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RESEARCH

PERCEPTION OF NURSING REGARDING CHALLENGES AND STRATEGIES IN THE CONTEXT OF PEDIATRIC PATIENT SAFETY

PERCEPÇÃO DA ENFERMAGEM QUANTO AOS DESAFIOS E ESTRATÉGIAS NO CONTEXTO DA SEGURANÇA DO PACIENTE PEDIÁTRICO

PERCEPCIÓN DE ENFERMERÍA SOBRE LOS RETOS Y ESTRATEGIAS EN EL CONTEXTO DE SEGURIDAD DEL PACIENTE PEDIÁTRICO

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ABSTRACT

Objective: to understand the perception of the Nursing team regarding the challenges and strategies experienced in relation to pediatric patient safety. Methods: qualitative, exploratory study, conducted with 16 Nursing professionals who work in a pediatric intensive care unit of a public hospital in Minas Gerais, Brazil. Data were collected through semi-structured interviews and submitted to thematic analysis, using symbolic interactionism as a theoretical framework. Results: the findings were divided into two categories: "challenges experienced by the Nursing team to achieve patient safety" and "strategies used to ensure patient safety". The perception of the Nursing team encompasses aspects that range from the lack of alignment in relation to the knowledge on the subject of patient safety to the difficulty in recognizing the risks, problems in the notification of the adverse event, work overload and lack of routine in the service. However, it was observed that the professionals made propositions and recognized the need to invest in relevant strategies to improve patient safety that have not been implemented so far. Conclusion: the challenges experienced need to be evaluated by professionals and managers in search of planning and execution of more effective strategies in the search for improving the safety of pediatric patients, which includes investment in training professionals and encouraging the involvement of family members.

Keywords: Patient Safety; Intensive Care Units, Pediatric; Child, Hospitalized; Nursing, Team; Pediatric Nursing.

RESUMO

Objetivo: compreender a percepção da equipe de Enfermagem quanto aos desafios e estratégias vivenciados em relação à segurança do paciente pediátrico. Métodos: estudo qualitativo, exploratório, realizado com 16 profissionais de Enfermagem que atuam em uma unidade de terapia intensiva pediátrica de um hospital público de Minas Gerais, Brasil. Os dados foram coletados por meio entrevistas semiestruturadas e submetidos à análise temática, utilizando interacionismo simbólico como referencial teórico. Resultados: os achados foram divididos em duas categorias: "desafios vivenciados pela equipe de Enfermagem para o alcance da segurança do paciente" e "estratégias utilizadas para garantia da segurança do paciente". A percepção da equipe de Enfermagem abrange aspectos que perpassam desde a falta de alinhamento em relação ao conhecimento sobre a temática da segurança do paciente até a dificuldade em reconhecer os riscos, problemas na notificação do evento adverso, sobrecarga de trabalho e falta de rotina no serviço. Observou-

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se, porém, que os profissionais fizeram proposições e reconheceram a necessidade de investimento em estratégias relevantes para o aprimoramento da segurança do paciente que até o momento não foram efetivadas. Conclusão: os desafios vivenciados precisam ser avaliados pelos profissionais e gestores em busca de planejamento e execução de estratégias mais efetivas na busca de melhoria da segurança dos pacientes pediátricos, o que inclui o investimento na capacitação de profissionais e estímulo ao envolvimento de familiares.

Palavras-chave: Segurança do Paciente; Unidades de Terapia Intensiva Pediátrica; Criança Hospitalizada; Equipe de Enfermagem; Enfermagem Pediátrica.

RESUMEN

Objetivo: comprender la percepción del personal de enfermería sobre los desafíos y estrategias relacionados con la seguridad del paciente pediátrico. Métodos: estudio exploratorio cualitativollevado a cabo con 16 profesionales de enfermería de cuidados intensivos pediátricos de un hospital público de Minas Gerais, Brasil. La recogida de datos se realizómediante entrevistas semiestructuradas;para el análisis de los datos se utilizó el análisis temático; el interaccionismo simbólico se utilizó como marco teórico. Resultados: los resultados se dividieron en dos categorías: "desafíos delpersonal de enfermería para la seguridad del paciente" y "estrategias para garantizar la seguridad del paciente". La percepción del personal de enfermería engloba aspectos desde la ausencia de consenso en relación al conocimiento sobre el tema seguridad del paciente hasta la dificultad para reconocer los riesgos, problemas en la notificación del evento adverso, sobrecarga de trabajo y falta de rutina en los servicios. Sin embargo, se observó que el personal presentó propuestas yreconoció la necesidad de invertir en estrategias relevantes para mejorar la seguridad del paciente, medidas no implementadas hasta ahora. Conclusión: los retos deben ser evaluados por profesionales y gestores con miras a la planificación y ejecución de estrategias más efectivas para la seguridad del paciente pediátrico, concapacitación de profesionales y estímulo a la participación de los familiares.

Palabras clave: Seguridad del Paciente; Unidades de Cuidado Intensivo Pediátrico; Niño Hospitalizado; Grupo de Enfermería; Enfermería Pediátrica.

INTRODUCTION

In 2000, the report "To Erris Human: Buidilng a Safer Health Care System" was published, revealing that patients are exposed to risks that can interfere with their safety, resulting in mistakes and damage to health. Then, this report started a worldwide movement in search of patient safety.[1,2]

Patient safety is a topic that has been systematically addressed by the Brazilian National Health Surveillance Agency (Agência Nacional de Vigilância Sanitária - ANVISA) since 2004, having been reinforced with the publication of the guidelines established in the National Patient Safety Program (Programa Nacional de Segurança do Paciente - PNSP) in 2013.[2] The PNSP aims to cooperate for the quality of health care in all health services, through a set of preventive measures and reduction of the occurrence of incidents in health services.[2]

Some strategies were adopted worldwide to improve the health services safety scenario, such as the implementation of Ordinance Nr. 529, which deepened the discussions on the topic in the country, as well as the Resolution of the Directors' Collegiate (RDC) Nr. 36 of the ANVISA, which instituted specific guidelines and actions for the quality of health services and promotion of patient safety.[3,4]

Also noteworthy is the creation of the Brazilian Network of Nursing and Patient Safety (Rede Brasileira de Enfermagem e Segurança do Paciente-REBRAENSP) in 2008 as a strategy for binding, cooperation and synergy between people and institutions concerned with the joint improvement of health care, management, research, information and patient safety education.[5]

Patient safety is understood as a strategy that aims to reduce to an acceptable minimum the risk of unnecessary harm related to health care. In this sense, adverse events are defined as undesirable complications resulting from the care provided to the patient, not attributed to the natural evolution of the disease.[2]

Currently, avoiding adverse events (AEs) is one of the biggest challenges for improving safety in health care.[6] Internationally, the frequency of these events has provoked discussions due to their impact on morbidity and mortality rates, prolongation of hospital stay and rising health care costs.[6] National studies showed a prevalence of 20 to 46% of AEs in hospitalized patients.[7,8] An American study showed that among 3,790 records, reviewers identified 414 AEs (19.1 AEs per 1,000 patient-days) and 210 preventable AEs (9.5 AEs per 1,000 patient-days). On average, teaching hospitals had higher AE rates when compared to other hospitals.[7]

Patient safety has been a concern in health care in several areas and especially in pediatric intensive care units (PICU).[7,8] The critically ill child demands a series of interventions necessary to maintain their clinical conditions. This increased exposure associated with specificities related to the lower body surface, body composition and systemic immaturity of organs and tissues makes this group

susceptible to increasing the chances of suffering some type of adverse event.[6,7]

A study that sought to profile the notifications that occurred in the pediatric unit of a public university hospital in the south of the country, identified 40 notifications in the year, 32% of which were mild, 55% moderate, 5% severe and 8%, due to factors not related to assistance. As for the type of incidents, the data showed that most of them (40%) were associated with medications, followed by allergies caused by wristbands and risk of falls (22%).[9]A retrospective study carried out in pediatric intensive care units in the United States analyzed 3,790 records, of which 414 AEs (19.1 AEs per 1,000 patient-days) and 210 preventable AEs (9.5 AEs per 1,000 patient-days) were identified.[10]

Despite advances in patient safety, the mistake usually involves health professionals, especially the Nursing team, for performing most of the care actions and for being involved in long-term care practices, therefore being more exposed.[7,11] In this context, the performance of the Nursing team is fundamental for the identification of risk situations, and may contribute to the reduction of adverse events through the planning and execution of safe practices.[11]

Several authors address the safety of pediatric patients, especially with regard to the prevention of adverse events[7,11], however, there are few studies that discuss the challenges and strategies experienced by Nursing teams in the context of Pediatrics. In view of the above, the following question arose: what is the Nursing team's understanding of the challenges and strategies experienced in relation to pediatric patient safety?

Our findings may be an opportunity to unveil the Nursing team's practice scenario with regard to patient safety in the Pediatric setting, in search of elements that support discussions and guide the plan and the implementation of effective and safe actions regarding care pediatric patient. The Nursing team is in a unique position, since it has the capacity to develop and implement simple and effective strategies by following specific protocols, associated with the use of safety barriers and permanent education.[11]

Given the risks that permeate pediatric patient care in the PICU, as well as the opportunity for the Nursing team to actively participate in patient safety, this research aimed to understand the perceptions of the Nursing team regarding the challenges and strategies experienced in relation to the pediatric patient safety.

METHOD

This is a qualitative, exploratory, and descriptive study, aimed at understanding the meaning that the subject attributes to the objective of the study, which in this case was patient safety. Thus, it was based on the theoretical methodological framework symbolic interactionism, since meanings are instituted in the daily lives of social authors because of the interaction between them and through actions, symbols and words that convey meaning to those involved.[12]

This research was developed at the PICU of a general public teaching and research hospital located in Minas Gerais, Brazil, a state reference in child health care and which offers care via the Unified Health System. Several actions aimed at improving patient safety have been developed in the study unit, in order to offer support in the construction and monitoring of projects on patient safety and risk management.

The unit has 10 beds and has a Nursing team composed of six nurses and 20 Nursing technicians. The PICU serves critically ill children, aged between zero and 14 years, with clinical and surgical diagnoses and has a monthly occupation that varies between 80 and 90%.

Data collection was carried out through individual interviews using a semi-structured script and were conducted by one of the researchers from August to September 2018. All professionals were invited to participate in the research in person. Those who signaled acceptance participated in the interview in a reserved space at the participant's place and time of work after signing the Informed Consent Form (ICF).

The research was carried out with 16 collaborators of the Nursing team, six nurses and 10 Nursing technicians who provided direct assistance to children and their families and who had been in the service for more than three months. Regarding Nursing technicians, those who were on vacation or leave were excluded. All nurses agreed to participate in the research after being invited by the researcher.

The interview script was composed of four questions: how do you perceive patient safety in this service? How do you perceive the involvement of professionals and managers in relation to patient safety? What are the challenges and strategies for patient safety experienced by the staff of this service? Report a situation you have witnessed that exemplifies the team's actions in search of patient safety. The interviews were recorded and later transcribed in full. To maintain anonymity, the fragments of each professional interviewed were encoded by the letters E (Nurse) or T (Nursing Technician), followed by a number to represent the order of participation, from 1 to 16.

Data collection was interrupted when the criteria for redundancy and repetition of responses were met[13] suspending the inclusion of new participants in the 16th

interview. It is noteworthy that there were no refusals by professionals to participate or a request to interrupt participation.

In the data analysis, the thematic content analysis technique proposed by Minayo[13] was adopted. The material was explored through in-depth reading and, subsequently, the treatment and interpretation of the results was carried out, which consisted of a moment of critical reflection of these in order to understand the perception of the participants, in addition to making interpretations and comparing them with other findings in the literature related to the patient safety framework.

The ethical precepts described in Resolution Nr. 466/2012 of the National Health Council were respected and the research was approved by the institution's Ethics and Research Committee under Opinion Report Nr. 1,363,357 and CAAE Nr. 42537115.5.0000.5129.

RESULTS

The study relied on the participation of 16 collaborators of the Nursing team, being 10 Nursing technicians and six nurses. All participants were female, aged from 28 to 54 years old. Of the 10 Nursing technicians, the professional training of two was a higher education Nursing course, despite working as a mid-level professional. Among nurses, four had specialization. Most of them were between five and ten years at the institution, all with statutory ties.

After data analysis, the recommendations of the qualitative approach were followed from the perspective of symbolic interactionism. The authors identified and interpreted the meanings attributed to patient safety from the perspective of the Nursing team.

Thus, these units of meaning originated the following categories: "challenges experienced by the Nursing team to achieve patient safety" and "strategies used to guarantee patient safety".

Challenges experienced by the Nursing team to achieve patient safety

Through the interviews, it was perceived that one of the great challenges faced by the Nursing team was the lack of alignment in relation to the knowledge on the topic of patient safety, an aspect that can compromise the consolidation of the safety culture and the operationalization of safecare. It is observed that this meaning can occur due to an institution that does not have a consolidated safety culture among professionals, which influences the investment in safe practice, as mentioned by one participant.

> [...] It is anything we do to avoid adverse events (T5).

> [...] We do everything to avoid the adverse event (E2).

> [...] It is about taking good care of the patient and not making mistakes (T6).

> [...] Not everyone here is sure what comprehends patient safety and what should be done. Perhaps the institution does not invest much in this (E3).

> [...] A large part of the team does not care about safety goals; they may not even know about them (E4).

Among the significant aspects for patient safety is the professionals' recognition of the importance of seeking knowledge and understanding the relevance of the team's social interaction in search of comprehensive care based on safe practices. Furthermore, the participants emphasized the difficulty in ensuring patient safety during care, since the possibility of mistake is constant. They also expressed the importance of strengthening the safety culture to achieve safer practices.

> [...] It is difficult to maintain 100% attention, everyone makes a mistake at a certain moment, when one least expects it (T3).

> [...] We need to work together, as a team to warn each other of the mistake. The safety culture needs to be strong among us. Everyone needs to understand about safety (E1).

> [...] When we seek more knowledge, we discuss cases and evaluate ourselves, this brings information that is helpful to patient safety (E3).

The team also exposed the difficulty in identifying risk situations that predispose to the occurrence of the adverse event, the ways of preventing mistakes and showed doubt regarding the recognition of the adverse event.

> [...] The mistake can sometimes be missed by the team at the appropriate moment. When the event is not identified, it is difficult to act (E3).

> [...] There are mistakes that occur that we do not even know about. We also need to think about risk prevention and recognition (T7).

The professionals reported problems regarding the execution of multiple working hours, lack of routine or protocol, work overload and excessive tiredness, aspects that, in their perception, can be obstacles for the team to maintain the barriers of protection against the occurrence of adverse events.

> [...] Work overload and the excessive workload lead us making more mistakes (T7).

> [...] The mistake can come from lack of attention, work overload, lack of routine (E4).

Institutional difficulties were also cited as challenges, such as: reduced number of Nursing professionals, lack of dialogue between managers and professionals, lack of care planning and fragility in permanent education, elements clearly described in the literature as determinants for the prevention of adverse events.

> [...] Lack of staff, lack of training for everyone, lack of experience (E1).

> [...] A work schedule of insufficient of people, lack of team training, all of these can lead to adverse events (T5).

> [...] I notice that managers do not talk or discuss enough with the professionals. They need to be closer to us (E4).

> [...] training does not always achieve a goal that we want. I think they need to change (E5).

The longer length of stay of the patient in the unit was mentioned as a major risk factor for the occurrence of adverse events and, consequently, a breach of safety, since usually in the sector, the team memorizes care and prescription, failing to check it, before carrying out the assistance activity.

> [...] Longer patient time in the unit increases the chance of adverse events (E4).

> [...] We do the same thing so much and that when it changes, we do not realize it (T3).

Professionals also reinforced that the absence of a notification system for adverse events in the sector makes it difficult to identify the cause of the problem, compromises the adoption of actions to restructure the work process and makes it difficult to analyze the mistakes made. Thus, the team recognizes the symbology attributed to the punishment in finding the mistake and does not identify opportunities for improvement arising from the experience.

> [...] In the past, we even had a spreadsheet, where we marked adverse events, and then we gathered, discussed but not now (E4).

> [...] The adverse event book here in the sector ended up becoming another book to frame an employee. And not to solve a problem (T2).

As the mistake is still seen as punishment, some professionals said that they do not feel comfortable reporting the incidents, which results in the omission and concealment of adverse events among those involved.

> [...] It depends on my boss. If it is a manager who gives support to solve the problem and gives psychological support to the employee who is suffering from the adverse event, it will be worked in a way that helps us. Then, it is reported (T10).

> [...] But there are still some people in the team who cannot know that something wrong has happened (T5).

Strategies used to ensure patient safety

Respondents highlighted their beliefs about including structured methods for presenting and transferring patient information. According to them, this strategy provides elements for safe communication between professionals regarding the patient's situation and condition, especially during shift changes. However, they comment that this initiative is incipient and has not been consolidated so far.

> [...] Communicating well and systematically is the key to safety. It talks about how the patient is doing (E2).

> [...] We need to improve our communication, our shift change. This is very important to avoid mistakes. We are trying to use SBAR, I do not know if we are

> going to make it. Many are resistant and do not want to learn (T7).

The nurse was recognized by the Nursing technician as someone to whom he can communicate possible risk situations or obtain the resolution of possible problems. In addition, the nurse can be responsible for making team members reflect on the importance of recording, notification, and the need for commitment in the work process in search of patient safety.

> [...] I call a nurse and communicate immediately, as soon as I detect the possibility of this adverse event happening. He also helps us to notify and record (T1).

> [...] You approach the person, not in a posture to punish, but to guide, precisely so that he does not any other mistake. We should not see mistake as punishment, but as an opportunity to improve (E4).

> [...] I call a nurse to help me when I have doubts or problems (T5).

Nurses underlined the importance of improving the use of bed checklists that are being used in the unit as a strategy to achieve patient safety, in addition to the implementation of other protocols based on scientific evidence. But they emphasized that this practice has not been systematically performed by all professionals.

> [...] The checklist helps a lot about safety, it helps the team to remind of important things. Too bad it is not done by everyone (E5).

> [...] When the team follows the protocol based on evidence, it avoids mistakes and care is safer (E2).

The professionals emphasized the importance of the teaching process, even considering that in-service training and continuing education are strategies little practiced in the studied unit. They recognized that a well-trained employee may be able to identify early signs of complication, and their position in front of the team can collaborate in decision-making processes. The record of one of the interviewees demonstrated how their perception can influence the decision-making process and the quality of care provided.

> [...] A new device arrives; the team has to be trained (E8).

> [...] We really need training to seek safety and learn new things. A more qualified group generates more safety (E3).

> [...] I liked the experience of discussing patients' cases and trying to improve care (E5).

Respondents also mentioned positive meanings regarding the presence of the family, helping to detect mistakes and prevent the occurrence of adverse events. In the same direction, the participants understand that family participation can contribute to patient safety, as long as it is well oriented. One interviewee warned that the team does not feel prepared to act and include family members in the care.

> [...] A lot of people do not like the family, but I think it helps us to recognize mistakes before they happen. A mother has already warned me that the medication I was preparing was not the right one for that time (E5).

> [...] We need to incorporate parents in the search for safety. But we need to provide guidance (E2).

> [...] I do not feel qualified to help the father to contribute to safety (E7).

DISCUSSION

The findings on the knowledge of the Nursing team about patient safety confirm other studies that reveal superficial knowledge on the part of the health team, which can hinder the search for behavior change and the promotion of a culture of safety. The recognition of AEs and other occurrences can also be related to the culture, belief, and knowledge of professionals about the problem since some have difficulties in perceiving the mistake. It is observed that these meanings about patient safety result from concepts acquired by professionals during their career and that has not been explored in the institution.

This situation highlights the need to plan educational actions to train these professionals regarding the concept, monitoring and strategies to promote safety. Furthermore, it is suggested that, although the team states that it participates in training, these may not be effective, which implies the need to rethink other knowledge supply strategies. Clinical simulation appears as an important and innovative strategy that aims to consolidate and facilitate the teaching-learning process of professionals, improving the provision of health services, especially in intensive care

areas. Some effective risk assessment strategies for patients are to verify the readiness of the situation, implement new protocols, test new instruments, improve communication, and also learn new concepts or procedural skills.[14]

Permanent health education (PHE) experiences with service professionals, teachers and students can add value to safe care, while helping to incorporate changes into the work process. PHE initiatives based on problematizing practices based on learning articulated with the service environment, comprising action-reflection-action as a guide, are fundamental in learning and in work relationships. The main benefit of these practices in services is related to open dialogue in conversation circles, formed by discussion groups with positive statements regarding the commitment to work and strengthening the teaching-service integration, preparing the professional for the development of capacity critical, innovative and proactive stance.[15]

In this investigation, there was recognition of the difficulty in perceiving the mistake at the appropriate time. It is known that the analysis of the incident must take place from the moment it occurred, it is essential to analyze the risks to which children are exposed and to plan strategies to prevent recurrences of injuries.[6,7] Authors emphasize that Pediatric professionals should act as advocates for best practices and policies, with the aim of preventing the unique risks of children, identifying and supporting a safety culture, and leading efforts to eliminate preventable damage in any environment where care is provided to patients.[16] In addition, it is suggested that failure analysis should be part of the rounds' routines (multidisciplinary meetings), double checking and checklist as one of the foundations for the implementation of a safety system and continuous improvement.[17]

The scarcity of human and material resources and work overload were causes of mistakes cited by the Nursing team, corroborating other studies that mention that factors related to the lack of preparation of professionals, inadequate academic training and inattention contribute to the occurrence of mistakes. It is important to highlight that the worker is the subject of his/her own action and of his/her relationship with the environment, and must therefore seek the best working conditions.[7,8] It is in this context that the dimensioning of Nursing personnel, as well as the training of professionals, must be considered in the work process and, consequently, in the planning and safet-y of assistance.[18] It is highlighted that in order to develop safe health systems, it is necessary to include both professionals in the assistance area and those in management, in view of the need to everyone is responsible for patient safety.[16]

The longer time the patient stayed in the unit as a factor that increased the rate of adverse events was also expressed by the professionals. A study shows that adverse events were associated with an increase in the average length of stay in the intensive care unit, so that a long stay is associated with a reduction in the quality of care provided, which can result in complications for the patient.[9]

Furthermore, management must provide resources and the necessary structure to promote patient safety and consider it to be an element adjusted to the institution's financial and operational goals. Investing in building a culture of patient safety at the institution, despite initially appearing to be more expensive, has positive financial impacts, as it results in fewer complications, less hospital stay and better patient experience.[16] Authors point out that the process of change from institutional to safety culture stems from the need to invest in continuous and permanent education initiatives. In addition, it is essential to raise awareness and engage from top management to frontline employees in search of offering safe and quality care.[18]

Another issue addressed was the absence of a record of notification of adverse events. Through the Nursing records, professionals can recognize and notify the adverse event, adopting preventive measures, possible corrections, reduction and/or elimination of occurrences, following the development of the actions implemented to improve health practice.[6,7]

When a mistake is found, it is important to intervene to prevent possible associated complications. The communication of the mistake once identified, is an action reported in the literature. In the Nursing team, communicating the mistake to the nurse is one of the strategies adopted by Nursing technicians in the search for guidance and conduct. This attitude is relevant when showing that these professionals, through the testimonies, recognize the nurse as a professional who has technical and scientific ability to indicate solutions that will solve the problem.[16-20]

The literature mentions that the safety culture does not focus on individual failures, as adverse events within organizations that deal with high risk rarely have their process mistakes caused in individual behavior. Highly credible organizations recognize the variability of processes as a constant variable and are focused on minimizing this variability and its effects.[7,11,16-19]

The interviewees stressed that, depending on the boss, the mistake is not reported due to fear of punishment, which makes it possible to infer that this may be one of the reasons for underreporting in this unit. Thus, the results indicate the need to develop a culture of safety among the

Nursing team in the pediatric scenario so that the adverse event, as well founded in the literature, is seen as a learning opportunity, to improve the work processes together, to systematize decision-making in the face of an event and to ensure the quality of the assistance offered.[7,8,11,16]

Effective communication was valued by the interviewees and accentuated by other authors who identified that clear, structured language and the use of different communication techniques are essential for patient safety.[16-19]

The strategy called SBAR (Situation, Background, Assessment, Recommendation) has also been cited in other research as a tactic that provides elements for communication between professionals about the patient's situation and allows them to anticipate the next actions in favor of quality and safety in care.[15] Furthermore, researchers suggest the technique read back in order to validate the information transmitted during the shift between work shifts in which the professional writes down the information received and repeats it to the person who transmitted it, in order to confirm that he understood it correctly.[20]

Related to these initiatives, the literature also presents structured communication protocols, such as briefing (before) and debriefings (after) the execution of certain procedures, actions, or case discussions.[21]

Another strategy reported was permanent health education, which encourages the sharing of knowledge and experiences in daily work. It is important to include the subject of patient safety through conversation circles, provoking health professionals to reflect on their practices and conduct, in addition to promoting more integration of the teams in favor of the hospitalized child.[20] It is noteworthy that the permanent education should be used as a managerial tool to improve professional performance, contributing to an effective and safe practice, becoming an instrument capable of enhancing communication and interpersonal relationships in Nursing work.[12,14]

An important aspect reported by the interviewees is the symbolism of the involvement of family members in the care of pediatric patients. When the caregiver understands the importance of the care provided, he/she becomes a partner in ensuring patient safety. Family members are usually receptive to receiving guidance and being included in the care of their children, placing themselves as barriers to the prevention of adverse events.[7,23,24]

The involvement of the patient and family in patient care requires a mix of changes in health care systems and the expectations of suppliers and consumers.[23] In addition to involving patients and family members in family-centered rounds at the units, many institutions are encouraging families reporting safety concerns to improve prevention and problem identification. The centralization of the patient and the family plays important roles in the safety culture, including the consideration of ethnic culture and language, as well as the level of health literacy.[23]

Literature suggests that there are several moments of hospitalization in which the family could assist in the early detection of incidents, such as the observation of medications taken, the signaling of possible allergies and the surveillance of the hand hygiene of professionals, becoming agents of infection control , as long as they are well oriented and informed.[7-11,19] In this sense, it is recommended, in addition to verbal guidance, the use of illustrated booklets aiding in the understanding of actions, in addition to the read back technique to validate the information transmitted to parents or caregivers.[20,21]

Still regarding the participation of caregivers and patients in the context of safety, there are important considerations, such as: the good relationship between caregivers, health professionals and children results in more satisfaction for those involved; double checking between patients/caregivers and professionals promotes more security; and properly guided patients and caregivers are promoters of their safety.[24]

The difficulty of some professionals in dealing with the family is reported in other studies, due to the resistance of the renunciation of care. However, this challenge is already being worked on in daily care, aiming at the insertion of the family member in the care of hospitalized children.[24] These authors also evidenced the need to improve verbal communication techniques and methodologies for the guidance and education of patients and family members.

There are some limitations of this study with regard to the lack of inclusion of other professionals from the multiprofessional team, as well as the fact that the research is restricted to the space of the experiences of the subjects involved. However, the study contributed to fill a gap in the literature regarding the challenges and strategies experienced by the Nursing team in relation to pediatric patient safety.

FINAL CONSIDERATIONS

The perception of the Nursing team about the challenges in the context of patient safety encompasses aspects that range from the lack of alignment in relation to the knowledge on the subject of patient safety to the difficulty in recognizing the risks, problems in the notification of the adverse event, work overload and lack of routine in the service. But even with so many challenges

experienced, the importance and the need for investment in relevant strategies for the improvement of patient safety were recognized, such as effective communication through SBAR, the incorporation of checklist and protocols based on scientific evidence, the demand through continuing education, the involvement of managers, engagement in promoting a culture of safety and the identification of possibilities for family involvement in care. It is noted that many strategies mentioned are still in the field of experimentation and have not been implemented as a change in practice.

Thus, the results reinforce the importance of raising awareness and providing elements to professionals and managers for discussion, planning and elaboration of effective strategies to promote safety. Thus, new research is needed to support and monitor these actions regarding the safety of hospitalized pediatric patients.

As a proposal for new investigations, evaluations in other Pediatric settings in public and private hospitals are recommended, as well as with the other professionals who make up the multidisciplinary team.

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