

PATIENT SAFETY IN OBSTETRICS

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ABSTRACT

Objective: To evaluate the importance of patient safety in the obstetric area based on scientific articles published in national and international databases. Methodology: This is an Integrative Literature Review, in which the MEDLINE, SCIELO, BDENF and LILACS databases were used. The inclusion criteria for the study were: scientific articles published in Portuguese, English, and Spanish, from July 2019 to July 2024, using the descriptors "Patient safety" and "Obstetrics". Scientific articles that were not available in full, duplicate articles in the databases, articles that did not answer the research question, master's dissertations, doctoral theses, editorials, and integrative reviews were excluded from the study. Results: Nine scientific articles published in the national and international reality were included in the Integrative Review. Most studies address the issue of the need to report, investigate and analyze adverse events that occur in obstetric care, in order to identify their causes and determinants, with a view to mitigating the risks to which women and newborns are exposed. In addition, patient guidance and effective communication between the multiprofessional health team are also crucial for promoting patient safety. Conclusions: Patient safety is paramount in the scenario of obstetric practice, considering that in the context of labor and birth it is essential to reduce adverse events and promote patient safety, in order to provide safe care to women and newborns, in addition to contributing to the reduction of maternal and neonatal mortality and morbidity. In this context, it is necessary to implement a fair safety culture in obstetrics services, with a non-punitive approach and a focus on improving care processes, seeking to promote safe, quality care based on scientific evidence.

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INTRODUCTION

Patient safety is defined by the World Health Organization as "a framework of organized activities that creates cultures, processes, procedures, behaviors, technologies, and environments in health that consistently and sustainably reduces risk, decreases the occurrence of preventable harm, makes errors less likely, and reduces the impact of harm when it occurs" (WHO, 2021).

Patient safety is a serious public health problem. The damage resulting from patient care has significant implications for morbidity, mortality, and quality of life, in addition to negatively affecting the image of both care institutions and health professionals (Prates *et al.*, 2019).

Approximately three million births occur per year in Brazil, which represents six million patients (women and newborns) in need of assistance. Due to the high number of patients, the potential for adverse events to occur during the care process is strong, and it is necessary that patient safety also reaches the maternal and child context, since within this area of care there is still a very serious adverse event: maternal mortality. Inadequate care provided during labor is a factor that is strongly associated with maternal mortality, as simple interventions could prevent this mortality rate (Pedroni *et al.*, 2020).

The promotion of women's safety is essential in obstetrics care units, due to the fact that each intervention can involve a double risk of maternal and fetal morbidity and mortality. Safety, particularly in maternity wards, can be influenced by organizational culture, teamwork, communication, non-punitive responses, and team perceptions of patient safety (Brás; Figueiredo, Ferreira, 2023).

To conduct the study, the following research question was elaborated: "What is the importance of patient safety in the obstetric area?".

Based on the findings presented, this study aims to evaluate the importance of patient safety in the obstetric area based on scientific articles published in national and international databases.

METHODOLOGY

This is an Integrative Literature Review. Due to its methodological approach, the integrative review allows the inclusion of diverse methods, which have the potential to play an important role in evidence-based practice in nursing. In addition, the integrative literature review has the ability to synthesize results on a given topic or issue in a clear and simple way, which favors the synthesis of the best scientific evidence available in the literature for application in professional practice (Dantas *et al.*, 2021).



In the present study, the MEDLINE, SCIELO, BDENF and LILACS databases were used. The inclusion criteria for the study were: scientific articles published in Portuguese, English, and Spanish, from July 2019 to July 2024, using the descriptors "Patient safety" and "Obstetrics". Scientific articles that were not available in full, duplicate articles in the databases, articles that did not answer the research question, master's dissertations, doctoral theses, editorials, and integrative reviews were excluded from the study.

RESULTS

Figure 1 presents the summary of the search for scientific articles carried out in the MEDLINE, SCIELO, BDENF and LILACS databases.

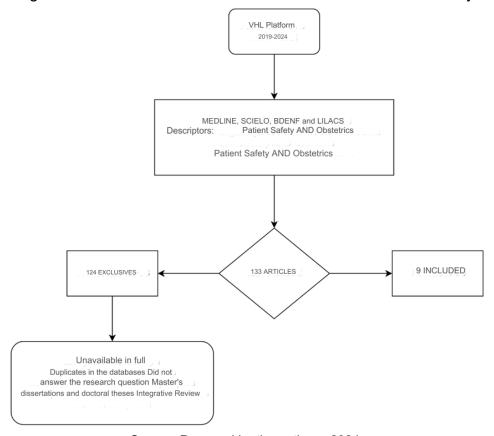


Figure 1 - Flowchart of the scientific articles included in the study.

Source: Prepared by the authors, 2024.

Table 1 shows the distribution of publications included in the integrative review according to authors, year of publication, journal, title of scientific articles and authors' conclusions.



Table 1 - Summary of the scientific articles included in the sample.

A		NEWSPARE	<i>t</i>	
AUTHORS	YEAR	NEWSPAPER	ARTICLE TITLE	CONCLUSIONS
Brás; Figueiredo; Ferreira.	2023	Text & Context Nursing	Safety culture in the clinical practice of nurse-midwives.	Communication between managers and nurses plays a fundamental role in patient safety, in order to avoid the occurrence of errors. Debating potential risks is a priority over responsibility in maternal and child care.
Hüner <i>et al</i> .	2023	BMC Pregnancy and Childbirth	Reducing preventable adverse events in obstetrics by improving interprofessional communication skills – Results of an intervention study.	The study shows that human error in the health area must be addressed constructively through the notification of adverse events. Preventable adverse events need to be treated more transparently to reduce the occurrence of harm to women and newborns.
Lúcio <i>et al.</i>	2023	Research Journal Care is Fundamental Online	Scientific production on quality and safety in obstetric care: a bibliometric study.	To offer respectful, woman- and neonate- centered care, it is essential to monitor risks and adverse events in order to promote safe obstetric care.
Silva <i>et al.</i>	2021	Latin American Journal of Nursing	Patient safety culture, omitted nursing care and its reasons in obstetrics.	The importance of the involvement of leaders in order to promote safe care based on lessons learned after notified events was evidenced. The greater the number of adverse event notifications is made, the better the rate of promotion of patient safety.
Carmo <i>et al.</i>	2020	Brazilian Journal of Nursing	Patient safety culture in hospital units of gynecology and obstetrics: a crosssectional study.	In the study, the frequency of reported adverse events was low, which may be related to the fact that many professionals have the perspective of a punitive safety culture.
Decesare et al.	2020	Journal of Patient Safety	Impact of an Obstetrical Hospitalist Program on the Safety Events in a Mid-Sized Obstetrical Unit.	The study brings the importance of encouraging the improvement of results in the obstetric area, with the increase in notifications of adverse events, based on a culture of constructive safety.
Pedroni <i>et al.</i>	2020	Gaucho Journal of Nursing	Patient safety culture in the maternal-child area of a university hospital.	The authors emphasize that it is important to promote meetings and training to reinforce the need for notification of adverse events, with emphasis on the non-punitive approach, which is essential for patient safety.
Lippke <i>et al.</i>	2019	BMC Health Services Research	Communication and patient safety in gynecology and obstetrics - study protocol of an intervention study.	Effective communication is essential to improve clinical outcomes and increase the safety and satisfaction of patients and healthcare professionals. Lack of proper communication can lead to burnout and unsafe caregiving.
Moraes et al.	2019	Cuidarte Enfermagem	Quality and safety in the area of maternal and child health: evaluation of adverse events.	The authors highlight that it is necessary to reinforce the importance of the culture of reporting adverse events, because through notifications it is possible to develop strategies to reduce errors.

Source: Prepared by the authors, 2024.



DISCUSSION

Based on the scientific articles included in the present study, it was predominantly observed that health institutions in the obstetric area adopt a non-punitive patient safety culture, which encourages the notification of adverse events and contributes to the improvement of care processes in the scenario of labor and birth. Most studies address the issue of the need to report, investigate and analyze adverse incidents/events that occur in obstetric care, in order to identify their causes and determinants, aiming to mitigate the risks to which women and newborns are exposed, especially when incidents with permanent damage occur, such as neonatal asphyxia and also adverse events involving maternal deaths, fetal and neonatal (Hüner et al., 2023, Lúcio et al., 2023, Silva et al., 2021, Carmo et al., 2020, Decesare et al., 2020, Pedroni et al., 2020, Moraes et al., 2019).

In addition, according to the available scientific evidence, incidents with the potential to cause harm to women and newborns should also receive attention and investigation, in order to prevent potential harm in obstetric care (Brás; Flowers; Ferreira, 2023).

Patient safety is cited in studies as an essential component for improving the quality of care, and it is essential to reduce unnecessary interventions in childbirth care, such as the indiscriminate use of oxytocin and episiotomy, in addition to reducing cesarean section rates, in view of the increased risk of obstetric and anesthetic complications associated with surgical delivery. Maternal mortality and morbidity, such as the occurrence of postpartum hemorrhage, surgical wound infection, headache associated with anesthetic techniques, among other complications, are potentially avoidable, based on care that prioritizes safety and is based on scientific evidence (Lúcio *et al.*, 2023, Silva *et al.*, 2021, Decesare *et al.*, 2020, Moraes *et al.*, 2019).

The studies included in the sample show that it is necessary to proactively assess risks, including obstetric risk due to previous pathologies of the patient or pathologies developed during pregnancy, such as hypertensive disorders, gestational diabetes mellitus, infectious diseases, hemorrhages, history of pregnancy losses or prematurity, in order to identify risks and possible complications related to pregnancy early, to labor and birth, aiming to institute measures to prevent and mitigate risks, considering that most adverse events that occur in obstetric care are preventable (Brás; Flowers; Ferreira, 2023, Pedroni *et al.*, 2020).



According to the studies in question, guidance by health professionals, especially nurses, has the potential to improve patient safety, as they are the professionals who are closest to the patients, identifying the needs of each pregnant or puerperal woman, as well as being able to act in the prevention of puerperal infection, severe perineal trauma, anesthetic complications, falls, failures related to medication administration, patient identification failures, and also to act in the conduct of a safe delivery and birth, following institutional protocols and the best scientific evidence available in the obstetric area (Brás; Flowers; Ferreira, 2023, Silva *et al.*, 2021, Pedroni et al., 2020).

In addition, communication was also cited as an essential component to improve obstetric and neonatal outcomes, and increase the safety and satisfaction of patients and health professionals. According to studies, the lack of adequate communication among the multidisciplinary team can lead to unsafe care (Brás; Flowers; Ferreira, 2023, Lippke *et al.*, 2019).

CONCLUSION

In view of the findings of the present study, it can be inferred that patient safety is paramount in the scenario of obstetric practice, considering that in the context of labor and birth it is essential to reduce adverse events and promote patient safety, in order to provide safe care to women and newborns, in addition to contributing to the reduction of maternal and neonatal mortality and morbidity.

In addition to these findings, it is necessary to implement a fair safety culture in obstetrics services, with a non-punitive approach and a focus on improving care processes, seeking to promote safe, quality care based on scientific evidence, which is essential in the context of labor and birth care.



REFERENCES

- Brás, C. P. C., Figueiredo, M. C. A. B., & Ferreira, M. M. C. (2023). Cultura de segurança na prática clínica dos enfermeiros obstetras. *Revista Texto & Contexto Enfermagem, 32*, e20220330. https://doi.org/10.1590/1980-265X-TCE-2022-0330pt
- Carmo, J. M. A., et al. (2020). Cultura de segurança do paciente em unidades hospitalares de ginecologia e obstetrícia: Estudo transversal. *Revista Brasileira de Enfermagem, 73*(5), 1-7. http://dx.doi.org/10.1590/0034-7167-2019-0576
- 3. Dantas, H. L. L., et al. (2021). Como elaborar uma revisão integrativa: Sistematização do método científico. *Revista Recien, 12*(37), 334-345. https://doi.org/10.24276/rrecien2022.12.37.334-345
- 4. Decesare, J. Z., et al. (2020). Impacto de um programa hospitalar obstétrico nos eventos de segurança em uma unidade obstétrica de médio porte. *Journal of Patient Safety, 16*(3), 179-181.
- Huner, B., et al. (2023). Redução de eventos adversos evitáveis em obstetrícia através da melhoria das habilidades de comunicação interprofissional – Resultados de um estudo de intervenção. *BMC Pregnancy and Childbirth, 23*(55), 1-13. https://doi.org/10.1186/s12884-022-05304-8
- 6. Lippke, S., et al. (2019). Comunicação e segurança do paciente em ginecologia e obstetrícia Protocolo de estudo de um estudo de intervenção. *BMC Health Services Research, 19*, 908. https://doi.org/10.1186/s12913-019-4579-y
- 7. Lúcio, P. S., et al. (2023). Produção científica sobre qualidade e segurança na assistência obstétrica: Estudo bibliométrico. *Revista de Pesquisa Cuidado é Fundamental, 15*, e12697. https://doi.org/10.9789/2175-5361.rpcfo.v15.12697
- 8. Moraes, A. I. S., et al. (2019). Qualidade e segurança na área da saúde materno-infantil: Avaliação de eventos adversos. *Cuidarte Enfermagem, 13*(1), 32-37. https://www.webfipa.net/facfipa/ner/sumarios/cuidarte/2019v1/32.pdf
- 9. Organização Mundial da Saúde (OMS). (2021). *Plano de ação global para a segurança do paciente 2021-2030: Em busca da eliminação dos danos evitáveis nos cuidados de saúde*. Genebra: Organização Mundial da Saúde. 96 p. https://www.gov.br/anvisa/pt-br/centraisdeconteudo/publicacoes/servicosdesaude/publicacoes/plano-de-acao-global-para-a-seguranca-do-paciente-2021-2030-traduzido-para-portugues/view
- Pedroni, V. S., et al. (2020). Cultura de segurança do paciente na área materno-infantil de hospital universitário. *Revista Gaúcha de Enfermagem, 41*(esp), e20190171. https://doi.org/10.1590/1983-1447.2020.20190171
- 11. Prates, C. G., et al. (2019). Núcleo de segurança do paciente: O caminho das pedras em um hospital geral. *Revista Gaúcha de Enfermagem, 40*(esp), e20180150. https://doi.org/10.1590/19831447.2019.20180150



12. Silva, S. C., et al. (2021). Cultura de segurança do paciente, cuidados de enfermagem omitidos e suas razões na obstetrícia. *Revista Latino-Americana de Enfermagem, 29*, e3461. https://doi.org/10.1590/1518-8345.4855.3461