epidemiologic crises impact the limitation of financial, material and human resources, challenging managers and service providers to better plan their budgets without compromising the quality of assistance.[6] Finally, health organizations can implement improvements aiming to promote PS with significative decrease of undesirable events.[1,3]

In face of this, it is necessary to know the existing PSC since it configures relevant strategies in knowing the situational diagnosis, identifying areas that need greater efforts, mantaining the focus on the quality of care, benefiting patients and the entire team.[1,3,7] In view of 583 incidents related to child birth and postnatal depression that happened during 2015 in Brazil, and over a thousand notifications involving newborns in health institutions,[7] their fragility and relevance is displayed. For that reason, the assessment in a specific sector is planned and, in dealing with maternity, provides relevant information for managers to improve maternal-infantile assistance using updated protocols, periodic trainings, notification systems and event monitoring, among others. This way questioning: what is the current culture of

patient safety like in the maternity? With that, this research aimed to assess the culture of patient safety from the perspective of the multiprofessional maternity team.

Methodology

It involves a discriptive, exploratory, transversal study, through quantitative analysis, developed in the maternity of a teaching hospital, with reference to a high complexity service provided by the universal healthcare system, to a population of over 1,2 million habitants of the macroregion, located in Rio Grande do Sul (RS), Brazil. The hospital provides 403 beds, 31 of which belong to the refered unit for the care of pregnant and postnatal patients. Besides, the hospital has the Sector of Health and PS Vigilance of which the Group for Patient Safety (GPS) is a part of. The assistance given in the maternity comes from a multiprofessional team, constituted by auxiliaries and technicians of nursing, nurses, physiotherapists, obstetry and pediatry physicians, psychologists, social assistants, multiprofessional residents of obstetry and pediatry.

The multiprofessional team was composed of 76 professionals, of male and female gender. Out of these, 62 participated in the study. The criteria of inclusion were: professionals who have direct activities with patients, who have exerted their function for at least four weeks in their given sector (due to the adaptation period of new servers and residents); with at least six hours per week (since there are split shifts); including admissions by entrance examination, hired staff and residents of the first year of obstetry, pediatry and multiprofessional. Professionals excluded were the ones on sick leave of any nature, maternity leave; on vacation, on call and residents with shifts in another sector. The sample calculation was done, from which, considering a certainty level of 95% (Z=1,96) and a maximum margin of error of 5%, the sample number of 59 participants was obtained.

The invite to voluntary participation happened during the work hours. Following the verbal acceptance, the professionals were briefed on the objective of the research, reading

requirements and signing of two copies of the Informed Consent Form (ICF), as well as recieving instructions to fill the questionnaire and turn it in at the end of the shift. There was a sample loss of six professionals due to them not handing in the instrument to the researcher, and the remaining did not fit the inclusion criteria. There were no refusals to participating in the research.

The collection of data occured in the period between May and June of 2016, via the self-applicable instrument *Hospital Survey on Patient Safety Culture* (HSOPSC), validated for the brazilian version.[8] It shows the sociodemographic data of PSC based on 12 dimensions: management support, teamwork among hospital units; internal transferences and call turnover; expectations and actions from supervisors/managers; organizational learning and continuous improvement; teamwork in the unit; openness to communication; feedback and communication regarding errors; general perception of patient safety; frequency of related events and, two other variables regarding the degree of PS and number os events communicated in the last 12 months.

The answers characterize values atributed in a *Likert* scale of five points, with degrees of agreement, neutral or disagreement and, of frequency. The positive answers corresponded to the options agree, agree completely, almost always and always; the neutral don't agree nor disagree and sometimes; the negatives disagree, disagree completely, never and rarely. In relation to reverse questions (formulated with negative statements), these were codified inversely before the analysis.

The data from the HSOPSC questionnaire were transcribed to a spreadsheet using the software *Excel® for Windows®* with posterior exporting to *International Business Machines* (IBM) *Statistical Package for the Social Sciences* (SPSS), version 22.0. The sociodemographic data were analyzed via relative and absolute frequencies, while the rest of it was via relative frequencies of each dimension and in areas of positive forces (above 75%), neutral (between 50 and 75%) and the ones with potential for improvements for the PS (below 50%), for each category.

The chi-squared test was used to verify the association of the PS degree and the events notified with the professional categories. Considering a significance level $\alpha<0,05$. With the purpose of improving the interpretation, the data were categorized in two groups: nursing (nurses, technicians and auxiliaries in nursing); others (obstetry, pediatry and multiprofessional first year residents, obstetry and pediatry physicians, physiotherapist, social assistant, occupational therapist, psychologist) compounding in total, the team.

The research project followed the ethical precepts demanded in the Resolution 466/2012 of the National Health Council; acquired authorization from the Hospital's Teaching and Research Management in 30/03/2016; approval from the Franciscan University Human Research Ethics Committee with report number 1.506.961 in 19/04/2016.

Results

The sociodemographic profile of the team was predominantly characterised by the female sex (93,5%), belonging to the age band of 30 t0 39 years old (43,6%). Regarding the work data, nursing represented the highest professional quantitative (62,9%) and the team stood out for including post-graduates in its majority (58%), being young in the professional exercise (38,7%), in the work period in maternity (74,2%) and at the instituition (61,3%) considering the period of up to 5 years, besides exerting the weekly work load of up to 39 hours (67,8%), except the residents with 60 hours weekly. In the matter of sample loss, it approximated 8%, being higher among pediatry residents (67%).

In the dimensios of the HSOPSC no results were found with a frequency that identified areas of positive force (above 75%), only as neutral (50 to 75%) and with potential for improvement (below 50%). The Table 1 presents all the dimensions assessed in the eligible categories and for the multiprofessional team.

Table 1- Frequency of positive answers from Maternity professionals, in the 12 dimensions of the HSOPSC. RS, Brazil, 2016. (n=62)

Dimensions	Nursing n=39 %	Others* n=23 %	Total† n=62 %
Work Unit			
Expectations and actions of supervisors	57,1	45,1	51,1
Organizational learning and continuous improvement	56,8	62,3	59,5
Team work at the unit	39,5	55,4	47,5
Openness to communication	45,3	50,7	48,0
F*eedback*/Error communication	31,1	33,7	32,4
Personal	47,9	42,4	45,2
Non-Punitive Responses	14,7	16,2	15,5
Hospital Organization			
Management support	32,7	26,5	29,6
Team work between units	26,5	41,7	34,1
Transfers and call turnover	48,1	36,9	42,5
Result Variables			
Perception of patient safety	31,8	42,5	37,2
Frequency of related events	22,2	40,6	31,4

Source: research data, 2016. *Others: physiotherapist, social assistant, occupational therapist, obstetry, pediatry, psychologist and residents. †Results of the entire multiprofessional team

The multiprofessional maternity team did not show any area of positive force, but two dimensions charecterized as a neutral area (16,7%), corresponding to organizational learning and continuous improvement, expectations and actions of supervisors. The assessments with potential for improvements totalized ten, the lowest being related to the non-punitive responses with 15,5% and, support from management with 29,6%; characterizing that the majority of the dimensions has potential for improvements (83,3%).

Below, it is observed in Table 2 the percentages atributed to the classification of PS levels in the unit and the number of notifications filled in the last 12 months, in the category of nursing, other professionals and the multiprofessional team.

Table 2- Frequency of the degree of patient safety and events notified in the last 12 months in the maternity, according to HSOPSC. RS, Brazil, 2016. (n=62)

Assessments	Nursing n=39 %	Others* n=23 %	Total† n=62 %
Safety Degree			
Excellent	-	8,7	3,2
Very Good	33,3	39,1	35,5
Regular	64,1	52,2	59,7
Bad	2,6	-	1,6
Events notified in the last 12 months			
No notifications	76,8	86,9	80,6
From 1 to 2 notifications	10,3	8,7	9,7
From 3 to 5 notifications	10,3	-	6,5
From 6 to 10 notifications	-	-	-
From 11 to 20 notifications	2,6	-	1,6
Over 21 notifications	-	4,4	1,6

Source: research data, 2016. *Others: physiotherapist, social assistant, occupational therapist, obstetry, pediatry, psychologist and residents. †Results of the entire multiprofessional team

The classification of the PS degree that prevailed in the multiprofessional team was regular with almost 60%. Regarding the events related, around 80% of the professionals did not make any notifications. No significative associations were observed between the degree of PS and the events notified with the categories (p= 0,22 and p=0,30, respectively).

Discussion

The assessment of the multiprofessional team in regard to PSC in the maternity identified that all dimensions need improvement due to the absence of positive assessments. In the dimensions classified as neutral, there was an emphasis on organizational learning and continuous improvement in both categories, demonstrating that the team is sensible to the proposals. The majority show potential to improve, given that the most inferior results corresponded to non-punitive responses and management support.

About the organizational learning dimension, it relates to the efficacy of the implemented actions after the occurence of errors. Regarding this, it was inferred that the team identified the strategies used by the institution for the strengthening of organizational culture, implementing corrections in the noting of deviations, revising the work documents and processes, besides constructing manuals of unit management and amplifying the assistance and service protocols. Some national studies conducted in a Intensive Care Unit and in a large scale hospital, found inferior values,[9-10] but another conducted in China obtained expressive positive result,[11] noting there are more actions to be taken and that these need to be reassessed.

Still in the same area, the expectations and actions of supervisors/management dimension showed good evaluation, collaborating in the reciprocity between manager and health team, for the suggestions and questionings in favor of PS. It is worth noting that there were divergences among the categories, perhaps due to gaps in communication and not prioritizing the PS topic in their disscussions. In face of that, it is noticeable that there are possibilities to achieve more fruitful results via common objectives, information sharing, search for improvement, development of leadership and communication skills.[11] Regarding leadership, there is the need for it to mobilize and incentivize the team permanently towards safer work processess.[9-10]

The remaining dimensions assessed by the team obtained results in the area with potential to improve. This way, the openness to communication can be understood as the freedom of the professionals to make questions and/or elucidate doubts with surrounding colleagues, independent from hierarchy, motivated to assure safe care and to identify flaws before they evolve into an accident. In this perspective, other strategies will need to be incentivized in the search for a horizontal, clarifying, concise and efficient communication to obtain more successful results.[11-12]

It is noted that team work in the unit, which relates to the cooperation between the professionals and the sufficient number of these for the safe care, presented itself with lower

numbers in the nursing category. It can be inferred that the little collaboration between team members may be related to factors such as communication problems, organizational structure, disagreements, resource scarcity, undervaluing the work of colleagues, lack of motivation, insecurity, individuality, lack of empathy. Aiming to improve this situation, the leaderships may utilize conflict management strategies to harmonize the team, promoting commitment and cooperation, giving opportunity to positive changes in personal and organizational aspects, with positive effects.[13]

In face of this, the diversity in results causes concern, however it serves as stimulus to the search for better indexes amog the categories. Therefore, institutionally, actions will need to be implemented for the professionals to develop collaborative practices that optimize individual skills, amplify knowledge and capacity of assistence, providing satisfactory team results.[14]

With regards to the personal dimension, this relates to the sufficient number of professionals for the safe care. The categories' result considered the insufficient quantitative of professionals, fact that can be confirmed, partly, with the fulfillment of several extra hours, becoming a factor that challenges PS.[9] Although, useful tools for professional dimensioning are available, following legislation, influencing positively the safe practices, given that their dismissal increases the risks for patients and professionals.[15]

Regarding the dimensions of internal transfers and call turnover, it relates to the little valorization of the information transmitted in two moments, be it during the transfer between assistence points, be it between the shifts of the unit. The results reflect the low quality of communication, having repercussions in risks due to the discontinuity of some care, having the need for specific training and protocols.[16] The development of checklists for the intersectorial transfers and the objective and relevant debriefing for the call turnover must be reflected upon by the team. Many studies[9-10,17-18] found similar results, showing concern with the passing of

information, requiring urgent interventions with the action of permanent education of the institution.[19]

Facing the general perception of PS, which involves the institutional work processes in the effective prevention of errors, this result is found to be low in all categories, corroborating other studies.[9-10,18,20-21] In light of the findings, strategies must be implemented, disseminated and disscussed with the professionals to favor the action of prevention to the occurence of errors, with responsibility, commitment in continued assistence and open communication, collaborating in the general PS perception.[18]

It can be ssen that the dimensions of team work among the units, feedbak/error communication, and frequency of related events got proximal results. These dimensions are respective to the collaboration of the sectors in offering safe care, to the information of incidents and return of implemented actions, and if errors identified before reaching the patient are conveyed. The low percentages found compromise the PSC, since they cover collective responsibility, interprofessional collaboration and communication, assessment of unsafe work processes, fundamental to the intended quality[9,18]

It is worth to highlight that the flaws in team work between units and in communication contribute to the fragmentation of service, the occurence of errors, as well as, resulting in barely satisfactory results.[18] Better results may be obtained by figuring out the activities in other units, building devolving flows of the executed actions, presenting reports in team meetings, using boards, as well as, stimulating the registry of intercurrences in the available systems in the institutions.

The dimensions of management support is related to the promotion of PS as priority by the hospital management and it is found to have a low evaluation score from the categories and maternity team. The result is found to be in conformity with other studies[9-10,18] that attributed little commitment from management. In light of these results, the hospital organizations need

to obtain greater support from managers to the questions of PS, recognizing the value and learning about the subject, stimulating and prioritizing strategies that promote PSC in the institution.[20-21]

It is remarked that the dimensions of non-punitive responses to errors, when these are conveyed by the professionals, was the branch that received the worst evaluation. The result is disconcerting since these professionals exert their activities in the front lines and represent one of the last stands to avoid errors. Both national[9,18,22] and internacional[12,17,23] studies found low numbers, but an asian study found this dimension in a neutral area.[11] The realization of this punitive landscape discourages the notification of errors and does not provide relevant information, hindering the analysis of the causes, obstructing or delaying the implementation of strategies to avoid new flaws, compromising the PS in the institution.

Referring to the variable of related events, an absence was noted in the filing of reports by over 80% of the multiprofessional team. Similar results were found in other hospitals, suggesting a frail, punitive culture with low resolution due to lack of knowledge about the situations.[10,17-18] The notification of incidents needs to be encouraged, since systemic flaws exist and need to be monitored, discussed within the team, possibilitating a situational diagnosis and promoting a change of paradigm from the punitive culture to one of learning from mistakes.[7, 18]

Through the analysis of this variable by categories, nursing stood out a little in notifications, which can be attributed to factors such as access to collaborators, greater permanence in the unit and in the service of care. However, the medical professionals did not file notifications (datum not shown), troubling fact, since in this group there are the ones who define diagnosis, treatments, prescribe medications or perform surgery. Concerning this, there are data from the National Sanitary Surveillance Agency (ANVISA) in the Bulletin of PS, in which almost 30 thousand incidents occured in the assistence phase of providing care involving diagnosis mistakes, assessment, treatment or surgical intervention, signaling the small adherence from the professionals to the related instances.[7]

In association to the data of related events and of non-punitive responses to errors, it can be inferred that among professionals prevails a culture of not reporting so there won't be punishment. The results mentioned above show the existence of underreporting in the maternity, agreeing with the reports presented by ANVISA, that over 50% of brazilian health institutions did not constitute their GPS and, from the existent ones, 33% sent notifications in 2015.[7] Such findings are alarming given that institutions need to know and be aware of their shortcomings to correct them and thus improve their work processes.

With regards to the PS quality in the maternity, the regular classification prevailed, indicating that the professionals are aware of the situation and sensible to expanding their knowledge with the purpose of collaborating with essential advancements for the quality of the offered assistance.[15,18,20] Beyond that, managers and leaders must commit themselves to create favorable conditions for the development of safe practices in the institution, with transparency and responsibility to benefit the perception of PS.

Conclusion

The results found did not identify areas of positive force from the perspective of the maternity's multiprofessional team, indicating that all dimensions have potential to improve. It is concluded with the knowledge produced, a vulnerability in the PSC: the persistency of a punitive aspect, with weak adherence to the notifications, with the non-prioritization of PS. There is a need for more effort, initiatives and commitment from managers and professionals in the assessed dimensions, with emphasis on non-punitive responses to errors and support from management given the low scores shown. Organizational learning and continuous improvement, and expectations and actions from supervisors signal that the team can evolve to more fruitful results through analysis and specific interventions.

The organizational changes are of urgent character, essential for reaching better results, prioritizing the subject, sudsidizing discussions, transforming the assistance environment into a collaborative one, qualified, humanized, commited and resolute in favor of a safe maternity, throught putting PSC into effect. Furthermore, the results may be useful for planning action, optimizing them, improving management and the quality of service as well as for the commitment of all, aiming to increase PS in the institution.

It is cited among the limitations, the inexistence of previous studies with use of this questionnaire in the maternity, the punctuality of the query, the lack of concomitant analyses, which hindered the comparisons. However, it is believed that its data will sudsidize managerial instances for future decisions in favor of strengthening PSC. Other studies are suggested, associating the methodological approaches, amplifying the knowledge about the strengths and barriers to the promotion of PS in the maternity.

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Correspondent Author

Roselaine dos Santos Félix
E-mail: rsstfx@yahoo.com.br
Address: Agrimensor João Alves dos Santos Street, 165, Camobi, Santa Maria, RS, Brazil.
CEP: 97110-833

Authorial Contribution

1 – Roselaine dos Santos Félix
Project concept and construction; data collection, analysis and interpretation, article writing, critical subject review and approval of final version to be published.

2 – Nadiesca Taisa Filippin
Project concept and orientation; data analysis and interpretation, article writing, critical subject review and approval of final version to be published.

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