Revista
Torreón Universitario
ISSN 2410-5708 / e-ISSN 2313-7215
Year 12 | No. 35 | October 2023- January 2024

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Safety in user care in Nicaraguan health units: a scientificethical commitment of the health professional

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Submitted on 21th March, 2023 / Accepted on 22 th September, 2023
https://doi.org/10.5377/rtu.v12i35.16996

Keywords: Commitment, Ethical, Professional, Health, Safety, User.

ABSTRACT

This paper reflects on patient safety during the care process demanded in the different health units. Some norms and protocols guarantee the quality of care in the services provided by health professionals. Public and private healthcare institutions are committed to guaranteeing the conditions for a safe, effective, efficient, and error-free process to be carried out. Likewise, healthcare professionals, from their training, have

a commitment that demands ethical and deontological principles, so they all have to comply with these standards that guarantee the safeguarding of the patient's health and life under the principle of non-maleficence. The World Health Organization, for its part, has strongly emphasized strategies that guarantee safety in user care designed in the different instruments for monitoring and evaluating health service indicators. These strategies are directed from structural and organizational aspects in the public health system, but also to human action; how health professionals can work as a team, to interact effectively in each context of action without losing sight of the fact that each one has a different responsibility in the care process. For this reason, it is affirmed that patient safety is not only the responsibility of the nursing staff, even though they are the ones who have a strong responsibility towards them.

INTRODUCTION

"Safety in patient care is not only a nursing responsibility".

Based on this statement, it is recognized that there are determinants and conditions in patient safety related to the processes during care, derived from their health care needs.

> The determinants and conditions of patient safety are linked to processes inherent to care, such as the organization of services and their capacity to provide an optimal quality of care, care for and protect users, anticipate harm and promote healthy environments, inclusive and free of threats to people's integrity (Cometto, et. al. 2011). In this sense, healthcare professionals are immersed in this complex environment where patient care, care safety, and patient satisfaction revolve, without detracting from the fact that each one has a strong responsibility in the process of caring for, protecting, recovering, and rehabilitating the health of those who have demanded care.

The World Health Organization states that ensuring good safety in user care requires "ensuring successful implementation of patient safety strategies, clear policies, leadership, data to drive safety improvements, skilled health professionals, and effective patient engagement" (WHO, 2019). Although the nursing staff is a health sector it has an important presence and a strong responsibility and is not the only professional figure in which patient safety falls, therefore, it is meritorious to recognize the multidisciplinarity that ensures such safe and effective care for the maintenance of the health of the population.

According to the Mexican Ministry of Health (2018), safety for the patient during health care processes is a priority. According to estimates, in Mexico, 2% of hospitalized patients die, and 8% suffer some harm, because of adverse events related to patient safety.

The regulation of the General Health Law (2003) in its chapter I, article 7, numeral 18 indicates that health service providers must guarantee the conditions for the proper safeguarding

of the user's health, this allows quality in the processes and results in health care and turns the satisfaction, credibility and trust in the health system.

The General Health Law (2002) in its Chapter I, on the competencies of the Ministry of Health, Article 8, numeral 28, states that in matters of prevention and control of diseases and accidents, without prejudice to the provisions of labor laws on occupational hazards, the Ministry of Health is responsible for issuing technical standards for the prevention of diseases and accidents. Section 14 states that the user must demand that the services provided for his/her health care comply with the quality standards accepted in the institutional and professional procedures and practices.

All human resources that provide direct or indirect services in the care of the user from the formative process have the responsibility to ensure the safety of the same, this differs from the idea that this corresponds to the exclusive care of nursing professionals.

DEVELOPMENT

Among the diversity of definitions of user safety, the following are mentioned:

A set of organized structures and/or processes that reduce the probability of adverse effects and resulting exposure to the health care system from diseases and procedures either as the reduction of risk or as the reduction of the risk of unnecessary harm associated with health care to a minimum (A. Muiño, et. Al 2009).

> Among the main parties involved in and responsible for the quality and safety of care, three fundamental areas stand out: the clinician, the educator, and the user receiving the care. The synergy between these three areas is considered the structural axis to guarantee user safety in health care, favorable for the quality of life of the vulnerable population (Moreno, 2013).

In the clinical area, human errors and system failures are included, among the former are mentioned in the procedural action process, such is the case in the application of incorrect techniques, communication problems, full confidence in the memoiristic aspects, lack of feedback and permanent study; system failures include work overload, long and mixed working hours, insufficient and inadequate material resources, high labor turnover of human resources fosters the lack of personal commitment related to institutional objectives.

Actions that help reduce the risks associated with healthcare.

> Health institutions should be equipped with all the essential elements (such as facilities, supplies, materials that ensure infection control), be available at national and institutional level, incorporate a system for reporting and surveillance of the risks or consequences of care that favor the monitoring of sentinel events and the existence of the minimum necessary material resources together with the implementation of hygienic sanitary habits during care

> and encourage the updating of knowledge and skills for the welfare of users (Cometto, M. et al. 2011).

An important aspect to take into account is the adequate teaching-learning process in the training and updating of knowledge of health professionals that favors the development of skills in risk prevention and quality of care, whose impact is measured in the quality and safety of the services offered to the population at different levels of care, increasing user demand.

The user receiving care also has intervening factors such as nutritional status, personal and family pathological and behavioral history, hygiene and health promotion habits, age, the severity of their underlying pathology, and a low level of awareness regarding their health and immune diseases, these factors are defined in the International Classification of Patient Safety (ICPS) Fernandez (2015) in (WHO, 2009). This classification allows international standardization of the monitoring of quality and patient safety actions within the routine processes of public and private health care and administration systems.

This tool (International Patient Safety Classification) highlights those aspects that should be observed, evaluated, and controlled employing continuous improvement strategies that favor the reduction of risks and damage to the health of users of health services of any kind.

International Classification of Patient Safety (ICPS)

The use of this classification is necessary because it allows for strengthening user safety in terms of risk prevention and harm to health through an international standardized ordering that recognizes that incidents and adverse events as the most visible part of patient insecurity, the content offers a set of categories, variables, and classifications oriented to a global understanding of the subject and its objective is to represent a continuous cycle of learning and improvement emphasizing the identification and reduction of risks, prevention, detection, incident recovery, and system evaluation, which appear at any time and any point within the framework and integrates ten classes or higher categories, also recognizing the diversity in the demand for health care, interculturality, population susceptibility, highlighting very particular factors such as: Contributing factors that potentiate patient insecurity, as mentioned by the (CISP).

> It refers to circumstances, actions, or influences that are believed to have played a role in the origin or development of an incident or that raise the risk of its occurrence, such as health personnel behavior, performance, or communication; system factors such as the work environment; and external factors beyond the control of the organization, such as the natural environment or legislative policies (...) (Fernandez, 2015).

Vlayen, A. et al (2015) in José Javier Vanegas (2014), mention the need to implement education strategies in the field of patient safety, as in the diligence of timely reporting, since

these do not adequately evidence for fear of institutional corrective measures. In other words, the (CISP) offers specific methods to detect an incident, such as the case of a sudden change in the patient's situation or through a monitor, an alarm, an audit, an examination or a risk assessment; being attentive to these changes is part of work ethics, deontological scientific knowledge, but above all it is a shared responsibility within the healthcare team: clinical staff (physicians, nurses, bioanalyst, nutritionist, pharmacist) and non-clinical (support staff: janitorial, wardrobe, security, assistants).

Patient safety is a shared responsibility.

When users attend a healthcare institution where professional multidisciplinarity converges, everyone is immersed in the process of their care, recovery, and rehabilitation, in this context (CISP) states that the repercussions for the organization are totally or partially attributable to an incident. They encompass direct consequences for the organization, such as increased resources allocated to patient care, media attention, or legal ramifications, as opposed to clinical or therapeutic consequences, which are considered outcomes for the patient (...) in this sense ethical precepts must remain in the critical sense of the actions of all those who carry with them the responsibility of providing health care.

The Consejo de Salubridad General (CSG) and the Dirección General de Calidad y Educación en Salud (2017), developed discussion tables to identify those aspects that should be followed by facilities that provide health care, for the benefit of the patient, emerging eight essential actions for patient safety, which apply to both inpatient and outpatient settings.

The eight actions and their general objectives are:

- ***Patient identification:*** Improving patient identification, allows to prevent errors that compromise the quality of care in the user.
- ***Effective Communication:*** Improve communication between health professionals, patients, and family members, to obtain correct, timely, and complete information during the care process and thus, reduce errors related to the issuance of verbal or telephone orders.
- ***Safety in the medication process:*** strengthen actions related to the storage, prescription, transcription, dispensing, and administration of medications, to prevent errors that could harm patients.
- ***Safety in procedures:*** Reinforce safety practices already internationally accepted and reduce adverse events to avoid the presence of sentinel events arising from surgical practice and high-risk procedures outside the operating room.

- ***Reducing the risk of Healthcare-Associated Infections (HAIs).*** Contribute to reducing HAIs, through the implementation of a comprehensive hand hygiene program during the care process.
- ***Reducing the risk of patient harm due to falls***. Prevent patient harm associated with falls in National Health System healthcare facilities by assessing and reducing the risk of falls.
- ***Recording and analysis of sentinel events, adverse events, and near misses.*** Generate information on near misses, adverse and sentinel events, through a recording tool that allows analysis and favors decision-making so that at the local level their occurrence is prevented.
- ***Patient safety culture.*** Measure the patient safety culture in the hospital setting, to favor decision-making to establish actions for continuous improvement of the safety climate in the hospitals of the National Health System.

Bioethics is a discipline that promotes human conduct to protect life.

The term bioethics is directly linked to patient safety, it promotes the principles of the most appropriate conduct concerning life, that is why the British Medical Association (BMA) elaborated the proposal of the Tavistock principles in 1997, directly focused on health care, specified as follows:

1. When it is necessary it is a right of the human being to receive health care, understanding the term of bioethics it has to be of quality and without risks.
2. The center of health care is the individual, but the health system must work to improve the health of the population.
3. The aims of the healthcare system are: to treat disease, alleviate suffering and disability, and promote health.
4. It is essential that those who work in the health system collaborate with each other, with patients, populations, and with other services or sectors.
5. Clinicians should promote the improvement of healthcare performance.
6. *Primum non nocere;* The Latin locution primum nil nocere or primum non nocere, which translates into English as 'first do no harm', corresponds to "a remnant of the distant past and probably originated with Hippocrates" It is a maxim applied today in the field of medicine, physiotherapy, nursing and health sciences (BMA, 1947).

Tavistock's principles in 1997 are related to the nursing code of ethics; CIE (2000), in that it establishes the standards of action based on values in the profession, delimits the competence of care in an environment of respect for human rights: values, customs, and spiritual beliefs, of the person, the family, and the community, and regulates the conduct of the nursing professional.

One of the elements that constitutes the framework of the standards of conduct regarding the nurse and practice, from the exercise and management of nursing practice should monitor and promote good individual and group health, but should also be strengthened in the field of teaching and research to strengthen the quality of care in patient safety.

The Nicaraguan Nurses Association (2008) established the code of ethics of the nursing profession, taken from the code of ethics to establish the standard of conduct oriented to professional performance. This code of ethics is also supported by the theory of the precursor of nursing Florence Nigthingale 1860 because her theory favors the quality of those who demand it and their safety.

Nursing and patient safety in the care process

> Nursing interventions are based on humanistic scientific principles that are specified in the code of ethics, in the application of knowledge but are also immersed in the code of ethics under the foundation of respect for life and human dignity, therefore, the challenge of nursing is to respond promptly to the needs of the patient, the challenge of nursing is to give timely response to the permanent changes generated by the transformation of paradigms in practice, research, and technical scientific training, from this perspective the scientific advancement of the profession is based on theories and models because they are aimed at the quality of patient care, thus ensuring health protection, maintenance and recovery of the same. (Urbina, 2011)

Urbina refers to Ernestina Wiedenbach's model because it is based on the art of nursing assistance, and requires extensive clinical and procedural knowledge, a deep understanding of human psychology, and a capacity for therapeutic communication with the patient or patient and family. Currently, it is a model whose guidelines are still in force in the training and performance of the nursing professional.

Nursing and patient safety in the health team.

Nursing in the health team develops a broad leadership as an agent of change, exercises specific functions of planning, direction, and control in the nursing care process, tests every moment its theoretical bases for safe and quality care, likewise, manages to develop a participatory leadership cohesive with health professionals through effective communication that allows them to develop strong interpersonal skills and teamwork skills for the proper functioning within the health team. (Garrido-Piosa, 2014) teamwork within health units is considered the cornerstone for the quality of services and satisfaction of demand.

Since its origins, the nursing profession has occupied a very important role in safety in patient care, highlighting the scientific and technical evidence in the practice of the profession; as such is expressed in this statement "For the professionals we provide, our care means that, if we do not progress every year, every month, every week, we are going backward". "No system that does not advance can endure" Florence Nightingale. (as cited in Suarez, 2022). Nursing care is considered an art because since its genesis it has faithfully complied with every detail in the field of action, with a high sense of empathy, respect, and safety, permanently updated in the light of science and technology, for this reason, nursing care cannot be imitated or empirical. Those who provide it are responsible for its guarantee and quality.

In the field of health care, the prevention and timely detection of harm is sought through the analysis of errors in the professional's actions and a culture of not fearing corrective measures, but rather a permanent practice of ethical and deontological principles.

CONCLUSIONS

All care is considered safe as long as it adheres to the quality standards that are expressions that allow clinical guidelines, which emerge from the evidence resulting from research. It should not be taken for granted that safety levels should be a function of clinical and administrative safety based on knowledge, experience, regulations, logistics, and infrastructure whose reengineering provides a real and tangible guarantee of care and protection of the user.

Making errors visible should not be limited to processes of punishment and stigmatization of a sector within the healthcare team; on the contrary, user safety is the responsibility of the multidisciplinary team.

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