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RESTRICTIVE FACTORS FOR PROMOTING CARE SAFETY IN PSYCHOSOCIAL CARE

FATORES RESTRITIVOS PARA A PROMOÇÃO DA SEGURANÇA DO CUIDADO NA ATENÇÃO PSICOSSOCIAL

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ABSTRACT: **Objective:** to analyze the restrictive factors for promoting care safety in Psychosocial Care Centers, from the professionals' perspective. **Method:** descriptive, exploratory study of a qualitative nature. Seventeen professionals from two Psychosocial Care Centers in the central region of Brazil participated. Data collection was performed through individual semi-structured online interviews. The data were subjected to thematic content analysis. **Results:** professionals' little knowledge about patient safety, ineffective guidance, discontinuity of monitoring of users and their families, low cognition of users to continue providing care, and the context of social vulnerability in which they live are challenges for the consolidation of care safety. **Final considerations:** the study allowed for a broader understanding of the factors that restrict the consolidation of care safety in the daily routine of community health services, which requires continuing health education to qualify professional practice.

KEYWORDS: Mental health care; Patient care team; Mental health; Patient safety; Community mental health services.

RESUMO: **Objetivo:** analisar os fatores restritivos para a promoção da segurança do cuidado em Centros de Atenção Psicossocial, na perspectiva dos profissionais. **Método:** estudo descritivo, exploratório de natureza qualitativa. Participaram 17 profissionais de dois Centros de Atenção Psicossocial da região central do Brasil. A coleta de dados foi realizada por meio de entrevista *on-line* individual semiestruturada. Os dados foram submetidos à análise de conteúdo temática. **Resultados:** pouco conhecimento dos profissionais sobre segurança do paciente, orientações ineficazes, descontinuidade do acompanhamento dos usuários e seus familiares, baixa cognição deles para darem continuidade nos cuidados, e o contexto de vulnerabilidade social que eles vivem são desafios para a consolidação da segurança do cuidado. **Conclusão:** o estudo permitiu ampliar a compreensão dos fatores que restringem a consolidação da segurança do cuidado no cotidiano dos serviços comunitários de saúde, requerendo educação permanente em saúde para a qualificação da prática profissional.

PALAVRAS-CHAVE: Assistência à saúde mental; Equipe de assistência ao paciente; Saúde mental; Segurança do paciente; Serviços comunitários de saúde mental.

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INTRODUCTION

The National Patient Safety Program (PNSP, in Portuguese) was created through Ordinance GM/MS No. 529 of 2013 to qualify healthcare throughout Brazil. Patient safety is one of the six attributes underpinning healthcare quality worldwide; it focuses on minimizing risks in the care context since healthcare-related incidents influence the significant increase in morbidity and mortality[1].

The PNSP's guidelines are linked to health promotion actions, as their implementation is related to the development of public policies that aim to transform behaviors that may be detrimental to health care. In addition, the PNSP encourages people's autonomy and involvement in consolidating an environment conducive to health and proposes reorganizing health services to prevent harm[2].

In the healthcare setting, risks are part of the work process and can harm users, leading to more extended hospital stays, permanent injuries, and, in some situations, death[3]. Faced with the need to develop patient safety, the view of healthcare has changed in recent times, strengthening studies and actions aimed at reducing harm and human error and preventing them[4].

A study that analyzed the concept of safe care using Walker and Avant's method showed that, across the 21 studies evaluated, the expression - safe care - refers to health care provided to the user in an appropriate and qualified manner, both in practical, technical, and social terms[5].

In this context, the audience, as healthcare professionals, researchers, and policymakers, play a pivotal role in promoting safe care. Identifying the barriers and factors that facilitate user involvement in care is a crucial step toward formulating strategies, policies, and programs that encourage active participation in their care[6].

The triad of family, user, and professional, when engaged in care, results in a better response to the therapeutic proposal and, at the same time, favors safety in care and a reduction in the risk of adverse events in psychosocial health[7]. Thus, for users and their families to successfully self-manage their health care, it is essential to have continuity of care in the territory, inside and outside health institutions, to develop their protagonism during treatment. As a result, safer practices will be adopted to reduce the occurrence of adverse events.

No cenário da saúde mental, os serviços voltados para essas demandas assistenciais estão organizados na Rede de Atenção Psicossocial (RAPS). Trata-se de vários serviços interligados e disponíveis nos territórios, direcionados a pessoas com transtornos mentais ou com problemas relacionados à drogadição[8], que devem prezar pela permanência, adesão e participação dos usuários no processo de reabilitação psicossocial e oferecer uma assistência segura.

In the mental health scenario, the services aimed at these care demands are organized in the Psychosocial Care Network (RAPS). These are a number of interconnected services available in the territories, aimed at people with mental disorders or drug addiction problems8, which must ensure the permanence, adherence and participation of users in the psychosocial rehabilitation process and offer safe care.

A study that discusses how the Psychosocial Care Network (RAPS) in Natal-RN is articulated, considering the recursiveness that is established between them and the characteristics of continuous care in the territory, pointed to the difficulty users have in understanding the meaning of matrix support and its importance in promoting continuity and consistency of care. Understanding these points contributes to fewer readmissions and increased use of other therapeutic spaces that go beyond the walls of mental health institutions[9].

In the context of psychosocial care, a study that sought to understand the factors that interfere with drug users' adherence to outpatient treatment showed that the family influences the continuity of

treatment. Factors that enhance adherence are family support, the user's desire to stop using the substance(s), the bond built with the health team, and ease of access to the service[10].

Although some professional categories recognize the importance of implementing safe care during their work, other employees who work in the service and assist the same user feel discouraged from adopting the same stance. Therefore, establishing a safety culture is essential for uniting users, their families, and the multi-professional team, each assuming their responsibilities so that successful treatment can be achieved[11].

A systematic literature review and meta-synthesis on patient safety related to mental health patients showed that research into patient safety in the mental health setting is still embryonic compared to other healthcare environments. In addition, the research revealed that the environments in which patients are hospitalized with mental health demands present specific risks for patient safety, requiring new studies and the development of policies aimed at this phenomenon[12].

An integrative literature review analyzing scientific production on patient safety in mental health showed the need to publish new studies to help qualify teams through continuing education processes, as 64% of the studies analyzed pointed to a lack of research[13].

Considering the above, users and their families are co-responsible for continuity of care. Factors that negatively interfere with this process are gaps in knowledge that need to be clarified. In this way, it will be possible to support the practice of health professionals, making it more intelligent for the development of users in the self-management of care, consequently guaranteeing therapeutic continuity and safety. Scientific evidence indicates that there is a shortage of studies on strategies to promote user involvement in safe care[14]. Therefore, this investigation analyzes the factors restricting care safety in Psychosocial Care Centers.

METHODOLOGY

This is a descriptive, exploratory, qualitative study. The study was conducted in two Psychosocial Care Centers (CAPS) in a municipality in the metropolitan region of Goiânia, located in central Brazil. One of them is classified as a Child and Adolescent Psychosocial Care Center (CAPSi) with a focus on mental health care for children and adolescents distressed/with cognitive disorders, with commercial opening hours; the other is characterized as a Type III Alcohol and Drug Psychosocial Care Center (CAPSad) aimed at caring for people over the age of 18 with problems related to drug addiction, operating 24 hours a day, including holidays and weekends. It is worth mentioning that the CAPS selected for the study were recommended by the mental health manager of the municipality where the research was carried out while getting to know the field.

Seventeen professionals participated in the study, six from CAPSi and 11 from CAPSad III, selected by non-probabilistic convenience sampling. Members of the multi-professional teams aged 18 or over who provided direct assistance to users and their families were included, and those on official leave from the service, such as licenses and vacations, were excluded.

Data was collected between June and August 2021 using an interview technique guided by a questionnaire with sociodemographic aspects such as age, gender, color, marital status, level of education, professional category, type of employment in the service, whether they had contact with the subject of patient safety during their training and whether they had participated in training on the subject after starting their career and an open question: what factors hinder user participation in the safety of care at CAPS?

A pilot test of the instrument was carried out with 11 CAPS professionals from another municipality to simulate the stages of the survey and check the suitability of the questions, which allowed adjustments to the instrument. After this stage, the field was approached virtually due to the COVID-19 pandemic.

The municipality's mental health coordinator was contacted through a virtual meeting. The research proposal was explained to check the field's availability and interest in participating in the research to obtain a letter of consent for the collection to begin. Once the professional had given her permission, meetings were scheduled at each CAPS with the managers and teams of the services to raise awareness of the need to participate in the research. At the end of the meeting, the Free and Informed Consent Form (FICF) was made available via a Google Forms link in the professionals' work group for virtual signature, along with a sociodemographic and occupational profile questionnaire, as well as a space to schedule possible dates for individual interviews.

The interviews were conducted one-to-one online via the Google Meet platform and recorded in video format. The average duration was twenty-five minutes, and the main researcher and a doctoral student in nursing conducted them. The researchers kept field diary notes on their perceptions of the participants, contributing to the data analysis process for inferences, interpretations, and discussion of the results.

The content resulting from the interviews was transcribed in full. The data was subjected to thematic content analysis according to the recommended stages[15]: 1. pre-analysis; 2. exploration of the material; and 3. treatment of the results: inference and interpretation. To begin with, the materials that would undergo the analytical process were selected: the interview transcripts, followed by a floating reading. The data was then coded by identifying the units of record and context, grouped by similarity to form the nuclei of meaning. Finally, the thematic category, *Restrictive factors for promoting safe care, was presented*.

The study was submitted to the Ethics Committee, CAAE no. 22469119.0.0000.5078, with an opinion no. 4.298.136. All participants signed the Free and Informed Consent Form (FICF) electronically, by the recommendations of Resolution 466 of 201216. To ensure confidentiality, each participant was identified by professional category, interview sequence number, and the types of CAPS to which they were affiliated.

RESULTS

The study involved 17 health professionals who provide direct care to users of the two CAPS, whose characteristics are shown in Table 1.

Table 1. Sociodemographic characteristics of the study participants. Aparecida de Goiânia, Goiás. Brazil, 2021. (N= 17).

Variables	N	(%)
Gender		
Female	15	88.2
Male	2	11.8
Age		
30 to 39 years old	6	35.0
40 to 49 years old	6	35.0
50 to 59 years old	2	12.0
60 to 69 years old	3	18.0
Professional category		
Psychologist	5	29.5
Nursing Technician	5	29.5
Nurse	3	17.6
Social worker	2	11.8
Pharmacist	1	5.9
Speech therapist	1	5.9
Patient safety addressed in the course		
No	10	58.8
Yes	7	41.2
Patient safety training		
Did not participate	8	41.7
Yes, outside the institution	7	41.2
Yes, within the institution	2	11.8

Source: The authors

The content analysis process emerged with the thematic category *Restrictive factors for the promotion of safe care,* which elucidates, from the professionals' point of view, the challenges to consolidating patient safety in community mental health services (Figure 1).

Figure 1 - Coding tree of the study categories.
Source: the authors. The coding tree was generated based on the participants' accounts.

During the interviews, it was possible to see that the participants had little knowledge of patient safety, especially the psychology professionals, as evidenced by the following reports:

> "(...) When you talk about patient safety, what does it cover?" (P4 - Psychologist - CAPSi)

> "(...) Are you asking about his [the patient's] safety as a person or in the sense that, within the treatment, he has some specific management?" (P17 - Psychologist - CAPS AD)

One professional mentioned ineffective guidance on care as a factor that undermines the safety of care because users attempt self-extermination by misusing the medication provided:

> "(...) Some patients come in and say: 'Come here, I took a lot of these, a handful of these pills, and I didn't die.' In other words, they tell us that they tried to kill themselves, you know? Unfortunately, it happens that we fail to guide them, and they attempt suicide, there are more difficult patients... The response to medication is very individual, and our reality there is complicated (...)." (P13 - Nurse - CAPS AD)

It emerged in one participant's statement that the low cognition of users and their families to continue their care outside the CAPS environment, especially regarding drug therapy, is a factor that interferes with the safety of the care provided to the user:

> "(...) When the user leaves, even with our guidance, I believe that they don't have family support; sometimes, even the cognitive abilities of the users and their families interfere. So it ends up becoming an often unsafe care, also related to the administration of medication." (P2 - Psychologist - CAPSi)

In the context of CAPSad, a collaborator mentioned that the social vulnerability of users who live on the streets and end up exposing themselves to various risks undermines the safety of care and hinders the complete success of treatment, as evidenced by the statement:

> "(...) This leaves a lot to be desired because most of them don't return to their homes. They go back to the street, and there they fall short... because they forget it's past time to take their medication. They usually come back here later with reports that they've been mugged and that their things have been taken, their medication. I mean, security in this respect is a gap." (P15 - Nursing Technician - CAPS AD)

One participant reported that an obstacle to promoting safe care in the CAPS context is the fact that users and their families move away from the services. This leads to discontinuity in monitoring these people, who can expose themselves to risky situations that are beyond the control of the CAPS team, as illustrated by the following statement:

> "(...) I think that there isn't that much continuity and that there is a lack of security. Even because, at a certain point, when the user is in the CAPS, and the family is too, we manage to have... it's not control, but we follow the process safely (...)." (P2 - Psychologist - CAPSi)

DISCUSSION

The most significant number of professionals working in CAPS had the following characteristics: female (88.2%), aged between 30 and 49 (70%), and trained as psychologists (29.5%) and nursing technicians (29.5%). In addition, (58.8%) of the study participants said that they had had no contact with patient safety during their training and, after working in mental health services (41.7%), had not taken part in any training on the subject. This data is reflected in the interviews with the teams.

The need for more knowledge of professionals working in psychosocial care on patient safety, especially members of the psychology team, is an obstacle to promoting safe care. If the collaborator has yet to learn safe practices, it will be difficult for them to take measures to minimize harm to users and their families. This highlights the importance of addressing this issue in multidisciplinary training courses for health professionals and corroborates the findings of another study in which CAPS professionals need to expand their knowledge of patient safety through educational processes[17].

An integrative literature review that analyzed knowledge about the care provided to people with mental disorders from a patient safety perspective pointed out that in this scenario, there is a greater risk of adverse events, episodes of violence, and difficulties for users to access services, requiring permanent health education for the teams[7]. This strategy provides them with theoretical and practical tools to consolidate a culture of safety in the services.

In addition, content about patient safety must be offered during the training period for the various professional categories working in community mental health services and about patient safety. This approach brings them closer to this subject, gives new meaning to mental health care, and emphasizes the importance of collaboration. A qualitative study that aimed to understand the perception of undergraduates at a higher education institution about the teaching of the patient safety theme, including courses in nursing, physiotherapy, biomedicine, nutrition, pharmacy, occupational therapy, and medicine, pointed to the need to sensitize teachers to the inclusion of this theme in the curricula, in addition to presenting the content through an interdisciplinary approach [18].

The discontinuity of care caused by users and their families leaving the CAPS was cited as a factor that makes it impossible to provide safe care. A qualitative study that focused on analyzing the therapeutic itineraries of users who abandoned treatment at type III Psychosocial Care Centers (CAPS), identifying the factors that led to the abandonment of care, and analyzing users' perceptions of the services and treatments offered revealed that about CAPS, discontinuity of care emerged recurrently. The leading causes of care abandonment were errors in the Singular Therapeutic Project (PTS, in Portuguese), lack of bonding and accountability, little importance given to the unwanted effects of medications, ineffective listening, and failures in referrals[19].

Unsuccessful guidance to users was a verbalized issue that hinders the promotion of safe care in psychosocial care, evidenced by the realization of attempts at self-extermination, according to one professional. A qualitative investigation that analyzed the perceptions of family members of users of a psychosocial care center for children and adolescents about the factors that facilitate and hinder communication with health professionals pointed out that the actions committed by the CAPS team that hinder assertive communication are the distant performance of professionals, scarce humanized car, and little guidance[20], which can negatively impact the resoluteness of mental health care.

Furthermore, the quality of communication in the context of health care is essential for achieving patient safety[21]. Evaluating communication between members of multi-professional health teams favors processes to improve this vital mechanism of work processes for safe care[22]. In addition, cultivating an organizational culture that employs successful communication tools directly influences the quality of care and patient safety[23]. It should be extended beyond the hospital environment to include community mental health services.

Users' and family members' low level of cognition to reproduce care outside the CAPS was another factor that was found to hinder safe care, especially the administration of medication. Quantitative research focused on describing the profile of CAPSad users and verifying how substance abuse can affect cognitive components and the execution of significant activities of these subjects pointed out that most users had low schooling and 93.3% had cognitive impairment, especially in language, vision, memory, and executive functions, affecting work, study and family relationships[24], which can extend to activities related to care and administration of medication to maintain care at home.

In this sense, despite the compromised cognition of some users and their family members, CAPS professionals must formulate creative strategies with these critical social actors that are aligned with the contexts and realities of life of each person assisted by the services to promote their willingness to engage in mental health care within the existing therapeutic possibilities. A literature review that aimed to review the international literature on the relationship between creativity and Subjective Well-Being revealed that stimulating creativity favors subjective well-being and thus enables the promotion of mental health[25].

One of the participants mentioned the social vulnerability of street users assisted by CAPS as a barrier to safe care. On the streets, they are exposed to theft and other types of violence that put their

physical integrity at risk, and they are unable to take their medication on time. A survey of 11 homeless people, which aimed to identify their perceptions of the barriers they face in accessing health services, revealed that living on the streets is marked by numerous difficulties such as cold weather, sleepless nights, lack of food, and risky situations. In addition, there is a sense of hopelessness about being able to transform their lives. In addition, conflicts with the family were the main reason for continuing to live on the streets[26].

In this sense, CAPS professionals must consider the context of users' lives to build a Singular Therapeutic Project that meets emerging needs, with actions linked to other services, such as the Street Clinics, to provide comprehensive care through the Expanded Clinic. However, barriers must be overcome if this approach between services is effective, as shown by an investigation carried out in three Street Clinics in the Central Region of Brazil. The investigation pointed out the difficulty of integration and communication between the health units investigated and the other services in the Health Care Network (RAS)[27].

Given the above, CAPS teams, managers, and training institutions must unite their efforts. This collaboration is essential to overcome the challenges that hinder patient safety in psychosocial care. It is not enough to place the responsibility solely on the users. The literature demonstrates that ineffective and inconsistent communication during health care obstructs users and their families from gaining autonomy and co-management in self-care[28].

As a practical implication, the findings of this research offer a comprehensive understanding of the factors that disrupt safer actions in mental health care. This understanding can guide the health team in redirecting the work process. By familiarizing themselves with these phenomena, managers, professionals, users, and family members can collaboratively build an organizational culture that aligns with the principles of the patient safety movement.

CONCLUSION

The study allowed us to broaden our understanding of the factors that restrict the consolidation of safe care in the daily routine of community mental health services, issues that are inherent to the professionals, such as little knowledge of patient safety and ineffective guidance techniques for users and their families, aspects related to the contexts of life of users and their families such as low adherence to treatment, generating discontinuity in the monitoring of therapeutic progress, low cognition that hinders the maintenance of care outside the CAPS and the context of social vulnerability in which they live that exposes them to risk situations. In addition, issues of organizational structure, such as the user needing to be under the direct care of professionals, were also highlighted as a challenge to safe care.

A limitation of the study is that it was carried out virtually due to the instability of the internet signal of some participants during the COVID-19 pandemic during the online interviews.

Studies are recommended that address other perspectives on the safety of care in community mental health services, such as users and their families. In addition, research that combines continuing health education processes to qualify the professional practice of service teams could contribute to promoting safer psychosocial care.

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